Printed: 03/16/2010 6:00:55PM
Due Date: 04/04/2010
Priority: Non-IJ Medium

Intake ID: NV00024655
Facility ID: NVS666HOS / HOSP-ACU
Provider Number: 290007

# ACTS Complaint/Incident Investigation Report

## PROVIDER INFORMATION

Name: UMC OF SOUTHERN NEVADA
Address: 1800 W CHARLESTON BLVD
City/State/Zip/County: LAS VEGAS, NV, 89102, CLARK
Telephone: (702) 383-2000

License #: 666
Type: HOSP-A
Medicaid #:
Administrator: KATHLEEN SILVER

## INTAKE INFORMATION

Taken by - Staff: [redacted]
Location Received: NORTHERN NEVADA
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact: [redacted]
RO Contact:
Responsible Team: SOUTHERN NEVADA
Source: Other State Agency

Received Start: 03/05/2010 At 10:21
Received End: 03/05/2010 At 10:21
Received by: E-Mail
State Complaint ID:
CIS Number:

## COMPLAINANTS

| Name | Address | Home Phone | Work Phone | Link ID |
|---|---|---|---|---|
| Not Applicable / Anonymous (Primary) | | | | 02UIWZ |
| [redacted] | [redacted] | | [redacted] | 107XO1 |

## RESIDENTS/PATIENTS/CLIENTS - No Data

## ALLEGED PERPETRATORS - No Data

## INTAKE DETAIL

Date of Alleged Event: Time: Shift:

Standard Notes: Please see attached email from [redacted] regarding alleged HIPAA violations involving destruction of protected information. [redacted]
*********
Per [redacted], sent referral to Federal Office of Civil Right, Dept of HHS. Letter sent 3/8/10 mlc

Extended RO Notes:
Extended CO Notes:

## ALLEGATIONS

Category: Other
Subcategory: Other
Seriousness: Moderate
Findings: Substantiated:State deficiencies related to the alleg are cited
Details:

Findings Text:

## SURVEY INFORMATION

| Event ID | Start Date | Exit Date | Team Members | Staff ID |
|---|---|---|---|---|
| 6VPI11 | 03/04/10 | 03/05/10 | [redacted] | [redacted] |

Intakes Investigated: NV00023725(Received: 12/01/2009); NV00024655(Received: 03/05/2010); NV00024669(Received: 03/09/2010)

# ACTS Complaint/Incident Investigation Report

SUMMARY OF CITATIONS:

| Event ID | Exit Date | Tag |
|---|---|---|
| 6VPI11 | 03/05/2010 | |

State - Not Related to any Intakes

S0000-Initial Comments

S0514-Medical Records

S0292-Nursing Services

**EMTALA INFORMATION - No Data**

**DEEMED/RO APPROVAL INFORMATION - No Data**

## ACTIVITIES

| Type | Assigned | Due | Completed | Responsible Staff Member |
|---|---|---|---|---|
| Schedule Onsite Visit | 03/04/2010 | 03/04/2010 | 03/05/2010 | [redacted] |

## INVESTIGATIVE NOTES

Complaint #24655
3/5/2010

An anonymous complaint indicated the facility failed to account for secure key access to its recycling bins.

Policy and Interviews: The facility's key control policy (V2), dated 7/11/07, outlined the process for key accountability in the facility. The policy highlighted the following employees as sharing some responsibility for key control, regarding recycling bin keys: Director of Public Safety, Director of Plant Operations, and Facilities Maintenance Locksmith. Additionally, I interviewed the Director of Environmental Services, an assistant locksmith, the Deputy Chief of Public Safety (because of the unavailability of the Director of Public Safety), the Clark County Privacy Officer, the environmental services manager who signed the original receipt of keys from the contractor handling the recycling bins, and a representative for the contractor actively managing the recycling bins under current contract.

Summary of interviews and policy review: The facility contracted with a third party contractor to provide 108 or so recycling bins. This contract was initiated on June 13, 2008 and renewed in March 2009. The contractor's representative provided a key release form, dated June 13, 2008, signed by an environmental services manager. The environmental services manager indicated she received 10-12 keys. The form she signed indicated the facility received 100 recycling bin keys and 108 recycling bins. Environmental services is actually a third party contractor for the facility also. Each bin was fastened with a lock; the same key was capable of opening each lock. An undetermined majority of the bins were also stored in a locked closet or utility room. Facility personnel indicated they could account for all closet/utility room keys by looking up each individual closet/utility room only. It was not possible to print out an entire list of key holders to the closet/utility rooms. Facility personnel failed to account for an exact number of recycling bins. Facility personnel failed to explain the difference between how many keys they thought they received and how many they signed for. Facility personnel provided a recycling bin key distribution log with 53 entries on it. Twenty-one of these entries were dated between 8/8/07 and 3/20/08, prior to the contract with the current recycling bin contractor. The remaining thirty-two entries were dated between 6/16/08 and 2/18/10. Four of the 32 entries were duplicates, meaning four individuals obtained additional keys. Facility personnel failed to indicate the reason for the duplicate entries. In other words, there was no way to tell whether the additional keys were replacing lost or stolen keys or were simply a second set for those individuals, or passed on to someone else, etc. The Deputy Chief of Public Safety failed to indicate any data on keys lost or stolen. The locksmith indicated key audits were not conducted on a regular basis. According to the aforementioned policy, the Director of Public Safety and the locksmith were responsible for data on keys lost or stolen and key audits respectively.

Result: Due to the above information, the allegation was substantiated with a deficiency (See Tag #514). Therefore, the complaint was substantiated with a deficiency.

In addition, I looked at an issue of stolen hard drives reported in the media the same day. I spoke to the County Privacy Officer who provided information technology directive #3, effective 10/1/09. In effect, this policy was Clark County's data breach policy to investigate the thefts and monitor quality control/risk management in regards to the hard drives and any potential compromise of sensitive data. I spoke to the Executive Director of Risk Management and the Assistant Director of Operations who gave a blow by blow analysis of how each theft was systematically approached and examined for cause, risk analysis, and implementation of preventive interventions. Five of the thefts were still undergoing review at the time of the on site visit. I examined a completed report of one of the thefts which was referred to in a trustee briefing report dated 2/26/10. The data breach analysis team determined the cardiac cath lab theft posed no significant risk of patient data compromise. The report indicated the image files could not be viewed without a manufacturer's proprietary software. The other investigations were ongoing.

[redacted]

**CONTACTS - No Data**

**AGENCY REFERRAL - No Data**

**LINKED COMPLAINTS - No Data**

# ACTS Complaint/Incident Investigation Report

## DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

## NOTICES

Letters:

| Created | Description |
|---|---|

Notification:

| Date | Type | Party | Method |
|---|---|---|---|

## PROPOSED ACTIONS - No Data

END OF COMPLAINT INVESTIGATION INFORMATION

Printed: 03/16/2010 6:03:04PM
Due Date: 04/08/2010
Priority: Non-IJ Medium

Intake ID: NV00024669
Facility ID: NVS666HOS / HOSP-ACU
Provider Number: 290007

# ACTS Complaint/Incident Investigation Report

## PROVIDER INFORMATION

Name: UMC OF SOUTHERN NEVADA
Address: 1800 W CHARLESTON BLVD
City/State/Zip/County: LAS VEGAS, NV, 89102, CLARK
Telephone: (702) 383-2000

License #: 666
Type: HOSP-A
Medicaid #:
Administrator: KATHLEEN SILVER

## INTAKE INFORMATION

Taken by - Staff: [redacted]
Location Received: SOUTHERN NEVADA
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact: [redacted]
RO Contact:
Responsible Team:
Source: State Survey Agency

Received Start: 03/09/2010 At 07:39
Received End: 03/09/2010 At 07:39
Received by: E-Mail
State Complaint ID:
CIS Number:

## COMPLAINANTS

| Name | Address | Home Phone | Work Phone | Link ID |
|---|---|---|---|---|
| Not Applicable / Anonymous (Primary) | | | | 02UIWZ |

## RESIDENTS/PATIENTS/CLIENTS - No Data

## ALLEGED PERPETRATORS - No Data

## INTAKE DETAIL

Date of Alleged Event: Time: Shift:

Standard Notes: Request from Carson City to investigate staffing in UMC ER on 2//19/10 at approximately 11 AM. Report was made that a meeting was held and staffing in the Er was below staffing requirements, leaving patients without adequate nursing staff.

Extended RO Notes:
Extended CO Notes:

## ALLEGATIONS

Category: Nursing Services
Subcategory:
Seriousness:
Findings: Substantiated:State deficiencies related to the alleg are cited
Details:

Findings Text:

## SURVEY INFORMATION

| Event ID | Start Date | Exit Date | Team Members | Staff ID |
|---|---|---|---|---|
| 6VPI11 | 03/04/10 | 03/05/10 | [redacted] | [redacted] |

Intakes Investigated: NV00023725(Received: 12/01/2009); NV00024655(Received: 03/05/2010); NV00024669(Received: 03/09/2010)

# ACTS Complaint/Incident Investigation Report

SUMMARY OF CITATIONS:

| Event ID | Exit Date | Tag |
|---|---|---|
| 6VPI11 | 03/05/2010 | |

State - Not Related to any Intakes

S0000-Initial Comments

S0514-Medical Records

S0292-Nursing Services

## EMTALA INFORMATION - No Data

## DEEMED/RO APPROVAL INFORMATION - No Data

## ACTIVITIES

| Type | Assigned | Due | Completed | Responsible Staff Member |
|---|---|---|---|---|
| Schedule Onsite Visit | 03/04/2010 | 03/04/2010 | 03/05/2010 | [redacted] |

## INVESTIGATIVE NOTES

Based upon interview and record review, it was determined that the facility did not maintain a sufficient number of Registered Nurses (RNs) to ensure that proper care was provided to each patient.

Findings:

An abbreviated survey was conducted on 03/04/10 and 03/05/10 to investigate an allegation that the facility did not provide an adequate number of RNs in the Emergency Department on 02/19/10.

The Clinical Manager of the Adult Emergency Department (Staff 1) was interviewed on 03/05/10 at 1:38 PM. She stated that on 02/19/10, at approximately 11:10 AM, she went from a budget meeting to the Emergency Department. She stated that she noticed that minimal staff were present, so she went to the staff break room. She indicated that she found that 6 of the 18 scheduled RNs in the Emergency Department were in attendance at an impromptu meeting in the break room. The Clinical Manager further stated that her concern at the time was staffing for the "Medical Pod", which consisted of twelve beds with cardiac monitoring capability. The Clinical Director then asked a nurse at the meeting about the staffing of the Medical Pod. The nurse answered that one RN was covering the Pod. The Clinical Director indicated that the staffing was inappropriate and some of the RNs then returned to their work stations to ensure patient safety. The Clinical Director estimated that there was one RN in the Medical Pod for approximately 25 minutes to care for nine patients, and that "there should have been three RNs in the Medical Pod" for the nine patients so that there would have been one RN for three patients.

The Clinical Manager was also asked to explain how staffing is arranged when meetings are held. She stated that meetings are scheduled near the change of shift so staff is always available to provide patient care.

On 03/05/10, the Associate Administrator (Staff 2), an RN, provided the Nurse-Surveyor with the Adult Emergency Department "Master Staffing Plan" for fiscal year 2010. The plan called for 18 RNs during the hours of 11:00 AM through 3:00 PM. The Associate Administrator was interviewed on 03/05/10 at 1:38 PM. She stated that she had investigated the 02/19/10 lack of RN coverage in the Emergency Department, and there had not been any adverse patient outcomes associated with the incident.

Based upon the findings of the investigation, the allegation that the facility did not ensure that a sufficient number of Registered Nurses (RNs) were on duty to ensure that proper care is provided to each patient was substantiated and a deficiency was cited. Please see the Statement of Deficiencies. [redacted]

## CONTACTS - No Data

## AGENCY REFERRAL - No Data

## LINKED COMPLAINTS - No Data

## DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

## NOTICES

Letters:

| Created | Description |
|---|---|

Notification:

| Date | Type | Party | Method |
|---|---|---|---|

## PROPOSED ACTIONS - No Data

END OF COMPLAINT INVESTIGATION INFORMATION