Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS661HOS	A. BUILDING _____ B. WING _____	04/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVI	6161 W CHARLESTON BLVD LAS VEGAS, NV 89102

(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) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 4/13/10 and finalized on 4/16/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00025035 was substantiated, see Tag S602. This complaint alleged the facility was not following policies for patients requiring one to one observation. On 4/16/10 at 10:00 AM, as the onsite investigation continued, the administrative staff was notified an immediate jeopary situation existed and an immediate plan of correction was needed. The immediate jeopary was abated at 5:30 PM. Please refer to Tags S310 and S602. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	S 000		
S 310 SS=J	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 310	Continued From page 1 review, the facility failed to provide Patient #1 with an accurate and comprehensive physical assessment upon nursing notification of a change in the patient's medical condition. Findings include: The discharge summary indicated Patient #1 was extremely agitated from the moment the patient arrived on the unit (admitted on 3/30/10). The patient was medicated with oral and intramuscular medications and was eventually placed in seclusion and restraints. During the hospital stay, the patient continued displaying agitation and verbal threats, use of foul language and aggression towards others. The patient was medicated several times with as needed medications. On 4/2/10, the electrocardiogram indicated the patient had cardiac arrhythmias. The physician discontinued the Geodon as it was known to cause arrhythmias. Patient #1 received three doses of Geodon from 3/31 to 4/2/10, prior to the discontinuation order written by the physician. The physician's notes documented the patient refused a physical examination. The discharge summary indicated on 4/4/10 around 5:15 AM - 5:30 AM, Patient #1 was found not breathing and unresponsive, cyanotic, lying in the prone position on the floor. The notes indicated it was questionable whether the patient had a pulse at that point. According to reports by the nurses, cardiopulmonary resuscitation (CPR) was given and the paramedics were called, but eventually the patient was pronounced dead. Progress notes written by the employees documented Patient #1 was found at 3:10 AM by an employee who thought the patient was not breathing and noted discoloration in the right	S 310		

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S 310	Continued From page 2 hand. The notes revealed Employee #7 assessed the patient and documented the patient was warm to touch and the patient was okay, just breathing low. On 4/15/10 at 10:50 AM, Employee #7 was interviewed via the telephone. The employee acknowledged she observed the patient breathing, but did not listen to the chest with a stethoscope and did not turn on any lights in the room. The progress notes indicated around 5:20 AM, the patient was observed to be unresponsive, not breathing and cyanotic. A faint radial pulse was documented as felt and cardio-pulmonary resuscitation (CPR) was started. The notes documented the paramedics arrived and indicated the patient was in asystole and the CPR was stopped. The police and coroner's office was notified. Multiple telephone and in person interviews were conducted with the staff working the night of the incident. Two employees stated the patient's door had been closed during the night shift. Multiple employee's noted the patient's lips were blue, the eyes were closed, saliva was on the patient's mouth and floor and a drop of blood was observed by the right nostril (smaller than the size of a penny) when the staff arrived in the patient's room around 5:20 AM. The employees noted a light brown substance from the mouth. The employees stated the patient was kind of stiff, one hand wasn't straight and the patient's arms were still above the patient's head. Upon initial assessment of the patient, a code blue was called and staff responded.	S 310		

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S 310	Continued From page 3 On 4/15/10 at 10:50 AM, Employee #7 was interviewed via the telephone. The employee stated when she arrived in the patient's room, the patient was cyanotic and arms were mottled. The employee stated a carotid pulse could not be found, but the patient had a thick neck. On 4/15/10 at 11:10 AM a phone interview was conducted with Employee #10. The employee stated three mental health technicians were standing in the patient's room wearing gloves and the room light was on. The employee ran to the room to see what was going on and noted the patient to be cyanotic and the arms were mottled. The employee stated she felt for a radial pulse and felt a questionable pulse. The employee explained since she felt it was a questionable pulse, the employee initiated cardiopulmonary resuscitation (CPR) and a code blue was called. The employee stated another employee provided the ventilations while she provided chest compressions. The employee explained periodically she would listen to the chest with a stethoscope. The employee stated she did not hear any heart beat. The employee explained she provided CPR for about five to eight minutes then stopped due to the patient's pupils were fixed and dilated, there was no heart rate and no respirations. The employee stated the patient exhibited signs of rigidity, the patient's teeth were clenched and it was difficult to move the patient's arms to the patient's side. The employee explained the patient preferred to sleep on her stomach with her arms up over her head. The employee stated the reason she stopped CPR was based on her medical background. The employee stated she was trained as a physician, but not licensed as such in Nevada. However, the employee confirmed she was working as a registered nurse at the facility.	S 310		

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S 310	Continued From page 4 The medication administration record (MAR) was reviewed. Patient #1 received both oral and intramuscular doses of Haldol, Ativan, Benadryl, Thorazine, Geodon and Cogentin during the patient's admission to the facility. On 4/3/10, the patient received a total of dosage of 6 milligrams (mg) of Ativan intramuscularly; 250 mg of Benadryl intramuscularly; 30 mg of Haldol intramuscularly and 100 mg of Thorazine intramuscularly. On 4/16/10 at 2:00 PM, Employee #14 was interviewed. The employee stated upon chart review after the patient's death, he had some concerns regarding the amount of medication the patient received within 24 hours. The employee stated he consulted with the head of pharmacy and was assured the acceptable parameters were met. The employee stated the pharmacist told him the patient received a high dose, but was not beyond the clinical justification. The employee acknowledged he had identified the lack of vital sign assessments of this patient to be of a concern while reviewing the medical record. Based on interview, record review and document review, the facility failed to provide an accurate and complete assessment on Patient #1 when a change of condition was noted. Severity: 4 Scope: 1	S 310		
S 602 SS=J	NAC 449.394 Psychiatric Services 3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and	S 602		

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S 602	Continued From page 5 services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. This Regulation is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to follow their Special Observation of Patients policy to ensure the safety of Patient #1. Findings include: On 4/1/10 at 8:10 AM, the physician wrote an order for one to one (1:1) observation and for no other patient to be admitted into the patient's bedroom due to bizarre and severe agitation towards others. Documentation indicated the patient remained on 1:1 observation until the patient's death. A review of the Special Observation of Patients policy was reviewed. The definition of 1:1 observation documented, "The Charge Nurse/MHT4 (Mental Health Technician 4) assigns a specific staff member, in writing, to maintain continuous, uninterrupted visual contact and close physical proximity to the patient. These staff members do not engage in any activities that could distract the staff member from performing patient surveillance. Staff members do not allow patients to take blankets, towels, sheets or any items that may cause harm into the bathroom. The Charge Nurse may restrict off unit privileges based on nursing assessment." The policy revealed the assigned staff member was to record routine observations every 15 minutes. The patient's room door was to remain	S 602		

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S 602	Continued From page 6 partially open and the staff was to remain in attendance just outside of the door. Continuous monitoring of the patient (both auditory and visual) was to be maintained even when the patient was asleep. On 4/15/10 at 12:30 PM, Employee #11 was interviewed via the telephone. The employee stated the report given from the swing shift nurse indicated Patient #1 had been loud and destructive and she had told the technicians to let the patient stay in the patient's room with the door shut. Employee #11 stated the resident's bedroom door had been closed all night. On 4/15/10 at 1:20 PM, Employee #8 was interviewed via telephone. The employee explained she was responsible for Patient #1 from 11:30 PM to 3:00 AM. The employee stated the patient's bedroom door was cracked open part of the night and closed part of the night. The employee stated she sat at the patient's door until her break. On 4/15/10 at 11:10 AM, Employee #10 was interviewed. The employee described the door to the patient's room had been closed and the staff member had been sitting outside of the patient's room. The employee explained when there was a very aggressive patient, the staff will allow the door to be closed, to decrease outside stimulus and to help calm the patient, however this was not indicated in the policy. The discharge summary for Patient #1 indicated on 4/4/10 around 5:15 AM - 5:30 AM, Patient #1 was found not breathing and unresponsive, cyanotic, lying in the prone position on the floor. The notes indicated it was questionable whether the patient had a pulse at that point. According to	S 602		

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S 602	Continued From page 7 reports by the nurses, cardiopulmonary resuscitation (CPR) was given and the paramedics were called, but eventually the patient was pronounced dead. On 4/16/10 at 12:50 PM, Patient #1's room was observed by the surveyor. An unidentified patient was observed lying on the bed with a blanket over them in room 146 (the bedroom previously occupied by Patient #1). The surveyor was unable to ascertain any respiratory effort from observation through the window in the bedroom door. The surveyor asked Employee #17 if he could identify if the patient was breathing. The employee stated he would not be able to tell if the patient was breathing especially with a blanket on the patient. The patient turned over and the employee and surveyor were able to visualize the back of the patient. Neither the employee nor the surveyor was able to ascertain a respiratory effort from observation through the window in the door. The employee stated he would have to go into the room to be able to see if the patient was breathing. At this time, the room was observed to be bright with outside light due to the blinds being partially opened. Based on interview, record review and document review, this complaint was substantiated. The facility failed to provide one to one observation of a patient in accordance with the facility's policy, for Patient #1. Severity: 4 Scope: 1 Complaint #NV00025035	S 602		