

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | <p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 5/4/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>Complaint #NV00025196 was substantiated with deficiencies cited. (See Tag S0602)</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>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.</p> | S 000 | | |
| S 602 SS=1 | <p>NAC 449.394 Psychiatric Services</p> <p>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 services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient.</p> <p>This Regulation is not met as evidenced by:</p> | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 1 Based on observation, interview, record review and document review, the facility failed to acknowledge and follow NRS 449.767, NRS 449.780 and NRS 449.786 for 10 of 10 patients reviewed. The facility failed to follow their Seclusion or Restraint of Patients policy for 10 of 10 patients reviewed. Findings include: A. Patient #1 was admitted to the facility on 4/26/10 with diagnoses including bipolar disorder and polysubstance dependence. The treatment/medication consent form was signed on 4/27/10. The medications authorized by the patient for staff to administer were Vistaril, Ambien and Trileptal. The patient did not authorize Abilify, Haldol, Klonopin, Depakote, Zyprexa and Benadryl to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #1 received an injection of Zyprexa and Ativan on 4/27/10 at 2:15 PM for agitation. There was no documented evidence of a nursing progress note found in the medical record regarding the behavior prior to and after receiving the injection. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. B. Patient #2 was admitted to the facility on 4/15/10 with a diagnosis of schizoaffective disorder. The treatment/medication consent form was signed on 4/17/10. The medications authorized by the patient for staff to administer were Prolixin, Zyprexa, Klonopin, Ativan, Depakene, Depakote and Artane. The patient did not authorize Seroquel, Geodon and Benadryl to be administered. There was no documented | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 2 Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #2 received an injection of Zyprexa on 4/16/10 for verbal and physical aggression towards staff. The patient received Geodon and Ativan IM for agitating other patients on 4/29/10. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. C. Patient #3 was admitted to the facility on 4/29/10 with a diagnosis of schizoaffective disorder. The treatment/medication consent form was signed on 4/30/10. The medications authorized by the patient for staff to administer were Risperdal, Zyprexa, and Ambien. The patient did not authorize Haldol, Zolof, Ativan and Benadryl to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #3 received an injection of Ativan, Benadryl and Haldol on 4/30/10. There was no documented reason for administration found on the physician's orders. The nursing progress notes indicated the patient was pacing the unit and darting at staff. There was no documented evidence a denial of rights was completed for the chemical restraint. D. Patient #4 was admitted to the facility on 5/1/10 with diagnoses including schizophrenia, paranoid type - chronic with acute exacerbation and history of traumatic brain injury. The treatment/medication consent form was signed on 5/2/10. The medications authorized by the patient for staff to administer were Risperdal, Ativan, Depakote and Benadryl. The patient did not authorize Thorazine, and Zyprexa to be administered. There was no documented Denial of Rights for Written Consent to Medical | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 3 Treatment found in the patient's medical record. Patient #4 received an injection of Benadryl and Thorazine on 5/1/10 for agitation. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. E. Patient #5 was admitted to the facility on 4/20/10 with diagnoses including schizophrenia, paranoid type unspecified and depressive disorder. The treatment/medication consent form was signed on 4/20/10. The medications authorized by the patient for staff to administer were Risperdal, Ativan, Lexapro, Ambien and Vistaril. The patient did not authorize Klonopin, and Haldol to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #5 received an injection of Benadryl, Ativan and Haldol on 5/3/10 for aggression towards peer, verbally abusive and defiant. The patient was also placed in four point restraints. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. F. Patient #6 was admitted to the facility on 3/24/10 with diagnoses including impulse control disorder, post traumatic stress disorder, mild mental retardation and personality disorder - mixed type-antisocial features-aggression. The treatment/medication consent form was signed on 3/24/10. The medications authorized by the guardian for staff to administer were Haldol, Geodon, Klonopin, Depakote and Benadryl. The patient did not authorize Ativan, and Ambien to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #6 received 12 injections from 4/18/10 to | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 4 4/29/10 for agitation or aggressive behavior. Benadryl, Ativan and Haldol and Geodon were administered. The patient was also placed in four point restraints multiple times. The patient remained on a 2:1 observation for safety. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. G. Patient #7 was admitted to the facility on 4/21/10 with diagnoses including delusional disorder, polysubstance dependenc3e and paranoid personality disorder with antisocial traits. The patient refused to sign the treatment/medication consent form but verbally consented to taking medications on 4/23/10. The medications authorized by the patient for staff to administer were Risperdal, Haldol and Zyprexa. The patient did not authorize Depakote to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #7 received an injection of Zyprexa and Benadryl on 4/24/10 for agitation. There was no documented evidence of the behavior found in the progress notes dated 4/24/10. The patient was also placed in four point restraints. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. H. Patient #8 was admitted to the facility on 4/21/10 with diagnoses including schizoaffective disorder, alcohol abuse, cannabis abuse and mild mental retardation. The treatment/medication consent form was signed on 4/26/10. The medications authorized by the patient for staff to administer were Seroquel, Ativan and Trileptal. The patient did not authorize Haldol, Zyprexa, Trazodone, Depakote or Benadryl to be | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| | | | | |
|---|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/04/2010 |
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 5 administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #8 received an injection of Benadryl and Haldol on 4/25/10 for verbal altercation with another patient. The patient received an injection of Zyprexa on 4/28/10 for severe agitation. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. I. Patient #9 was admitted to the facility on 4/14/10 with diagnoses including schizophrenia, disorganized type. The treatment/medication consent form was signed on 4/15/10. The medications authorized by the patient for staff to administer were Seroquel and Ativan. The patient did not authorize Benadryl and Haldol to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #9 received an injection of Benadryl, Ativan and Haldol on 4/23/10 for being combative and again on 5/4/10 for threatening staff and another patient. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. J. Patient #10 was admitted to the facility on 5/3/10 with diagnoses including psychotic disorder, amphetamine and THC abuse; rule out substance induced psychotic episode and five weeks pregnant. There was no signed treatment/medication consent form found in the medical record. The patient did not authorize Benadryl to be administered. There was no documented Denial of Rights for Written Consent to Medical Treatment found in the patient ' s medical record. Patient #10 received an injection of Benadryl, | S 602 | | |

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

Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS661HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/04/2010 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER SOUTHERN NEVADA ADULT MENTAL HEALTH SERV | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 602 | Continued From page 6 Ativan on 5/3/10 for anxiety and agitation. There was no documented evidence a denial of rights was completed for the chemical restraint nor was a copy of the report provided to the Health Division. Severity: 3 Scope: 3 | S 602 | | |

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