STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 000}	INITIAL COMMENTS	{A 000}		

This Statement of Deficiencies was generated as the result of a federal follow-up to the survey conducted January 7, 2019 through January 17, 2019. Two complaints were initiated on April 12, 2019 and finalized on June 14, 2019. This survey was conducted at your facility May 20, 2019 through June 14, 2019, in accordance with 42 Code of Federal Regulations (CFR) Part 482, Hospitals.

The facility failed to maintain condition level compliance with the following COP's:
§482.12 Condition of Participation: Governing Body
§482.13 Condition of Participation: Patient's Rights
§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program
§482.23 Condition of Participation: Nursing Services
§482.24 Condition of Participation: Medical Record Services

The census at the start of the survey was 112 patients. Ninety-four patient records were reviewed.

Two immediate jeopardy situations were identified.

On 06/05/19 at 6:25 PM, immediate jeopardy situation #1 was identified regarding two incidents of patients cheeking and/or hiding medications and giving medication to peers. The first incident involved a patient being discharged, that provided medication to another patient, who in turn hid the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 000}	Continued From page 1 medication in a Chapstick container. The second incident revealed a patient was cheeking medications and then spitting the medication into a cup. The patient then provided the medications to three peers. The second incident involved three of the same patients related to the first incident (See Tags A 0144, A 0145, A 0405). On 06/12/19 at 10:47 AM, immediate jeopardy situation #1 was abated. On 06/12/19 at 6:25 PM, immediate jeopardy situation #2 was identified regarding an incident that occurred on 06/04/19 at approximately 6:51 PM, involving, a patient setting off the sprinkler on the 300 Hall in a patient residential unit resulting in patients escaping the facility, and one patient not returning. On 06/05/19 at approximately 3:06 PM, a second incident occurred on the 400 Hall of the patient residential unit involving, a patient setting off the sprinkler, resulting in three patients escaping the facility. All three of these patients were recovered subsequent to this second incident (See Tag A 0145). On 06/12/19 at 10:47 AM, immediate jeopardy situation #2 was abated. Two complaints were investigated duing the survey. Complaint #NV00056772 was substantiated. Allegations included: the facility conducted inaccurate patient assessments (nursing) and treatment plans based on information provided by patients; there was one therapist covering the acute adolescent unit on 02/16/19 and on other days; there was repeated inappropriate sexual activity/contact between patients in the residential	{A 000}		

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{A 000}	Continued From page 2	{A 000}		

unit; there were inappropriate discharges of patients over the weekend; there were no discharge planners scheduled to cover the weekends; a patient fell and hit their head on the adult unit and was sent to the hospital. The patient that fell, died in the hospital due to a brain bleed. This complaint was substantiated (See Tags A 0145, A 0396, A 0438, A 0467).

The following allegations could not be substantiated.
Allegation #1: Patients in the residential unit had no assigned therapist for several weeks.

Allegation #2: Inappropriate sexual contact between patients in the residential unit.

Allegation #3: A patient discharged from the partial hospitalization program was found at home deceased as a result of taking 3200 milligrams of Seroquel after having a fight with his brother. The facility had knowledge of physical abuse by the mother's partner while the patient was in the residential program.

Allegation #4: A patient went on pass and returned with a broken arm, and there was no documentation of staff inquiring about the patient's broken arm. The patient created a comic strip of his life showing the abuse, staff were aware, and no one did anything.

Allegation #5: Inaccurate patient assessments (nursing) and treatment plans were conducted based on information provided by patients.

Allegation #6: There were no available therapists on the residential unit on 02/3/19. Calls were received from nursing informing that patients on

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{A 000}	Continued From page 3	{A 000}		

the residential unit were suicidal and/or homicidal and there was no staff to work with them. Therapists have not met with patients for greater than six weeks.

Allegation #7: There was no licensed therapist to complete two Sexually Restrictive Program (SRP) groups, on the residential unit.

Allegation #8: There were no qualified staff to complete SRP groups on 01/18/19 and 01/19/19.

Allegation #9: A patient tried to strangle self on 02/02/19.

Allegation #10: Staff talked trash to the patients.

Allegation #11: Social Services and therapy staff were told to just do the minimum. The Mental Health Technicians and Nurses run the floor.

Allegation #12: Staff witness inappropriateness and do not want to say anything for fear of retaliation.

The investigation into the allegations included:

Observation of patient grooming and physical appearance, interaction between staff and patients, staff treatment of patients, and a tour of the Adolescent Acute Unit, Residential Unit, Gero-Psychiatric Unit and the Adult Acute Unit.

Interviews were conducted with the Interim Chief Nursing Officer, Nurse Managers, Registered Nurses, Mental Health Technicians, Chief Clinical Officer, Licensed Clinical Social Workers (Therapists), Physicians, a Nurse Practitioner,

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{A 000}	Continued From page 4	{A 000}		

Continued From page 4

Director of Human Resources, Director of Medical Records, Director of Quality Compliance and Risk and patients.

Review of medical records including the patient of concern.

Review of the facility Patient Abuse or Neglect Policy, Algorithm entitled Steps to Take In the Event of Suspected or Potential Abuse, Employee Counseling Report, JITT (Just In Time Training) Code Blue Policy, Code White Policy, Therapist Assignment Sheets, Employee Files.

Complaint #NV 00056347 was substantiated without deficiencies.

Allegations including: the patient went out on pass and returned with a broken arm and committed suicide after being discharged from the outpatient program with having issues of suicidal ideation and abuse from his family, were substantiated with no deficiencies.

The investigation into the allegations included:

Interaction between staff and patients, staff treatment of patients and a tour of the Residential Unit.

Interviews were conducted with the Interim Chief Nursing Officer, a Nurse Manager, a Registered Nurse and patients.

Review of the medical record of the patient of concern.

Review of the facility Algorithm entitled Steps to be Taken If Suspected or Potential Abuse, Daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 000}	Continued From page 5 Residential Schedule, and Therapeutic Pass. During the investigation, a deficiency not related to the complaint was identified (See A 0458).	{A 000}		
{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure an effective governing body was legally responsible for the conduct of the hospital and failed to: 1) Ensure the medical staff was accountable to the governing body for the quality of care provided to patients (See Tag A 0049). 2) Ensure its Chief Executive Officer implemented established policies in the operation of the hospital (See Tag A 0057). The cumulative effect of these systematic practices resulted in the failure of the facility to deliver statutory-mandated care to patients.	{A 043}		
{A 049}	MEDICAL STAFF - ACCOUNTABILITY CFR(s): 482.12(a)(5) [The governing body must] ensure that the medical staff is accountable to the governing	{A 049}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 049}	Continued From page 6	{A 049}		

body for the quality of care provided to patients.

This STANDARD is not met as evidenced by:
Based on record review, interview and observation, the Governing Body failed to hold the Medical Staff accountable for quality of care provided to patients.

Findings include:

The Governing Body failed to meet the Condition of Participation of Patient Rights (Cross-Reference Tag A 0115).

The Governing Body failed to ensure patients received care in a safe setting (Cross-Reference Tag A 0144).

The Governing Body failed to ensure patients were free of and protected from abuse and neglect (Cross-Reference Tag A 0145).

The Governing Body failed to ensure clinicians determined less restrictive interventions were ineffective prior to the use of restraint or seclusion (Cross-Reference Tag A 0164).

The Governing Body failed to ensure a Clinical Therapist completed the required Handle with Care certification at hire (Cross-Reference Tag A 0196).

The Governing Body failed to meet the Condition of Participation of Quality Assurance and Performance Improvement (Cross-Reference Tag A 0263).

The Governing Body failed to ensure the Director of Compliance, Quality and Risk consistently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 049}	Continued From page 7	{A 049}		

maintained a program to identify, investigate, analyze and implement preventive actions regarding incidents affecting patient safety and abuse/neglect (Cross-Reference Tag A 0144, Tag A 0145 and Tag A 0286).

The Governing Body failed to ensure it addressed priorities for improved quality of care and patient safety regarding repeated and continuing issues related to its Clinical Therapists, Electronic Medical Records and Staff Training (Cross-Reference Tag A 0309).

Article XI, Section 3 Responsibilities in the 2019 Medical Staff Bylaws, Rules and Regulations documented the Medical Director and any Associate Medical Directors, appointed by the Governing Board were responsible for:

a) all clinically related activities of the Medical Staff service area.
e) the development and implementation of policies and procedures that guide and support the provision of services.

The following Medical Staff policies and regulations were not met.

Medical Record Requirements:

4/35. Within 24 hours, a psychiatric evaluation and history and physical would be completed and dictated (Multiple Patients in Cross-Reference Tags A 0450 and A 0467).

Treatment Plan:
8. The multi-disciplinary team shall develop an Individual Comprehensive Treatment Plan that is based on a comprehensive assessment of the

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{A 049}	Continued From page 8	{A 049}		

patient's needs. This plan will be reviewed at least weekly (Multiple Patients in Cross-Reference Tag A 0467).

10. Physicians and Clinicians providing services practiced in accordance with facility policy and regulatory requirements Multiple Patients in Cross-Reference Tags A 0144, A 0145, A 0164, A 0196, A 0286, A 0353, A 0385, A 0392, A 0395, A 0396, A 0397, A 0405, A 0438, A 0449, A 0450, A 0458 and A 0467).

12. For acute patients, physicians completed progress notes at least six days per week and other such notes clinically indicated (Patient #9 in Cross-Reference Tag A 0467).

15. Progress notes would include documentation of implementation of the Treatment Plan (Cross-Reference Tag A 0467).

17. All orders for treatment would be in writing (Patient #15 and #33 in Cross-Reference Tags A 0144 and A 0145).

20. Restraint or Seclusion would be used only when less restrictive interventions were determined to be ineffective (Patient #21 in Cross-Reference Tags A 0144 and A 0145).

27. Behavior Modification procedures would not be used (Patient #33 in Cross-Reference Tag A 0145).

On 06/11/19 at 10:30 AM, during an interview with the CEO with Corporate Associates present, verbalized the responsibility for overseeing Patient Rights, Quality Assurance and Performance Improvement, Nursing Services,

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{A 049} Continued From page 9

Therapy Services and Medical Records. The CEO also indicated being responsible for the resources to ensure safe/quality care, treatment and services and for implementing policies and training. Regardless of the policies and stated responsibilities, failures occurred in Abuse/Neglect and Incident Reporting and Investigating, Critical Event Analysis, Staff Competency and Training, Observation/Monitoring by Mental Health Techs/Nursing, Patient Contraband, Medication Administration, Electronic Medical Records, Treatment Plans and Nursing/Physician/Therapist requirements. These failures were acknowledged by the CEO.

{A 049}

A 057 CHIEF EXECUTIVE OFFICER
CFR(s): 482.12(b)

A 057

The governing body must appoint a chief executive officer who is responsible for managing the hospital.

This STANDARD is not met as evidenced by:
Based on document review, interview and observation, the facility's Governing Body failed to ensure the chief executive officer (CEO) was responsibly managing the facility.

Findings include:

On 06/11/19 at 10:30 AM, the CEO with Corporate Associates present, verbalized the responsibility for overseeing Patient Rights, Quality Assurance and Performance Improvement, Nursing Services, Therapy Services and Medical Records. The CEO also indicated being responsible for the resources to ensure safe/quality care, treatment and services

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	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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A 057	Continued From page 10	A 057		

and for implementing policies and training. Regardless of the policies and stated responsibilities, failures occured in Abuse/Neglect and Incident Reporting and Investigating, Critical Event Analysis, Staff Competency and Training, Observation/Monitoring by Mental Health Techs/Nursing, Patient Contraband, Medication Administration, Electronic Medical Records, Treatment Plans and Nursing/Physician/Therapist requirements. These failures were acknowledged by the CEO.

Article 3 Bylaw areas not met:
3.1 (f) To provide for the resources needed to maintain safe, quality care, treatment and services (See Tags A 0144, A 0145 and A 309).

3.2 Authority and responsibility for quality of care and performance improvement mechanisms (See Tags A 0286 and A 0309).

Article 4 Bylaw areas not met:
4.5.3.1 The CEO is responsible for the implementation of established policies in the operation of the facility (Cross-Reference Tags A 0144, A 0145, A 0164, A 0196, A 0286, A 0353, A 0392, A 0395, A 0396, A 0397, A 0405, A 0438, A 0449, A 0450, A 0458 and A 0467).

4.5.3.4 The CEO must organize the administrative functions of the facility, delegated duties and established formal means of accountability on the part of subordinates (Cross-Reference Tags A 0144, A 0145, A 0286, A 0392, A 0395, A 0397, A 0405, A 0438 and A 0450).

4.5.3.5 The CEO is responsible for selecting, employing and controlling employees and for

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	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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A 057	Continued From page 11 developing and maintaining personnel policies and practices for the facility (Cross-Reference Tags A 0144, A 0145, A 0196, A 0286, A 0392, A 0395, A 0397, A 0405, A 0438, A 0450 and A 0467). Article 5 Bylaw areas not met: 5.7 Ultimate responsibility for the safety and quality of care, treatment and services at the Hospital and provide oversight of all review functions of the Hospital by serving the following functions: 5.7.1 Oversight of facility compliance with the laws and regulations of federal, state and local governmental agencies...including the Centers for Medicare and Medicaid Services (Cross-Reference Tags A 0043, A 0115, A 0263, A 0385 and A 0431). 5.72 Provision for the resources necessary to maintain safe, quality care, treatment and services (Cross-Reference Tags A 0144, A 0145, A 0164, A 0196, A 0286, A, 0309, A 0353, A 0392, A 0395, A 0396, A 0397, A 0405, A 0438, A 0449, A 0450, A 0458 and A 0467). 5.74 Oversight of the safety and quality of care, treatment and services through quarterly review of reports on key quality measures and safety indicators as well as any safety and quality issues specific to the population served (Cross-Reference Tags A 0144, A 0145, A 0164, A 0196, A 0286, A 0353, A 0392, A 0395, A 0397, A 0405, A 0438, A 0449, A 0450, A 0458 and A 0467).	A 057		
{A 115}	PATIENT RIGHTS CFR(s): 482.13	{A 115}		

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{A 115} Continued From page 12 {A 115}

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:
Based on observation, interview, record review and document review, the facility failed to:

1) Ensure patients received care in a safe setting (See Tag A 0144).

2) Ensure patients were free from all forms of abuse or harassment (See Tag A 0145).

3) Ensure less restrictive interventions were ineffective prior to the use of restraint or seclusion (See Tag A 0164).

4) Ensure its staff members renewed their certifications for providing care for patients in restraint/seclusion (See Tag A 0196).

The cumulative effect of these systematic practices resulted in the failure of the facility to protect and promote patient's rights in the delivery of care to patients.

{A 144} PATIENT RIGHTS: CARE IN SAFE SETTING {A 144}
CFR(s): 482.13(c)(2)

The patient has the right to receive care in a safe setting.
This STANDARD is not met as evidenced by:
Based on observation, interview, record review and document review, the facility failed to:

1) Monitor and supervise patients to prevent three instances of patients tampering with fire-suppression sprinklers and subsequent

{A 144} Continued From page 13 {A 144}

elopements (Patient #42 did not return).

2) Follow policy after an allegation of staff-to-patient abuse and did not follow through with investigations regarding medication diversion with multiple incidents and patients (Patient #12, #22, #13 #15, #16, #36 and #43);

3) Thoroughly investigate peer to peer abuse incidents and did not protect patients from contact with peers after abuse incidents (Patients #13, #15, #21, #32, #43, #46);

4) Ensure hygiene supplies were secured in multiple patient rooms.

5) Failed to ensure oral medications were swallowed by patients (Patients #21, #30, #31).

6) Failed to perform a critical analysis within 30 days of an unwitnessed injury incident, review facility policies related to incidents, notify police when appropriate, and follow up on issues with patient supervision identified in an incident (Patient #21, #32).

7) Ensure patients wore identification armbands.

8) Follow the facility's plan of action to reeducate Mental Health Technicians (MHT's) after an allegation of staff-to-patient abuse prior to being allowed to return to work with patients.

Findings include:

Employee Abuse Incidents Associated With Care In An Unsafe Setting:

Patient #12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 14 Patient #12 was admitted on 05/13/19, with diagnoses including bipolar disorder without psychotic features. On 05/21/19 at 6:25 PM, an incident report revealed Patient #12 was involved in a fight with a MHT. The Director of Compliance, Quality and Risk (DCQR) recommended termination of the MHT involved. The investigation revealed Patient #12, via written statement, implied the MHT did not know how to properly restrain Patient #12 and this precipitated the fight. The lesson learned from the investigation showed the MHT should have called for help if unable to restrain a patient properly. The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor compliance with its policies and procedures going forward by ensuring staff were knowledgeable and following proper procedure. The Incident Investigation Worksheet lacked documented evidence the MHT's file was reviewed for current competency, training or re-training and Handle with Care certification. The MHT was penciled in to work a different unit on 5/25/19. On 06/11/19 at 10:30 AM, the DCQR reiterated his original recommendation of termination of the MHT above, but this action was still pending with the facility's Human Resources section. Patient #16 Patient #16 was admitted on 04/25/19, with	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 15 diagnoses including severe recurrent major depressive disorder without psychotic features. On 05/19/19, an Incident Investigation Worksheet revealed the facility documented an excessive force complaint lodged by Patient #16 (for an incident that occurred on 05/18/19). On 05/21/19 in the morning, the incident video from 05/18/19 was reviewed with the Chief Nursing Officer. The video lacked evidence substantiating the complaint but also lacked evidence exonerating the MHT, yet the investigation concluded the MHT did not use excessive force. The alleged incident occurred off-camera during the video viewed. On 05/23/19 at 12:45 PM, the Milieu Manager verbalized the on-call Administrator, Chief Executive Officer or Chief Nursing Officer would be contacted for a decision to put the accused employee on leave. The Milieu Manager also indicated, patients, witnesses and staff members were interviewed, surveillance video was reviewed and an Incident Investigation Worksheet would be initiated, as any abuse allegation should be treated the same. On 5/31/19 at 1:30 PM, a Registered Nurse (RN) Supervisor acknowledged the MHT was not suspended and continued to work on a different hallway on 5/20/19. On 5/20/19, the schedule showed the MHT worked the PM shift until midnight on the 100 hallway of the Adolescent Residential Unit. On 05/31/19 at 2:05 PM, a RN Supervisor indicated watching the video with the oncoming Nursing Supervisor and emailing the hierarchy	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 16	{A 144}		

regarding the incident. The RN Supervisor indicated the MHT was cleared after watching the video.

The facility Patient Abuse or Neglect policy #1800.30 revised 2/2019, Section IV Procedure A.2., revealed "the House Supervisor would immediately notify the RN Unit Manager, Chief Nursing Officer and Director of Compliance, Quality and Risk or the Administrator on-call if after hours".

On 05/31/19 at 2:05 PM, the RN Supervisor acknowledged not following the policy.

On 05/31/19 at 2:25 PM, the Interim Chief Nursing Officer acknowledged the facility did not follow the policy regarding contacting the after hours on-call Administrator and that an investigation did not end until it went through the Chief Nursing Officer and Director of Compliance, Quality and Risk.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor compliance with its policies and procedures going forward by ensuring staff was knowledgeable following proper procedure.

The facility Guidelines for Measuring Staff Competency policy #1300.30, last revised 09/2017, revealed Performance Evaluation and Review of Competency Education Requirements would be completed annually for all employees.

The MHT involved, hired 09/12/16, lacked documented evidence in the personnel file of an

{A 144} Continued From page 17 {A 144}

annual Mental Health Technician Competency Checklist. The file contained only one checklist dated 09/12/16.

On 06/06/19 at 11:00 AM, a Human Resources Generalist verbalized the MHT did not have evidence of a current Mental Health Technician Competency Checklist.

On 06/06/19 at 4:15 PM, the Vice President of Nursing, Assessments and Referrals verbalized job-related competencies were supposed to be completed at hire and annually.

Peer to Peer Abuse Incidents Associated With Care In an Unsafe Setting:

Patient #13
Patient #13 was admitted on 12/10/18, with diagnoses including severe, reoccurring major depressive disorder without psychosis.

An incident report on 4/26/19, revealed Patient #13 kissed Patient #22 on the neck. Patient #13 admitted the allegations.

The lesson learned from the investigation showed patients were not allowed to sit in each other's doorways. The action taken to prevent the incident from reoccurring was to make sure staff properly watched patients. Staff would keep eyes on patients and if necessary, call for assistance to maintain line of sight. Staff would set expectations with patients regarding boundaries.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 18	{A 144}		

compliance with its policies and procedures going forward by ensuring staff was re-educated about safety monitoring.

The Investigation Worksheet lacked documented evidence any responsible MHT's were identified and/or interviewed.

Patient #15
Patient #15 was admitted on 04/16/19, with diagnoses including bipolar disorder and unspecified major depressive disorder (single episode).

Patient #15's medical record lacked documented evidence of ever being on sexual reactive precautions (confirmed by the DCQR at 11:00 AM on 05/22/19).

On 05/10/19 at 3:00 PM, an incident report revealed Patient #36 grabbed the lower buttocks of Patient #15 while the patients left a classroom.

On 05/10/19 at 3:20 PM, a Registered Nurse documented the incident and documented physician notification with new orders including may change hall per sexual precaution. New order noted and carried out.

On 05/13/19 at 8:55 AM, the DCQR documented the patients were separated and placed on sexually reactive precautions pending further evaluation by the attending Psychiatrist.

On 05/13/19 at 10:55 AM, the Unit Nursing Manager documented the patients were placed on separate halls. The daily unit census worksheets showed Patient #15 was first included on a separate hallway as of 05/14/19.

{A 144} Continued From page 19 {A 144}

The Milieu Manager documented the patients were separated on different hallways and both were on sexual reactive precautions.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident.

On 05/20/19 at 9:10 AM, an incident report revealed Patient #34 scratched Patient #15 on the face and neck following a verbal argument in the cafeteria.

On 05/21/19 at 11:17 AM, the DCQR indicated the patients' treatment teams were aware of the incident and would consider possible revisions to the patients' treatment plans.

On 05/21/19 at 2:00 PM, only 11 days after the incident with Patient #36, a physician ordered Patient #15 to be moved back to the hallway with Patient #36.

On 05/21/19 at 4:00 PM, a Clinical Therapist documented the patient had bruises on the face and neck. The patient expressed not feeling safe with peers and staff. Patient stated not wanting to be in the hospital anymore. Patient stated it was difficult to cope with stress when being attacked by a peer.

On 05/23/19 at 10:36 AM, an unsigned psychiatric progress note revealed concerns for the patient's safety.

As of 05/23/19 at 1:36 PM, Patient #15's Treatment Plan lacked documented evidence the facility modified the treatment plan after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 20 incident dated 5/10/19 or 05/21/19 or care-planned the patient for safety. On 05/23/19 at 5:00 PM, Patient #15 was transferred to another unit. On 06/04/19 at 2:00 PM, the Chief Nursing Officer (CNO) acknowledged an order was not entered to move the patient. On 06/06/19 at 11:00 AM, the CNO acknowledged staff should have updated the treatment plan for safety and questioned why the facility moved Patient #15 back to the hallway with Patient #36 and indicated, acuity of patients should be considered in staffing the units. On 06/06/19 at 4:15 PM, the Vice President of Nursing, Assessments and Referrals verbalized treatment plans should have been updated every each incident. Victims/perpetrators could have intensified observation to prevent additional incidents. As of 05/31/19, Patient #36's medical record lacked documented evidence of a treatment plan update for the incident dated 05/10/19 and a physician order to move the patient after the incident on 05/10/19. On 5/22/19 at 4:00 PM, the Medical Director indicated Patient #15 should have been placed on sexual reactive precautions. Patient #43 Patient #43 was admitted on 03/25/19, with diagnoses bipolar disorder, major depressive disorder and paraphilia. The patient was discharged on 04/10/19.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 21	{A 144}		

An Incident Report dated 03/25/19 at 9:50 AM, showed Patient #43 kissed Patient #46.

On 05/23/19 at 1:45 PM, Patient #43's medical record lacked documented evidence of a treatment plan update for the incident dated 03/25/19.

Patient #46
Patient #46 was admitted on 12/12/18, with diagnoses including mood disorder and attention deficit hyperactivity disorder.

On 03/25/19 at 9:50 AM, an incident report revealed Patient #46 and Patient #43 shared a hug and attempted kissing. Patient #43 was transferred to youth acute afterward. Patient #46 documented staff members failed to warn or prompt the patients to watch boundaries.

The Incident Investigation Worksheet revealed staff members had their backs turned during the incident and lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor compliance with its policies and procedures going forward by adhering to safety monitoring policy and procedures.

On 05/22/19 at 10:45 AM, the DCQR acknowledged the facility failed to complete Incident Investigation Worksheets and described the process of investigations and related interventions for various incidents: "1) facility needed to ask itself why the event occurred. 2) facility needed to ask what systems issues were involved or if the event was even a system issue. 3) facility needed to ask what environmental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 22	{A 144}		

factors influenced the event. 4) facility needed to identify if a patient needed to be separated from higher functioning patients. 5) facility needed to identify if training with more advanced de-escalation techniques was feasible. 6) facility could try more distraction techniques. 7) facility could check work history of MHT's, if patients were directed to do things making them uncomfortable. 8) facility could shift personnel around more to cover breaks. 9) facility could emphasize roaming the halls more".

Elopement Incidents Associated With Care in an Unsafe Setting:

Adolescent Residential Unit 300 Hallway Elopement Incident:

On 06/04/19, the following occurred according to facility video provided by the Patient Advocate at 12:10 PM on 6/10/19:

6:29 PM: Patients returned to hallway.
6:31 PM: MHT sat on floor in hallway with back against wall.
6:32 PM: Nurse walks by MHT sitting on floor.
6:33 PM: A second MHT sat on floor in hallway with back against wall holding tablet.
6:34 PM: First MHT gets up and leaves area.
6:37 PM: Patient walking in hallway entered room. No reaction from MHT.
6:40 PM: Same Patient entered a second room.
6:41 PM: Nurse circulated through hallway and returned to nurse station.
6:42 PM: Patient(s) observed near the end room (where sprinkler was damaged triggering alarm and opening door).
6:43-44 PM: First MHT re-entered the area, walked to second to last room, entered, returned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}		{A 144}		

Continued From page 23
to hallway and back to nurse station.
6:45 PM: Patients gathered/talking near doorway of end room as above.
6:46 PM: Patient walks around peeps into rooms as MHT re-entered area. Same Patient observed in hallway most of the time standing adjacent to end room doorway from this point until sprinkler damaged in same end room.
6:47 PM: MHT sat on floor in hallway with back against wall next to other MHT.
6:47-49 PM: Patient walked down to end of hallway and shifted back and forth between last two end rooms, both MHT's eventually rose from floor and left area.
6:49 PM: Original MHT returned and sat on floor in hallway with back against wall with tablet.
6:50 PM: MHT stood up with tablet, leaning against wall.
6:51 PM: MHT hurried to end of hallway, looked in end room and ran back toward nurse station. Additional employees entered hall, looked in end room and ran back toward nurse station. Multiple patients stepped around the MHT standing near the exit door and exited the building.

At no time during the video did either MHT continuously rove the hallway while looking into each room, ensuring visual contact with each patient. At no time did the MHT or other employees appear to address patients congregating and entering each other's rooms.

Patient #42
Patient #42 was admitted on 06/04/19, with diagnoses including bipolar disorder and oppositional defiant disorder.

On 06/05/19 at 1:55 AM, an incident report revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}		{A 144}		

Continued From page 24

Patient #42 damaged a fire sprinkler in room 301 and eloped out the door at the end of the hallway. Several other patients followed Patient #42 out the door. All patients eventually returned except Patient #42. Police were notified. Patient #42 was a known elopement risk, having previously been at the facility.

The facility's Incident Investigation Worksheet revealed the staff needed to react when the fire alarm was set off and to relay information clearly when a patient eloped and staff needed education to coordinate when dealing with fire alarms. The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident. The Incident Investigation Worksheet lacked documented evidence the MHT's involved were interviewed.

The primary MHT observed was hired 01/07/19, according to an employee roster provided.

The primary MHT lacked documented evidence of a Mental Health Technician Competency Checklist at hire. The list provided showed a completion date of 05/21/19: the same day another MHT was previously identified without the checklist.

On 06/06/19 at 11:00 AM, a Human Resources Generalist verbalized the MHT did not have evidence of a Mental Health Technician Competency Checklist at hire.

On 6/6/19 at 4:15 PM, the Vice President of Nursing, Assessments and Referrals verbalized job-related competencies were completed at hire and annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 25	{A 144}		

Adolescent Residential Unit 400 Hallway Elopement Incident:

On 06/05/19, the following occurred according to facility video provided by the Patient Advocate at 12:10 PM on 06/10/19:

2:32 PM: MHT entered dayroom; nobody else on hallway.
2:36 PM: MHT exited dayroom; second MHT entered area.
2:37 PM: MHT left hallway; one MHT on the floor; MHT entered dayroom; nobody else on hallway.
2:41 PM: Original MHT left floor.
2:44 PM: Patient entered dayroom.
2:45 PM: Remaining MHT left dayroom and stood in hallway.
2:47 PM: Five patients congregated at end of hallway; three in the hallway and two in the last room (401).
2:48 PM: Second employee entered hallway and went into dayroom.
2:49 PM: Multiple patients congregated at the end of the hallway.
2:50 PM: Second employee left floor. Remaining MHT sat on floor with back against wall.
2:52 PM: Three patients clustered by the end room (401) again. Three to five patients migrated back and forth at the end of the hallway between the end rooms (401).
2:53 PM: Patients went in the dayroom.
2:57 PM: Three patients left end room (401). MHT rose from floor, checked the second last room and returned to nurse station.
2:58 PM: Patient entered end room (401) followed by second Patient.
2:59 PM: One Patient exited end room (401) and third Patient entered end room (401).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 26 3:00 PM: MHT circulated. 3:01 PM: Three Patients congregated by/in end room (401). 3:02 PM: One patient exited end room (401), walked length of hallway. MHT exited hallway. 3:03 PM: Three patients entered end room (401). Fourth patient outside end room (401). Another employee (Nurse) entered area, walked 3/4 of the hallway once and returned to the nurse station. 3:04 PM: MHT returned to hallway. 3:05 PM: Multiple patients continued to congregate [three in the end room (401) and two more just outside end room (401)]. Within seconds, patients ran out of the end room (401). MHT walked toward end room (401), looked inside and returned to nurse station waving arm/hand in the air. 3:06 PM: Fire alarm triggered and three patients exited the building followed by the MHT, a fourth patient and a Registered Nurse. At no time during the video did the MHT continuously rove the hallway while looking into each room, ensuring visual contact with each patient. At no time did the MHT or other employees appear to address patients congregating and entering each other's rooms. The Incident Investigation Worksheet revealed the lesson learned was MHT's must make continuous rounds. The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident. Adolescent Residential Unit 400 Hallway Elopement Incident: On 6/6/19 at 8:00 AM, a third elopement incident occurred in the 400 hallway of the Adolescent	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 27 Residential Unit. On 6/6/19 at 11:45 AM, the Interim Chief Nursing Officer and Patient Advocate acknowledged roving the hallways meant walking the residential hallways while peering into open rooms. There should be no more than two patients in a room, with the two patients being roommates only. The MHT's should have roved the hallways between observations. Roving the hallways was not accomplished in the elopement videos. The MHT's were under nursing supervision. There was indication that two MHT's and the Registered Nurse in the first incident's video would be handled by holding employees accountable. Policies were written and approved, but information was not being communicated. According to the facility's Residential Handbook, Patients were not permitted to enter each other's rooms. The Incident Investigation Worksheet revealed the lesson learned was MHT's must make continuous rounds. The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident. The MHT involved in third elopement incident, hired 06/20/16, lacked documented evidence of an annual Mental Health Technician Competency Checklist in the personnel file. The file contained the most recent checklist dated 03/21/17. On 06/06/19 at 11:00 AM, a Human Resources Generalist verbalized the MHT did not have evidence of a current Mental Health Technician Competency Checklist. On 06/06/19 at 4:15 PM, the Vice President of	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 28	{A 144}		

Nursing, Assessments and Referrals verbalized job-related competencies were supposed to be completed at hire and annually.

The facility Residential Handbook, Item 6 on Page 11 under the Patient Responsibilities section indicated: "Residents were not permitted to enter each other's rooms".

The facility Q 15 Minute Observations/Rounds section of the Levels Of Observation policy 1000.24, last approved 10/2018, Procedure #6, revealed assigned staff would make direct visual contact with patients and confirm they were in no danger or distress. Staff would be vigilant for potential risk factors identified for specific patients (levels of precautions), such as Patient #42's elopement risk. Staff [members] were to be roving the halls at all times while patients were in their rooms.

On 6/6/19 at 4:00 PM, an MHT (not involved in any of the above elopement incidents) indicated the following: Patients could not be in each other's rooms. If seen doing this, patients were reminded of rules. Doors were kept open when patients were inside rooms. Roving the hallways meant moving up and down the hallways to make sure things were ok, looking into rooms with patients while passing by. Techs would not sit on the floor because it would be inappropriate, making the Tech vulnerable to patients. Techs should physically eyeball patients for the 15 minute observations.

MHT Training:

On 6/11/19 at 8:40 AM, the Vice President of Nursing Assessment and Assessment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 29	{A 144}		

Referrals (VP) indicated specific milieu training was initiated a year ago and had been updated in the annual training since then (May 2018).

The training material provided included:

"Effective Milieu Management.
Understanding Your Population, including knowing behaviors you need to watch for.
Developing a Therapeutic Milieu, including active management by the staff of the program.
What makes a Successful Milieu?, including safety, education, structure and dignity.

Safety
Patients deserved to be protected and feel safe while in care. The number one way to know patients were safe was through observation, observing their affect, behavior and interaction with others."

Monitoring patients in all areas. This meant observation was ongoing between 15 minute rounding (MHT's were observed sitting on the floor for significant portions of time in the first two elopement videos, and most of the time MHT's were as physically far away from patients visible on the elopement videos).

No pre-filled or post-filled 15 minute rounding (MHT's appeared to be using their tablets while sitting on the floor in the first elopement video while not observing).

Doors should be opened when patients were in their rooms and closed and locked when they were not (Patients were free to roam in and out of each other's rooms at will in the elopement videos).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144} Continued From page 30 {A 144}

When on the hall, one team member should always watch the hall while another goes in rooms to complete 15 minute rounds. If patients were in their rooms, the two staff members should create zones for monitoring and not become stagnant in an area. (A significant proportion of the time there was one MHT on the hallways observed in the elopement videos).

Nurses would be aware when MHT's did rounds (In at least one instance, a nurse (identified by the Interim Chief Nursing Officer) walked by an MHT who was sitting on the floor in the first elopement video). Do not turn your back on the halls. (Observed in the video of the elopement incidents).

Patients in dayrooms needed to have staff monitoring activities and conversations.

At no time was a patient to touch another patient. Therapeutic or not it was the boundary that needed to be redirected (Patients were observed multiple times in close proximity to each other in the elopement videos).

Structure
Patients were not to be outside another patient's room conversing (Patients were observed standing in the doorways of patient rooms facing the inside of rooms multiple times throughout the elopement videos).

The schedule provided consistency and predictability within the milieu for patients. The schedule needed to be followed at all times".

On 5/20/19, the facility provided hallway

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 31	{A 144}		

schedules which were updated as of 4/30/19. Journaling Group was listed at 7:00 to 7:30 PM nightly as well as in the morning at different times on the 4 hallways of the Adolescent Residential Unit. A Clinical Therapist insisted the groups were held multiple times throughout the inspection.

On 05/21/19, Patient #20, who was admitted 01/09/19, indicated journaling groups were not conducted. Other sampled patients did not know about journaling groups in the Adolescent Residential Unit. The Clinical Therapist did not provide any documented evidence the facility conducted the scheduled journaling groups.

On 05/31/19 at 10:30 AM, the Chief Clinical Officer acknowledged the facility did not conduct journaling groups in the Adolescent Residential Unit.

Staff Expectation:
Keep moving at all times. Know where patients were and what they were doing at all times.

Mental Health Technician Position Summary (approved 01/05/15) revealed under Essential Job Function and Responsibilities: "Therapeutic Milieu 4) Observes group member's dynamics and takes initiative to reduce problematic behaviors. 5) High visibility during increased acuity and takes an active role with indicated interventions. 7) Records patient observations during indicated timeframe; after the fact documentation is not an approved practice".

Personal Hygiene Supplies:

The following unattended hygiene supplies were observed in the Adolescent Residential Unit:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 32	{A 144}		

On 5/24/19 at 3:15 PM:
Room 405 A: Brown grocery bag full of personal hygiene items, such as body lotion, shampoo.
Room 401: Brown grocery bag full of personal hygiene items.

On 5/24/19 at 3:20 PM:
Room 300: Lip balm.
Room 301: Hair conditioner.
Room 304: Body lotion.
Room 305: Body wash and moisturizer.

On 5/24/19 at 3:25 PM:
Day room: A patient's container of styling gel sitting on a ledge.

On 5/24/19 at 3:30 PM:
Room 202: Body wash, conditioner and shampoo.

On 05/28/19 at 11:10 AM:
Room 401A: Body lotion on a shelf.
Room 404B: Brown grocery bag full of personal hygiene items.

On 05/31/19 at 1:30 PM, a Registered Nurse Supervisor acknowledged hygiene items were considered contraband in the Adolescent Residential Unit. Patients were searched for contraband after returning from passes. Two individuals searched patients after patients were stripped down. Patients were checked for swallowing medications by having them stick out their tongues, saying "aaahhhhhh" and checking the mouth.

The facility Patient Belongings and Contraband policy #1000.8, last revised 4/2018, defined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144} Continued From page 33

following as contraband: "Medications, bottles or containers of any kind (toiletries would be supplied by the facility) and colored pencils/markers. Personal hygiene products could be used only with a physician order and under close supervision".

Patient Medication Diversion and Failure to Document Contraband Searches after Therapeutic Passes:

Patient #12
Patient #12 was admitted on 05/13/19, with diagnoses including bipolar disorder without psychotic features.

On 05/20/19 at 1:18 PM, an incident report revealed Patient #12 reported receiving Seroquel medication from a peer and swallowing it. The report showed Patient #12 verbalized the medication came from a recently discharged patient who hid the medication in a Chapstick container. Patient #12 felt tired.

The DCQR's documentation characterized the incident as a medication error that reached the patient but did not cause patient harm.

Patient #17
Patient #17 was admitted on 03/27/19, with diagnoses including recurrent, severe major depressive disorder without psychosis.

On 05/27/19, Patient #17 was out on pass from the facility between 10:00 AM and 8:30 PM, as documented. Sections V and VII were left blank on the patient's therapeutic pass form regarding conflicts/problems with family members and whether or not a nurse assessed the patient's

{A 144}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144} Continued From page 34 {A 144}

condition and performed a contraband search upon return.

On 06/06/19 at 2:55 PM, the Interim Chief Nursing Officer acknowledged Patient #17 lacked post therapeutic contraband search documentation.

On 05/27/19, the daily unit census worksheet showed nurses were supposed to monitor Patient #17 for possessing pencils due to self-harm.

Patient #37
Patient #37 was admitted on 05/02/19, with diagnoses including bipolar disorder and major depressive disorder with psychotic features: hearing voices.

On 05/20/19, an incident report showed Patient #37 received a Seroquel tablet from another patient and swallowed it. Patient #37 indicated it came from a recently discharged patient who hid the medication in a Chapstick container. Patient #37 felt tired.

The DCQR's documentation of the incident characterized the incident type as an inappropriate attitude with distraction as a contributing cause.

On 05/22/19, Patient #37 was out on pass from the facility between 9:00 AM and 1:00 PM, as documented. Sections V, VI and VII were left blank on the patient's therapeutic pass form regarding conflicts/problems with family members and whether or not a nurse assessed the patient's condition and performed a contraband search upon return.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144}

Continued From page 35

On 05/22/19, the daily unit census worksheet showed nurses were supposed to monitor Patient #37 for harm to others and self-harm.

On 05/31/19 at 1:30 PM, a Registered Nurse Supervisor acknowledged hygiene items were considered contraband in the Adolescent Residential Unit. Hygiene supplies were supposed to be secured after use. Patients were supposed to be searched for contraband after returning from passes. Two individuals searched patients after patients were stripped down. Patients were checked for swallowing medications by having them stick out their tongues, saying "aaahhhhhh" and checking the mouth.

As of 06/04/19 at 1:31 PM, Patient #37's treatment plan lacked documented evidence medication diversion was addressed.

On 06/06/19 at 2:55 PM, the Interim Chief Nursing Officer acknowledged Patient #37 lacked post therapeutic contraband search documentation.

Patient #46
Patient #46 was admitted on 12/12/18, with diagnoses including mood disorder and attention deficit hyperactivity disorder.

From at least 05/10/19 - 05/17/19, the daily unit census worksheet showed nurses were supposed to monitor Patient #46 for cheeking medication every time nurses administered medication to Patient #46. Patient #46 was discharged on 05/17/19.

The facility Medication Administration policy

{A 144}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 36 1000.42, last approved 9/2017 revealed the nurse would check to make sure the "patient swallowed medication". Patient #39 Patient #39 was admitted on 04/26/19, with diagnoses including severe, recurrent major depressive disorder without psychosis. On 05/28/19 at 10:40 AM, Patient #39 verbalized receiving Seroquel from Patient #46 just prior to Patient #46's discharge. Patient #46 hid the Seroquel in a Chapstick container, which was left on a shelf when Patient #46 left. The daily unit census worksheet showed Patient #39 and #46 were roommates on 05/17/19, the last day Patient #46 was on the unit. On 06/04/19, a record review yielded the following nursing progress note: On 05/31/19 at 4:30 PM, the Milieu Manager reported the patient confessed to cheeking night medication and gave it to other patients in the residential hall. A Registered Nurse spoke to the patient about the situation. The patient indicated cheeking medication for a while and flushed some down the toilet. Patient #39 further indicated giving a medication to another patient and finding another patient's medication and offering it to two other patients. The Clinical Therapist, Psychiatrist and Nursing Supervisor were notified. The Registered Nurse signed the note at 11:35 AM on 06/01/19. On 06/03/19 at 9:10 AM, the Patient Advocate interviewed Patient #39. Patient #39 indicated cheeking medication for 4-5 weeks. Patient #39	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144} Continued From page 37 {A 144}

pretended to drink water and spit medication into the water cup. Patient #39 acknowledged providing medication to Patient #12, #37 and #40.

Patient #40 was discharged on 05/31/19. On 06/04/19, a Clinical Therapist documented a statement regarding a phone call received by a second Clinical Therapist about Patient #40. The parent of Patient #40 had indicated unprescribed medication was provided by another patient (Patient #39) to Patient #40. The Clinical Therapist saw Patient #39 on 06/03/19. Patient #39 admitted not taking medication for some time and providing medication to other patients instead.

On 06/04/19 at 1:35 PM, the DCQR acknowledged first being notified of the incident reported on 5/31/19.

On 06/04/19 at 2:00 PM, the Interim Chief Nursing Officer did not know anything about the incident on 05/31/19, and indicated staff should have incorporated any medication diversion among patients into the treatment plan for any patients involved.

On 06/06/19 at 2:15 PM, the DCQR acknowledged the Registered Nurse, who entered the nursing progress note at 11:35 AM on 06/01/19, did not initiate an incident report.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident or obtained employee statements related to the allegations and investigation. The lessons learned were Registered Nurses needed to be more intrusive when doing mouth checks at med pass. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 38	{A 144}		

Registered Nurses were re-educated, but the Incident Investigation Worksheet lacked documented evidence what the education entailed.
On 06/05/19 at 2:27 PM, a family member explained meeting with the facility to discuss a patient's plan prior to discharge and noticed the patient looked groggy and sleepy like the patient had taken something. The family member indicated someone made a comment about well-being and the family member commented the patient did not look normal. The family member verbalized the patient confided in the family member for the first time and indicated, "All the girls were doing it too. They're not taking their medications but taking everyone else's medications." The family member verbalized the patient indicated this had been going on for a while. The family member verbalized, "I don't know what she took". The family member indicated telling the patient's father and the Therapist. The family member was advised by the Therapist to pick the patient up that night because of being worried about the patient's well-being due to snitching. The Therapist indicated there were about two or three fights on the unit daily. The family member indicated she followed the Therapist's advice and checked the patient out of the facility for the patient's safety.

Personal Hygiene Supplies:
On 06/11/19 at 3:32 PM an environment check conducted on the Adolescent Acute Unit revealed the following:
Room #106 a large container of body wash and two wash clothes in shower.
Room #108 two large towels on a patient bed, 3 cups and patient arm band on sink counter top.
Room #111 a tube of toothpaste and tooth brush

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 39	{A 144}		

on sink counter top.
Room #114 a cup on sink counter top.
Room #115 a gown on a patient's bed and cup on the sink counter top.

Interviews with MHT's on 06/10/19 revealed patients were not allowed to have hygiene items, cups, or additional clothing in their rooms.

On 06/11/19 at 3:46 PM, the Milieu Manager indicated the patients in Room #108 were moved due to the tampering with showers or sinks. Milieu Manager indicated the patients were moved out of the unit prior to breakfast. The Milieu Manager indicated the rooms should have been checked.

On 06/11/19 at 3:58 PM, the MHT identified gown and cup taken from Room #115. The Director of Medical Records was present and confirmed the findings.
Medication Pass

Patients #30 and #31:

On 06/06/19 at 8:45 AM, a Registered Nurse (RN) administered medication at the Adult Acute Unit nursing station. Patients #30 and #31 were given oral medications from across a counter-top. The patients were not wearing identification arm bands. The RN identified the patients by asking their names and looking at a photograph on the Electronic Medication Administration Record computer screen. After giving the medications the RN did not ask the patients to open their mouths to check if the medications were swallowed. The patients brought their own white Styrofoam water cups and also left the desk area with the same cups after taking the medications. The RN stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 40	{A 144}		

a mouth check was not usually done when giving medications on the Adult Acute unit unless a patient had a known behavior cheeking medications. The RN reported on the Chemical Dependency Unit, a mouth check was done, particularly if narcotics were given. The The RN acknowledged not doing a mouth check for Patient #30 and #31, as they did not have any issues related to cheeking medications. The RN stated patients filled cups with water from a day room water source and brought it to the nursing station for medication pass, and were allowed to take the cup away with them afterward.

On 06/06/19 at 9:10 AM, the Adult Services Nurse Manager reported facility policy and procedure was nurses were to perform a mouth check on all patients after administering medications, not just for patients with a known behavior of cheeking medications. The Nurse Manager stated the facility practice was patients would bring their own water cups for medication pass and could take these away with them.

On 06/06/19 at 11:45 AM, the Interim Chief Nursing Officer (CNO) revealed patients should be wearing arm bands and nurses should check for the arm band to identify patients during medication administration.

The facility policy Medication Administration dated 03/26/06, indicated the nurse would confirm the patient's identity before offering medication by verification of two patient identifiers. The nurse would check to make sure the patient swallowed the medication.

Patient #21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}		{A 144}		

Continued From page 41

1) Facility Incident Report #14865:

Patient #21 was admitted on 04/17/19 with diagnoses including unspecified psychosis.

Incident Report #14865 dated 04/22/19, indicated there was an allegation of abuse. Patient #21 was found in a room unconscious with abrasions on the neck and arms after being assaulted by Patient #32. An emergency ambulance was called and the patient was sent to a local hospital for further treatment. The report was reviewed by the Director of Compliance, Quality and Risk (DCQR). The DCQR documented due to the severity of the incident, a formal investigation would be conducted.

The Incident Investigation Worksheet dated 04/25/19, included patient and staff interviews and a video camera review. The police were not notified. There was no evidence a review of facility policies was done in connection with the incident.

The incident occurred in the Adult South Hall. Video camera review revealed Patient #21 was in Room 123 at 6:02 PM. Patient #32 entered the Room 123 at 6:02 PM. Patient #32 exited Room 123 and made hand gestures for staff to come at 6:07 PM. Staff responded to the room at 6:07 PM. An emergency response team left the unit with Patient #21 at 6:27 PM.

The summary of an interview with Patient #32 dated 04/22/19 documented Patient #32 admitted to assaulting Patient #21, stating "she asked for a fade, so I gave her a fade."

The summary of an interview with a Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 42	{A 144}		

Health Technician (MHT) dated 04/22/19, documented one MHT was on break and only one MHT was on duty for that hallway.

The summary of an interview with a different MHT on 04/25/19, documented the MHT was in the dayroom area after finishing 15 minute checks. A patient yelled to go check on the patient. The MHT found the patient unresponsive. The MHT called nurses.

The summary of an interview with a Registered Nurse on 04/25/19, documented the patient did not have a pulse. Cardiopulmonary Resuscitation (CPR) was started. The patient had return of pulse and breathing after one minute of CPR.

The summary of an interview with Patient #21 on 04/25/19, documented Patient #21 did not remember what happened. Patient #21 stated the incident was very traumatizing. There was no documentation Patient #21 was asked about, or made, a decision about wanting to press criminal charges against Patient #32 or not.

The Incident Investigation Worksheet documented lessons learned was "the importance of staff roaming the halls between rounds." Actions taken to prevent the incident from happening again were "reeducation for adult services staff on the importance of roaming the halls between rounds." Monitoring of of compliance with facility policies and procedures going forward included "monitoring at least once daily while on shift to ensure roaming was being done, and video monitoring biweekly at times manager was not present to ensure compliance with roaming in between 15 minute rounds."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 43 Observations documented in Patient #21's medical record indicated the patient was housed in Room 232, and Room 123 was not the patient's own room. On 04/22/19 at 5:58 PM, the patient was at the nurses station and at 6:13 PM was in a patient's room lying/sitting. Observations documented in Patient #32's medical record indicated the patient was housed in Room 118. On 04/22/19 at 5:59 PM and at 6:15 PM, Patient #32 was in the patient's room lying/sitting. On 06/06/19 at 09:45 AM, a Mental Health Technician (MHT) revealed on 04/22/19 they were working in the South Side of the Adult Acute Unit along with one other MHT. The MHT had just returned to the unit from a break when Patient #32 summoned the MHT to go to Room 123. Upon arriving to the room, Patient #21 was unconscious on the floor and staff called a code. The MHT scooped the patient off the floor after "she took her last breath." The MHT noted red marks in the shape of hand prints on Patient #21's neck, indicated the patient had been choked. The MHT checked the patient's pulse, and there was none. The Charge Nurse arrived to the room and did chest compressions on the patient and she had return of pulse. The MHT reported not being informed about a prior altercation between the two patients so he could have been more aware. The two patients did not get along and should have been kept apart. On 06/06/19 at 11:45 AM, the Interim Chief Nursing Officer indicated MHT's needed to do more roaming, and more training and reinforcement on the importance of roaming between rounds. The Chief Nursing Officer	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 44	{A 144}		

described MHT's were supervised by the Registered Nurse (RN). The RN was responsible for ensuring MHT's were performing the 15 minute checks and roaming the unit between checks. RN's should intervene if observing MHT's not doing these tasks.

On 06/06/19 at 4:00 PM, an MHT indicated per facility rules patients were not allowed to enter the rooms of other patients. The MHT stated if a patient or patients were seen entering another patient's room they should be informed of the rules. The MHT indicated in between round the MHT should be roaming the hallway and looking into rooms to verify safety.

On 06/7/19 at 11:30 AM, the DCQR verified police were not notified regarding the incident. Facility policy was to notify police automatically for persons under the age of 18 or over the age of 65, or for an adult with a disability. For this incident, the patient was not under 18 or over 65 and did not ask to press charges, and for that reason police were not notified. The DCQR acknowledged the patient was having mental health symptoms which could impair judgement, and acknowledged the incident was serious given Patient #21 was choked and required CPR to revive (a near homicide).

The DCQR described the police should have been notified and the police could make a decision regarding charges. The DCQR described due to the serious nature of the incident, a critical analysis should have been performed within 30 days, along with a root cause analysis, but this was not done. The DCQR recounted the Nurse Manager who was to monitor compliance with facility policies regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 144}	Continued From page 45 ensuring roaming was done by MHT's was no longer employed at the facility. The DCQR reported not knowing if compliance was monitored with daily shift checks and with video monitoring biweekly as documented in the incident report. The facility policy Critical Event Review and Reporting, revised 01/20/19, indicated critical events included any unwitnessed injury. For these an investigation would be done to ensure the unwitnessed injury was not due to patient abuse or neglect. A Critical Event Analysis would be done to determine the underlying causes of the critical event and to determine processes to reduce the risk or recurrence of the critical event. A Critical Event Analysis would be completed within 30 days of knowledge of the event. 2) Second incident involving Patient #21 and Patient #32 on 04/27/19, lack of incident report Patient #21 was readmitted on 04/23/19 with diagnoses including psychosis after being hospitalized on 04/22/19 following an assault by Patient #32. The Initial Psychiatric Evaluation dated 04/25/19, indicated Patient #21 reported homicidal ideation towards the patient who assaulted her (Patient #32) and towards staff and Patient #21 was placed on 1:1 observation. A Nursing Progress Note dated 04/27/19 indicated Patient #21 was punched in the face by another patient (name of this patient was not identified in the note) without provocation at the nursing station on the North Side of the Adult Acute Unit. The patients were separated and	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 46	{A 144}		

Patient #21 was put on the South Side of the Adult Acute Unit. When Patient #21 entered the day room on the South Side, the patient who assaulted Patient #21 on 04/22/19 [Patient #32] charged at her. Patient #21 was then placed in the seclusion room for safety.

The Commission on Behavioral Health Report Form (referred to as the restraint/seclusion record), dated 04/27/19 indicated Patient #21 was punched by a peer without provocation and was picked up and placed in the seclusion room for safety at 10:55 AM. There was no incident report documented regarding this incident.

Patient #21's Treatment Plan lacked documented evidence the facility modified the treatment plan after the incidents involving Patient #32 dated 04/22/19 or 4/27/19 or care-planned the patient for safety regarding a prior conflict with Patient #32.

On 06/07/19 at 11:30 AM, the DCQR indicated Patient #21's treatment plan should have been updated to include both incidents with Patient #32. Staff should not have placed Patient #21 back into proximity to Patient #32 because of their history of prior altercation and Patient #21 verbalizing homicidal ideation towards Patient #32. The DCQR stated the patient should have been moved to another location such as the Chemical Dependency Unit. The DCQR indicated facility policy was to keep patients from having contact following an altercation. The DCQR verified no incident report was submitted by staff regarding the incident on 04/27/19 where Patient #21 was punched by another patient, had a confrontation with Patient #32 and was placed in seclusion. The DCQR reported facility policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 47	{A 144}		

procedure required staff to submit an incident report for assaults and for use of restraint/seclusion, and neither was done.

The facility policy Completion of Incident Reports, dated 01/01/17, indicated an Incident Report must be filed for incidents outside the course of routine care, treatment, and services. Incident Reports were not part of the patient's medical record. The policy indicated an Incident Report must be filed for physical altercations, harm to patient actual or potential, abuse or neglect of a patient, injury to a patient, or use of restraint or seclusion.

3) Noncompliance with Medications

On 05/23/19 at 2:30 PM, a Psychiatrist indicated Patient #21 had a high incidence of using restraint and/or seclusion. The Psychiatrist reported Patient #21 was given oral medications but these were not effective in reducing behaviors of conflict with staff and other patients.
The Psychiatrist described the patient was suspected of spitting out the medications instead of swallowing them. The patient was in multiple physical assaults and required a high number of injections. The patient was subsequently put on Haldol Decanoate injections (a long-acting antipsychotic medication) to address the spitting out of medications. The Psychiatrist verbalized Patient #21's behavior of non-compliance with swallowing oral medications should also have been addressed with other interventions recommended by the therapist and physician. The patient's Treatment Plan should document the problems and the interventions.

Patient #21's Treatment Plan lacked documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 48	{A 144}		

evidence the facility modified the treatment plan to include a problem with or interventions for suspected noncompliance with swallowing oral medications. There was no intervention regarding checking to make sure the patient swallowed medications.

On 05/29/19 at 7:30 AM, the Registered Nurse stated patients with a behavior of not swallowing medications should be placed on "check for cheeking" precautions, which entailed the nurse making a careful check of the patient's mouth for any pills retained in the cheeks or mouth.

Patient #32
Patient #32 was admitted on 04/22/19 with diagnoses including major depressive disorder with suicidal and homicidal ideations.

A Nursing Progress Note dated 04/23/19 indicated the patient was upset regarding a situation which occurred yesterday. The patient was mad at staff for not helping her. The patient was encouraged to take responsibility for her action of choking another patient.

A Nursing Progress Note dated 04/25/19 indicated the patient got agitated after seeing another patient on the other side of the nursing station. The patient stated "I get very angry agitated when I see that patient, I do not want to see her."

A Nursing Progress Note dated 04/27/19 indicated the patient became extremely agitated regarding a female peer being in the south side hallway. The patient yelled "Keep me away from her, I'm tired of her coming around me!"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 49	{A 144}		

A Psychiatric Progress Note dated 04/25/19 documented the patient was agitated regarding a conflict with a peer with ongoing homicidal ideation and thinking about getting this peer alone to "break her neck."

A Psychiatric Progress Note dated 04/26/19 documented the patient reported homicidal ideation with frustration/anger at a peer on the unit.

A Psychiatric Progress Note dated 04/27/19 documented the patient complained "she was attacking me and nobody was going to help."

Review of an incident report indicated Patient #32 had a physical altercation with Patient #21 on 04/22/19 and psychiatric notes indicated Patient #32 had ongoing homicidal ideation towards Patient #21. Patient #32's Treatment Plan lacked documented evidence of safety planning in regards to the altercation with Patient #21 on 04/22/19, or the homicidal ideation towards Patient #21. Review of Patient #21's record indicated the two patients were allowed to be in close proximity on 04/27/19 when staff placed Patient #21 in Adult Unit South and Patient #32 charged at Patient #21 in the day room.

On 05/23/19 at 2:30 PM, a Psychiatrist verified Patient #21 was assaulted by Patient #32, and was nearly assaulted a second time by Patient #32. The reasons for the repeated assaults was not known. Each patient's Treatment Plan should document the problems they are having and the interventions regarding the problem. The Psychiatrist explained it was hard to change the overall treatment plan because the template for the Treatment Plan form in the Electronic Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 50	{A 144}		

Record (EHR) had limited space for text. The EHR template needed more options.

The facility policy and procedure titled Patient Abuse and Neglect, revised 02/2019, indicated physical abuse was defined as contact or actions resulting in injury or pain such as hitting, pinching, yanking, shoving, and pulling hair. Each employee was to be informed of the policies on abuse and neglect during initial orientation and yearly thereafter. Anyone who witnessed or learned of an incident of neglect must immediately separate the patient from any potential aggressors, perpetrators, or any others who may have the potential to inflict abuse upon the patient. If the abuse was patient-to-patient, the patients will be separated so they cannot have contact with one another. If the abuse was staff-to-patient, the staff member would be placed on administrative leave until a formal investigation could be completed. The policy indicated in instances of patient abuse or neglect, Hospital Leadership would engage in a critical event analysis.

The facility policy and procedure titled Treatment Plan, revised 03/2017, indicated the hospital would develop an individualized treatment plan for every active problem for every patient. The treatment plans would include individualized plans of care and unique interventions identified by the team. Safety concerns would be clearly documented on the Treatment Plan and individualized plans of care would be developed to maintain safety.

Arm Bands:

On 06/05/19 at 9:45 AM, three patients including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 51	{A 144}		

Patient #20 were observed to have no identification wristbands (referred to as arm bands, usually in the form of plastic bracelets worn at the wrist area which had the patients name and other information printed on them).

On 06/05/19 at 10:00 AM, eight patients from the Adolescent Residential Unit were in a hallway accompanied by two staff, being escorted to the gym. None of the patients were wearing arm bands. The Interim Chief Nursing Officer (CNO) approached the group and stated all patients must wear arm bands and directed staff to apply the arm bands. One patient stated they would not wear an arm band. The CNO verbalized if the patient was not wearing an arm band they would not be allowed off of the housing unit. The CNO reported the facility policy was all patients should wear arm bands. The arm bands were needed as an identifier for medication administration safety. The CNO verbalized nursing staff were not ensuring arm bands were on the patients and the problem had been ongoing.

On 06/11/19 at 10:20 AM, the DCQR indicated an issue with patients not having arm bands was not identified as a Quality Assurance & Performance Improvement (QAPI) process improvement project or need. The DCQR acknowledged it was a problem and needed to be addressed.

Hygiene Supplies in Acute Youth Unit:

Patient #7
Patient #7 was admitted on 5/18/19 with diagnoses including major depressive disorder. The 05/18/19 Treatment Plan indicated the patient had a potential for self harm. The unit worksheet indicated the patient was on suicide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 144} Continued From page 52 {A 144}

precautions.

On 05/29/19 at 4:40 PM, a tour of the Adolescent Acute Unit was conducted with a Nurse Manager. Room 102 had a toothbrush, toothpaste, lotion, deodorant, a comb and a hairbrush next to the sink. The Nurse Manager indicated the room was occupied by Patient #7. The Nurse Manager was not sure if the hygiene items were permitted in the room. Two additional rooms had unsecured hygiene supplies. Room 104 had deodorant, a comb and a hairbrush next to the sink. Room 111 had a toothbrush, toothpaste, and hairbrush next to the sink.

On 05/29/19 at 4:45 PM, the Registered Nurse (RN) on the Adolescent Acute Unit reported Patient #7 was on Suicide Precautions. The RN stated patients were allowed to keep the hygiene items in the rooms, unless there were signs of wanting to self harm. The RN stated Patient #7 was not currently having signs and was permitted to store hospital issued hygiene items such as the toothbrush, toothpaste, lotion, and deodorant in the room. The RN stated the items would be removed if needed for safety.

On 06/06/19 at 3:45 PM, the Youth Services Nurse Manager reported facility policy was hygiene supplies should not be stored in patient rooms. The policy was for nurses or Mental Health Technicians to give the patient the supplies when they asked for them. After the patient was done using the supplies, staff were supposed to collect these and return them to a storage area inaccessible to patients.

{A 145} PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT {A 145}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 53 CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based observation, interview, record review, and document review the facility failed to: 1) Follow the facility's policy and procedures an allegation of staff-to-patient abuse, did not follow through with investigations regarding medication diversion with multiple incidents and patients (Patient #12, #22, #13 #15, #16, #34, #36 and #43). 2) Ensure a patient was not made to wear a gown as a form of behavior modification (Patient #43). 3) Ensure the primary physician, medical physician or licensed practitioner on call was notified when a patient was found on the floor, an order for a neurological checks was obtained and not conducted after a suspected unwitnessed fall, the correct code was implemented for an unresponsive patient with agonal breathing, the emergency support activities were documented on a code record after a code was called for an unresponsive patient with respiratory distress (Patient #29). 4) Follow the facility's plan of action to reeducate Mental Health Technician's (MHT'S) after an allegation of staff-to-patient abuse prior to being allowed to return to work patient. 5) Failed to complete five incident reports on the same patient following the use of seclusion and restraint, failed to perform a critical analysis within	{A 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 54	{A 145}		

30 days of an unwitnessed injury incident, review facility policies related to incidents, notify police when appropriate, and follow up on issues with patient supervision identified in an incident (Patient #21, #32).

Findings include:

The facility Patient Abuse or Neglect Policy #1800.30, last revised September 2017, revealed neglect was a form of abuse in which there was failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Patient #12
Patient #12 was admitted on 05/13/19 with with diagnoses including bipolar disorder without psychotic features.

On 05/21/19 at 6:25 PM, an incident report revealed Patient #12 was involved in a fight with a Mental Health Tech, and the Director of Compliance, Quality and Risk (DCQR) recommended termination of the Mental Health Tech involved.

The investigation revealed Patient #12, via written statement, implied the Mental Health Technician (MHT) did not know how to properly restrain Patient #12, precipitating the fight. The lesson learned from the investigation showed the MHT should have called for help if unable to restrain a patient properly.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 55	{A 145}		

compliance with its policies and procedures going forward by ensuring staff was knowledgeable and following proper procedure.

The Incident Investigation Worksheet lacked documented evidence the MHT's file was reviewed for current competency, training or re-training and "Handle with Care" certification. Four days after the incident and termination recommendation, the same MHT was penciled in to work a different unit on 05/25/19.

On 06/11/19 at 10:30 AM, during interview, the DCQR reiterated the original recommendation of termination of the MHT, which was still pending with Human Resources.

Patient #13
Patient #13 was admitted on 12/10/18 with diagnoses including severe, reoccurring major depressive disorder without psychosis.

On 04/26/19, an incident report revealed Patient #13 kissed Patient #22 on the neck. Patient #13 admitted the allegations.

The lesson learned from the investigation showed patients were not allowed to sit in each other's doorways. The action taken to prevent the incident from reoccurring was to make sure staff properly watched patients. Staff would keep eyes on patients and if necessary, call for assistance to maintain line of sight. Staff would set expectations with patients regarding boundaries.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 56	{A 145}		

compliance with its policies and procedures going forward by ensuring staff were re-educated about safety monitoring.

The Investigation Worksheet lacked documented evidence any responsible MHT's were identified and/or interviewed.

On 06/10/19 at 4:30 PM, during interview the DCQR acknowledged employees involved in incidents should be interviewed for investigations.

Patient #15
Patient #15 was admitted on 04/16/19, with diagnoses including bipolar disorder and unspecified major depressive disorder (single episode).

Patient #15's medical record lacked documented evidence of ever being on sexual reactive precautions (confirmed by the DCQR at 11:00 AM on 05/22/19).

On 05/10/19 at 3:00 PM, an incident report revealed Patient #36 grabbed the lower buttocks of Patient #15 while the patients left a classroom.

On 05/10/19 at 3:20 PM, a Registered Nurse documented the incident and documented physician notification with new orders including may change hall per sexual precaution. New order noted and carried out.

On 05/13/19 at 8:55 AM, the DCQR documented the patients were separated and placed on sexually reactive precautions pending further evaluation by the attending Psychiatrist.

On 05/13/19 at 10:55 AM, the Unit Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 57	{A 145}		

Manager documented the patients were placed on separate halls. The daily unit census worksheets showed Patient #15 was first included on a separate hallway as of 05/14/19.

The Milieu Manager documented the patients were separated on different hallways and both were on sexual reactive precautions.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident.

On 05/20/19 at 9:10 AM, an incident report revealed Patient #34 scratched Patient #15 on the face and neck following a verbal argument in the cafeteria.

On 05/21/19 at 11:17 AM, the DCQR indicated the patients' treatment teams were aware of the incident and would consider possible revisions to the patients' treatment plans.

On 05/21/19 at 2:00 PM, a physician ordered Patient #15 to be moved back to the hallway with Patient #36, only 11 days after the incident with Patient #36.

On 05/21/19 at 4:00 PM, a Clinical Therapist documented the patient had bruises on the face and neck. The patient expressed not feeling safe with peers and staff. Patient stated not wanting to be in the hospital anymore. Patient stated it was difficult to cope with stress when being attacked by a peer.

On 05/23/19 at 10:36 AM, an unsigned psychiatric progress note revealed concerns for the patient's safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 58	{A 145}		

As of 05/23/19 at 1:36 PM, Patient #15's Treatment Plan lacked documented evidence the facility modified the treatment plan after the incident dated 5/10/19 or 05/21/19 or care-planned the patient for safety.

On 05/23/19 5:00 at PM, Patient #15 was transferred to another unit.

On 06/04/19 at 2:00 PM, the Chief Nursing Officer (CNO) acknowledged an order was not entered to move the patient.

On 06/06/19 at 11:00 AM, the CNO acknowledged staff should have updated the treatment plan for safety and questioned why the facility moved Patient #15 back to the hallway with Patient #36 and indicated, acuity of patients should be considered in staffing the units.

On 06/06/19 at 4:15 PM, the Vice President of Nursing, Assessments and Referrals verbalized treatment plans should have been updated with each incident and that victims/perpetrators could have intensified observation to prevent additional incidents.

As of 05/31/19, Patient #36's medical record lacked documented evidence of a treatment plan update for the incident dated 05/10/19 and a physician order to move the patient after the incident on 05/10/19.

On 5/22/19 at 4:00 PM, the Medical Director indicated Patient #15 should have been placed on sexual reactive precautions.

Patient #16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 59	{A 145}		

Patient #16 was admitted on 4/25/19, with diagnoses including severe recurrent major depressive disorder without psychotic features.

On 5/19/19, an Incident Investigation Worksheet revealed the facility documented an excessive force complaint lodged by Patient #16 (for an incident that occurred on 5/18/19).

On 5/21/19 in the morning, the incident video was reviewed with the Chief Nursing Officer. The video lacked evidence substantiating the complaint but also lacked evidence exonerating the Mental Health Tech, yet the investigation concluded the Mental Health Tech did not use excessive force. The alleged incident occurred off-camera during the video viewed.

On 5/23/19 at 12:45 PM, the Milieu Manager verbalized the on-call Administrator, Chief Executive Officer or Chief Nursing Officer would be contacted for a decision to put the accused employee on leave. Patients, witnesses and staff members were interviewed. Surveillance video was reviewed. The Milieu Manager indicated an Incident Investigation Worksheet was initiated and all abuse allegation should be treated the same.

On 05/31/19 at 1:30 PM, a Registered Nurse Supervisor acknowledged the Mental Health Tech was not suspended and continued to work on a different hallway on 05/20/19. On 05/20/19, the schedule showed the Mental Health Tech worked the PM shift until midnight on the 100 hallway of the Adolescent Residential Unit.

On 05/31/19 at 2:05 PM, a Registered Nurse Supervisor indicated watching the video with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 60	{A 145}		

oncoming Nursing Supervisor and e-mailing the hierarchy regarding the incident. The Registered Nurse Supervisor indicated the Mental Health Tech was cleared after watching the video.

The facility Patient Abuse or Neglect Policy #1800.30 revised 02/2019, Section IV Procedure A.2., revealed "The House Supervisor would a) immediately notify the RN Unit Manager, Chief Nursing Officer and Director of Compliance, Quality and Risk (or the Administrator on-call if after hours)".

On 05/31/19 at 2:05 PM, the Registered Nurse Supervisor acknowledged not following the policy.

On 05/31/19 at 2:25 PM, the Interim Chief Nursing Officer acknowledged the facility did not follow the policy regarding contacting the after hours on-call Administrator and the policy regarding an investigation not ending until it went through the Chief Nursing Officer and Director of Compliance, Quality and Risk.

The Incident Investigation Worksheet lacked documented evidence the facility reviewed policies related to the incident, yet the investigation revealed the facility would monitor compliance with its policies and procedures going forward by ensuring staff was knowledgeable following proper procedure.

The facility Guidelines for Measuring Staff Competency policy#1300.30, last revised 09/2017, Procedure IV, revealed Performance Evaluation and Review of Competency Education Requirements would be completed annually for all employees.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 61	{A 145}		

The MHT involved, hired 09/12/16, lacked documented evidence in the personnel file of annual competencies. The file contained only one competency check list dated 09/12/16.

On 06/6/19 at 4:15 PM, the Vice President of Nursing, Assessments and Referrals verbalized job-related competencies were supposed to be completed at hire and annually.

Elopement Incidents:

Patient #33
Patient #33 was admitted on 04/23/19, with diagnoses including bipolar disorder and history of elopement, suicidal ideation and property destruction.

Nursing Progress Notes dated 04/23/19, 05/01/19, 05/06/19 and 06/01/19, showed Patient #33 had physical altercations with other patients, requiring physical restraint holds.

The medical record showed staff did not update the Treatment Plan until 05/07/19 for restraint or seclusion (physical altercation with peer).

A Nursing Progress Note, dated 05/20/19, showed Patient #33 eloped from the facility and the police returned Patient #33.

On 05/21/19, a physician ordered elopement precautions.

On 5/22/19 at 2:30 PM, Patient #33 was observed ambulating on a unit wearing a green hospital gown. The patient acknowledged the gown was uncomfortable and made the neck itch. The patient verbalized having to wear the gown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 62	{A 145}		

because of elopement behavior.

The facility Elopement Precautions and Occurrence policy 1000.30, last approved 9/2017 revealed patients on elopement precautions could wear personal clothing with the exception of shoes per unit policy. Patient could be placed in hospital gown or scrubs, with a physician order, if elopement attempts were persistent. Patients who posed a severe and persistent risk of elopement could have street clothes replaced with scrubs or gowns only with a physician order and clear documentation justifying restriction of patient rights.

On 05/22/19 at 2:35 PM, a Nurse Manager verbalized there was no physician order for the gown, but knew another nurse took an order from a physician.

On 05/22/19 at 2:50 PM, a Registered Nurse indicated gowns were used as a last resort and required a physician order, likely followed by an evaluation the same or following day.

On 05/22/19 at 3:20 PM, a Registered Nurse indicated an order was received from a Physician regarding wearing the gown, but the nurse went to a code and did not document the order.

On 05/22/19 at 3:34 PM, a Psychiatrist ordered denial of rights and to place Patient #33 in a gown with no frequency.

On 05/22/19 at 4:00 PM, the Medical Director acknowledged a physician order should have been obtained to place a patient in a gown for eloping.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 63	{A 145}		

On 05/29/19 at 9:40 AM, a Psychiatrist verbalized gowns were used for safety for aggressive patients and as a deterrent for eloping and that the decision to use gowns was driven by nursing.

The facility Denial of Rights policy #1800.4, last reviewed/revised 1/2018 revealed denial of rights required a physician's order. The policy indicated the order must delineate the clinical justification for the denial of rights, specify which right(s) were to be denied and must be time-limited with the time limitation stated in the order.

The physician's order dated 05/22/19 at 3:34 PM, lacked documented evidence of all required points of the Denial of Rights policy.

On 05/29/19 at 12:30 PM, the Medical Director verbalized the gown served as a physical identifier, so the patient could be easily found in public after eloping. The gown also served as a psychological hindrance for the patient who thought of eloping. The Medical Director indicated there should have been an analysis as to why the patient eloped and tried to elope and there should have been documentation justifying a restriction of patient rights. The Medical Director indicated the facility may have to revisit the Elopement policy.

On 05/31/19 at 11:00 AM, a Registered Nurse Supervisor verbalized the patient wore the gown for safety reasons, but the gowns could be humiliating and that there should have been a progression of interventions prior to placing patients in gowns as the gown should be a last resort.

On 06/06/19 at 10:15 AM, the Chief Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 64	{A 145}		

Officer (CCO) indicated adolescents wearing gowns would not have been therapeutic at all, rather there should have been positive reinforcement, not punitive singling out of a patient. The CCO indicated self-worth and self-esteem issues should have been paramount. The CCO indicated when trying to promote inclusiveness, one would not want to use gowns.

Patient #43
Patient #43 was admitted on 03/25/19, with diagnoses bipolar disorder, major depressive disorder and paraphilia.

On 03/25/19 at 9:50 AM, an incident report showed Patient #43 kissed Patient #46.

On 04/10/19, Patient #43 was discharged.

On 05/23/19 at 1:45 PM, Patient #43 lacked documented evidence of a treatment plan update for the incident dated 03/25/19.

Patient #46
Patient #46 was admitted on 12/12/18, with diagnoses including mood disorder and attention deficit hyperactivity disorder.

On 03/25/19 at 9:50 AM, an incident report revealed Patient #46 and Patient #43 shared a hug and attempted kissing. Patient #43 was transferred to youth acute afterward. Patient #46 documented staff members failed to warn or prompt the patients to watch boundaries.

The Incident Investigation Worksheet revealed staff members had their backs turned during the incident and lacked documented evidence the facility reviewed policies related to the incident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 65	{A 145}		

yet the investigation revealed the facility would monitor compliance with its policies and procedures going forward by adhering to safety monitoring policy and procedures.

On 05/22/19 at 10:45 AM, the DCQR verbalized the facility failed to complete Incident Investigation Worksheets and described the process of investigations and related interventions for various incidents and identified the following issues: "1) facility needed to ask itself why the event occurred. 2) facility needed ask what systems issues were involved or if the event was even a system issue. 3) facility needed to ask what environmental factors influenced the event. 4) facility needed to identify if a patient needed to be separated from higher functioning patients. 5) facility needed to identify if training with more advanced de-escalation techniques was feasible. 6) facility could try more distraction techniques. 7) facility could check work history of Mental Health Techs if patients were directed to do things making them uncomfortable. 8) facility could shift personnel around more to cover breaks. 9) facility could emphasize roaming the halls more".

Patient #29
Patient #29 was admitted on 02/23/19 with diagnoses including intermittent explosive disorder, major depressive disorder (MDD), recurrent, severe with psychotic symptoms, and selective mutism.

A History and Physical Examination documented with observation date of 03/14/19, with a signature date of 02/23/19 (these are actually the dates documented on the form), documented the patient had MDD, seizures, chronic obstructive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 66
pulmonary disease (COPD), neuropathy to bilateral arms and legs, chronic low back pain with sciatica intermittently, gait abnormality, a history of transient ischemic attack (stroke), deep vein thrombosis (DVT), and pulmonary embolism (PE).

Treatment Plan initiated on 02/23/19 documented the patient would do the following:
Falls (moderate fall risk and used a walker)
Goal: Patient #29 will remain free from falls.
-Report feelings of lightheadedness immediately to staff.
-Remain in sitting position after walking for at least three minutes to prevent fall.
-Wear non-skid socks at all times when not wearing shoes.

Pain (Chronic pain from neuropathy)
Goal: Patient #29 will articulate alternative pain relieving measure.

Risk for Seizure (history of seizures, last seizure a few days ago)
Goal: Patient #29 will remain safe and not have a seizure while admitted to the hospital.
-Remain free from seizures
-Report lightheadedness immediately to staff.

A Nursing Progress Note dated 02/23/19 documented Patient #29 was agitated and the RN gave the patient as needed Vistaril 50 mg which did not help the patient calm down. The patient started hitting his head on the door and the House Supervisor placed the patient in a safety hold to prevent self harm. The note indicated the attending physician was notified of the incident and emergency medications Haldol 5 milligrams (mg) intramuscular (IM), Benadryl 50 mg IM, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 67	{A 145}		

Ativan 2 mg IM were ordered and administered. The note indicated no injuries were observed.

A Commission on Behavioral Health Report Form - Seclusion and Restraint Orders dated 02/23/19 documented in the RN narrative the patient was becoming more agitated, hitting himself in the head.

On 05/31/19 at 11:12 AM, a RN indicated remembering Patient #29 purposely hitting himself in the head using the door. The RN indicated the physician was notified, but could not remember if it was the medical or the psychiatric physician.

On 05/31/19 at 2:30 PM, a House Supervisor indicated during the incident when Patient #29 began banging his head, "I put my hand between the doorway and the patient's head". The House Supervisor indicated if someone was self-harming, throwing self from the wheelchair and hitting self the psychiatric provider on call would have been called. The House Supervisor indicated remembering the patient being in a wheelchair but was ambulatory.

The House Supervisor indicated if there were any visible signs of injury the patient would have been sent to the emergency room and ff hitting self in the head the patient would have been placed on a medical consult list but if no apparent or obvious injuries then staff would merely document the incident.

The Fall Assessment - Adult dated 02/23/19, revealed the following:
- Most recent fall was on 02/22/19.
- Continence status as independent and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 68	{A 145}		

continent.
- The patient ambulated without problem and with devices (wheelchair, walker, cane).
- The patient maintained balance while standing and sitting.

The patient's fall risk score was 11 indicating moderate risk

A Nursing Progress Note dated 02/27/19 at 2:09 AM, documented at around 11:30 PM, Patient #29 was seen on the floor by a Mental Health Technician (MHT) naked and indicated the patient stated he could not move legs and hands. Patient #29 was helped back to bed and a new gown was placed on the patient with the help of another nurse and a MHT. The Nursing Progress Note indicated the RN noticed the patient was able to move his hands and could bear weight on legs, and patient denied pain or hitting his head. The Nursing Progress Note indicated the MHT reported seeing the patient moving his legs and arms trying to intentionally get on the floor while on rounds.

The Nursing Progress Note documented at approximately 1:20 AM, the patient was found on the floor again by the MHT with feces on his bottom. The patient was helped back to bed, cleaned up and a new gown put on the patient. The Nursing Progress Note indicated the patient was able move all extremities but would not comply and was difficult to redirect. The patient denied pain and denied hitting his head. The House Supervisor was aware and present and the on call Nurse Practitioner (NP) was notified, and no new orders were received. Vital signs documented were blood pressure 133/88, heart rate 84, respiratory rate 16, oxygen saturations 95%, and temperature 98.3. The RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 69	{A 145}		

administered as needed (prn) Vistaril and Trazodone. The note indicated the patient was able to sit up on his own, hold a cup of water, and drink medications.

The progress note lacked documented evidence neurological checks were completed and a medical physician or nurse practitioner was called when the patient was seen on the floor by the MHT at 11:30 PM, and the reason prn Vistaril and Trazodone were administered after the patient was found on the floor at 1:20 AM.

On 05/23/19 at 4:23 PM, an Interim Nurse Manager explained when a patient is found on the floor it depended on if anyone had seen what happened with the patient, if not it was considered an unwitnessed fall. The RN indicated for an unwitnessed fall the physician was notified, if the patient has a roommate they are asked if anything happened. The physician would be asked if they would like to order neuro checks. The RN verbalized, "we notify on any unwitnessed fall." The RN identified the Nurse Practitioner (NP) called was a psychiatric NP. The RN indicated they typically call medical as well as psychiatry.

On 05/29/19 at 12:40 PM, a Nurse Manager indicated the MHT should have looked for signs of breathing or movement.

On 05/31/19 at 7:55 AM, a MHT verbalized he typically worked the night shift and floated to other units. The MHT verbalized not being aware a fall incident occurred with Patient #29 on the evening of 02/26/19 and denied reporting seeing Patient #29 moving his legs and arms trying to intentionally get on the floor while on rounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 70 On 05/31/19 in the morning, a Nurse Practitioner (NP) identified self as a Psychiatric NP. The NP indicated it was reported Patient #29 banged his head against the wall and purposely threw himself on the floor and intentionally used the bathroom on himself, and wanted the staff to clean him. The NP acknowledged receiving a call regarding Patient #29. The NP indicated a progress note was done when she actually saw a patient. The NP indicated not seeing the patient. The NP indicated being made aware of the patient's prn medications and indicated they were not needed. The NP verbalized there were steps to avoid giving the prn medications. The NP indicated the nurse should have put in the note what was said regarding Patient #29's medications. The NP verbalized for any type of head injury, vital signs, neurological checks would have been monitored and the medical doctor notified immediately. The NP indicated being on call 10:00 PM - 7:00 AM. The NP indicated being typically called for patient admissions, medications, but if there were obvious medical issues a medical physician was called. The NP indicated being informed by the nurse that earlier the patient was found on the floor and could move all extremities, and the MHT found the patient sliding out of the wheelchair. The NP disclosed only being called once regarding the two incidents and staff did not say it was unwitnessed. The NP indicated being told the patient was getting out of the wheelchair throughout the day and getting on the floor. The NP indicated not knowing anything about the patient's mutism. The NP indicated she was	{A 145}		

{A 145} Continued From page 71 {A 145}

notified of the earlier incident but assumed someone else was called. The NP indicated the staff called about the second incident of the patient being found on the floor.

If the patient had hit his head, "I would say call medical". The NP indicated being told the patient did not hit his head. The NP stated, "I would typically order neuro checks, vital signs and to monitor". The NP acknowledged staff should have called her or medical when the patient was found on the floor the first time.

The NP indicated Patient #29 would have been given the prn Vistaril if the patient verbalized anxiety. The NP indicated not finding out Patient #29 banged his head on the door until after the patient had been sent out to the hospital the next day. The NP verbalized the patient's behaviors of throwing himself out of the wheelchair and sliding to the floor purposely should have been documented.

On 06/06/19 in the afternoon, the Director of Compliance Quality and Risk (DCQR) was informed the NP was not notified when the patient was found on the floor at 11:30 PM and the DCQR acknowledged there was no documentation to show a call was made.

A facility policy entitled Neurological Checks, policy #1300.10, revised January 2017 and reviewed January 2018 documented neurological checks should always be performed immediately on a patient who has experienced or is suspected of experiencing a fall. Neurological checks are also performed when ordered by a physician.

If a patient falls, or is suspected of falling, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 72	{A 145}		

nurse will immediately assess the patient.
- An initial neurological check will be performed immediately.
- The patient's medical doctor and psychiatrist will be notified.

The facility Fall Precautions Policy #1000.103 last revised and approved March 2019, documented each patient considered at risk for falls due to current physical status, history and/or treatment regimen would have been placed on Fall Precautions and a Functional Screen would have been performed at the time of admission using a Falls Risk Factors Assessment Form for adult patients.

Patients deemed a fall risk would have been placed on Fall Precautions including the following:
-A fall sticker placed on the outside of the chart to alert staff that the patient was a fall risk.
-Patient placed on a minimal observation level of every (Q) Q15 minute checks.
-The Treatment Plan would have included a problem sheet for Fall Risk.
-The form was used to create a problem sheet in the Treatment Plan and included as a part of the Nursing Assessment.
-Patient encouraged to participate in physical activity as appropriate and safe for their conditions.
-Patient educated and assessed regarding safety and fall precautions; document in progress on every shift while awake.
-Write Fall Precaution on observation check form to alert Mental Health Technician to fall risk.
-When patient conditions change a Fall Assessment is done.
-All falls occurring on the unit would have been reported to the primary physician, medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 73	{A 145}		

physician, the supervisor, a family member and if applicable Risk Management by the nurse in charge.
-Following the administration of emergency medication, a patient would be on line of sight observations for six hours.

Nursing Progress Note dated 02/27/19 documented the RN went to Patient #29's room to give medications and found the patient unresponsive to verbal commands, tapped the patient on the shoulder and received no response. The RN noticed the patient had gargled breath and agonal breathing. The nurse began sternal rub and called a "code white". The RN indicated the patient had a palpable pulse. The head of the bed was elevated. Oxygen was applied via mask. Vital signs were: BP 122/85, pulse 50 and O2 sats 98 % on 10 liters, blood glucose 126. The RN indicated the patient was suctioned and food residue was removed from the patient's mouth. The ambulance was called and patient remained unresponsive. The patient was transferred to an acute care hospital and the physician was notified.

Final Ancillary Orders (non-med) dated 02/27/19 documented the patient was admitted to an acute care hospital with a diagnoses of intracranial hemorrhage.

Discharge Summary dated 03/04/19 documented the patient was transported to the hospital after nursing found him unresponsive on 02/27/19.

An Organ Procurement Operative Report dated 03/06/19, documented the diagnosis and brain death secondary to head trauma.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 74	{A 145}		

A Computed Tomography (CT) of Head or Brain without (w/o) contrast dated 02/27/19, documented a large subdural hematoma seen primarily in the interhemishperic fissure maximum diameter measuring 15 mm with a smaller subdural hematoma seen along the right parietal lobe, and a significant right to left midline shift with evidence of transfalcine herniation with dilated left temporal horn. A questionable minimal subarachnoid hemorrhage. Diffuse edema was seen primarily within the right temporal lobe extending to the parietal lobe.

A Discharge Summary from an Acute Care Hospital dated 02/21/19 revealed a CT of Head or Brain w/o contrast done on 02/19/19. The reason for the exam was headache without cerebrovascular accident. The findings included there was no hemorrhage, no mass or mass effect, and no abnormal extra-axial fluid. The ventricles, sulci, and cisternal spaces were normal in size for patient age. The was no evidence of acute ischemia. There was no depressed, or widely displaced calvarial fracture and the visualized sinuses were well aerated.

On 04/12/19 at 4:48 PM, a Registered Nurse (RN) indicated a MHT found the patient on the floor (the RN interviewed indicated they were not working the shift at the time). The RN indicated when a patient had an unwitnessed fall or was found on the floor by staff; vital signs and an assessment was done by the nurse. The RN indicated for immediate danger, the physician would by notified, neurological checks would be done, and an increase to line of site would be done, and if unsteady 1:1 line of site would be necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 75	{A 145}		

Continued From page 75

The RN indicated being aware of the patients history. The RN indicated the patient placed himself on the floor and when he could not get his way, he would bang his head into things. The RN indicated the patient was placed on 1:1 because he threw himself to the floor.

The RN indicated when a patient was found unresponsive a code white is called, vital signs are taken and Oxygen (O2) started if needed. If breathing regularly no O2 would be needed. The RN indicated patients in need of O2, were placed on 10 Liters of O2 via a venti mask.

On 05/21/19 at 11:43 AM, an Interim Nurse Manager indicated being the RN who found the patient unresponsive on the morning of 02/27/19. The RN indicated the patient was found on the floor by an MHT on 02/26/19. The RN indicated the patient had no injuries.

The RN indicated the most recent fall on the Fall Risk Assessment dated 02/23/19, was reported by the patient and not an actual fall. The RN indicated the patient utilized a wheelchair to get around. The RN revealed the patient hada history of seizures, DVT, PE, neuropathy of the right leg from traumatic brain injury (TBI), and received Lovenox at the time while maneuvering devices. The RN indicated the patient requested the wheelchair. The RN indicated the patient was assessed by a physician for use of the wheelchair.

On 05/23/19 at 4:23 PM, the RN explained a Code Blue was called for cardiac and respiratory arrest. A Code White was called for a patient not responding, seizures or any other medical issue. The RN indicated one would respond in the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 76
way and be prepared or both codes could be called.

The RN explained when a patient is found on the floor it depended on whether anyone had seen what happened with the patient, if not it is considered an unwitnessed fall. The RN indicated for an unwitnessed fall the physician was notified, if the patient has a room mate they are asked if anything happened. The physician is asked if they would like to order neuro checks. The RN verbalized, "we notify on any unwitnessed fall." The RN identified the NP called was a psychiatric NP. The RN indicated typically a medical physician as well as psychiatry was notified.

On 05/29/19 in the afternoon, the Interim Chief Nursing Officer (CNO) indicated a Code White was a medical incident and a Code Blue was no breath sounds. The CNO verbalized a Code White could have turned into a Code Blue.

On 05/29/19 at 12:40 PM, a Nurse Manager explained when a patient was found on the floor the nurse should have notified the medical physician and completed a full assessment including neuro checks and a post fall assessment. The Nurse Manager indicated the medical physician should have been called with any incidents involving the patient and the psychiatric physician should also be notified.

On 06/04/19 in the evening, the Interim CNO confirmed a Code Blue and a Code White were not the same.

On 06/04/19 at 3:14 PM, the Interim CNO verbalized a code report was not done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 77

On 06/06/19 at 1:58 PM, a Nurse Manager confirmed there was no Code Blue report for Patient #29. The Nurse Manager verbalized a code report should have been completed.

On 06/06/19 at 4:00 PM, a MHT indicated when doing rounds on Patient #29 everything appeared to be okay and the patient was asleep. The MHT verbalized, "I know Patient #29". The MHT indicated noticing a bruise on the patient's forehead and remembered the patient saying he got it from somewhere else. The MHT remembered coming to work and the patient had the bruise but could not remember the time or date.

The MHT indicated when doing rounds she looked in a patient's room, if visible from the doorway and if not visible stepped into the room. The MHT verbalized the process for monitoring a patient while in the room resting or sleeping as looking for visible movement, chest rising and falling while not touching the patient physically. The MHT indicated she was on break and not the MHT on the floor at the time of the incident.

Physician Medication Orders - Final included the following medications:
Fluticasone-salmeterol 100 microgram (mcg) inhalation, 1 puff daily for COPD.
Albuterol chlorofluorocarbon free inhalation 90 mcg/INH AERO 18, 2 puffs four times daily as needed (prn)for Asthma.
Levetiracetam 1000 milligrams (mg) by mouth (PO) twice daily for seizures.
Acetaminophen 81 mg PO daily for a history (hx) of blood clot.
Enoxaparin injectable 100 mg/milliliters (ml) subcutaneous twice daily for PE/DVT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 78
Gabapentin 200 mg PO three times daily for neuropathy.
Trazodone 50 mg HS for insomnia
Ibuprofen 400 mg q4h for pain for 3-6 on pain scale
Acetaminophen 650 mg q4h for pain 1-2 on pain scale
Hydroxyzone Pamoate 50 mg q4h prn mild anxiety
Methocarbamol 750 mg q8h for spasms
Diphenhydramine injectable 50 mg IM potential for self harm
Lorazepam Injectable 2 mg IM potential for harm
Haloperidol Injectable 5 mg potential for harm

The facility Code Blue Policy #1000.13 last revised September 2017 included a facility clinical staff member trained in cardiopulmonary resuscitation (CPR) would implement the Code Blue in the event of cardiac or respiratory arrest. A staff member trained in CPR would assess the absence of ventilation and/or circulation. A staff member would announce Code Blue, and give the precise location over the facility's paging system three times. The Code Blue Leader would assign documentation of emergency support care activities using Code Blue Report.

The facility Code White, Rapid Medical Response Team Policy and Procedure #1000.56, effective 09/10/15, and revised 12/20/18 documented the purpose of the Code White Rapid Medical Response Team was to bring rapid medical expertise to the patient's bedside.

The Code White response team will assist staff members in assessing and stabilizing the patient's condition and organizing information to be communicated to the patient's physician. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 79	{A 145}		

response team members will also provide education and support at the time of the call and start assembling various pieces of clinical information and formulating a clear time picture of the underlying patient condition. Should circumstances warrant, the team members will also arrange transport to a higher level of care (i.e. 911).

Nursing staff will receive education and training on the following:
- Early warning signs, criteria and procedures for calling/notifying the Medical Response Team.
- Communication and teamwork skills including the use of the situation, background, assessment, recommendation (SBAR) method, appropriate assertion and critical language speaking.
- Appropriate expectations of when to call and what happens after the call is made.
- What information to have available for the Code White Team when they arrive.

Early Warning Signs/Criteria for activating the Code White Team included any or all of the following:
- Acute change in urinary output to <50 ml in 4 hours (on patients with I/O being monitored)
- Acute Mental Status Change, drooling, slurred speech, left or right sided weakness
- Seizure activity
- Change in LOC (Level Of Consciousness)
- Difficulty Speaking (new onset)
- Patient with a recent fall requiring medical assistance.

Procedure:
1. When any one of the qualifying criteria is met, either the patient's nurse or designee will call the nursing supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 80

6. The Code Team documentation will be completed by Code White Team members and the staff nurse including completion of the Code Team Record.
7. If the patient is at immediate risk of arrest, a "Code Blue" will be called stat for emergency medical management.
9. A debriefing of the code and education should take place immediately after the situation is controlled to allow for opportunities of leaning and improvement for all team members.
11. The Code White Team Record will be completed and signed by all involved practitioners.

Documentation:
1. Documentation will be completed on the medical response record and maintained in the patient's permanent record, a copy will be sent to the QI department for periodic review by the medical response members for a continued quality improvement and education.
2. Results of the reviews will be reported to the Quality Committee on a monthly basis.

A Registered Nurse/LPN - Competency Checklist (Self-Assessment) for Employee #5 dated 05/20/19 indicated staff must complete, prior to or during orientation, a competency checklist of his or her position. The checklist is a self-assessment of current level of knowledge and skill.

The competency checklist indicated the supervisor/manager within 30 days of the employment would assess and rate employee competency based upon demonstration and/or verbalization of the employee's ability to perform skills which included response to critical incidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 81
and emergency procedures.

Review of Employee #5's record revealed the employee was hired in November 2018 and the competency was not completed until 05/20/19.

On 06/07/19 in the morning, the Human Resources Director acknowledged the Registered Nurse was hired in a staff RN position then transitioned to an Interim Nurse Manager position and the competency was not completed. The Director of Human Resources verbalized the competency should have been completed. The RN was not due for an annual evaluation until November 2019. The Human Resources Director indicated an audit was done and confirmed competencies were not completed. This information was forwarded to the unit managers who were responsible for ensuring the competencies were completed for their area.

On 06/07/19 at 12:48 PM, an interview was conducted with the Medical Director, the Assistant Medical Director, a Psychiatric Physician and the Director of Internal Medicine.

The Director of Internal Medicine indicated the patient was admitted the previous month. The patient had a lot of behaviors and personality type issues, and participated when he got what he wanted. The patient's behaviors were not specific to one thing. The Director of Internal Medicine indicated the patient was on regular pain medications, narcotic type substances. The patient was deliberating coming out of the wheelchair. The staff watched the patient weight bear on and move extremities. The patient acted like he could not talk. The patient had manipulative type behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 82	{A 145}		

A Physician indicated the patient had a history of PE and was on Lovenox. The patient was scoped by GI and resumed all blood thinners that were previously discontinued.

The Director of Internal Medicine indicated remembering the nurse saying the patient was sliding out the chair and it was part of the issue. The physician verbalized, "I felt that we documented sufficiently but should have mentioned previous falls."

A Physician explained the patient was unreliable and they tried to filter and write to the most important things that needed to be addressed.

A physician explained if a patient was found on the floor, staff called the medical physician. Whether a patient could move or not, if no deficit, then an order for neuro checks, if no neurological condition continue to monitor. If the patient fell, and the neuro checks were deficient the patient would be transferred out right away. The physician verbalized neuro checks were not deemed necessary at the time.

The Director of Internal Medicine acknowledged the nurse should have called when the patient was found on the floor at 11:30 PM on 02/26/19. The physician indicated the nurse may have called the medical team. The patient was crawling on the floor and then crawled and went back to bed. The Director indicated, Nursing calls all the time. The Director stated she remembered being called. When the patient was found on the floor, there were no signs of neuro deficits, standing, talking going back to bed. The nurse tried to access the patient and the patient did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 83	{A 145}		

complain of dizziness and denied having headache.

The physician verbalized, "I honestly wish I can recall if we ordered neuro checks". It was brought to the physicians attention the patient's medical record and the treatment plan lacked documented evidence of the patient behaviors of intentionally sliding out of the wheelchair and throwing self to the floor.

The physicians agreed they relied on the nurses' information. They were not sure what transpired.

The Medical Director was not aware of code report not being done. The Medical Director replied Emergency Medical Services did the code. The Medical Director indicated the patient had a diagnoses that carried a risk for brain bleed. The Medica Director indicated the patient's head banging was not consistent and the patient had other behaviors that were inconsistent. The Medical Director indicated the patient's behaviors were action seeking and one could not know the predictability.

A physician indicated the patient had a risk for hemorrhage being on blood thinners and that the patient was placed on fall preventions.

The Director of Internal Medicine verbalized, "I agree things should have been documented". The Medical Director indicated the nursing documentation should have been more detailed.

In summary, Patient #29 was admitted on 02/23/19 and shortly after had an incident with banging his head on the door. Three days later, on 02/26/19 at around 11:30 PM, the patient was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 84	{A 145}		

found on the floor and again on 02/27/19 at approximately 1:20 AM. Confirmed by interview with a Registered Nurse, Nurse Manager, Interim Chief Nurse Officer, Nurse Practitioner and Physician, when a patient is found on the floor and it is not witnessed it by anyone it is considered an unwitnessed fall. The unwitnessed fall occurring at 11:30 PM was not reported to a physician and neuro checks were not done. On 02/27/19 at approximately 9:30 AM, the patient was found unresponsive and was transported to the hospital. A Computed Tomography of Head or Brain without contrast done on 02/27/19, documented the patient had a large subdural hematoma. The Coroners Report revealed the patient was diagnosed with an acute subdural hematoma with a minimal subarachnoid hemorrhage. The patient deteriorated and was pronounced brain dead on 03/03/19. The Organ Procurement Operative Report dated 03/06/19, documented the diagnosis as brain death secondary to head trauma.

The Fall Risk Assessment dated 02/23/19 lacked documented evidence of systolic blood pressure (BP) while lying, sitting and 1 and 3 minutes after standing. The assessment indicated "No drop in pressure noted." The corresponding vitals sign observations dated 02/23/19 documented the BP as 116 mmHg/72 mmHg. The was no indication whether this blood pressure was taken while the patient was lying, sitting or standing.

General Vitals Signs revealed the following:
On 02/24/19 heart rate 69 beats/min, respirations 18 resp/min, bp 109/73 mmHg.
On 02/26/19 heart rate 89 beats/min, respirations 18 resp/min, bp 113/75 mmHg SPO2 96 % room air.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 145}	Continued From page 85	{A 145}		

On 05/21/19 at 12:10 PM, the Nurse Manager confirmed there were no orthostatic blood pressure done.

Inappropriate Staff Conduct

An investigation regarding an allegation of inappropriate sexual contact between patients and staff in the residential unit revealed the following:

A Hospital Employee Counseling Report dated 03/05/19 for MHT #1 documented a Final Written Warning that the staff failed to maintain professional boundaries with patients and used poor judgment while performing duties as a MHT.

The expectation improvements and time frames to resolve the issue indicated the staff would conduct himself in a professional manner at all times and set firm boundaries with patients. Additionally, staff would complete a refresher training on setting boundaries with patients.

The Employee Counseling report was signed by the MHT #1.

A Hospital Employee Counseling Report for MHT #2 dated 03/06/19 documented a Final Written Warning that the staff failed to maintain professional boundaries with patients and used poor judgment while performing duties as a MHT.

The expectation improvements and time frames to resolve the issue indicated staff would conduct himself in a professional manner at all times and set firm boundaries with patients. Additionally, staff would complete a refresher training on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 86	{A 145}		

setting boundaries with patients.

The Employee Counseling report was signed by the MHT #2.

An document titled Incident Information (undated) revealed the facility concluded that based on statements presented and the lack of evidence that alleged sexual misconduct occurred, the leadership team determined the MHT's would have received; a written reprimand in the form of a final warning notice; and re-education regarding appropriate boundaries with patients.

The document revealed all direct care staff would have been assigned and required to complete a one hour online training on maintaining appropriate patient boundaries to be completed by 03/22/19.

On 04/12/19 at approximately 10:00 AM, the Nurse Manager of the residential unit indicated the facility followed an algorithm regarding any allegation of physical, sexual abuse or inappropriateness with a patient. If the allegation was against a staff member, the facility ensured the patient was safe, statements would have been obtained, the badge and keys were taken, statements obtained from anyone with knowledge of the alleged abuse, informed the parents, doctors, and the Chief Nursing Officer (CNO).

The Nurse Manager indicated to protect the patient, the staff would have been placed on administrative leave pending an investigation. If they could not substantiate the allegation the leave was lifted and the staff placed on another unit until the patient discharged from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 87	{A 145}		

The Nurse Manager indicated the facility tried to keep male Mental Health Technicians (MHT's) on the male side of the unit and female MHT's on the female side of the unit, however this changed based on staff availability.

On 04/12/19 in the afternoon, the Nurse Manager discussed staff education and retraining involving setting boundaries. The Nurse Manager indicated there was no specific timeframe for the staff to complete the training, and it depended on each individual Nurse Manager. The Nurse Manager indicated the staff would sit down with their specific Manager and discuss the refresher. The Nurse Manager verified and confirmed the MHT's had not completed the refresher training on setting boundaries with patients.

On 04/16/19 at approximately 12:45 PM, the Chief Executive Officer indicated the facility followed the Abuse Policy regarding the inappropriate behavior. A Copy of the test provided via email on 04/16/19 revealed the MHT's took the refresher course on 04/16/19.

Complaint #NV00056772

Patient #21
Patient #21 was admitted on 04/17/19 with diagnoses including unspecified psychosis.

1) Incident Reports following the use of Restraint/Seclusion

A review of hospital seclusion and restraint reports titled Commission on Behavioral Health Report Form, Seclusion and Restraint Orders, and facility incident reports, indicated Patient #21 was placed in seclusions/restraint and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 88	{A 145}		

corresponding incident reports were done as follows:

04/19/19 at 10:15 PM, Incident Report #14789
04/19/19 at 10:53 PM, Incident Report #14799
04/20/19 at 11:45 AM, No Incident Report
04/21/19 at 9:00 AM, No Incident Report
04/21/19 at 1:30 PM, Incident Report #14808
04/22/19 at 1:50 AM, No Incident Report
04/22/19 at 9:09 AM, Incident Report #14867
04/22/19 at 4:45 PM, No Incident Report
04/24/19 at 10:00 AM, No Incident Report
04/27/19 at 10:55 AM, No Incident Report

On 05/23/19 at 1:50 PM, the Director of Compliance, Quality and Risk (DCQR) verbalized incident reports were not submitted by staff following six episodes of restraint/seclusion for Patient #21. The DCQR did not know why staff did not submit the incident reports. The DCQR revealed the Chief Nursing Officer (CNO) reported on incidents in morning meetings. The Psychiatrist and Medical Director should be informed and recommend interventions.

On 05/22/19, in the afternoon, the Interim Chief Nursing Officer reported being "way behind" on reviewing incident reports.

On 05/23/19 at 10:05 AM, the Nurse Manager of Adult Services revealed Patient #21 was admitted on 04/17/19. Patient #21 had severe psychosis and the patient had a high usage of restraint, seclusion, and emergency medications. Patients with two usages within 24 hours may require medication. The Treatment Plan did not reflect any changes or revisions were added following episodes of restraint/seclusion occurring on 04/19/19, 04/20/19, and 04/22/19. The Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 89	{A 145}		

Manager reported the Treatment Plan should have been updated following each specific incident of restraint, seclusion, or use of emergency medications. Different actions steps and interventions should have been listed. The nurse can write in free text into the Treatment Plan. The Nurse Manager verbalized nurses were trained on how to do this.

A review of the record revealed there was no nursing progress notes documenting the episode of restraint/seclusion that place on 04/24/19 at 10:00 AM. Following this episode the patient was discharged to the hospital and was readmitted greater than 24 hours later, on 04/23/19. The Treatment Plan for this admission was initiated on 04/25/19. The Nurse Manager indicated there should have been a nursing progress notes documented for each incident of restraint or seclusion and a Treatment Plan should have been initiated within 8 hours of admission, so this was late.

On 05/23/19 at 4:25 PM, the DCQR revealed after detection of a patient with a high incidence of use of restraints and seclusion, the DCQR would talk to the treatment team as to what could be done differently. If there was oversight of the treatment team it would spur more action. The DCQR revealed there was no process to cross reference the incident reports with the restraint/seclusion forms.

On 05/29/19 at 8:50 AM, the Registered Nurse (RN) acknowledged an incident report should be done following restraint/seclusion of a patient.

On 05/29/19 at 9:15 AM, the Nurse Manager did not know why the incident reports were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 90	{A 145}		

submitted. The Nurse Manager stated audits were done to ensure the incident reports were done, but these incidents "slipped through the cracks."

2) Facility Incident Report #14865:

Patient #21
Patient #21 was admitted on 04/17/19 with diagnoses including unspecified psychosis.

Incident Report #14865 dated 04/22/19, indicated there was an allegation of abuse. Patient #21 was found in a room unconscious with abrasions on the neck and arms after being assaulted by Patient #32. An emergency ambulance was called and the patient was sent to a local hospital for further treatment. The report was reviewed by the Director of Compliance, Quality and Risk (DCQR). The DCQR documented due to the severity of the incident, a formal investigation would be conducted.

The Incident Investigation Worksheet dated 04/25/19, included patient and staff interviews and a video camera review. The police were not notified. There was no evidence a review of facility policies was done in connection with the incident.

The incident occurred in the Adult South Hall. Video camera review revealed Patient #21 was in Room 123 at 6:02 PM. Patient #32 entered the Room 123 at 6:02 PM. Patient #32 exited Room 123 and made hand gestures for staff to come at 6:07 PM. Staff responded to the room at 6:07 PM. An emergency response team left the unit with Patient #21 at 6:27 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 91	{A 145}		

The summary of an interview with Patient #32 dated 04/22/19 documented Patient #32 admitted to assaulting Patient #21, stating "she asked for a fade, so I gave her a fade."

The summary of an interview with a Mental Health Technician (MHT) dated 04/22/19, documented one MHT was on break and only one MHT was on duty for that hallway.

The summary of an interview with a different MHT on 04/25/19, documented the MHT was in the dayroom area after finishing 15 minute checks. A patient yelled to go check on the patient. The MHT found the patient unresponsive. The MHT called nurses.

The summary of an interview with a Registered Nurse on 04/25/19, documented the patient did not have a pulse. Cardiopulmonary Resuscitation (CPR) was started. The patient had return of pulse and breathing after one minute of CPR.

The summary of an interview with Patient #21 on 04/25/19, documented Patient #21 did not remember what happened. Patient #21 stated the incident was very traumatizing. There was no documentation Patient #21 was asked about, or made, a decision about wanting to press criminal charges against Patient #32 or not.

The Incident Investigation Worksheet documented lessons learned was "the importance of staff roaming the halls between rounds." Actions taken to prevent the incident from happening again were "reeducation for adult services staff on the importance of roaming the halls between rounds." Monitoring of of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 92	{A 145}		

compliance with facility policies and procedures going forward included "monitoring at least once daily while on shift to ensure roaming was being done, and video monitoring biweekly at times manager was not present to ensure compliance with roaming in between 15 minute rounds."

Observations documented in Patient #21's medical record indicated the patient was housed in Room 232, and Room 123 was not the patient's own room. On 04/22/19 at 5:58 PM, the patient was at the nurses station and at 6:13 PM was in a patient's room lying/sitting.

Observations documented in Patient #32's medical record indicated the patient was housed in Room 118. On 04/22/19 at 5:59 PM and at 6:15 PM, Patient #32 was in the patient's room lying/sitting.

On 06/06/19 at 09:45 AM, a Mental Health Technician (MHT) revealed on 04/22/19 they were working in the South Side of the Adult Acute Unit along with one other MHT. The MHT had just returned to the unit from a break when Patient #32 summoned the MHT to go to Room 123. Upon arriving to the room, Patient #21 was unconscious on the floor and staff called a code. The MHT scooped the patient off the floor after "she took her last breath." The MHT noted red marks in the shape of hand prints on Patient #21's neck, indicated the patient had been choked. The MHT checked the patient's pulse, and there was none. The Charge Nurse arrived to the room and did chest compressions on the patient and she had return of pulse. The MHT reported not being informed about a prior altercation between the two patients so he could have been more aware. The two patients did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C **06/14/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE** **LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 93	{A 145}		

get along and should have been kept apart.

On 06/06/19 at 11:45 AM, the Interim Chief Nursing Officer indicated MHT's needed to do more roaming, and more training and reinforcement on the importance of roaming between rounds. The Chief Nursing Officer described MHT's were supervised by the Registered Nurse (RN). The RN was responsible for ensuring MHT's were performing the 15 minute checks and roaming the unit between checks. RN's should intervene if observing MHT's not doing these tasks.

On 06/06/19 at 4:00 PM, an MHT indicated per facility rules patients were not allowed to enter the rooms of other patients. The MHT stated if a patient or patients were seen entering another patient's room they should be informed of the rules. The MHT indicated in between round the MHT should be roaming the hallway and looking into rooms to verify safety.

On 06/7/19 at 11:30 AM, the DCQR verified police were not notified regarding the incident. Facility policy was to notify police automatically for persons under the age of 18 or over the age of 65, or for an adult with a disability. For this incident, the patient was not under 18 or over 65 and did not ask to press charges, and for that reason police were not notified. The DCQR acknowledged the patient was having mental health symptoms which could impair judgement, and acknowledged the incident was serious given Patient #21 was choked and required CPR to revive (a near homicide). The DCQR described the police should have been notified and the police could make a decision regarding charges. The DCQR described due to the serious nature of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 94	{A 145}		

Continued From page 94

the incident, a Critical Analysis should have been performed within 30 days, with a root cause analysis, but this was not done. The DCQR recounted the Nurse Manager who was to monitor compliance with facility policies regarding ensuring roaming was done by MHT's was no longer employed at the facility. The DCQR reported not knowing if compliance was monitored with daily shift checks and with video monitoring biweekly as documented in the incident report.

The facility policy Critical Event Review and Reporting, revised 01/20/19, indicated critical events included any unwitnessed injury. For these an investigation would be done to ensure the unwitnessed injury was not due to patient abuse or neglect. A Critical Event Analysis would be done to determine the underlying causes of the critical event and to determine processes to reduce the risk or recurrence of the critical event. A Critical Event Analysis would be completed within 30 days of knowledge of the event.

3) Second incident involving Patient #21 and Patient #32 on 04/27/19 with no incident report.

Patient #21 was readmitted on 04/23/19 with diagnoses including psychosis after being hospitalized on 04/22/19 following an assault by Patient #32.

The Initial Psychiatric Evaluation dated 04/25/19, indicated Patient #21 reported homicidal ideation towards the patient who assaulted her (Patient #32) and towards staff and Patient #21 was placed on 1:1 observation.

A Nursing Progress Note dated 04/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 95	{A 145}		

indicated Patient #21 was punched in the face by another patient (name of this patient was not identified in the note) without provocation at the nursing station on the North Side of the Adult Acute Unit. The patients were separated and Patient #21 was put on the South Side of the Adult Acute Unit. When Patient #21 entered the day room on the South Side, the patient who assaulted Patient #21 on 04/22/19 [Patient #32] charged at her. Patient #21 was then placed in the seclusion room for safety.

The Commission on Behavioral Health Report Form (referred to as the restraint/seclusion record), dated 04/27/19 indicated Patient #21 was punched by a peer without provocation and was picked up and placed in the seclusion room for safety at 10:55 AM. There was no incident report documented regarding this incident.

Patient #21's Treatment Plan lacked documented evidence the facility modified the treatment plan after the incidents involving Patient #32 dated 04/22/19 or 4/27/19 or care-planned the patient for safety regarding a prior conflict with Patient #32.

On 06/07/19 at 11:30 AM, the DCQR indicated Patient #21's treatment plan should have been updated to include both incidents with Patient #32. Staff should not have placed Patient #21 back into proximity to Patient #32 because of their history of prior altercation and Patient #21 verbalizing homicidal ideation towards Patient #32. The DCQR stated the patient should have been moved to another location such as the Chemical Dependency Unit. The DCQR indicated facility policy was to keep patients from having contact following an altercation. The DCQR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}		{A 145}		

Continued From page 96

verified no incident report was submitted by staff regarding the incident on 04/27/19 where Patient #21 was punched by another patient, had a confrontation with Patient #32 and was placed in seclusion. The DCQR reported facility policy and procedure required staff to submit an incident report for assaults and for use of restraint/seclusion, and neither was done.

The facility policy Completion of Incident Reports, dated 01/01/17, indicated an Incident Report must be filed for incidents outside the course of routine care, treatment, and services. Incident Reports were not part of the patient's medical record. The policy indicated an Incident Report must be filed for physical altercations, harm to patient actual or potential, abuse or neglect of a patient, injury to a patient, or use of restraint or seclusion.

Patient #32
Patient #32 was admitted on 04/22/19 with diagnoses including major depressive disorder with suicidal and homicidal ideations.

A Nursing Progress Note dated 04/23/19 indicated the patient was upset regarding a situation which occurred yesterday. The patient was mad at staff for not helping her. The patient was encouraged to take responsibility for her action of choking another patient.

A Nursing Progress Note dated 04/25/19 indicated the patient got agitated after seeing another patient on the other side of the nursing station. The patient stated "I get very angry agitated when I see that patient, I do not want to see her."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 145} Continued From page 97 {A 145}

A Nursing Progress Note dated 04/27/19 indicated the patient became extremely agitated regarding a female peer being in the south side hallway. The patient yelled "Keep me away from her, I'm tired of her coming around me!"

A Psychiatric Progress Note dated 04/25/19 documented the patient was agitated regarding a conflict with a peer with ongoing homicidal ideation and thinking about getting this peer alone to "break her neck."

A Psychiatric Progress Note dated 04/26/19 documented the patient reported homicidal ideation with frustration/anger at a peer on the unit.

A Psychiatric Progress Note dated 04/27/19 documented the patient complained "she was attacking me and nobody was going to help."

Review of an incident report indicated Patient #32 had a physical altercation with Patient #21 on 04/22/19 and psychiatric notes indicated Patient #32 had ongoing homicidal ideation towards Patient #21. Patient #32's Treatment Plan lacked documented evidence of safety planning in regards to the altercation with Patient #21 on 04/22/19, or the homicidal ideation towards Patient #21. Review of Patient #21's record indicated the two patients were allowed to be in close proximity on 04/27/19 when staff placed Patient #21 in Adult Unit South and Patient #32 charged at Patient #21 in the day room.

On 05/23/19 at 2:30 PM, a Psychiatrist verified Patient #21 was assaulted by Patient #32, and was nearly assaulted a second time by Patient #32. The reasons for the repeated assaults was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 145}	Continued From page 98	{A 145}		

not known. Each patient's Treatment Plan should document the problems they are having and the interventions regarding the problem. The Psychiatrist explained it was hard to change the overall treatment plan because the template for the Treatment Plan form in the Electronic Health Record (EHR) had limited space for text. The EHR template needed more options.

The facility policy and procedure titled Patient Abuse and Neglect, revised 02/2019, indicated "physical abuse was defined as contact or actions resulting in injury or pain such as hitting, pinching, yanking, shoving, and pulling hair. Each employee was to be informed of the policies on abuse and neglect during initial orientation and yearly thereafter. Anyone who witnessed or learned of an incident of neglect must immediately separate the patient from any potential aggressors, perpetrators, or any others who may have the potential to inflict abuse upon the patient. If the abuse was patient-to-patient, the patients will be separated so they cannot have contact with one another. If the abuse was staff-to-patient, the staff member would be placed on administrative leave until a formal investigation could be completed. The policy indicated in instances of patient abuse or neglect, Hospital Leadership would engage in a Critical Event Analysis".

The facility policy and procedure titled Treatment Plan, revised 03/2017, indicated the hospital would develop an individualized treatment plan for every active problem for every patient. The treatment plans would include individualized plans of care and unique interventions identified by the team. Safety concerns would be clearly documented on the Treatment Plan and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 145} Continued From page 99 {A 145}

individualized plans of care would be developed to maintain safety.

A 164 PATIENT RIGHTS: RESTRAINT OR SECLUSION A 164

CFR(s): 482.13(e)(2)

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to determine less restrictive interventions were ineffective prior to the use of restraint or seclusion for one sampled patient(Patient #21).

Findings include:

The facility policy and procedure titled Seclusion and Physical or Chemical Restraint, revised 08/2018, indicated the facility would utilize the least restrictive measures to prevent a patient from injuring self or others in an emergency safety situation.

-A debriefing would be conducted within 24 hours of the emergency safety intervention. Any changes that result from this debriefing must be incorporated into the patient's Treatment Plan, as appropriate, to delineate strategies to prevent future episodes of physical/chemical restraint no later than 5 days after a patient had been subject to an emergency safety intervention, physical or chemical restraint or seclusion.

-The policy indicated an emergency treatment team convened within 5 calendar days of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164		A 164		

Continued From page 100
triggering event. The treatment team included but was not limited to the patient, the psychiatrist, therapist, nurse, and other direct care staff as needed. The purpose was to review the events leading up to the seclusion and/or restraint with specific focus on prevention as well as the development of newly identified treatment interventions and strategies that will be helpful for the patient. These strategies would encompass client specific, agreed upon strategies promoting de-escalation of patient.

-The Registered Nurse must notify the Chief Executive Officer, the Clinical Director, and the Medical Director if the patient experiences two or more separate episodes of an emergency safety intervention, physical/chemical restraint or seclusion within a 12 hour period. This notification must be documented in the clinical record.

-The Quality/PI Council, the Medical Executive Committee, and the Governing Board would review whether the emergency safety intervention was the least intrusive intervention and appropriate. Compliance with the requirement to hold an emergency treatment team meeting no later than five calendar days had been subjected to an emergency safety intervention, with review the incident and revision of the treatment plan as appropriate, would be monitored.

Patient #21
Patient #21 was admitted to the facility on 04/17/19 with diagnoses including unspecified psychosis.

A review of hospital seclusion and restraint reports titled Commission on Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164	Continued From page 101 Report Form, Seclusion and Restraint Orders [these will be referred to herein as emergency safety intervention reports] indicated Patient #21 was given emergency medications and/or placed in seclusions/restraint as follows: -On 04/19/19 at 10:15 PM, the patient was aggressive and combative towards staff. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, and limit setting. The patient received intramuscular (IM) emergency medications and was placed in seclusion for 15 minutes. -On 04/19/19 at 10:53 PM, the patient was aggressive and combative towards staff. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, and limit setting. The patient was given IM emergency medication and placed in seclusion for 7 minutes. -On 04/20/19 at 11:45 AM, the patient was threatening staff and peers, spitting at staff, and banging on walls. There was no documentation less restrictive methods were used to avoid restraint and seclusion. The patient received oral emergency medications and was placed in seclusion for 5 hours and 15 minutes. There was no documentation the report was reviewed by the Medical Director and the Chief Executive Officer. -On 04/21/19 at 9:00 AM, the patient was threatening staff, shouting at a peer, and spitting at staff. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, 1:1 interaction with staff, reduction of stimuli, and limit setting. The patient	A 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164	Continued From page 102	A 164		

received oral emergency medications and was placed in seclusion for 1 hour. There was no documentation the report was reviewed by the Chief Nursing Office, the Medical Director, or the Chief Executive Officer.

On 04/21/19 at 1:30 PM, the patient attempted to hit staff, and would not follow directions and was verbally threatening staff. Methods used to avoid restraint and seclusion included verbal reassurance/redirection, reduction of stimuli, and limit setting. The patient was placed in seclusion for 2 hours and 10 minutes. There was no documentation the report was reviewed by the Chief Nursing Office, the Medical Director, or the Chief Executive Officer.

On 04/22/19 at 1:58 AM, the patient was aggressive, throwing things at the nurses station, and threatening staff. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, and reduction of stimuli. The patient was given emergency medication IM and placed in seclusion for 3 hours and 52 minutes.

On 04/22/19 at 9:09 AM, the patient attacked staff and was attempting to harm other patients. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, 1:1 interaction with staff, reduction of stimuli, and environmental change. The patient was given emergency medication IM and placed in seclusion for 39 minutes.

On 04/22/19 at 4:45 PM, the patient was in a physical altercation with another patient and was placed in seclusion for 15 minutes. Methods used to avoid restraint and seclusion included

A 164 | A 164

Continued From page 103
ventilation of feelings, verbal reassurance/redirection, 1:1 interaction with staff, and environmental change. There was no documentation the report was reviewed by the Chief Nursing Office, the Medical Director, or the Chief Executive Officer.

On 04/24/19 at 10:00 AM, the patient attempted to attack another patient. Methods used to avoid restraint and seclusion included ventilation of feelings, verbal reassurance/redirection, 1:1 interaction with staff, and limit setting. The patient was placed in seclusion for 45 minutes.

On 04/27/19 at 10:55 AM, the patient was punched by a peer and was put in a physical hold and moved to the seclusion room for safety. There was documentation of less restrictive interventions tried prior to the use of the physical hold. There was no documentation the report was reviewed by the Chief Nursing Office, the Medical Director, or the Chief Executive Officer.

Patient #21's record lacked documentation of a Treatment Team Meeting following any of the emergency safety incidents.

On 06/20/19 at 3:45 PM, the Chief Executive Officer (CEO) reported being responsible for reviewing all emergency safety intervention reports to ensure facility policy and procedure was followed, including ensuring staff tried less restrictive interventions prior to the use of restraint or seclusion. The CEO acknowledged not reviewing 5 out of the 10 reports for Patient #21.

On 05/21/19 at 1:00 PM, the Interim Chief Nursing Officer (CNO) stated the amount of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164	Continued From page 104	A 164		

restraint/seclusion used for the patient was excessive. Less restrictive interventions which could have been tried prior to use of emergency safety interventions would include putting the patient on line of sight observations, housing in a room closest to the nurses station, looking for trends with a specific staff member, day of the week, in order to better predict the causative factors, and augment the staff. The reviews of some reports were not completed because these occurred before 03/14/19, the starting date for this CNO. The prior CNO was not performing this function.

On 05/23/19 at 10:05 AM, the Nurse Manager of Adult Services revealed Patient #21 was admitted on 04/17/19. Patient #21 had severe psychosis and the patient had a high usage of restraint, seclusion, and emergency medications. The Treatment Plan did not reflect any changes or revisions were added following episodes of restraint/seclusion occurring on 04/19/19, 04/20/19, and 04/22/19. The Nurse Managerreported the Treatment Plan should have been updated following each specific incident of restraint, seclusion, or use of emergency medications. Different actions steps and interventions should be listed.

On 05/23/19 at 4:25 PM, the Director of Compliance, Quality, and Risk (DCQR) revealed after detection of a patient with a high incidence of use of restraints and seclusion, the DCQR would talk to the treatment team as to what could be done differently. If there was oversight of the treatment team it would spur more action. The DCQR verbalized staff were supposed to file a separate incident report in the electronic incident reporting system following every use of restraint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 164	Continued From page 105 or seclusion. The DCQR acknowledged not being aware of some of the emergency safety intervention reports due to staff failure to submit incident reports following episodes on 04/20/19, 04/21/19, 04/22/19, 04/24/19, and 04/27/19. The DCQR reported not receiving the emergency safety intervention reports directly. The DCQR described only getting knowledge of the reports after staff filed the related incident reports which were sent directly to the DCQR. The DCQR indicated there was no system to cross reference incident reports and the emergency safety intervention reports. The DCQR verified lack of documentation in the record of Emergency Team Meetings within 5 days for any of the incidents. The DCQR reviewed Patient #21's emergency safety intervention reports and verbalized staff did not consistently implement less restrictive interventions.	A 164		
{A 196}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Clinical Therapist completed its Handle with Care certification at hire.	{A 196}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 196}	Continued From page 106	{A 196}		

Findings include:

A per diem Clinical Therapist, rehired on 12/10/18, lacked documented evidence of a current Handle with Care certification at rehire. The last documented Handle with Care certificate was dated 11/2/17.

On 05/30/19 in the afternoon, a Human Resources representative provided the latest Handle with Care certificate dated 05/25/19.

{A 263} QAPI {A 263}
CFR(s): 482.21

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:
Based on document review and interview, the facility failed to implement and maintain an effective ongoing, hospital wide, data driven quality assessment and performance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 263}	Continued From page 107 improvement plan (QAPI), that reflected the complexity of the hospital's organization and services involving all hospital departments and contracted services. Specifically, the hospital failed: to: 1) Consistently maintain a program to identify, investigate, analyze and implement preventive actions regarding incidents affecting patient safety and quality of care, and ensure information was documented completely and accurately reported to identify trends (See Tag A 0286). 2) Ensure quality assessment and performance improvement efforts addressed a previously identified priority for improved quality of care and patient safety (See Tag A 0309). The cumulative effect of these systemic practices resulted in the failure to ensure an effective ongoing, hospital wide, data driven quality assessment and performance improvement plan implementation in the delivery of care to patients.	{A 263}		
{A 286}	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events,	{A 286}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 108	{A 286}		

analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...
(3) That clear expectations for safety are established.
This STANDARD is not met as evidenced by:
Based on record review, interview, policy review and observation, the facility's Director of Compliance, Quality and Risk failed to consistently maintain a program of Quality Assurance and Performance Improvement (QAPI) to identify, investigate, analyze and implement preventive actions regarding adverse patient events and patient safety for 13 of 94 sampled patients (Patient #12, #13, #15, #16, #17, #21, #32, #33, #37, #39, #42, #43 and #46).

Findings include:

Employee Abuse Allegation Incidents Not Addressed For QAPI:

Patient #12, (Cross-Reference Tag A 0144)

Patient #16, (Cross-Reference Tag A 0144)

Peer to Peer Abuse Incidents Not Addressed For QAPI:

Patient #13, (Cross-Reference Tag A 0144)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING B. WING	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 109	{A 286}		

Patient #15, (Cross-Reference Tag A 0144)

Patient #43, (Cross-Reference Tag A 0144)

Patient #46, (Cross-Reference Tag A 0144)

Patient #32, (Cross-Reference Tag A 0144)

Elopement Incidents Not Addressed For QAPI:

Patient #33, (Cross-Reference Tag A 0145)

Patient #42, (Cross-Reference Tag A 0144)

MHT Training Not Addressed For QAPI:

On 06/11/19 at 8:40 AM, the Vice President of Nursing Assessment and Assessment and Referrals indicated specific milieu training was initiated a year ago and had been updated in the annual training since then (May 2018), yet numerous adverse and unsafe incidents occured regardless of training updates and inclusions identified below:

The training material provided included:

Effective Milieu Management.
Understanding Your Population, including knowing behaviors you need to watch for.
Developing a Therapeutic Milieu, including active management by the staff of the program.
What makes a Successful Milieu?, including safety, education, structure and dignity.

Safety
Patients deserved to be protected and feel safe while in care. The number one way to know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 110 patients were safe was through observation, observing their affect, behavior and interaction with others. Monitoring patients in all areas. This meant observation was ongoing between 15 minute rounding (MHT's were observed sitting on the floor for significant portions of time in the first two elopement videos, and most of the time MHT's were as physically far away from patients visible on the elopement videos). No pre-filled or post-filled 15 minute rounding (MHT's appeared to be using their tablets while sitting on the floor in the first elopement video while not observing). Doors should be opened when patients were in their rooms and closed and locked when they were not (Patients were free to roam in and out of each other's rooms at will in the elopement videos). When on the hall, one team member should always watch the hall while another goes in rooms to complete 15 minute rounds. If patients were in their rooms, the two staff members should create zones for monitoring and not become stagnant in an area. (A significant proportion of the time there was one MHT on the hallways observed in the elopement videos). Nurses would be aware when MHT's did rounds (In at least one instance, a nurse (identified by the Interim Chief Nursing Officer) walked by a Mental Health who was sitting on the floor in the first elopement video). Do not turn your back on the halls. (Observed in the video of the elopement incidents).	{A 286}		

{A 286} Continued From page 111 {A 286}

Patients in dayrooms needed to have staff monitoring activities and conversations.

At no time was a patient to touch another patient. Therapeutic or not it was the boundary that needed to be redirected (Patients were observed multiple times in close proximity to each other in the elopement videos).

Structure
Patients were not to be outside another patient's room conversing (Patients were observed standing in the doorways of patient rooms facing the inside of rooms multiple times throughout the elopement videos).

The schedule provided consistency and predictability within the milieu for patients. The schedule needed to be followed at all times.

Staff Expectation
Keep moving at all times. Know where patients were and what they were doing at all times.

MHT Position Summary (approved 01/05/15) revealed under Essential Job Function and Responsibilities: Therapeutic Milieu 4) Observes group member's dynamics and takes initiative to reduce problematic behaviors. 5) High visibility during increased acuity and takes an active role with indicated interventions. 7) Records patient observations during indicated timeframe; after the fact documentation is not an approved practice.

Personal Hygiene Supplies:

The facility Patient Belongings and Contraband policy, #1000.8, last revised 04/2018, defined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 112	{A 286}		

following items as contraband: Medications, bottles or containers of any kind (toiletries would be supplied by the facility) and colored pencils/markers. Personal hygiene products could be used only with a physician order and under close supervision.

Failure to Follow Facility Policies Regarding Patients Out On Pass Not Addressed For QAPI

Patient #17
On 05/27/19, Patient #17 was out on pass from the facility between 10:00 AM and 8:30 PM, as documented. Sections V and VII were left blank on the patient's therapeutic pass form regarding conflicts/problems with family members and whether or not a nurse assessed the patient's condition and performed a contraband search upon return.

On 06/06/19 at 2:55 PM, the Interim Chief Nursing Officer acknowledged Patient #17 lacked post therapeutic contraband search documentation.

On 05/27/19, the daily unit census worksheet showed nurses were supposed to monitor Patient #17 for possessing pencils due to self-harm.

Patient #37
On 05/22/19, Patient #37 was out on pass from the facility between 9:00 AM and 1:00 PM, as documented. Sections V, VI and VII were left blank on the patient's therapeutic pass form regarding conflicts/problems with family members and whether or not a nurse assessed the patient's condition and performed a contraband search upon return.

{A 286} Continued From page 113 {A 286}

On 05/22/19, the daily unit census worksheet showed nurses were supposed to monitor Patient #37 for harm to others and self-harm.

On 05/31/19 at 1:30 PM, a Registered Nurse Supervisor acknowledged hygiene items were considered contraband in the Adolescent Residential Unit. Hygiene supplies were supposed to be secured after use. Patients were supposed to be searched for contraband after returning from passes.

Failure of Staff Not Enforcing Medication Administration Policy Not Addressed For QAPI

Patient #39
On 05/28/19 at 10:40 AM, Patient #39 verbalized receiving Seroquel from Patient #46 just prior to Patient #46's discharge. Patient #46 hid the Seroquel in a Chapstick container, which was left on a shelf when Patient #46 left.

The daily unit census worksheet showed Patient #39 and #46 were roommates on 05/17/19, the last day Patient #46 was on the unit.

On 06/04/19, a record review yielded the following nursing progress note:

On 05/31/19 at 4:30 PM, the Milieu Manager reported the patient confessed to cheeking night medication and gave it to other patients in the residential hall. A Registered Nurse spoke to the patient about the situation. The patient indicated cheeking medication for a while and flushed some down the toilet. Patient #39 further indicated giving a medication to another patient and finding another patient's medication and offering it to two other patients. The Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 114	{A 286}		

Therapist, Psychiatrist and Nursing Supervisor were notified.

The Registered Nurse signed the note at 11:35 AM on 06/01/19.

On 06/03/19 at 9:10 AM, the Patient Advocate interviewed Patient #39. Patient #39 indicated cheeking medication for 4-5 weeks. Patient #39 pretended to drink water and spit medication into the water cup. Patient #39 acknowledged providing medication to Patient #12, #37 and #40.

Patient #40 was discharged on 05/31/19. On 06/04/19, a Clinical Therapist documented a statement regarding a phone call received by a second Clinical Therapist about Patient #40. The parent of Patient #40 had indicated unprescribed medication was provided by another patient (Patient #39) to Patient #40. The Clinical Therapist saw Patient #39 on 06/03/19. Patient #39 admitted not taking medication for some time time and provided medication to other patients instead.

On 06/04/19 at 1:35 PM, the DCQR acknowledged first being notified of the incident reported on 05/31/19.

On 06/04/19 at 2:00 PM, the Interim Chief Nursing Officer did not know anything about the incident on 05/31/19, and indicated staff should have incorporated any medication diversion among patients into the treatment plan for any patients involved.

On 06/06/19 at 2:15 PM, the DCQR acknowledged the Registered Nurse, who entered the nursing progress note at 11:35 AM on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}		{A 286}		

Continued From page 115
06/01/19, did not initiate an incident report.

Failure of Staff To Follow Policies Regarding Restraints/Seclusion Not Addressed For QAPI

Patient #21
A review of hospital seclusion and restraint reports titled Commission on Behavioral Health Report Form, Seclusion and Restraint Orders, and facility incident reports, indicated Patient #21 was placed in seclusions/restraint and corresponding incident reports were done as follows:

04/19/19 at 10:15 PM, Incident Report #14789
04/19/19 at 10:53 PM, Incident Report #14799
04/20/19 at 11:45 AM, No Incident Report
04/21/19 at 9:00 AM, No Incident Report
04/21/19 at 1:30 PM, Incident Report #14808
04/22/19 at 1:50 AM, No Incident Report
04/22/19 at 9:09 AM, Incident Report #14867
04/22/19 at 4:45 PM, No Incident Report
04/24/19 at 10:00 AM, No Incident Report
04/27/19 at 10:55 AM, No Incident Report

On 05/23/19 at 1:50 PM, the Director of Compliance, Quality and Risk (DCQR) verbalized incident reports were not submitted by staff following six episodes of restraint/seclusion for Patient #21. The DCQR did not know why staff did not submit the incident reports. The DCQR revealed the Chief Nursing Officer (CNO) reported on incidents in morning meetings.

On 05/29/19 at 8:50 AM, the Registered Nurse (RN) acknowledged an incident report should be done following restraint/seclusion of a patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE** **LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 286}	Continued From page 116 On 05/29/19 at 9:15 AM, the Nurse Manager did not know why the incident reports were not submitted. The Nurse Manager stated audits were done to ensure the incident reports were done, but these incidents "slipped through the cracks."	{A 286}		
A 309	QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5) The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on document review and interview, the facility's Governing Body failed to address priorities for improved quality of care and patient safety regarding repeated and continuing issues related to its Clinical Therapists, Electronic Medical Records and Staff Training.	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 309	Continued From page 117	A 309		

Findings include:

The facility's Quality Assurance and Performance Improvement (QAPI)plan: Overview of the Program document revealed the following on page 12:

The Chief Executive Officer requires and supports the maintenance of the Quality and Performance Improvement Program through the provision of the physical and human resources necessary to fulfill the requirements of the program. These resources include an adequate allocation of personnel, information systems, data management processes and staff training.

Adequate Allocation of Personnel: The lack of Clinical Therapists and failure to conduct and document therapy group notes was previously identified in January 2019 and again identified during the revisit (Cross-Reference Tag A 0392 and A 0467). Therapists interviewed were unable to identify if they had a representative for the QAPI meetings (Cross-Reference Tag A 0467).

On 05/31/19 at 9:30 AM, the Chief Clinical Officer (CCO), who was a member of the Governing Body, Quality Assurance/Performance Improvement and the Medical Executive Committee, acknowledged the facility lacked therapists. The Director of Therapy left for this reason. The CCO indicated the schedule did not predicate what would actually happen. The facility was being staffed based on its average census and not with a 1:15 ratio, yet the facility handbook showed staffing with 1:10 ratio.

The CCO indicated the corporate office was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 309	Continued From page 118	A 309		

dictating the numbers of therapists based on census alone. The Chief Executive Officer continued to tell therapists they could do the work. Therapists continued to float to other units. Patients were being discharged over the weekends, but Care Managers were not doing the paperwork. Therapists had to catch-up with the weekend documentation during the week. Therapists were supposed to conduct therapy groups twice daily seven days per week. This was not happening in the Adolescent Residential Unit. Treatment needs were not being met if the groups were not conducted. The lead Therapists provided 10% sample data to analyze for quality data. The therapy department was failing to meet its quality indicator expectations of a 90% rate, regarding formulating goals, treatment plans and updates. The CCO indicated trying multiple times to work on acquiring more staff, but the facility chose not to hire more than 11 full time therapists.

On 6/11/19 at 9:00 AM, the Director of Compliance, Quality and Risk indicated the therapy groups were not being conducted earlier in the year. The patients rate the therapy groups low when the groups were conducted. Therapists and therapy group issues were raised in QAPI meetings, but the issues were not addressed.

On 6/11/19 at 10:30 AM, the CEO indicated the facility had a lack of leadership in Therapy Services, and therapists were not trained properly. The Quality Indicator achievement rate was overstated regarding therapy services. The CEO verbalized the facility had enough therapists and wondered what else the therapists could be doing, despite the many lapses in the conduction and documentation of group therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 309		A 309		

Continued From page 119
(Cross-Reference Tags A 0392, A 0438, A 0450 and A 0467).

Facility QAPI Program policy #700.1, last revised 9/2017, procedure #1 showed the facility at a minimum collected and analyzed data on performance improvement priorities identified by leaders. The CEO expressed awareness of the issues with Therapy Services (which were previously identified in January 2019), but there were no quality indicators which focused on the conduction of therapy groups and/or completion of therapy group notes beyond treatment plans.

On 6/11/19 at 10:30 AM, the CEO indicated the facility monitored CMS corrections via its Corrective Action Scorecard, but the scorecard itself was not part of the QAPI Program. The scorecard, with weekly monitoring documented between 3/18/19 and 6/6/19, showed the facility documented 100% compliance with therapist to patient ratio of 1:15 or better, despite the contradictions identified on site (Cross-Reference Tag A 0392 and A 0467).

Electronic Medical Records System Failures (Cross-Reference Tag A 0438, A 0450 and A 0467). The electronic medical system was not featured in the facility's QAPI Program.

On 6/4/19 at 3:20 PM, the facility's electronic medical records representatives acknowledged:

The corporation endorsed the electronic medical records system used, which had to be retrofitted for the facility. The Information Technology Representative provided system logins for all employees, which showed multiple employees with multiple logins. A Nurse Practitioner, for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 309	Continued From page 120	A 309		

example, had two accounts: one with the title and one without. A Clinical Therapist had an account without a title. The system allowed employees to add additional logins after the initial account set-up in orientation unbeknownst to the facility's hierarchy. Other issues included patients being electronically placed in the same room/bed in the medical records, the daily room census worksheet and therapy assignments.

On 6/11/19 at 10:30 AM, the CEO indicated the Governing Body was responsible for the electronic medical records system failures. The facility had used the system for about a year without Information Technology realizing multiple employees had duplicate logins. The facility took time adapting to the system.

Staff Training Issues as detailed in Cross-Reference Tag A 0196 (in reference to Handle with Care training) and A 0395 (in reference to Mental Health Technician competency and training regarding monitoring patients according to policy and training resulting in multiple elopements and immediate jeopardy (Cross-Reference Tag A 0144).

On 6/11/19 at 10:30 AM, the CEO indicated the facility monitored CMS corrections via its Corrective Action Scorecard, but the scorecard itself was not part of the QAPI Program.

The scorecard showed the facility was unable to meet 100% employees certified in Handle with Care training for the time monitored between 3/18/19 and 6/6/19, yet the training was required for all direct care staff. One therapist was identified as out of compliance on site (Cross-Reference Tag A 0196).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 309	Continued From page 121 On 6/11/19 at 10:30 AM, the CEO verbalized the failures of Mental Health Techs during the first elopement incident in the 300 hallway but felt the monitoring was adequate during the second elopement incident in the 400 hallway, despite the policy and training lapses acknowledged, discussed and outlined (Cross-Reference Tags A 0144 and A 0395).	A 309		
{A 353}	MEDICAL STAFF BYLAWS CFR(s): 482.22(c) The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: This STANDARD is not met as evidenced by: Based on record review, interview and document review, the facility failed to abide by and enforce its Medical Staff Bylaws, Rules and Regulations treatment plans and psychiatric progress notes, adherence to medical staff and facility requirements and care of the patient. Findings include: The State Licensing and Certification records for the facility revealed the facility was only licensed as a psychiatric hospital. The facility did not have a separate license or certification as a psychiatric residential treatment facility. Therefore, sections of the Bylaws and Rules and Regulations of the Medical Staff that attempted to distinguish different frequencies/levels of obligations on behalf of providers/clinicians as those distinctions applied to in-patients vs. residential patients (such as acute patients vs. Adolescent Residential Unit patients) are a misrepresentation of the services that must be provided to all	{A 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 353}	Continued From page 122	{A 353}		

hospital patients and are not be applicable. Although the facility's Rules and Regulations above referred to acute care patients, "completing progress notes at least six days per week and other such notes as clinically indicated during the patient's length of stay" would apply to all patients.

None of the patients in the Adolescent Residential Unit had such entries.

Medical Staff Rules and Regulations (2019):

Treatment Plan:
8. The multi-disciplinary team shall develop an Individual Comprehensive Treatment Plan that is based on a comprehensive assessment of the patient's needs. This plan will be reviewed at least weekly.

Plans were reviewed monthly for the Adolescent Residential Unit patients [and not maintained and updated as necessary (See A 0467)]. The Chief Clinical Officer acknowledged the monthly reviews.

Adherence to Medical Staff and Facility Requirements:
"13. Each Attending Medical Staff member on the Active Medical Staff shall attend treatment team meetings conducted concerning his/her patient, and for acute care patients, is responsible for completing progress notes at least six days per week and other such notes as clinically indicated during the patient's length of stay.

Care of the Patient:
15. Progress notes shall be made by the attending medical staff member, on the acute

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 353}	Continued From page 123	{A 353}		

care unit, at least six days weekly and preferably on each patient visit".

On 05/22/19 at 4:00 PM, the Medical Director did not identify the facility's practice standard regarding the physician visit/progress note frequency for patients in the Adolescent Residential Unit when asked.

On 06/11/19 at 10:45 AM, the Chief Executive Officer (CEO) indicated the facility followed national practice standards regarding physician visit/progress note frequency in its Adolescent Residential Unit. The CEO indicated weekly physician visits/notes were sufficient, but the facility had increased its frequency to twice weekly for some patients. Despite multiple inquiries previously throughout the inspection, the CEO did not identify the national practice standard used in the facility, nor did the 2019 Medical Staff Bylaws, Rules and Regulations identify the source of the practice standard.

The Medical Director was responsible for the clinical operations of the hospital; for improving patient safety; for continually assessing and improving the activities and quality of patient care; for making recommendations to the hospital's administrative staff regarding the planning of hospital facilities, equipment, routine procedures and other patient care matters.

The Medical Director and any Associate Medical Directors appointed by the Governing Board were responsible for the development and implementation of policies and procedures that guide and support the provision of services, and the continuous assessment and improvement of the care and services provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 353}		{A 353}		

Continued From page 124

The facility's Rules and Regulations above referred to acute care patients, "completing progress notes at least six days per week and other such notes as clinically indicated during the patient's length of stay." The Medical Staff Bylaws and Rules and Regulations lacked documented evidence of provider frequency obligations for patients in the Adolescent Residential Unit, since those patients were not considered acute care patients.

2019 Medical Staff Bylaws, Rules and Regulations.
Article IV: Categories of The Medical Staff:
"Each member of the medical staff will:
b. abide by the medical staff bylaws, rules and regulations, and by all other hospital and service area standards, policies, rules and regulations.
d. prepare and complete in a timely manner medical records and all other required records of all patients he/she admits or in any way provides patient care services to in the hospital".

Patient #9 (not an Adolescent Residential Unit Patient)

Patient #9 was admitted on 04/16/19, with diagnoses including recurrent, severe major depressive disorder with psychosis.

On 05/31/19 at 3:37 PM, the Medical Records Director acknowledged the following psychiatric progress notes:

Week of April 21, 2019 - April 27, 2019: three entries dated 04/23/19, 04/25/19, and 04/26/19.
Week of April 28, 2019 - May 4, 2019: four entries dated 04/28/19 and 05/02/19 - 05/04/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 353}	Continued From page 125 Week of May 5, 2019 - May 11, 2019: one entry dated 05/05/19. Week of May 12, 2019 - May 18, 2019: three entries dated 05/12/19, 05/16/19, and 05/17/19. The medical record lacked documented evidence of 6 acute care entries weekly for an acute patient.	{A 353}		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and document review the facility failed to: 1) Ensure there was adequate therapist coverage to ensure the needs of the patients were met including the timely completion of patient Therapy Initial Contact Notes (See Tag A 0392) 2) Ensure patients were not cheeking and/or hiding medications, and giving medication to peers (See Tag A 0405). 3) Ensure nursing staff adhered to the process of implementing and updating patient care plans in a timely manner based on patient care needs, documented patient behaviors and the care provided to patients, a physician or physician extender was notified of a suspected unwitnessed fall and an assessment was completed after a patient's suspected unwitnessed fall (See Tag A 0396)	A 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A 385 — Continued From page 126 — A 385

4) Ensure staff competencies were completed in a timely manner (See Tag A 0397).

The cumulative effect of these systematic practices resulted in the failure of the facility to deliver statutory-mandated care to patients.

{A 392} STAFFING AND DELIVERY OF CARE — {A 392}
CFR(s): 482.23(b)

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on document review, record review and interview the facility failed to ensure there was adequate therapy staff to initiate and complete Therapy Initial Contact Notes within 24 hours of admission and there was adequate therapist coverage to ensure the needs of the patients were met including the timely completion of patient Therapy Initial Contact Notes.

Findings include:

Review of Therapy Initial Therapy Contact Notes from March 2019 - May 2019 revealed 34 patient Therapy Initial Therapy Contact Notes were not initiated within 24 hours of admission.

Review of the Therapist Assignment Sheets dated 03/18/19 - 03/31/19 for the acute youth and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}		{A 392}		

Continued From page 127
residential unite revealed the following:

03/18/19, one therapist scheduled on the residential unit with a caseload of 27 patients. Off was written next to the other therapist names.
03/22/19, one therapist scheduled on the residential unit with a caseload of 28 patients. Off was written next to the other therapist names. The acute youth did not have an assigned therapist on the assignment sheet.
03/25/19, one therapist scheduled on the residential unit with a caseload of 23 patients.
03/26/19, one therapist on acute youth with a caseload of 19.
03/27/19, one therapist on acute youth with a caseload of 27.
03/29/19, no therapist assigned to the residential unit with a case load of 15, and no therapist assigned to the acute youth with a caseload of 24.

A comparison of using Therapist Assignment Sheets, Payroll Detail and patient census from 05/12/19 - 05/25/19 revealed the following:

On 05/12/19, Adolescent Acute had no coverage with a census of 12, Gero-Psychiatric unit (Gero-Psych) had no coverage with a census of 11, Acute Adult with a census of 34. One therapist worked in the Acute Adult unit. The therapist documented on the schedule to cover the Adolescent acute and Gero-Psych units did not work according to the payroll detail.

On 05/18/19, the Chemical Dependency Unit (CD) had no one assigned therapist on the schedule with a census of 5, Residential unit had a census of 36, Gero-Psych had a census of 16 and Trauma had a census of 2. The schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}		{A 392}		

Continued From page 128
documented 1 person was to float between the Gero-Psych unit and the residential unit.

On 05/19/19, Adolescent Acute had no coverage with a census of 7 and Acute Adult had no coverage with a census of 38. The schedule documented a prn therapist for the Adolescent Acute and a therapist for Acute Adult. These therapists did not work according to the payroll detail.

On 05/25/19, CD had no assigned therapist scheduled with a census of 12, Residential unit had a census of 36, Gero-Psych had a census of 18 and the trauma unit had no assigned therapist scheduled with a census of 6. The prn therapist was expected to float between Gero-Psych and the residential unit. The prn therapist worked 8:49 AM - 2:00 PM, according to the payroll detail.

On 05/26/19, Adolescent Acute had no coverage with a census of 11, Gero Psych had a census of 19 and trauma a census of 7. A therapist was assigned to float between Gero Psych and Trauma.

On 05/21/19 at 9:45 AM, an interview was conducted with Chief Clinical Officer (CCO) and the Chief Executive Officer (CEO) regarding the Therapist Assignment Sheets.

CCO confirmed being the one responsible for the therapist schedules. The CCO explained when the therapist had scheduled off days or if there were sick calls a therapist from another unit floated to cover the unit. The CCO indicated typically the same therapist was utilized to ensure continuity of care. The CCO verified the units on the Therapist schedule for the months of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}		{A 392}		

Continued From page 129
February and March. 2019.

The CCO verbalized if there was a call off it was an expectation that another therapist would have been assigned to oversee the unit. The CCO indicated it would have been indicated in the patient record if they were seen. The CEO and CCO confirmed the caseload for the therapists' was 1:15 across the board in every unit. The therapist floated to other units when needed and as needed staff was utilized when necessary. The patients were shifted over to the covering Therapist's caseload.

The CEO indicated when there were call offs or scheduled days off the it should have been hand written on the schedule when updated.

On 05/23/19 at 2:02 PM, a Licensed Clinical Social Worker (LCSW) explained the evening nurse communicated any admissions and the therapist schedule was adjusted prior to going out. The LCSW indicated the residential unit consisted of two full time therapist and two prn therapist. The LCSW verbalized each prn therapist worked three nights a week and a full day on Saturday. The LCSW explained the prn staff assisted the therapist when we were unable to complete group; may do process groups and discharges to ensure they were completed in the time frame.

The LCSW indicated the therapist were required to see the patients once weekly for individual, once for family, and the process group done. The LCSW indicated the therapist covered each other. The LCSW indicated the patient load was a bit higher than anticipated. Typically, the therapist patient ratio was 12-15 patients, and slightly lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}	Continued From page 130	{A 392}		

for the lead. The LCSW indicated the residential caseload was higher than the acute youth.

On 05/23/19 at 2:38 PM, a LCSW indicated the patient therapist ratio has been 18-19 patients. The LCSW indicated the therapist saw the patients once a week individually and every two weeks for family. The therapist assignment reflected the caseload and not whose seen on a daily basis. The LCSW verbalized we have two prn therapist on the floor. The therapist verbalized setting a goal of how many patients that had to be seen a day and indicated will have patients to added the caseload as necessary. The therapist verbalized "the caseload now is 18-19 which is not over the ratio".

On 05/23/19 in the afternoon a LCSW, explained being in training for two weeks orientation and one week with another therapist on the floor. The LCSW indicated the expectation was to pick up on things because due to being a licensed therapist. The LCSW verbalized, "I had to learn on the go". The LCSW indicated the patient therapist ratio was 1:15.

The LCSW indicated the therapist see patients once a week, individual, and family before discharge. The average stay was 5 - 7 days. The treatment team was held weekly, and groups held daily and depending on the census held by gender. The therapist indicated prn therapist covered on the weekends. The LCSW verbalized, "I been juggling things and it's been very busy."

On 05/31/19 at 9:45 AM, the Chief Clinical Officer (CCO) indicated the schedules we were provided were tentative schedules. The CCO indicated attempting to schedule people but did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}	Continued From page 131	{A 392}		

the staff. The CCO verbalized the hospital followed the census and not the 1:15 ratio, "It's been a battle" which was the reason the previous Director of Therapy left. The CCO indicated the staff were not taking breaks and were working nonstop because the "workload is too heavy".

The CCO indicated the prn therapist had full time jobs elsewhere. The CCO indicated the facility may be out of a therapist due to health reasons which will leave the other therapist by herself. The facility was trying to make the Director take a caseload.

The CCO indicated the facility had 11 full time therapist which was based on the hospital's census. There were four halls on the residential unit with two therapist and four groups. The CCO indicated the therapist were not taking breaks and worked over their time. There were late discharges happening. The prn therapist could only work night shift. The prn therapist did the night groups on the residential unit to alleviate the groups during the day. The groups are held twice daily 7 days a week. SRP's were additional therapy held twice a week. The lead therapist just started full time in May 2019. The other therapist was by herself in the residential unit. Now, there are two Therapist for four halls. The CCO indicated the CEO and home office are aware.

The CCO verbalized if we want quality of patient care the therapist need to be with their patients. The CCO indicated the Therapist were barely surviving with the caseload they had. The CCO indicated the facility was not following their own policy of a 1:10 ratio for the therapist.

The facility document with a hand written title

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}	Continued From page 132	{A 392}		

Clinical Director Training Manual 2018 included a Power Point slide #6, entitled Assignment of Patient Indicator: Daily Therapist Assignments which indicated to assign patient based on clinician strengths and patient needs, maintain a reasonable patient to therapist ratio of 1:10 ratio ensuring patients needs can be met.

On 05/31/19 at 11:55 AM, The CCO indicated the Care Managers in Utilization Review do not complete patient care items all their stuff that is not done has to be completed by the Therapist.

On 06/04/19 at 4:59 PM, the Director of Medical Records confirmed the patient census the Adolescent Acute, Gero-Psychiatric, Acute Adult, Residential, Trauma and Chemical Dependency units for 05/12/19, 05/18/19, 05/19/19 and 05/26/19.

On 06/05/19 at 10:10 AM, the CCO confirmed there was no therapy staff covering on the Saturday and Sunday. The CCO indicated the care managers typically did not work on the weekend. The CCO indicated the care managers were responsible for the discharges and they worked Monday through Friday. The CCO indicated anything to do with discharge planning and overflow fell on the therapist.
On 05/20/19 at 11:30 AM, the Licensed Clinical Professional Counselor (LCPC) stated the case load assigned to the therapist was 14-15 patients. The LCPC indicated duties included conducting individual and group therapy sessions, including the initial or intake therapy interview. This initial therapy interview should occur within 72 hours of the each patient's admission. The LCPC indicated the work load was heavy but each therapist did the best they could to keep up. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 392}	Continued From page 133	{A 392}		

LCPC indicated the hospital needed more therapists. The LCPC indicated speaking with the Chief Clinical Officer regarding this concern.

On 05/21/19 at 10:45 AM, the Licensed Mental Health Counselor (LMHC) conducted a group therapy session attended by 14 patients on the Adult Acute Unit. The topic was Core Beliefs. The LMHC stated the facility did not have many therapists and so instead of doing 4 groups with fewer patients, the LMHC conducted two larger group sessions. The LMHC revealed there was an additional therapist assigned to the unit who was performing discharge documentation. The LMHC reported taking one and a half hours to document up to 30 therapy notes a day. The LMHC described it was difficult to find time to accomplish meetings with patients.

On 05/29/19 at 2:30 PM, a Therapist reported working only on weekdays, and another therapist was supposed to perform and document therapist sessions on the weekends, however when returning on Monday the Therapist would find nothing had been done on the weekends in the Gero-psych unit. The Therapist indicated other units were preferentially staffed over the Geropsychiatric unit. The Therapist stated the Chief Clinical Officer made out the therapy schedules, and the therapist assignments were often inaccurate and did not depict actual therapist staffing.

On 05/29/19, Patient #23's medical record lacked a therapy initial contact note. The first therapy note, dated 05/21/19, was for discharge planning.

On 06/06/19 at 10:25 AM, the Chief Clinical Officer verified the record lacked an initial therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{A 392} Continued From page 134 {A 392}

contact note. The Chief Clinical Officer reported the therapist should meet with the patient within 24 hours after admission and then document an initial contact note.

A 396 NURSING CARE PLAN A 396
CFR(s): 482.23(b)(4)

The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan

This STANDARD is not met as evidenced by:
Based on interview, record review and document review the facility failed to ensure the nursing component of the treatment plans were initiated and consistent with the plan for care of the described realistic patient goals as part of the patient's nursing care assessment and revisions to the plan were completed in a timely manner for 3 of 94 sampled patients (Patient #1, #5 #2).

Findings include:

Patient #1
Patient #1 was admitted on 05/08/19, and readmitted on 05/18/19 with diagnoses including schizophrenia, bipolar type and unspecified psychosis.

A History and Physician Examination dated 05/18/19 documented the patient had hypertension. Vital signs measurements revealed the blood pressure was 175 millimeters of mercury (mmHg)/ 81 mmHg. The H&P indicated to add blood pressure medications.

A Nursing Admission Assessment dated 05/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 135	A 396		

documented the patient had hypertension.

A Fall Risk Assessment dated 05/18/19 documented the patient had a score of 12 identified the patient as a moderate risk for falls.

Patient #1's treatment plan initiated on 05/19/19 lacked documented evidence of the patient's medical diagnoses related to blood pressure and a fall risk

On 06/04/19 at 3:58 PM, a Nurse Manager indicated the patient's treatment plan should have included the patient was a fall risk.

Patient #5
Patient #5 was admitted on 05/13/19, with diagnoses including alcohol dependence and major depressive disorder.

A Initial Psychiatric Evaluation dated 05/14/19 documented the patient had three psychiatric hospitalizations and was diagnosed with bipolar II and depression.

The Treatment Plan initiated on 05/14/19 lacked documented evidence of the bipolar II and depression diagnoses.

Patient #2
Patient #2 was admitted on 05/17/19 with diagnoses including unspecified dementia with behavior disturbance.

1) A History and Physical Examination dated 05/17/19 documented Patient #2 had past medical history of diabetes mellitus, hypertension, anemia, and fall risk debility. Vital signs measured on the patients left arm revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396		A 396		

Continued From page 136

blood pressure was 178 millimeters of mercury (mmHg) /70 mmHg. The examining provider's impressions revealed diagnoses including diabetes mellitus (DM), hypertension (HTN), hyperlipidemia (HLD), anemia, fall risk, debility, general weakness and multiple skin issues/wounds.

A Fall Risk Assessment -Adult dated 05/17/19 documented the patient had moderate impaired - limited vision, but could identify objects. The Fall Risk Assessment documented the patient's fall risk score as a 26; which the score key identified as 13 plus as "High Risk". The assessment indicated to initiate fall precautions and treatment plan for moderate or high risk patients, and to consider environmental risk factors in patient's interventions.

The Medication Administration Record dated 05/17/19 - 05/28/19 revealed Patient #29 had orders for the following medications:
-Mupirocin topical 2 % ointment (Bacitracin) 22 gram twice daily for wound care
-Glimepiride (Amaryl) 4 milligrams (mg) use two each for DM
-Insulin Lispro solution (Humalog) 2 -15 units subcutaneous sliding scale and needed.

Blood Sugar	Dose
151-200	2 units
201-250	4 units
251-300	6 units
301-350	8 units
351-400	10 units
401-450	12 units
Greater than 400	15 units and call Medical Doctor

A Treatment Plan Assessment dated 05/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ___ B. WING ___	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 137	A 396		

documented due to dementia Patient #2 was unable to express a goal for treatment and the patient had a poor memory. The Treatment Plan Assessment dated 05/17/19 was signed by a nurse on 05/17/19.

A Treatment Plan with a start date of 05/17/19 documented under medical "Above Ideal Body Weight (BMI 30.7). The clinical long term goal indicated to maintain diet and exercise regimen conductive to a healthy lifestyle. The target date was listed as 05/24/19.

The Treatment Plan lacked documented evidence of Patient #2's medical diagnoses related to diabetes mellitus, hypertension, hyperlipidemia, anemia, fall risk, debility, general weakness and multiple skin issues/wounds.

On 05/29/19 at 9:31 AM, a Registered Nurse (RN) Patient #2 was aggressive and sometimes compliant with medications. The RN indicated the patient attended groups but did not participate. Patient #2 was provided handouts when the patient did not attend the group therapy the nurse went over the hand out the patient. The nurse indicated attempting to get the patient to answer The RN verbalized, "I think she understands some of the handouts but do know how much. I don't think she fully understands what's fully going on".

The RN explained not going through dementia training at the facility. The RN verbalized, "It's something you usually learn along the way". The RN indicated the physician discussed the different phases of dementia when she had questions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 138	A 396		

On 05/29/19 11:56 am, the CNO explained the medical diagnoses whether under control or not were required to be on the treatment plans. The CNO acknowledged a patient had a high risk for falls and utilizing devices should have been placed on the treatment plan.

On 05/29/19 in the afternoon, The CNO verbalized the electronic medical record was not meeting the needs for the required documentation. The CNO indicated the system did not allow the for the input of templates for specific documentation. The CNO indicated there were only two nursing diagnoses in the system.

The RN identified Patient #2 as a fall risk and a one person assist.

2) The RN updated on 05/29/19 the patients Treatment Plan to include the diagnosis of diabetes mellitus. The The Treatment Plan included to following clinical long term goals with the target date of 05/31/19 for Patient #29:

-Patient will demonstrate how to take own blood glucose levels and self-administer oral medications or insulin.
-Patient will discuss possible complications of diabetes.
-Patient will state dietary and exercise goals.

The treatment plan included unrealistic goals for a patient with dementia and poor memory who is unable to express a goals for treatment as noted in the patient's Treatment Plan Assessment.

The treatment plan lacked documented evidence it was updated with the patient's diagnoses including hypertension, hyperlipidemia, anemia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 139	A 396		

fall risk, debility, general weakness and multiple skin issues/wounds.

On 05/31/19 at 10:46 AM, the Interim CNO acknowledged the treatment plan goals for Patient #2 were unrealistic. The verbalized a more appropriate goal would have been the patient would agree or allow the nurse to give the medications or test the glucose as a short-term goal.

On 06/04/19 at 3:58 PM, a RN indicated the patient's treatment plan would have needed to be updated based on the patient's cognition. The RN indicated the treatment plan is updated after the treatment team meeting or if there are any changes.

The Facility policy Assessment & Reassessment of the Patient, Policy #1300.1A, effective June 2016 indicated the purpose was to collect data based on an assessment of the relevant needs of the patient to be able to devise a patient plan of care. And, to ensure that after reassessment of the patient the treatment planning and patient care were updated to meet the changes/condition of the patient. The nurse initiated the preliminary treatment plan based upon findings of the assessment. Treatment Plan Meeting were held weekly and during this meeting the patient's condition was reassessed and the treatment plans and goals evaluated.

A 397 PATIENT CARE ASSIGNMENTS (A 397)
CFR(s): 482.23(b)(5)

A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 397	Continued From page 140	A 397		

specialized qualifications and competence of the nursing staff available.

This STANDARD is not met as evidenced by:
Based on interview, employee file review and document review the facility failed to ensure an Employee Job-related Competency Checklist (Self-Assessments) was completed for one nurse employee.

Findings include:

A Registered Nurse/LPN - Competency Checklist (Self-Assessment) for Employee #5 dated 05/20/19 indicated staff must complete, prior to or during orientation, a competency checklist of this or her position, The checklist is a self-assessment of current level of knowledge and skill. Current competencies should be rated accordingly.

The competency checklist indicated the supervisor/manager within 30 days of the employment would assess and rate the employee competency based upon demonstration and/or verbalization of the employee's ability to perform skills which included response to critical incidents and emergency procedures.

Review of Employee #5's record revealed the employee was hired in November 2018 and the competency was not completed until 05/20/19.

On 06/07/19 in the morning, the Human Resources Director acknowledged the Registered Nurse was hired in the staff RN position and transitioned to an Interim Nurse Manager position and the competency was not completed. The Director of Human Resources verbalized the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A 397 — Continued From page 141 — A 397

competency should have been done. The RN was not due for an annual evaluation until November 2019. The Human Resources Director indicated an audit was done and confirmed competencies were not done. This information was forwarded to the unit managers who were responsible for ensuring the competencies were done for their area.

The facility Guidelines for Measuring Staff Competency policy #1300.30, last revised 09/2017, revealed Performance Evaluation and Review of Competency Education Requirements would be completed annually for all employees.

A 405 — ADMINISTRATION OF DRUGS — A 405

CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2)

(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405	Continued From page 142	A 405		

policies and procedures.
This STANDARD is not met as evidenced by:
Based on observation, record review, interview and document review the facility failed to ensure the physician was notified of patient medication refusals for 2 of 94 patients (Patient #4, #6), failed to prevent patient medication diversion for 4 of 94 patients (Patient #12, #37, #39, #40) and failed to perform a mouth check on patients after administering medications 3 of 94 (Patient #46, #30, #31).

Findings include:

Physicians Not Notified of Patients Medication Refusal:

Patient #4
Patient #4 was admitted on 05/18/19 with diagnoses including unspecified psychosis, out of contact with reality and diabetes.

A Medication Administration Record (MAR) dated 05/18/19 - 05/27/19 revealed an order for Haloperidol 5 milligrams (mg) twice daily for psychosis and Benztropine 1 mg twice daily for side effects.

The MAR indicated Haloperidol was scheduled to be administered at 9:00 AM and 9:00 PM. The MAR revealed Patient #4 refused the Medication 05/18/19 - 05/23/19 for a total of 12 doses prior to the Nurse Practitioner being made aware.

The MAR indicated Benztropine was scheduled to be administered at 9:00 AM and 9:00 PM. The MAR revealed Patient #4 refused the Medication 05/18/19 - 05/23/19 for a total of 12 doses prior to the Nurse Practitioner being made aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405		A 405		

Continued From page 143

On 05/31/19 at 10:46 AM, the Interim CNO verbalized the physician should have been notified regarding the patient refusal. The physician could have done an early intervention or court order. The provider should have been made aware at the first refusal.

On 06/04/19 at 3:18 PM, a RN indicated when a patient refused medications it needed to be documented and the physician informed. The RN indicated this could have been done verbally and documented. The RN verified there was no notification to the physician regarding the patient's refused medication.

On 06/04/19 in the afternoon, a RN indicated if the patient refused medication they were encouraged to take it. The risk and benefits are discussed. If the patient still refuses notify the physician and document on the MAR. The RN indicted we usually notify the physician right away because they come in every day. The RN indicated they should let the provider know verbally if the patient refused medications. The RN indicated physician providers have access to the patient's record.

Patient #6
Patient #6 was admitted on 04/29/19, and readmitted on 05/15/19 with diagnoses including schizophrenia affective disorder bipolar type, alcohol abuse, uncomplicated, post traumatic stress disorder, potential for self-harm and candidias of skin and nails.

Physician Medication Orders - Final included the following medications with a start date of 05/15/19 and stop date of 06/14/19:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405		A 405		

Continued From page 144

Nystatin topical powder 100,000 units/gram, one application three times a day for fungal rash bilateral groin and below breast. Start date 5/18/19, Stop date 05/22/19.

Guaifenesin liquid 100 milligram/5 milliliter (200 ml), every six hours by mouth for cough. Start date 5/16/19, Stop date 06/14/19.

The Medication Administration Record (MAR) dated 05/15/19 - 05/28/19 revealed the following:

Nystatin was scheduled to be administered at 9:00 AM, 3:00 PM and 9:00 PM. The MAR revealed Patient #6 refused the 9:00 AM, 3:00 PM and 9:00 PM dose on 05/17/19, 05/18/19, 05/19/19, 05/20/19 05/21/19 and 05/22/19. On 05/21/19, the MAR documented at 9:00 AM Patient #6 said, "I don't need any more" (sic).

Guaifenesin was scheduled to be administered at 12:00 PM, 6:00 PM, 12:00 AM and 6:00 AM. The MAR documented Patient #6 refused the medication from 05/17/19 - 05/20/19 at 6:00 AM, 05/21/19 - 05/23/19 at 12:00 PM, and 05/23/19 at 12:00 AM -05/28/19 at 6:00 AM.

The medical record lacked documented evidence the physician was notified of the medication refusals.

On 05/31/19 at 10:49 AM, the Interim CNO verbalized if a patient refused medications the nurse should have tried to find someone to help the patient to be more agreeable with taking medications.

Facility policy entitled Medication Administration,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405	Continued From page 145	A 405		

Policy number: 1000.42 last revised August 2017, indicated the Nurse will handle the refusal of the patient medication accordingly:
-Return the unopened packet to the patient's medication drawer.
-Notify the physician that the patient refused the medication and the reason for refusing.
-Circle the schedule dosage times on the Medication Sheet and write "ref" in the site space, and initial.
-The nurse will handle missed does due to nursing error according to the Medication Variance Policy.

Patient Medication Diversion:

Patient #12
Patient #12 was admitted on 05/13/19, with diagnoses including bipolar disorder without psychotic features.

On 05/20/19 at 1:18 PM, an incident report revealed Patient #12 reported receiving Seroquel medication from a peer and swallowing it. The report showed Patient #12 verbalized the medication came from a recently discharged patient who hid the medication in a Chapstick container. Patient #12 felt tired.

The DCQR's documentation characterized the incident as a medication error that reached the patient but did not cause patient harm.

Patient #37
Patient #37 was admitted on 05/02/19, with diagnoses including bipolar disorder and major depressive disorder with psychotic features: hearing voices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405		A 405		

Continued From page 146

On 05/20/19, an incident report showed Patient #37 received a Seroquel tablet from another patient and swallowed it. Patient #37 indicated it came from a recently discharged patient who hid the medication in a Chapstick container. Patient #37 felt tired.

As of 06/04/19 at 1:31 PM, Patient #37's treatment plan lacked documented evidence medication diversion was addressed.

Patient #39
Patient #39 was admitted on 04/26/19, with diagnoses including severe, recurrent major depressive disorder without psychosis.

On 05/28/19 at 10:40 AM, Patient #39 verbalized receiving Seroquel from Patient #46 just prior to Patient #46's discharge. Patient #46 hid the Seroquel in a Chapstick container, which was left on a shelf when Patient #46 left.

The daily unit census worksheet showed Patient #39 and #46 were roommates on 05/17/19, the last day Patient #46 was on the unit.

On 06/04/19, a record review yielded the following nursing progress note:

On 05/31/19 at 4:30 PM, the Milieu Manager reported the patient confessed to cheeking night medication and gave it to other patients in the residential hall. A Registered Nurse spoke to the patient about the situation. The patient indicated cheeking medication for a while and flushed some down the toilet. Patient #39 further indicated giving a medication to another patient and finding another patient's medication and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405	Continued From page 147	A 405		

offering it to two other patients. The Clinical Therapist, Psychiatrist and Nursing Supervisor were notified.

The Registered Nurse signed the note at 11:35 AM on 06/01/19.

On 06/03/19 at 9:10 AM, the Patient Advocate interviewed Patient #39. Patient #39 indicated cheeking medication for 4-5 weeks. Patient #39 pretended to drink water and spit medication into the water cup. Patient #39 acknowledged providing medication to Patient #12, #37 and #40.

Patient #40
Patient #40 was discharged on 05/31/19. On 06/04/19, a Clinical Therapist documented a statement regarding a phone call received by a second Clinical Therapist about Patient #40. The parent of Patient #40 had indicated unprescribed medication was provided by another patient (Patient #39) to Patient #40. The Clinical Therapist saw Patient #39 on 06/03/19. Patient #39 admitted not taking medication for some time time and provided medication to other patients instead.

Nursing Staff Failed To Perform Mouth Checks After Medication Administration:

Patient #30 was admitted on 06/03/19 with diagnoses including anxiety disorder.
Patient #31 was admitted on 06/02/19 with diagnoses including major depressive disorder with psychotic symptoms.

On 06/06/19 at 8:45 AM, a Registered Nurse (RN) was administering medication at the Adult

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405	Continued From page 148 Acute Unit nursing station. Patients #30 and #31 were given oral medications from across a counter-top. The patients were not wearing identification arm bands. The RN identified the patients by asking their names and looking at a photograph on Electronic Health Record. After giving the medications the RN did not ask the patients to open their mouths to check if the medications were swallowed. The patients brought their own white Styrofoam water cups and also left the desk area with the same cups after taking the medications. The RN stated a mouth check was not usually done when giving medications on the Adult Acute unit unless a patient had a known behavior cheeking medications. The RN reported on the Chemical Dependency Unit, a mouth check was done, particularly if narcotics were given. The The RN acknowledged not doing a mouth check for Patient #30 and #31, as they did not have any issues related to cheeking medications. The RN stated patients filled cups with water from a day room water source and brought it to the nursing station for medication pass, and were allowed to take the cup away with them afterward. On 06/06/19 at 9:10 AM, a Nurse Manager reported per facility policy nurses were to perform a mouth check on all patients after administering medications, not just for patients with a known behavior of cheeking medications. The Nurse Manager stated the facility practice was patients would bring their own water cups for medication pass and could take these away with them. On 06/06/19 at 11:45 AM, the Interim Chief Nursing Officer revealed patients should have been wearing arm bands and nurses should check for the arm band to identify patients during	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 405	Continued From page 149 medication administration. The facility policy Medication Administration dated 03/26/2006, indicated the nurse would confirm the patient's identity before offering medication by verification of two patient identifiers. The nurse would check to make sure the patient swallowed the medication. The policy did not address checking water cups to see if patients were spitting medications back into the cup instead of swallowing them.	A 405		
{A 431}	MEDICAL RECORD SERVICES CFR(s): 482.24 The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital. This CONDITION is not met as evidenced by: Based on interview, record review and document review, the facility failed to: 1) Ensure medical records were authenticated,complete and secure (See Tag A 0438). 2) Ensure emergency support activities were documented on a code record after a code was called for a patient with no pulse or respiration, and an unresponsive patient with respiratory distress (See Tag A 0449). 3) Complete medical records in a timely fashion (See Tag A 0450). 4) complete and enter history and physicals within	{A 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 431}	Continued From page 150 24 hours (See Tag A 0458). 5) Document information necessary to monitor each patient's condition (See Tag A 0467). The cumulative effect of these systematic practices resulted in the failure of the facility to deliver statutory-mandated care to patients.	{A 431}		
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on record review, interview and policy review, the facility failed to use a system of author identification and record maintenance that ensured the integrity of the authentication and protected the security of all record entries. Specifically, the facility failed to: 1) Ensure staff securely signed off assigned tablet while on break to prevent another staff member from documenting an incident under their name (Patient #21) 2) Ensure patient therapy notes were note predated (Patient #10). 3) Ensure a Clinical Therapist and a nurse included their titles when signing off notes	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A 438 Continued From page 151 A 438

(Patient #33) and a Psychiatrist signed a therapy note (Patient 15).

Findings include:

Patient #21
Patient #21 was admitted to the facility on 04/17/19 with diagnoses including unspecified psychosis.

Incident Report #14865 dated 04/22/19, indicated there was an allegation of abuse. Patient #21 was found in a room unconscious with abrasions on the neck and arms after being assaulted another patient.

The Incident Investigation Worksheet dated 04/25/19, included staff interviews. The incident occurred in the Adult South Hall. The summary of an interview conducted on 04/22/19 with a Mental Health Technician (MHT) documented one MHT was on break and only one MHT was on duty for that hallway at the time of the incident.

On 05/22/19 in the morning, the MHT on break during the incident was interviewed regarding observations this MHT documented during the incident. Observations were documented as occurring while the MHT was on break and off the unit. The MHT indicated the electronic tablet was handed off (without logging out) to another MHT prior to leaving for break. The second MHT then likely documented under the first MHT's name. The summary of an interview conducted on 04/25/19 with a different MHT documented that MHT was in the dayroom area after finishing 15 minute checks.

The Incident Investigation Worksheet lacked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 438	Continued From page 152	A 438		

documented evidence the DCQR interviewed the MHT who was on break and failed to identify a second MHT documented under the first MHT's name.

The facility Mobile Device policy, IT120 2.0, last reviewed 10/17/17, revealed under the Supplied Tablet section: 5. "Tablets should be secured at all times from theft or unauthorized use".

Patient #10
Patient #10 was admitted on 05/13/19, with diagnoses including major depressive disorder without psychosis.

On 05/10/19 at 8:04 AM, a Clinical Therapist entered an electronic therapy group note which predated the admission date. The note was signed at 8:20 AM on 05/19/19.

On 05/18/19, Patient #10 lacked documented evidence of therapy group notes.

On 05/22/19, a psychiatric progress note lacked a signature.

On 05/31/19 at 3:35 PM, the Medical Records Director acknowledged the above.

Many clinicians documented without proper authentication. The following examples are a few:

A Clinical Therapist electronically signed therapy group notes for Patient #33 without using a clinician title on 04/27/19, 05/02/19, 05/04/19, 05/09/19, 05/17/19 and 05/18/19.

A Registered Nurse electronically signed nursing progress notes for Patient #33 without using a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 438	Continued From page 153	A 438		

clinician title on 04/21/19.

As of 05/31/19, a Psychiatrist failed to sign a psychiatric progress note for Patient #15 entered for 10:36 AM on 05/23/19.

On 6/4/19 at 3:20 PM, the facility's electronic medical records representatives acknowledged:

The corporation endorsed the electronic medical records system used, which had to be retrofitted for the facility. The Information Technology Representative provided system logins for all employees, which showed multiple employees with multiple logins. A Nurse Practitioner, for example, had two accounts: one with the title and one without. A Clinical Therapist had an account without a title. The system allowed employees to add additional logins after the initial account set-up in orientation unbeknownst to the facility's hierarchy. Other issues included patients being electronically placed in the same room/bed in the medical records, the daily room census worksheet and therapy assignments.

On 06/05/19 at 1:15 PM, the Information Technology Representative indicated audit trails were comprehensive and it was possible the Director of Medical Records did not know how to access the real time origination of some documentation.

The facility Documentation and Documentation Retention Policy #1400.6, last revised 9/2017, revealed under "procedure #3. The Physician was responsible for the history and physical examination records. #5.2 The attending Physician would complete and sign the psychiatric evaluation within 24 hours. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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A 438	Continued From page 154 psychiatric evaluation must also be dictated within 24 hours. 9. Group Therapist would document daily the issues discussed in Group Therapy and the affect/behavior as noted by the Therapist". The facility General Guidelines EMR Documentation policy, #1400.90, effective 6/1/2018, revealed under "procedure #2. Entries must be accurate, relevant, timely and complete. #9. Authentication included the identity and professional discipline of the author, the date, and the time signed".	A 438		
A 449	CONTENT OF RECORD CFR(s): 482.24(c) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on record review, interview and document review the facility failed to ensure a code record was completed after a code was called for an unresponsive patient with respiratory distress (Patient #29) and to document a Code Blue after Cardiopulmonary Resuscitation (CPR) was initiated on a patient (Patient #21). Findings include: The facility Code Blue Policy #1000.13 last revised September 2017 included the Code Blue Leader would assign documentation of emergency support care activities using Code Blue Report.	A 449		

A 449 Continued From page 155 A 449

The facility Code White, Rapid Medical Response Team Policy and Procedure #1000.56, effective 09/10/15, and revised 12/20/18 included the Code Team documentation will be completed by Code White Team members and the staff nurse including completion of the Code Team Record. The Code White Team Record will be completed and signed by all involved practitioners. Documentation will be completed on the medical response record and maintained in the patient's permanent record, a copy will be sent to the Quality Improvement (QI) department for periodic review by the medical response members for a continued quality improvement and education.

Patient #29
Patient #29 was admitted on 02/23/19 with diagnoses including intermittent explosive disorder, major depressive (MDD) disorder, recurrent, sever with psychotic symptoms, and selective mutism.

A Nursing Progress Note dated 02/27/19 documented the RN went to Patient #29's room to give medications and found the patient unresponsive to verbal commands, tapped the patient on the shoulder and had no response. The RN noticed the patient had gargled breath and agonal breathing. The nurse began sternal rub and called a "code white". The RN indicated the patient had a palpable pulse. The head of bed was elevated. Oxygen applied via mask. Vitals signs BP 122/85, pulse 50 and O2 sats 98 % on 10 liters, blood glucose 126. The RN indicated the patient was suctioned and food residue was removed from the patient's mouth. The ambulance was called and patient remained unresponsive. The patient was transferred to an acute care hospital and the physician was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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A 449	Continued From page 156	A 449		

notified.

On 06/04/19 at 3:14 PM, the Interim CNO verbalized a code report was not done.

On 06/06/19 at 1:58 PM, a Nurse Manager confirmed there was no Code Blue report for Patient #29. The Nurse Manager verbalized a code report should have been completed.

Patient #21
Patient #21 was admitted to the facility on 04/17/19 with diagnoses including unspecified psychosis.

Incident Report #14865 dated 04/22/19, indicated Patient #21 was found in a room unconscious with abrasions on the neck and arms from another patient. An emergency ambulance was called and the patient was sent to a local hospital for further treatment.

The summary of an interview conducted on 04/25/19 with the Registered Nurse (RN) documented the patient did not have a pulse. Cardiopulmonary Resuscitation (CPR) was started. The patient had return of pulse and breathing after one minute of CPR.

A Nursing Note dated 04/22/19, indicated the patient was found unresponsive and unable to communicate after being attacked by another patient. The patient was lying on the floor in Room 123 with multiple abrasions. The patient was sent out to the hospital for treatment. The record lacked documentation of a Code Blue.

On 06/06/19 at 8:50 AM, the Registered Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 449	Continued From page 157 (RN) confirmed on 04/22/19 Patient #21 was found unresponsive, a Code Blue was called, and the RN gave chest compressions for a short duration. The patient was revived. The RN did not recall documenting the Code Blue for the patient's record. On 06/06/19, the Director of Health Information Management reported Patient #21's record lacked documentation of a Code Blue. The documentation was done on a paper form which was located in the emergency bag. The form would then be retained in the paper record and also scanned into the Electronic Health Record. A nursing note should also be documented. The facility policy and procedure titled Code Blue, revised 09/2017, indicated staff would document the emergency support care using the Code Blue Record.	A 449		
{A 450}	MEDICAL RECORD SERVICES CFR(s): 482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on record review, document review and interview the facility failed to ensure entries in the electronic medical record were accurate, relevant, timely, complete and authenticated by the person responsible for providing or evaluating the service provided. Specifically, the facility failed to:	{A 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 450}	Continued From page 158 1) Ensure the assigned therapist made contact with the patient within 24 hours of admission for 31 of 47 patient Therapy Initial Contact Notes reviewed (Patient #16, #34, #39, #48, #49, #50, #51, #52, #53, #54, #57, #58, #61, #66, #67, #69, #70, #73, #76, #77, #78, #79, #81, #82, #83, #87, #88, #89, #90, #93, #94). 2) Ensure the person responsible for providing or evaluating patient care signed Therapy Initial Contact Notes (Patient #42, #51, #55, #56, #67, #68, #69, #70, #86), and Therapy Services Progress Notes (Patient # 67). 3) Ensure the credentials and/or title of the person completed and signed was included on the History and Physical Examinations, Nursing Admission Assessments, Progress Note (Patient #1); Treatment Plan Updates and Therapy Group Notes (Patient #43); and Therapy Initial Contact Notes (Patient #51). Review of Therapy Initial Contact Notes for March 2019 - May 2019 revealed the assigned therapist did not initiate contact with the following patients within 24 hours of admission: Patient #16 Patient #16 was admitted on 04/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/27/19, two days after admission. Patient #34 Patient #34 was admitted on 04/24/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/26/19, two days after admission.	{A 450}		

{A 450} Continued From page 159 {A 450}

Patient #39
Patient #39 was admitted on 04/26/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/28/19, two days after admission.

Patient #48
Patient #48 was admitted on 03/18/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, six days after admission.

Patient #49
Patient #49 was admitted on 03/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/27/19, two days after admission.

Patient #50
Patient #50 was admitted on 03/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/19/19, three days after admission.

Patient #51
Patient #51 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission. The Therapy Initial Contact Notes lacked the signature of a therapist.

Patient #52
Patient #52 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/26/19, five days after admission.

Patient #53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 450}	Continued From page 160 Patient #53 was admitted on 03/22/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, three days after admission. Patient #54 Patient #54 was admitted on 03/23/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/26/19, three days after admission. Patient #57 Patient #57 was admitted on 03/15/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/17/19, two days after admission. Patient #58 Patient #58 was admitted on 03/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/19/19, two days after admission. Patient #61 Patient #61 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission. Patient #66 Patient #66 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, three days after admission. Patient #67 Patient #67 was admitted on 03/14/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the	{A 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 450}

Continued From page 161

patient on 03/17/19, three days after admission.

Patient #69
Patient #69 was admitted on 03/20/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, five days after admission.

Patient #70
Patient #70 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, three days after admission.

Patient #73
Patient #73 was admitted on 04/30/19. A Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/01/19, two days after admission.

Patient #76
Patient #76 was admitted on 05/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/20/19, three days after admission.

Patient #77
Patient #77 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/27/19, two days after admission.

Patient #78
Patient #78 was admitted on 05/07/19. The Therapy Initial Contact Note initiated and signed by a therapist on 05/09/19, two days after admission.

Patient #79

{A 450}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 450}	Continued From page 162 Patient #79 was admitted on 05/10/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/14/19, four days after admission. Patient #81 Patient #81 was admitted on 05/09/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/12/19, three days after admission. Patient #82 Patient #82 was admitted on 05/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/18/19, two days after admission. Patient #83 Patient #83 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/27/19, two days after admission. Patient #87 Patient #87 was admitted on 05/28/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/31/19, three days after admission. Patient #88 Patient #88 was admitted on 05/24/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/31/19, seven days after admission. Patient #89 Patient #89 was admitted on 05/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the	{A 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 450}	Continued From page 163 patient on 05/18/19, two days after admission. Patient #90 Patient #90 was admitted on 05/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/19/19, two days after admission. Patient #93 Patient #93 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/28/19, three days after admission. Patient #94 Patient #94 was admitted on 05/27/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/30/19, three days after admission. Review of Therapy Initial Contact Notes and Therapy Services Progress Notes for March 2019 - May 2019 revealed the following lacked signatures: Patient #42 Patient #42 was admitted on 05/28/19. The Therapy Initial Contact Note with an observation date of 05/29/19 lacked the signature of a therapist. Patient #51 Patient #51 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission. The Therapy Initial Contact Notes lacked the signature of a therapist.	{A 450}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 450}	Continued From page 164	{A 450}		

Patient #55
Patient #55 was admitted on 03/19/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/20/19. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #56
Patient #56 was admitted on 03/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/15/19, which is a day before the patient was admitted to the facility. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #67
Patient #67 was admitted on 03/14/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/17/19, three days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #67's medical record revealed two Therapy Services Progress Notes initiated on 03/17/19 and another on 03/21/19. Therapy Services Progress Notes lacked the signature of a therapist.

Patient #68
Patient #68 was admitted on 03/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/16/19. The Therapy Initial Contact Notes lacked the signature of a therapist.

Patient #69
Patient #69 was admitted on 03/20/19. The

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	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 450}	Continued From page 165	{A 450}		

Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, five days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #70
Patient #70 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, three days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #86
Patient #86 was admitted on 05/29/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/30/19. The Therapy Initial Contact Note lacked the signature of the therapist.

Review of History and Physical Examinations, Nursing Admission Assessments, Progress Notes, Treatment Plan Updates, Therapy Group Notes and Therapy Initial Contact Notes for March 2019 - May 2019 revealed the following lacked credentials and/or title of the person who completed the documents:

Patient #1
Patient #1 was admitted on 05/08/19, and readmitted on 05/18/19 with diagnoses including schizophrenia, bipolar type and unspecified psychosis.

A History and Physical Examination dated 05/18/19 lacked documented evidence of the title of the provider who completed and signed the document.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 450}	Continued From page 166	{A 450}		

A Nursing Admission Assessment dated 05/18/19 lacked documented evidence of the title of the nurse who completed and signed the document.

A Progress Note dated 05/20/19 lacked documented evidence of the title of the provider who completed and signed the document.

Patient #43
Patient #43 admitted on 03/25/19. Patient #43's medical record revealed a Treatment Plan Update initiated on 03/27/19, a Treatment Plan Assessment Update initiated on 04/03/19. The documents lacked the signature of the person responsible for updating the plans.

Patient #43's Therapy Group Notes dated 04/03/19 and 04/04/19, lacked the signature of the person responsible for running group.

Patient #51
Patient #51 was admitted on 03/21/19. A Therapy Initial Contact Note documented an observation date of 04/03/19, and another date of 03/2519. A second Therapy Initial Contact documented an observation date of 03/26/19. Both Therapy Initial Contact Notes lacked a Therapist's signature.

On 06/05/19 at 1:15 PM, the Information Technology (IT) Technician explained the medical practice software was the facility's source system for documentation. The IT Technician indicated as an example of a pre-admission; the facility was allowed to input patients and pull their information over to start documentation for patient admission and push the information forth. The IT Technician verbalized it allowed for collection of data which was one example why the issue may exist. The IT

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	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 450}	Continued From page 167	{A 450}		

Technician acknowledged individual's could go into and manipulate the documentation.

On 05/31/19 at 9:45 AM, the Chief Clinical Officer (CCO) acknowledged the Therapy Initial Contact notes were not done timely.

On 06/06/19 at 10:27 AM, the Chief Clinical Officer (CCO) acknowledged the Therapy Initial Contact Notes were not completed or late. The CCO verbalized, "We just don't have enough staff". The CCO indicated that staff are working late at night and have work left to do.

Facility Therapist Handbook 2018 documented to complete Therapist Initial Contact Note which included documentation of Initial Contact made by assigned therapist within 24 hours of admission.
Facility Documentation and Documentation Retention Policy #1400.6, last revised 9/2017, revealed under "Procedure #3: The Physician was responsible for the history and physical examination records. #5.2 The attending Physician would complete and sign the psychiatric evaluation within 24 hours. The psychiatric evaluation must also be dictated within 24 hours. 9. Group Therapist would document daily the issues discussed in Group Therapy and the affect/behavior as noted by the Therapist."

Facility General Guidelines Electronic Medical Record (EMR) Documentation Policy #1400.90, effective 06/01/2018, revealed under "Procedure #2: Entries must be accurate, relevant, timely and complete. #9. Authentication included the identity and professional discipline of the author, the date, and the time signed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 458	Continued From page 168	A 458		
A 458	CONTENT OF RECORD: HISTORY & PHYSICAL CFR(s): 482.24(c)(4)(i)(A) All records must document the following, as appropriate: (i) Evidence of-- (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. This STANDARD is not met as evidenced by: Based on record review and interview, a physician failed to enter a history and physical within 24 hours as required for 1 of 94 patients (Patient #11). Findings include: Patient #11 Patient #11 was admitted on 05/10/19, with diagnoses including major depressive disorder without psychosis and potential for self-harm. Patient #11's medical record revealed the History and Physical was initiated on 05/12/19. On 06/04/19 at 10:40 AM, the Medical Records Director acknowledged the following late history and physical.	A 458		
{A 467}	CONTENT OF RECORD:	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 467}

Continued From page 169

ORDERS,NOTES,REPORTS
CFR(s): 482.24(c)(4)(vi)

[All records must document the following, as appropriate:]
All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

This STANDARD is not met as evidenced by:
Based on interview, record review and document review the facility failed to ensure documentation in patients records were timely and included all information necessary to monitor the patient's condition. Specifically, the facility failed to:

1) Ensure Psychiatric Evaluations were completed within 24 hours of admission for 6 of 94 patients (Patient #21, #11, #14, #39, #40, #47).

2) Ensure Treatment Plans were initiated within the first 24 hours of admission for 3 of 94 patients (Patient #21, #24, #11).

3) Ensure a corresponding nurses progress note was documented following the use of restraint/seclusion (Patient #21); and patient blood pressures were appropriately assessed and documented in the falls assessment (Patient #29, #2).

4) Ensure the assigned therapist made contact with the patient and documented an Initial Contact Note within 24 hours of admission 34 of 94 patients (Patient #23, #11, #14, #16, #34, #39,

{A 467}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ___ B. WING ___	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 170	{A 467}		

#48, #49, #50, #51, #52, #53, #54, #57, #58, #61, #66, #67, #69, #70, #73, #76, #77, #78, #79, #81, #82, #83, #87, #88, #89, #90, #93, #94).

5) Ensure treatment plans were based on the specific individualized needs of the patient including behaviors, past mental and medical health issues and interventions to treat the identified problems for 2 of 94 patients (Patient #28, #29).

6) Ensure staff responsible for group therapy notes included information useful to gauge the patient's response to therapy for 2 of 94 patients (Patient #28, #2).

7) Ensure Therapy Group Note entries were documented for 12 of 94 patients (#9, #11, #12, #13, #14, #15, #16, #17, #18, #37, #38, #39).

Findings include:

Patient #21
Patient #21 was readmitted on 04/23/19 with diagnoses including unspecified psychosis.

Review of Patient #21's medical record revealed the following:
- The Initial Psychiatric Evaluation was completed 04/25/19.
- The Treatment Plan was initiated on 04/25/19.
- Patient #21 had an episode of restraint/seclusion on 04/24/19 at 10:00 AM, and the medical record lacked documentation of a corresponding nursing progress note.

On 05/23/19 at 10:05 AM, the Nurse Manager of Adult Services reported there should have been a nursing progress note documented regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 171	{A 467}		

each incident of restraint or seclusion. The Nurse Manager verified the record lacked a nursing note for the incident on 04/24/19.

On 05/23/19 in the morning, the Nurse Manager indicated a Treatment Plan should have been initiated within 8 hours of admission. The Nurse Manager stated the Treatment Plan was not initiated within the required time-frame.

On 05/29/19 in the afternoon, the Director of Medical Records confirmed Patient #21 did not have a psychiatric evaluation within 24 hours of admission. The Director of Medical Records indicated the facility policy was a psychiatric evaluation should have been completed and documented within 24 hours of admission.

Patient #23
Patient #23 was admitted on 05/19/19 with diagnoses including psychosis.

On 05/20/19 at 9:30 AM, Patient #23 reported not talking to a therapist since admission.

On 05/20/19 at 11:30 AM, a Licensed Clinical Professional Counselor (LCPC) verbalized the case load assigned to the therapist was 14-15 patients. The LCPC indicated duties included conducting individual and group therapy sessions, including the initial or intake therapy interview. This initial therapy interview should have occurred within 72 hours of the each patient's admission.

On 05/23/19, Patient #23's medical record lacked a therapy initial contact note. The first therapy note dated 05/21/19 was for discharge planning.

On 06/06/19 at 10:25 AM, the Chief Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 172	{A 467}		

Continued From page 172

Officer (CCO) verified the record lacked an therapy initial contact note. The CCO reported the therapist should have met with the patient as soon as possible after admission and documented an initial note.

Patient #24
Patient #24 was admitted to the hospital's outpatient program on 06/06/19 with diagnoses including depression.

The inter-hospital transfer form revealed the patient had a history of interacting online with an older male and sending nude photos to people on the Internet.

Patient #24's Treatment Plan initiated on 06/06/19, indicated a problem regarding potential harm to others, mood swings, poor impulse control, and aggression towards others, but did not address the history of sexual behaviors or any interventions to treat sexual behavior.

On 05/22/19 at 11:30 AM, a Marriage Family Therapist (MFT) indicated the Treatment Plan did not include the history of sexual behaviors, but were part of the problems the patient was being treated for and should have been included in the Treatment Plan. The MFT was not sure why the Treatment Plan did not include interventions for the patient's history of sexual behavior.

On 05/22/19 in the afternoon, the Director of Outpatient Services acknowledged Patient #24's Treatment Plan did not reflect or address the patient's history of sexual behavior.

On 05/22/19 in the afternoon the Medical Director confirmed Patient #24's Treatment Plan should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}		{A 467}		

Continued From page 173
include the history of having contact with an older male and of sending sexual images over the Internet.

2) On 05/22/19 at 11:30 AM, a Marriage Family Therapist (MFT) indicated not knowing how to enter some items into the Treatment Plan on the Electronic Health Record (EHR).

On 05/22/19 in the afternoon, the Director of Outpatient Services reported individualizing Treatment Plans in the EHR was limited to certain pre-set options which did not include the ability to enter individualized items. The Director of Outpatient Services described being aware this could be done but needed training on how to specifically add individualized Treatment Plan entries.

Patient #28
Patient #28 was admitted on 05/15/19 with diagnoses including dementia with behavioral disturbances.

1) The Treatment Plan initiated on 05/15/19, indicated a problem of being out of contact with reality due to dementia. Interventions included staff would facilitate psychoeducation groups daily to explore triggers and warning signs for delusions, and three triggers for or warning signs for anxiety/anxiousness. The Treatment Plan did not identify behavior symptoms of being intrusive or wandering.

On 05/21/19 at 8:55 AM, Patient #28 was in the Geropsychiatric unit and attended a Goals Group led by a Mental Health Technician (MHT). There were seven other patients attending the group. Patient #28 was given an inventory paper to fill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 467}	Continued From page 174	{A 467}		

but was unable to read it or write on it. The MHT was busy with other patients and did not have an opportunity to assist the patient. The patient moved away from the group and went back to his room.

2) Review of Patient #28's MHT Therapy Group Notes revealed the following:
-A Therapy Group Note documented on 05/20/19, indicated the patient did not attend a Process Group, but the patient was very intrusive.
-Therapy Group Notes documented on 05/22/19, 05/23/19, 05/24/19, and 05/27/19 indicated the patient was intrusive, wandered off from groups, or did not attend.

On 05/29/19 at 2:30 PM, a Therapist reviewed the group notes for Patient #28. The Therapist indicated the group notes documented by the MHT did not include information which could be used by the therapist to gauge the patient's response to therapy or progress in general. The Therapist reported not relying on the MHT group notes in any way for clinical decision.

Further review revealed the notes were sparse, and the topics presented to Patient #28 in the group therapy did not correspond with the patient's symptoms of mental confusion and diagnosis of dementia.

On 05/29/19 at 2:30 PM, the Therapist disclosed not being sufficiently trained on the facility EHR system and having difficulties with using the system. The Therapist indicated this concern about training to use the EHR system had been expressed to the Chief Clinical Officer (CCO) but no additional training was provided. The Therapist added the CCO was also not proficient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 175	{A 467}		

in use of the EHR.

On 05/29/19 at 3:00 PM, the Director of Medical Records was aware of staff concerns regarding training to use the EHR. The Director of Medical Records indicated the CCO was working with the therapist staff for specific training needs in that area. The Director of Medical Records indicated EHR trainers should have been super-users with a known proficiency at using the system. The Director of Medical Records acknowledged the CCO was not a super user.

The Director of Medical Records verified being aware of an issue with the Treatment Plans being generic and lacking individualized content. The Director of Medical Records was not sure if EHR reference and training materials were located on the units to assist staff. The Director of Medical Records confirmed the medical diagnoses should have been on the treatment plans.

The facility's policy titled Interdisciplinary Assessments, revised 10/2017, indicated a complete psychiatric assessment should have been done within 24 hours of a patients' admission.

The facility Therapist Handbook 2018, indicated once the patient responsibilities included opening the chart and implementing the treatment plan. The Handbook indicated the first 24 hours of admission was known as "opening the chart". The Handbook documented to complete Treatment Plan "develop treatment plan with specific goals, objectives, and interventions. Complete Therapist Initial Contact Note which included documentation of Initial Contact made by assigned therapist within 24 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}		{A 467}		

Continued From page 176

The Handbook indicated the initial contact not documented the first interaction between the assigned therapist and the patient.

Patient #9
Patient #9 was admitted on 04/16/19 with diagnoses including recurrent, severe major depressive disorder with psychosis.

Patient #9's medical record lacked documented evidence of six acute care entries weekly.

On 05/31/19 at 3:37 PM, the Director of Medical Records acknowledged the following psychiatric progress notes:

Week of April 21, 2019 - April 27, 2019: three entries dated 04/23/19, 04/25/19 and 04/26/19.

Week of April 28, 2019 - May 4, 2019: four entries dated 04/28/19, 05/02/19, 05/03/19 and 05/04/19.

Week of May 5, 2019 - May 11, 2019: one entry dated 05/05/19.

Week of May 12, 2019 - May 18, 2019: three entries dated May 05/12/19, 05/16/19 and 05/17/19.

A Clinical Therapist started an Initial Therapy Contact note at 12:46 PM on 04/17/19. The note was signed days later. The Director of Medical Records acknowledged the electronic medical records system only allowed a review of electronic entries dating back to 05/01/19 to identify whether the Clinical Therapist started the note on 04/17/19 in real time or whether there was simply a manual late entry not acknowledged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ____ B. WING ____	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}		{A 467}		

Continued From page 177
as such by the system.

On 05/30/19 at 12:50 PM and 05/31/19 at 3:37 PM, the Director of Medical Records acknowledged the facility's electronic medical records system allowed employees unlimited access to backdate or forward-date entries without acknowledging such in the system. The Director of Medical Records understood the dilemma, and as a result, a determination could not be made. Clinicians were expected to document entries within 24 hours of the patient contact.

The facility Medical Staff Rules and Regulations (2019) indicated the following:

"Adherence to Medical Staff and Facility Requirements:
13. Each Attending Medical Staff member on the Active Medical Staff shall attend treatment team meetings conducted concerning his/her patient, and for acute care patients, is responsible for completing progress notes at least six days per week and other such notes as clinically indicated during the patient's length of stay.

Care of the Patient:
16. Progress notes shall be made by the attending medical staff member, on the acute care unit, at least six days weekly and preferably on each patient visit".

Patient #11
Patient #11 was admitted on 05/10/19, with diagnoses including major depressive disorder without psychosis and potential for self-harm.

Review of the medical record revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 178 following: An Initial Therapy Contact Note initiated on 05/12/19, two days after admission. An Initial Psychiatric Evaluation was dated 05/14/19, four days after admission. Therapy Group Notes documented one entry per day on 05/14/19 - 05/19/19, 05/22/19 and no entries on 05/24/19 - 05/31/19; and 05/15/19, 05/21/19 and 05/23/19. On 06/04/19 at 10:40 AM, the Director of Medical Records acknowledged therapy group note entries; and the late Initial Psychiatric Evaluation and Initial Therapy Contact Note. Patient #12 Patient #12 was admitted on 5/13/19, with diagnoses including bipolar disorder and attention deficit disorder. Patient #12's medical record revealed Therapy Group Notes documented one entry on 05/17/19, 05/18/19, 05/20/19, and no entries 05/17/19 and 05/21/19. On 06/04/19 at 10:30 AM, the Director of Medical Records acknowledged the lack of therapy group note entries. Patient #13 Patient #13 was admitted on 12/10/18, with diagnoses including recurrent, severe major depressive disorder without psychosis. Patient #13's medical record lacked Therapy Group Notes entries on 03/22/19, 03/23/19, 03/27/19, 03/29/19, 03/30/19 and 05/19/19. And,	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 179	{A 467}		

one entry per day was documented on 04/10/19, 04/12/19, 04/13/19, 04/15/19, 04/18/19, 04/19/19, 05/11/19, 05/17/19, 05/25/19 and 05/26/19.

On 06/04/19 at 12:10 PM, the Director of Medical Records acknowledged the lack of therapy group notes.

Patient #14
Patient #14 was admitted on 03/22/19, with diagnoses including bipolar disorder and recurrent, severe major depressive disorder without psychosis.

Review of the medical record revealed the following:
An Initial Therapy Contact Note initiated on 03/2419, two days after admission.

An Initial Psychiatric Evaluation dated 03/24/19, four days after admission.

Therapy Group Notes documented one entry per day on 04/01/19, 04/03/19, 04/05/19 - 04/07/19, 04/10/19, 04/12/19, 04/13/19, 04/19/19 - 04/22/19, 04/26/19, 04/28/19, 05/03/19, 05/08/19, 05/09/19, 05/11/19, 05/13/19 - 05/17/19, 05/23/19 and 05/26/19 - 05/28/19.

On 06/04/19 at 3:00 PM, the Director of Medical Records acknowledged the late entries and therapy group notes.

Patient #15
Patient #15 was admitted on 04/16/19, with diagnoses including bipolar disorder and unspecified major depressive disorder.

On 06/04/19 at 12:30 PM, the Director of Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}		{A 467}		

Continued From page 180
Records acknowledged the following therapy group notes:

Therapy Group Notes documented one entry per day on 04/19/19 - 04/11/19, 04/24/19 and 04/28/19 - 04/30/19, 05/01/19, 05/07/19, 05/11/19, 05/14/19, 05/17/19 - 05/19/19, 05/24/19, 05/26/19 and no entries 05/31/19; and 05/03/19, 05/13/19, 05/15/19 and 05/25/19.

Patient #16
Patient #16 was admitted on 04/25/19, with diagnoses including recurrent, severe major depressive disorder without psychotic features.

On 06/4/19 at 12:35 PM, the Director of Medical Records acknowledged the following therapy group notes:

Therapy Group Notes documented one entry per day on 04/26/19 and 04/28/19 - 04/30/19, 05/03/19, 05/09/19, 05/11/19, 05/14/19, 05/17/19, 05/18/19, 05/23/19 and 05/25/19 - 05/30/19 and no entries on 05/13/19 and 05/15/19.

Patient #17
Patient #17 was admitted on 3/27/19, with diagnoses including recurrent, severe major depressive disorder without psychosis.

On 06/4/19 at 12:05 PM, the Director of Medical Records acknowledged the following therapy group notes:

Patient #17's medical record lacked Therapy Group Note entries on 04/01/19, 04/03/19, 04/05/19 - 04/07/19, 04/10/19, 04/12/19, 04/19/19, 04/20/19, 04/21/19, 04/26/19 - 4/30/19 and 05/15/19; and one entry per day on 05/14/19,

{A 467} Continued From page 181 {A 467}

05/17/19, 05/18/19, 05/23/19, 05/25/19 - 05/31/19.

Patient #18
Patient #18 was admitted on 03/29/19, with diagnoses including disruptive mood dysregulation disorder

On 06/04/19 at 11:45 AM, the Director of Medical Records acknowledged the following therapy group notes:

Patient #18's medical record lacked Therapy Group Note entries on 04/01/19, 04/03/19, 04/05/19 - 04/07/19, 04/10/19, 04/12/19, 04/13/19, 04/19/19 - 04/22/19, 04/26/19, 04/28/19, 4/29/19, 05/01/19, 05/03/19, 05/06/19, 05/08/19, 05/09/19, 05/11/19, 05/13/19, 05/15/19, 05/17/19, 05/18/19, 05/21/19, and 05/23/19 - 05/26/19.

Patient #37
Patient #37 was admitted on 5/2/19, with diagnoses including bipolar disorder and major depressive disorder with psychotic features: hearing voices.

On 06/04/19 at 11:30 AM, the Director of Medical Records acknowledged the following therapy group notes:

The medical record revealed therapy group notes documented one entry per day 05/09/19, 05/11/19, 05/14/19, 05/17/19, 05/18/19, 05/21/19, 05/24/19 and 05/26/19; and no entries on 05/07/19, 05/13/19, 05/15/19 and 05/19/19.

Patient #38
Patient #38 was admitted on 04/01/19, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 182 diagnoses including unspecified mood disorder. The medical record revealed therapy group notes documented one entry per day on the following dates: 04/12/19, 04/13/19, 04/18/19, 04/19/19 and 04/20/19, 05/11/19, 05/17/19, 05/25/19 - 05/28/19, and 05/30/19. On 06/04/19 at 12:25 PM, the Director of Medical Records acknowledged the following therapy group notes. Patient #39 Patient #39 was admitted on 04/26/19, with diagnoses including recurrent, severe major depressive disorder without psychosis. On 06/04/19 at 11:10 AM, the Director of Medical Records acknowledged the late psychiatric evaluation and the following therapy group notes: Psychiatric Evaluation dated 04/29/19, completed three days after admission. Therapy Group Notes documented one entry per day 05/07/19, 05/09/19, 05/11/19, 05/16/19, 05/17/19, 05/19/19, 05/23/19 and 05/24/19; and no entries on 05/13/19, 05/14/19 and 05/21/19. Patient #40 Patient #40 was admitted on 05/17/19, with diagnoses including major depressive disorder. Review of the medical record revealed a Psychiatric Evaluation dated 05/21/19, four days after admission. On 06/11/19 at 11:42 AM, the Director of Medical Records acknowledged the late psychiatric	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 467}	Continued From page 183 evaluation. On 05/29/19 at 11:05 AM, a Clinical Therapist indicated the therapists, at times, were unable to stick with their assignments and also conduct groups twice daily and complete group notes. On 05/29/19 at 11:20 AM, a second Clinical Therapist indicated therapists received help with groups once in a blue moon, and therapists were unable to float to other units to assist, even though they were scheduled to do so because of the patient workload. Weekend work would be left over on Mondays. It impacted care and documentation because sometimes the psychosocial assessments, safety plans and discharges were entered simultaneously because therapists would be behind in their workload. There was no alternative method to document to accommodate therapist workload. The Therapist was unaware of a Quality Assurance representative for therapists or performance measures in the department. Patients could be at risk asking to be seen, and therapists could not always see them. Management was aware the actual workloads of therapists did not match the assignment sheets, as far as patient ratios. The facility needed four more therapists. On 05/29/19 at 1:55 PM, a third Clinical Therapist was unaware of a Quality Assurance representative for therapists or performance measures in the department. On 05/29/19 at 3:00 PM, a fourth Clinical Therapist was unaware of a Quality Assurance representative for therapists or performance measures in the department.	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING _______ B. WING _______	R-C 06/14/2019

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{A 467}

Continued From page 184

On 05/29/19 at 3:30 PM, a fifth Clinical Therapist felt like drowning in work just the other day.

On 05/29/19 at 4:00 PM, a sixth Clinical Therapist was unaware of a Quality Assurance representative for therapists or performance measures in the department. The facility needed another 1-2 therapists at least. The therapist had not been off the unit in a couple weeks, even though scheduled to do so for a few patients on other units. There was only enough time to do the work on the unit.

On 05/31/19 at 9:30 AM, the Chief Clinical Officer (CCO), who was a member of the Governing Body, Quality Assurance/Performance Improvement and the Medical Executive Committee, acknowledged the facility lacked therapists. The Director of Therapy left for this reason. The CCO indicated the schedule did not predicate what would actually happen. The facility was being staffed based on its average census and not with a 1:15 ratio. The facility handbook showed 1:10 ratio.

The CCO indicted the corporate office was dictating the numbers of therapists based on census alone. The Chief Executive Officer continued to tell therapists they could do the work. Therapists continued to float to other units. Patients were being discharged over the weekends, but Care Managers were not doing the paperwork. Therapists had to catch-up with the weekend documentation during the week. Therapists were supposed to conduct therapy groups twice daily seven days per week. This was not happening in the Adolescent Residential Unit. Treatment needs were not being met if the groups were not conducted. The lead Therapists

{A 467}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 467}	Continued From page 185	{A 467}		

provided 10% sample data to analyze for quality data. The therapy department was failing to meet its quality indicator expectations of a 90% rate, regarding formulating goals, treatment plans and updates. The CCO indicated trying multiple times to work on acquiring more staff, but the facility was choosing not to hire more than 11 full time therapists.

The facility Documentation and Documentation Retention policy #1400.6, last revised 09/17, revealed under procedure #3. The Physician was responsible for the history and physical examination records. #5.2 The attending Physician would complete and sign the psychiatric evaluation within 24 hours. The psychiatric evaluation must also be dictated within 24 hours. 9. Group Therapist would document daily the issues discussed in Group Therapy and the affect/behavior as noted by the Therapist.

The facility General Guidelines Electronic Medical Record (EMR) Documentation policy #1400.90, effective 06/01/18, revealed under "procedure #2. Entries must be accurate, relevant, timely and complete. #9. Authentication included the identity and professional discipline of the author, the date, and the time signed."

Patient #47
Patient #47 was admitted on 11/09/18, with a past psychiatric history including bipolar disorder, autistic spectrum, attention deficit hyperactivity disorder and post traumatic stress disorder.

Review of the medical record revealed the Initial Psychiatric Evaluation for Patient #47 was conducted by the psychiatric physician on 11/12/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 467}	Continued From page 186	{A 467}		

On 04/12/19 in the afternoon, a Nurse Manager confirmed Patient #47 did not have a Psychiatric Evaluation within 24 hours of admission.

Complaint # 56772

Patient #29
Patient #29 Robert Glaunder was admitted on 02/23/19 with diagnoses including intermittent explosive disorder, major depressive disorder, recurrent, severe with psychotic symptoms, and selective mutism.

A Fall Risk Assessment dated 02/23/19 lacked documented evidence of a systolic blood pressure (BP) while lying, sitting and 1 & 3 minutes after standing. The assessment indicated "No drop in pressure noted." The corresponding vitals sign observations dated 02/23/19 documented the BP as 116 millimeters of mercury (mmHg)/72 mmHg. There was no indication whether this blood pressure was taken while the patient was lying, sitting or standing.

General Vitals Signs taken revealed the following BP's:
On 02/24/19 bp 109/73 mmHg.
On 02/26/19 bp 113/75 mmHg.

On 05/21/19 at 12:10 PM, a Nurse Manager confirmed there were no orthostatic blood pressures done.

On 05/21/19 at 12:10 PM, the Interim Chief Nursing Officer (CNO) verbalized "I have no answer".

Patient #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}		{A 467}		

Continued From page 187

Patient #2 was admitted on 05/17/19 with diagnoses including unspecified dementia with behavior disturbance.

A History And Physical Examination dated 05/17/19 documented Patient #2 had a past medical history of hypertension. Vital signs measured on the patient's left arm revealed the blood pressure was 178 millimeters of mercury (mmHg)/70 mmHg. The examining provider's impressions revealed diagnoses including hypertension.

A Fall Risk Assessment-Adult dated 05/17/19 indicated to measure systolic blood pressure while lying, sitting, and one and three minutes after standing. The area designated for documentation of the blood pressures and vitals indicated "No drop in pressure noted". The were no blood pressures noted in this area of the Fall Risk Assessment.

Nursing Group Notes revealed Patient #2 did not participate in the scheduled nursing group on 05/17/19 and 05/21/19 - 05/27/19. The Nursing Group Notes documented the patient received a worksheet/handout.

A Treatment Plan Assessment dated 05/17/19 documented due to dementia Patient #2 was unable to express a goal for treatment and the patient had a poor memory. The Treatment Plan Assessment dated 05/17/19 was signed by a nurse on 05/17/19.

On 05/29/19 at 9:31 AM, a Registered Nurse (RN) explained Patient #2 was aggressive and sometimes compliant with medications. The RN indicated the patient attended groups but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 467}	Continued From page 188	{A 467}		

participate. Patient #2 was provided handouts when the patient did not attend the group therapy and the nurse went over the hand out with the patient. The RN indicated attempting to get the patient to answer the questions. The RN verbalized, "I think she understands some of the handouts, but I don't know how much. I don't think she fully understands what's fully going on".

The RN indicated not going through dementia training at the facility. The RN verbalized,"It's something you usually learn along the way". The RN indicated the physician discussed the different phases of dementia when she had questions. The RN identified Patient #2 as a fall risk and a one person assist. The RN verbalized Patient #2's treatment plan should have been updated to include the medical diagnoses and treatments.

On 05/29/19 11:56 AM, the Interim CNO explained the medical diagnoses whether under control or not were required to be on the treatment plans. The Interim CNO acknowledged a patient had a high risk for falls and utilizing devices should have been placed on the treatment plan.

Mental Health Technician (MHT) Group dated 05/18/19,05/24/19, 05/25/19, and 05/26/19, revealed patient's response to the intervention as follows:
-Information sheet
-Patient attended group
-Discussed about the importance of being committed specially for patient wellness
-Patient attended group
-Discussed the importance of respecting own time and other's time as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 467}	Continued From page 189	{A 467}		

Plans documented included:
-Patient will try to make more commitments
-Patient does not have plans on committing Homicidal Ideation (HI) or Suicidal Ideation (SI) this visit.
-Patient will respect her time better in the future.
-No plans on SI or HI.

On 05/29/19 at 12:09 PM, the Nurse Manager acknowledged the documentation was not adequate for the nursing group and MHT notes.

Review of Therapy Initial Contact Notes for March 2019 - May 2019 revealed the assigned therapist did not initiate contact with the following patients within 24 hours of admission:

Patient #16
Patient #16 was admitted on 04/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/27/19, two days after admission.

Patient #34
Patient #34 was admitted on 04/24/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/26/19, two days after admission.

Patient #39
Patient #39 was admitted on 04/26/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 04/28/19, two days after admission.

Patient #48
Patient #48 was admitted on 03/18/19. The Therapy Initial Contact Note revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

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{A 467}	Continued From page 190 assigned therapist initiated contact with the patient on 03/24/19, six days after admission. Patient #49 Patient #49 was admitted on 03/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/27/19, two days after admission. Patient #50 Patient #50 was admitted on 03/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/19/19, three days after admission. Patient #51 Patient #51 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission. The Therapy Initial Contact Notes lacked the signature of a therapist. Patient #52 Patient #52 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/26/19, five days after admission. Patient #53 Patient #53 was admitted on 03/22/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, three days after admission. Patient #54 Patient #54 was admitted on 03/23/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 191	{A 467}		

patient on 03/26/19, three days after admission.

Patient #57
Patient #57 was admitted on 03/15/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/17/19, two days after admission.

Patient #58
Patient #58 was admitted on 03/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/19/19, two days after admission.

Patient #61
Patient #61 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission.

Patient #66
Patient #66 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, three days after admission.

Patient #67
Patient #67 was admitted on 03/14/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/17/19, three days after admission.

Patient #69
Patient #69 was admitted on 03/20/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, five days after admission.

Patient #70

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 192 Patient #70 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/24/19, three days after admission. Patient #73 Patient #73 was admitted on 04/30/19. A Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/01/19, two days after admission. Patient #76 Patient #76 was admitted on 05/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/20/19, three days after admission. Patient #77 Patient #77 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/27/19, two days after admission. Patient #78 Patient #78 was admitted on 05/07/19. The Therapy Initial Contact Note initiated and signed by a therapist on 05/09/19, two days after admission. Patient #79 Patient #79 was admitted on 05/10/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/14/19, four days after admission. Patient #81 Patient #81 was admitted on 05/09/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 193 patient on 05/12/19, three days after admission. Patient #82 Patient #82 was admitted on 05/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/18/19, two days after admission. Patient #83 Patient #83 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/27/19, two days after admission. Patient #87 Patient #87 was admitted on 05/28/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/31/19, three days after admission. Patient #88 Patient #88 was admitted on 05/24/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/31/19, seven days after admission. Patient #89 Patient #89 was admitted on 05/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/18/19, two days after admission. Patient #90 Patient #90 was admitted on 05/17/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/19/19, two days after admission. Patient #93	{A 467}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 467}	Continued From page 194	{A 467}		

Patient #93 was admitted on 05/25/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/28/19, three days after admission.

Patient #94
Patient #94 was admitted on 05/27/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/30/19, three days after admission.

Review of Therapy Initial Contact Notes and Therapy Services Progress Notes for March 2019 - May 2019 revealed the following lacked signatures:

Patient #42
Patient #42 was admitted on 05/28/19. The Therapy Initial Contact Note with an observation date of 05/29/19 lacked the signature of a therapist.

Patient #51
Patient #51 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, four days after admission. The Therapy Initial Contact Notes lacked the signature of a therapist.

Patient #55
Patient #55 was admitted on 03/19/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/20/19. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #56
Patient #56 was admitted on 03/16/19. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

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{A 467} Continued From page 195 {A 467}

Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/15/19, which is a day before the patient was admitted to the facility. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #67
Patient #67 was admitted on 03/14/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/17/19, three days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #67's medical record revealed two Therapy Services Progress Notes initiated on 03/17/19 and another on 03/21/19. Therapy Services Progress Notes lacked the signature of a therapist.

Patient #68
Patient #68 was admitted on 03/16/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/16/19. The Therapy Initial Contact Notes lacked the signature of a therapist.

Patient #69
Patient #69 was admitted on 03/20/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 03/25/19, five days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #70
Patient #70 was admitted on 03/21/19. The Therapy Initial Contact Note revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103

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{A 467} Continued From page 196 {A 467}

assigned therapist initiated contact with the patient on 03/24/19, three days after admission. The Therapy Initial Contact Note lacked the signature of a therapist.

Patient #86
Patient #86 was admitted on 05/29/19. The Therapy Initial Contact Note revealed the assigned therapist initiated contact with the patient on 05/30/19. The Therapy Initial Contact Note lacked the signature of the therapist.

On 06/06/19 at 10:27 AM, the Chief Clinical Officer (CCO) acknowledged the Therapy Initial Contact Notes were not completed or late. The CCO verbalized, "We just don't have enough staff". The CCO indicated that staff are working late at night and have work left to do.

{A 701} MAINTENANCE OF PHYSICAL PLANT {A 701}
CFR(s): 482.41(a)

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure the showers were not leaking and floors were not wet in patient rooms on the Acute Adolescent Unit (Room #102, #104, #107, #108, #110, #111, #112, #115).

Findings include:

On 06/11/19 at 3:32 PM, an environment check conducted on Acute Adolescent Unit revealed the following rooms with leaking showers and wet floors:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C 06/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE LAS VEGAS, NV 89103**

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{A 701}	Continued From page 197	{A 701}		

Room #102 Shower head leaking and water on the floor.

Room #104 Shower head leaking with water spilled out to the middle of the window in the patient room.

Room #107 Shower head leaking with a puddle of water on the floor.

Room #108 Shower head leaking.

Room #110 Shower head leaking and water flowing out of the shower onto the floor causing a pool of to form under the toilet.

Room #111 Shower head leaking out to floor.

Room #112 Four large towels on bathroom floor and shower head leaking.

Room #115 Shower head leaking and water flowing onto the bathroom floor.

On 06/11/19 in the afternoon, the Milieu Manager indicated Room#108 was closed the night before due to patients tampering with the shower. The Milieu Manager verbalized the rooms should have been checked. The Milieu Manager indicated whoever did rounds should have checked the showers.

On 06/11/19 at 4:04 PM, the Director of Plant Operations indicated the nursing staff were notifying of the leaking and put an order in. Possibly notified of the leaks this morning. Changing vales and replacing cartridges.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294009	A. BUILDING ______ B. WING ______	R-C **06/14/2019**

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MONTEVISTA HOSPITAL	**5900 WEST ROCHELLE AVENUE** **LAS VEGAS, NV 89103**

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{A 701}	Continued From page 198 On 06/11/19 at 4:04 PM, the Director of Plant Operations verified the following: Room #107 and #110 had small leaks. Room #111 panel and valve and will be replaced. Room #115 had a minor leak and the cartridge will be replaced.	{A 701}		