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
	NVS640HOS	A. BUILDING _____ B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 05/21/10 and finalized on 05/24/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00025388 was substantiated with deficiencies cited. (See Tags S0300, S0310, S0150, S0154) 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. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. 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 150 SS=D	NAC 449.332 Discharge Planning 8. Activities related to discharge planning must be conducted in a manner that does not contribute to delays in the discharge of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility's social worker, case manager	S 150		

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 150	Continued From page 1 and nursing staff failed to prevent a delay and a cancelation of the patients transfer to a psychiatric facility by not notifying the patients physician that a psychiatric evaluation ordered prior to the transfer had been completed. (Patient#1) Severity: 2 Scope: 1	S 150		
S 154 SS=J	NAC 449.332 Discharge Planning 12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility's social worker failed to read a comprehensive psychiatric assessment provided by an intake coordinator that indicated the patient was a suicide risk and required low risk suicide precautions. The facility failed to reassess the patients plan of care and provide for protective supervision and the patients safe and timely transfer to a psychiatric facility. (Patient#1) A Physician Order dated 05/19/10 at 9:40 AM documented the following: 1. (Psychiatric Hospital Psych eval). All in-patient psych facility eval. A Case Management Note dated 05/19/10 at 10:29 documented the following: "(Physician#1) wants a psych eval. (Psychiatric Hospital) to evaluate."	S 154		

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S 154	Continued From page 2 A Psychiatric Hospital Comprehensive Assessment Tool dated 05/19/10 at 11:20 AM and completed by an Intake Coordinator documented the following: "(Patient #1) [redacted] reports has been non compliant with medications for past week. Patient during assessment is easily overwhelmed and becomes frustrated stating he can' t think right. Patient ruminative about financial worries for himself, the state of the nation. Mild paranoia and delusional thinking; patient states he incorporates things from the television into real life, reporting that there has been a lot on TV about armageddon and that he sees signs of that in the real world around him. Patient reports daily flashbacks to Vietnam incorporating auditory, visual and olfactory hallucinations. Patient reports inability to sleep past 2-3 days, no appetite and that he has been isolating. Patient reports SI (suicidal ideation) but denies he would act on that. He reports a prior suicide attempt 3 years ago via hanging, "the rope broke." The Comprehensive Assessment Tool documented symptoms and behaviors that were indicative of the need for 24 hour monitoring and assessment of the patient's condition were documented as follows: 1. Hallucinations 2. Acute onset of confusion 3. Inability to sleep The Comprehensive Assessment Tool documented severe deterioration of level of functioning. The patient's medications included the following: 1. Wellbutrin 150 mg every morning.	S 154		

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S 154	Continued From page 3 2. Celexa 20 mg daily 3. Zyprexa 15 mg at night 4. Trazadone HCL 300 mg at night. 5. Xanax 5 mg when needed 6. Roxicodone 20 mg three times daily. The patient's mental status was described as alert to person, place and time. The patient was anxious, focused, paranoid, with auditory, visual and olfactory hallucinations during flash backs. The patient had no memory impairments and good insight. The patient's suicide risk included the following: 1. History of suicide attempts. 2. Impulsivity 3. Alcohol or heavy drug use Current Risk to self/others documented the following: 1. The patient was having suicidal ideation or making suicidal threats? Answer was yes. 2. Was the ideation repetitive or persistent? Answer was yes. 3. Three years ago the patient attempted to hang himself with a rope. The rope broke. The evaluation of suicide risk was low. The initial treatment focus documented the following: 1. Patient will demonstrate improved reality orientation. Cessation of acute psychotic symptomatology. 2. Initiated or stabilized medication regimen. 3. Patient will demonstrate improved-stabilized mood. The Psychiatric Hospital Comprehensive	S 154		

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S 154	Continued From page 4 Assessment High Risk Notification Alert Form dated 05/19/10 documented the following. The suicide precautions box was checked. Risk was documented as low. On 05/21/10 at 1:30 PM an interview was conducted with the patients Social Worker. The Social Worker reported the Intake Coordinator from the psychiatric hospital handed her the completed comprehensive assessment on Patient #1. The Social Worker reported due to the fact the patient signed voluntarily to be transferred to the psychiatric hospital and was not on a legal hold she placed the packet in the patients chart and did not read the comprehensive assessment. The Social Worker reported she was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Social Worker acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay. On 05/21/10 at 2:00 PM an interview was conducted with the patients Case Manager. The Case Manager reported see did not have contact or any conversation with the Intake Coordinator from the psychiatric hospital who conducted the comprehensive assessment on the patient. The Case Manager reported she never read the comprehensive assessment that had been done on the patient was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Case Manager acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric	S 154		

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S 154	Continued From page 5 facility or the reason for the delay. The Case Manager reported that comprehensive assessments were only reviewed if the patient was on a legal hold or at risk. The Case Manager reported after the comprehensive assessment was completed she called Physician#1 and advised him the patient had voluntarily signed himself into the psychiatric facility. Physician #1 advised he would be in personally to complete the transfer summary but never showed up. After reviewing the patient's comprehensive assessment the Case Manager stated, "This is one that should have been on a legal hold." The Case Manager acknowledged that the documentation in the assessment indicated the patient was having suicidal ideation that was repetitive and should have been on suicide precautions. A Case Manager Note dated 05/19/10 at 1:18 PM indicated Patient #1 signed himself voluntarily into a (psychiatric hospital). "Called and advised (Physician #1), he will return to do discharge summary." A Social Workers Note dated 05/19/10 at 5:58 PM indicated Physician #1 had not been in yet. The patients Social Worker gave report to the Charge R.N. "She will pass on to night charge that patient is accepted at the psychiatric hospital. Once (Physician #1) does the transfer summary, certificate of transfer, and order need to be added to the chart copy. Social Worker instructed Charge R.N. to call medicar for transport." On 05/21/10 at 2:00 PM a telephonic interview was conducted with the Intake Coordinator. The	S 154		

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S 154	Continued From page 6 Intake coordinator reported after completion of the psychiatric assessment on Patient #1 the report was handed to the patients social worker. The Intake Coordinator reported the social worker was to follow up with the patients physician and arrange transportation to the psychiatric hospital. The Intake Coordinator reported she was told the patient would be transferred within a few hours. The intake Coordinator reported she assumed the social worker would read the assessment and report the findings to the physician. The Intake Coordinator reported due to the patients suicidal ideation and the recommendations made on the psychiatric assessment report for low risk suicide precautions she assumed the facility would monitor the patient closely. On 05/24/10 at 9:00 AM, a telephonic interview was conducted with Physician #1. Physician #1 reported he was called by the Case Manager on 05/19/10 in the early afternoon and advised that the patient had agreed to voluntarily enter the psychiatric hospital for treatment. Physician #1 reported he was never notified by the Case Manager, Social Worker or Nursing staff that the the psychiatric evaluation had been completed or the results of the psychiatric evaluation conducted on the patient. Physician #1 reported if he had been provided with the results of the report that indicated the patient was having repetitive and persistent suicidal ideation with a past history of a suicide attempt by hanging he would have placed the patient on suicide precautions. Physician #1 reported it was his expectation that the Intake Coordinator, Social Worker, Case Manager or Nursing staff would have reviewed the report and notified him of its contents.	S 154		

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S 154	Continued From page 7 The facility Case Management Discharge Planning Policy last revised 09/29/08 documented the following: 1. "Case Manager and/or designee completes a discharge planning assessment, initiates the plan and coordinates the plan with patient, family, or significant other." 2. "The Case Manager and/or designee will arrange for any transfers to other facilities as needed. The patient, family or significant others will be kept informed of any changes and progress of the plan. The required documentation is completed." 3. "The Case Manager and/or designee will conduct an ongoing assessment and reassessment of the patients condition to determine any modifications to the plan. The plan will be revised if necessary with all revisions reported to the patient, family and significant others with documentation recorded in the medical record. Severity: 4 Scope: 1 Complaint # 25388	S 154		
S 300 SS=J	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering.	S 300		

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S 300	Continued From page 8 This Regulation is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to assess and provide appropriate care and protective supervision to a patient at risk for suicide that had psychiatric, behavioral and alcohol problems and repetitive and persistent suicidal ideation. (Patient #1) A facility Emergency Room Record dated 05/17/10 at 8:08 AM indicated the patient arrived by ambulance with chief complaints that included chest pain, decreased mental status and changed mental status which started several days ago and was still present. The patient had consumed alcohol recently. The patient appeared in distress and was disorientated to place, time and situation. The patients listed diagnoses included chest pain, anxiety disorder, bipolar disorder, post traumatic stress disorder, chronic pain syndrome, alcohol dependence and altered mental status. A Physician Consultation report dated 05/17/10 indicated the patient was a [redacted] with a history of coronary disease. "The patient was a very poor historian and had a history of bipolar disorder and anxiety disorder which can easily be provoked. The patient is admitted here for problems. He has multiple medical issues and also including a psychotic disorder. He is admitted here with a recent episode of chest pain symptoms." An Admission History and Physical dated 05/17/10 indicated the patient was admitted for evaluation and treatment of atypical chest pain.	S 300		

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S 300	Continued From page 9 The patient had a history of anxiety disorder and the plan of care included a psychiatric evaluation and Zyprexa medication. An Emergency Room Note dated 05/17/10 at 8:41 AM indicated the patients wife called to notify the facility the patient had not been taking his psychiatric medication and his psychiatrist at a (psychiatric hospital) would like the patient transferred to the psychiatric unit. Physician #2 was notified. Nursing Note dated 05/17/10 at 10:51 AM documented the following. "Spoke with Physician #2 regarding patient transfer. She will contact psychiatric hospital and call back to notify us if they are able to take him. " A Nursing Note dated 05/17/10 at 8:10 PM indicated the patients belonging list was completed and the patient s belongings were placed in a bag and given to hospital security. "Collection of belongings was witnessed by hospital staff." On 05/21/10 at 10:30 AM the facility Vice president of Quality and Risk Management provided a copy of the most current facility policy for Self Harm Risk Assessment/Suicide Precautions that the facility was following. The Vice President of Quality and Risk Management confirmed the facility nurses were following the above listed policy and procedure for self harm and risk assessment. The facility's Self Harm Risk Assessment/Suicide Precautions Policy and Procedure included the following: Scope: "All Inpatient Nursing Departments"	S 300		

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S 300	Continued From page 10 Purpose: A. "To provide guidelines for Registered Nurse (R.N.) performing suicide assessment." B. "To identify and provide optimal safety for patients at risk for suicide." Policy: A. Emergency Department: All patients presenting to the emergency department for psychiatric, behavioral, drug or alcohol problems, or with a history of the same, will be assessed for harm/suicide risk by R.N. Documentation will be completed in the T-System harm assessment/suicide screens. 1. All patients with above noted criteria will be placed on suicide precautions. 2. Patients found at risk for suicide will be screened further by a Mental Health Assessor." B. Inpatients: Inpatients exhibiting psychiatric, behavioral, drug or alcohol problems, or history of the same, will be screened by an R.N. utilizing the self harm risk screening tool in Meditech. "All personal items should be removed from the patient. This includes all clothing, colognes, writing instruments, sharps, plastic bags, medications, matches, lighters, and communication equipment. Document items removed and to which secure location they were sent. Belongings will not be returned to patients being transferred to psychiatric facilities, belongings will be given to the transporter at the time of transfer." On 05/21/10 at 10:30 AM, the Chief Nursing Officer provided a second Suicide Risk Policy effective 01/20/08 and last revised 03/13/08. The Chief Nurse indicated the second policy was the policy the nursing staff should follow for suicide	S 300		

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S 300	Continued From page 11 risk assessment. The policy included the following: Policy: "All patients presenting to the Emergency department for psychiatric, behavioral, drug or alcohol problems will be assessed for suicide risk." Procedure: "Utilizing the psychiatric complaint template in the T-System, suicidal and homicidal assessment will be completed. If it is determined that suicidal/homicidal tendencies exist, notify the Physician and place the patient on suicide precautions." "A search and recovery of all potentially harmful items should be conducted by an R.N. in the presence of Security personnel. All clothing should be removed. All sharps, including glass objects, razors, scissors, nail files, etc will be removed. Belts, scarves, matches and plastic bags should be sent home with the family or removed from the patient's room. All medications will be removed from the patient's room and sent to the pharmacy. Cell phones, I pods and electronic/communication equipment will be removed. The results of the search should be documented to include personnel present and all items removed. All items will be placed in the custody of security." "An RN/LPN will check the patient as his/her condition indicates, but no less than once every hour. Assessment of the intensity level of suicidal ideation will be charted each shift. The RN/LPN will notify the physician/psychiatrist of major changes in ideation." On 05/21/10 at 11:00 AM a review Patient #1s medical record revealed no documented	S 300		

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S 300	Continued From page 12 evidence that a self harm risk assessment for suicide precautions was completed by emergency room nursing staff and documented in the medical record. On 05/21/10 at 12:00 PM an interview was conducted with the Director of Emergency Services. The Director confirmed the emergency room nursing staff failed follow the facility's Self Harm Risk Assessment/Suicide Precautions policy and procedure. The Director confirmed the emergency room nursing staff failed to assess Patient #1 for suicide risk and failed to document any psychiatric assessments in the T-System Harm Assessment/Suicide Screen. On 05//21/10 at 10:30 AM, the Chief Nursing Officer reported due to the patient being a fall risk and having psychiatric diagnoses the patient was transferred to the fourth floor and placed in a camera room for 24 hour observation with another patient. Patient #1 was not placed suicide watch. The patients clothing had been taken and secured by security. A monitor technician was assigned to continuously observe 2 monitors that visualized 10 rooms and 12 patients. Some of the patients were on suicide watch. The camera could not visualize patients who entered the bathroom area. The Chief Nursing Officer reported there was no written facility policy or procedure that specified how many minutes could elapse when a patient entered the bathroom out of the visual field of the camera prior to notifying a staff member to check on the patient. The Chief Nursing Officer indicated the camera technicians should notify nursing staff to check on an at risk or suicide watch patients safety within 3 minutes of them entering a bathroom out of the cameras visual	S 300		

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S 300	Continued From page 13 field. The patient's physician ordered for a psychiatric evaluation to be completed on the patient. On 05/19/10 an Intake Coordinator from a psychiatric hospital responded and completed a comprehensive psychiatric assessment on the patient. The Intake Coordinator handed the assessment to the patients Social Worker who placed the packet in the patients chart. The discharge plan included transferring the patient to a psychiatric hospital for psychiatric care. The Chief Nurse acknowledged the Social Worker did not read the Intake Coordinators psychiatric assessment of the patient. The Chief Nursing Officer reported on 05/19/10 at approximately 4:30 PM facility security was called to bring the patients clothing up to the th floor nursing unit in preparation for the patients transfer. The Chief Nurse reported somehow the patient got access to his clothing and changed out of his gown and put his clothing on. The Chief Nursing Officer reported 4th floor staff on duty that night was questioned and no staff member acknowledged giving the patients his clothing. The Chief Nurse acknowledged Patient #1 was seen by his nurse at 8:00 PM lying in bed with street clothing on. The Chief Nursing officer acknowledged according to facility policy patients being transferred to a psychiatric facility should not have been given access to their street clothes and should have remained in a hospital gown while a patient at the hospital and during transport to a receiving facility. At 11:00 PM the patient was seen by the camera tech getting out of bed and walking into the bathroom. The door was left partially open. At 11:10 PM a CNA entered the patient's room to take vital signs on Patient #2. Patient #2 asked the CNA to check	S 300		

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S 300	Continued From page 14 on Patient #1. The CNA then entered the bathroom and found Patient #1 hanging from the shower rod by a belt around his neck. The patients nurse was notified by the CNA and responded and cut the belt from around the patient's neck and started CPR. (cardiopulmonary resuscitation) The Chief Nursing Officer reported there was a 10 minute window from the time the camera tech saw the patient enter the bathroom to the time the CNA discovered the patient hanging from a belt in the shower. A Nursing care Plan for Patient #1 initiated 05/17/10 included the following: The patients admit was related to an emotional or behavioral disorder. The patient's status was described as confused at times and afraid. The patient had a history of psychiatric care, excessive alcohol or drug abuse and a loss of rational thinking. Problems listed on the patients nursing care plan included the following: Suicide Risk/Ideation: Patient has risk for suicide. Patient will be free from suicidal ideation. A Physician Order dated 05/19/10 at 9:40 AM documented the following: 1. (Psychiatric Hospital Psych eval). All in-patient psych facility eval. A Case Management Note dated 05/19/10 at 10:29 documented the following. "(Physician#1) wants a psych eval. (Psychiatric Hospital) to evaluate." A Psychiatric Hospital Comprehensive Assessment Tool dated 05/19/10 at 11:20 AM	S 300		

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S 300	Continued From page 15 and completed by an Intake Coordinator documented the following: "(Patient #1) [redacted] reports has been non compliant with medications for past week. Patient during assessment is easily overwhelmed and becomes frustrated stating he can' t think right. Patient ruminative about financial worries for himself, the state of the nation. Mild paranoia and delusional thinking; patient states he incorporates things from the television into real life, reporting that there has been a lot on TV about Armageddon and that he sees signs of that in the real world around him. Patient reports daily flashbacks to Vietnam incorporating auditory, visual and olfactory hallucinations. Patient reports inability to sleep past 2-3 days, no appetite and that he has been isolating. Patient reports SI (suicidal ideation) but denies he would act on that. He reports a prior suicide attempt 3 years ago via hanging, "the rope broke." The Comprehensive Assessment Tool documented symptoms and behaviors that were indicative of the need for 24 hour monitoring and assessment of the patient's condition were documented as follows: 1. Hallucinations 2. Acute onset of confusion 3. Inability to sleep The Comprehensive Assessment Tool documented severe deterioration of level of functioning. The patient's medications included the following: 1. Wellbutrin 150 mg every morning. 2. Celexa 20 mg daily 3. Zyprexa 15 mg at night	S 300		

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S 300	Continued From page 16 4. Trazadone HCL 300 mg at night. 5. Xanax 5 mg when needed 6. Roxicodone 20 mg three times daily. The patient's mental status was described as alert to person, place and time. The patient was anxious, focused, paranoid, with auditory, visual and olfactory hallucinations during flash backs. The patient had no memory impairments and good insight. The patient's suicide risk included the following: 1. History of suicide attempts. 2. Impulsivity 3. Alcohol or heavy drug use Current Risk to self/others documented the following: 1. The patient was having suicidal ideation or making suicidal threats? Answer was yes. 2. Was the ideation repetitive or persistent? Answer was yes. 3. "Three years ago the patient attempted to hang himself with a rope. The rope broke." The evaluation of suicide risk was low. The initial treatment focus documented the following: 1. Patient will demonstrate improved reality orientation. Cessation of acute psychotic symptomatology. 2. Initiated or stabilized medication regimen. 3. Patient will demonstrate improved-stabilized mood. The Psychiatric Hospital Comprehensive Assessment High Risk Notification Alert Form dated 05/19/10 documented the following. The	S 300		

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S 300	Continued From page 17 suicide precautions box was checked. Risk was documented as low. On 05/21/10 at 1:30 PM an interview was conducted with the patients Social Worker. The Social Worker reported the Intake Coordinator from the psychiatric hospital handed her the completed comprehensive assessment on Patient #1. The Social Worker reported due to the fact the patient signed voluntarily to be transferred to the psychiatric hospital and was not on a legal hold she placed the packet in the patients chart and did not read the comprehensive assessment. The Social Worker reported she was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Social Worker acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay. On 05/21/10 at 2:00 PM an interview was conducted with the patients Case Manager. The Case Manager reported see did not have contact or any conversation with the Intake Coordinator from the psychiatric hospital who conducted the comprehensive assessment on the patient. The Case Manager reported she never read the comprehensive assessment that had been done on the patient was not aware the Intake Coordinator documented that the patient was experiencing repetitive and persistent suicidal ideation and recommended a low risk suicide precautions for the patient. The Case Manager acknowledged she did not notify the patient there was a delay in his transfer to the psychiatric facility or the reason for the delay.	S 300		

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S 300	Continued From page 18 The Case Manager reported that comprehensive assessments were only reviewed if the patient was on a legal hold or at risk. The Case Manager reported after the comprehensive assessment was completed she called Physician#1 and advised him the patient had voluntarily signed himself into the psychiatric facility. Physician #1 advised he would be in personally to complete the transfer summary but never showed up. After reviewing the patient's comprehensive assessment the Case Manager stated, "This is one that should have been on a legal hold." The Case Manager acknowledged that the documentation in the assessment indicated the patient was having suicidal ideation that was repetitive and should have been on suicide precautions. A Case Manager Note dated 05/19/10 at 1:18 PM indicated Patient #1 signed himself voluntarily into a (psychiatric hospital). "Called and advised (Physician #1), he will return to do discharge summary." A Social Workers Note dated 05/19/10 at 5:58 PM indicated Physician #1 had not been in yet. The patients Social Worker gave report to the Charge R.N. "She will pass on to night charge that patient is accepted at the psychiatric hospital. Once (Physician #1) does the transfer summary, certificate of transfer, and order need to be added to the chart copy. Social Worker instructed Charge R.N. to call medicar for transport." On 05/24/10 at 9:00 AM, a telephonic interview was conducted with Physician #1. Physician #1 reported he was called by the Case Manager on 05/19/10 in the early afternoon and advised that	S 300		

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S 300	Continued From page 19 the patient had agreed to voluntarily enter the psychiatric hospital for treatment. Physician #1 reported he was never notified by the Case Manager, Social Worker or Nursing staff that the the physicist evaluation had been completed or the results of the psychiatric evaluation conducted on the patient. Physician #1 reported if he had been provided with the results of the report that indicated the patient was having repetitive and persistent suicidal ideation with a past history of a suicide attempt by hanging he would have placed the patient on suicide precautions. Physician #1 reported it was his expectation that the Intake Coordinator, Social Worker, Case Manager or Nursing staff would have reviewed the report and notified him of its contents. On 05/21/10 at 2:00 PM a telephonic interview was conducted with the Intake Coordinator. The Intake coordinator reported after completion of the psychatric assessment on Patient #1 the report was handed to the patients social worker. The Intake Coordinator reported the social worker was to follow up with the patients physician and arrange transportation to the psychiatric hospital. The Intake Coordinator reported she was told the patient would be transferred within a few hours. The intake Coordinator reported she assumed the social worker would read the assessment and report the findings to the physician. The Intake Coordinator reported due to the patients suicidal indeation and the recommendations made on the psychiatric assessment report for low risk suicide precausions she assumed the facility would monitor the patient closely. On 05/21/10 at 9:50 AM an interview was conducted with CNA Camera Technician #1 on	S 300		

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S 300	Continued From page 20 the fourth floor. Camera Technician #1 reported she has been working as a camera technician for 4 years and was never given any written facility policy or procedure regarding the operation or monitoring of patients on camera beds. Camera Technician #1 reported based on her assessment of the patients being monitored and the report given on the patient's diagnosis, no more than 5 minutes should elapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 at 9:45 AM an interview was conducted with the Director of Medical Surgical floor. The Director reported there should be no more than a 2 to 3 minute time lapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 the Vice President of Quality and Risk Management reported she could not locate any written policy or procedure for the operation or monitoring of patients on camera beds. A Facility Security Patient Belongings Log indicated Patient #1s clothing was logged into security on 05/17/10, the date the patient was admitted. The log indicated the patients clothing was returned to staff on the th floor on 05/19/10. On 05/21/10 at 2:30 PM an interview was conducted with Security Guard #1. The Security Guard reported on 05/19/10 at 4:20 PM the nursing staff on 4 north requested Patient #1s belongings be brought up from security. The security Guard reported he brought the patients	S 300		

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S 300	Continued From page 21 clothing bag and cane to the 4 th floor at 4:30 PM and provided them to CNA Camera Technician #2. The patients clothing bag and cane were placed in the nursing station on the floor by a printer. Patient #1 was outside his room dressed in a hospital gown at the time and asked if he could have his cane. The Security Guard reported he advised the patient his cane and clothes would be given to the ambulance driver who transported him to the receiving facility. The Security Guard reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. On 05/21/10 at 3:00 PM an interview was conducted with CNA Camera Technician #2 who confirmed she took possession of the patients clothing bag from security on 05/19/10 at 4:30 PM. Camera Technician #2 reported she was relieved by another camera technician at 5:00 PM and saw that the patients clothing bag was still on the floor in the nursing station by a printer when she left. Camera Technician #2 reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. On 05/25/10 at 1:30 PM a telephonic interview was conducted with CNA Camera Technician #3 who reported she was monitoring the cameras the night Patient #1 attempted suicide. The Technician reported at 11:00 PM the patient was seen getting out of bed and walking into the bathroom. The bathroom door was partially ajar but she could not visualize the interior of the bathroom. At 11:10 the camera technician	S 300		

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S 300	Continued From page 22 observed a CNA enter the patients room and take vital signs on Patient #2. The Technician reported she observed the CNA enter the bathroom and quickly exit and inform staff the patient had hung himself. The Technician advised since the patient was not on a legal hold it could be up to 10 minutes before at staff member would check on a patient who entered the bathroom out of the cameras view. Technician #3 reported the facility did not have a written policy or procedure on camera observation duties and responsibilities. Nursing Documentation for 05/19/10 from the patients nurse, RN #1 included the following; 1. 8:00 PM: " Spoke with patient about transfer. He was resting comfortably in street clothes in bed. 2. 9:00 PM: " Rounded, patient medication given. 3. 10:45 PM: " Discovered transfer summary was never completed. Decided patient would have to stay another night. " 4. 10:55 PM: " Called Spring Mountain, informed them patient would not be transported. " 5. 11:00 PM: " Walked to patient room. Noticed him lying in bed. Looked like patient was sleeping. " 6. 11:10 PM: " CNA came down hall and informed she found patient hanging by his neck in bathroom. I ran to room. Found patient hanging by his belt. Cut belt. Lowered patient to the ground. Called code. Patient did not appear to give any warning intentions leading up to this event. " An Emergency Physician Record dated 05/19/10 at 11:15 PM, indicated the patient hung himself. The patient was last seen at 11:00 PM on his	S 300		

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S 300	Continued From page 23 way to a (psychiatric facility). A Respiratory Therapy note dated 05/19/10 at 11:58 PM documented the following: " Patient code 99 on fourth floor. Brought down to ICU. Setting were set by ER doctor. Breath sounds are diminished bilaterally. A Clinical Note dated 05/20/10 indicated Patient #1 had a suicide attempt and was found hanging in his bathroom unresponsive with asystole. The patient was transferred to the ICU. A Nursing Progress Note dated 05/20/10 at 8:26 AM indicated the Patient #1 had a cessation of life signs. The EKG showed flat line. The patient had no pulse or blood pressure. The patient was pronounced dead by R.N. designee. On 05/24/10 at 10:30 Am a telephonic interview was conducted with RN #1. RN #1 reported he was assigned to care for patient #1 on 05/19/10 during the 7:00 PM to 7:00 AM shift on the 4th floor. RN #1 reported when he arrived at 7:00 PM he noticed the patient was dressed in street clothes. RN #1 acknowledged he was aware the patient was being transferred to a psychiatric hospital during his shift but thought only patients on a legal hold were prohibited from wearing street clothing. RN #2 reported the patient did not receive any visitors during the shift. RN #1 reported the patients planned transfer was delayed because the physician had not completed the transfer summary. At 8:00 PM the patient inquired about the delay in his transfer. At 8:00 PM the psychiatric hospital called to inquire as to why the patient had not been transferred. RN #1 reported he found a note in the patients chart that indicated Physician #1 needed to complete the patients transfer summary. RN #1	S 300		

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S 300	Continued From page 24 acknowledged he did not call Physician #1 to inquire about the completion of the patients transfer summary. RN #1 indicated he met with the charge nurse at 11:00 PM and a decision was made to cancel the patients transfer. RN #1 called the psychiatric hospital and informed them the transfer was canceled. RN #1 informed the patient the transfer was canceled at 11:00 PM. RN #1 reported he left the patients room to obtain equipment to place the patient back on cardiac telemetry. At 11:10 PM a CNA came down hall and informed she found patient hanging by his neck in bathroom. He responded to the patients bathroom and found the patient hanging by his belt from a shower curtain rod. He cut the belt and lowered the patient to the ground and called a code. The patient did not appear to give any warning of suicidal intentions leading up to the event. On 05/21/10 at 9:55 AM an interview was conducted with Patient #2 who was the roommate of Patient #1. Patient #2 reported Patient #1 was in a heavy state of depression [redacted] Patient #2 reported Patient #1 spoke about being transferred to another facility for psychiatric help dealing with his depression. Patient #1s mood went from being depressed to feeling as if things were starting to look up for him due to the help he was going to have dealing with his depression and he was looking forward to his transfer to a mental health facility. Patient #2 reported Patient #1 became increasingly more anxious, agitated and depressed as the evening progressed due to the delay in his transfer.	S 300		

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S 300	Continued From page 25 Patient #2 reported he tried to offer assurance to Patient #1 that he would be transferred and that sometimes there can be delays in completing paper work for the transfer. Patient #2 reported on 05/19/10 at approximately 8:00 PM he saw Patient #1 change out of his gown and put on jeans and a shirt. Patient #2 reported he did not see who brought Patient #1s clothing in to him. Patient #1 was watching television and eating. Patient #2 reported he fell asleep around 10:30 PM. At around 12:00 PM a nurse entered the room to take his vital signs and he asked if the nurse to check on Patient #1 who was in the bathroom. Patient #2 then said he heard a lot of commotion and nursing staff running into the room and though they were performing CPR on Patient #1. Patient #2 reported he was then moved to another room. Patient #2 indicated he later learned Patient #1 had attempted to hang himself in the shower. Severity: 4 Scope: 1 Complaint # 25388	S 300		
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 observation, interview, record review and document review, the facility staff failed to	S 310		

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S 310	Continued From page 26 continually assess the needs of the patient and provide appropriate care and protective supervision to a patient at risk for suicide that had psychiatric, behavioral and alcohol problems and repetitive and persistent suicidal ideation. (Patient #1) A facility Emergency Room Record dated 05/17/10 at 8:08 AM indicated the patient arrived by ambulance with chief complaints that included chest pain, decreased mental status and changed mental status which started several days ago and was still present. The patient had consumed alcohol recently. The patient appeared in distress and was disorientated to place, time and situation. The patients listed diagnoses included chest pain, anxiety disorder, bipolar disorder, post traumatic stress disorder, chronic pain syndrome, alcohol dependence and altered mental status. A Physician Consultation report dated 05/17/10 indicated the patient was a [redacted]th a history of coronary disease. "The patient was a very poor historian and had a history of bipolar disorder and anxiety disorder which can easily be provoked. The patient is admitted here for problems. He has multiple medical issues and also including a psychotic disorder. He is admitted here with a recent episode of chest pain symptoms." An Admission History and Physical dated 05/17/10 indicated the patient was admitted for evaluation and treatment of atypical chest pain. The patient had a history of anxiety disorder and the plan of care included a psychiatric evaluation and Zyprexa medication. An Emergency Room Note dated 05/17/10 at	S 310		

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S 310	Continued From page 27 8:41 AM indicated the patients wife called to notify the facility the patient had not been taking his psychiatric medication and his psychiatrist at a (psychiatric hospital) would like the patient transferred to the psychiatric unit. Physician #2 was notified. Nursing Note dated 05/17/10 at 10:51 AM documented the following. "Spoke with Physician #2 regarding patient transfer. She will contact psychiatric hospital and call back to notify us if they are able to take him." A Nursing Note dated 05/17/10 at 8:10 PM indicated the patients belonging list was completed and the patient s belongings were placed in a bag and given to hospital security. "Collection of belongings was witnessed by hospital staff." On 05/21/10 at 10:30 AM the facility Vice president of Quality and Risk Management provided a copy of the most current facility policy for Self Harm Risk Assessment/Suicide Precautions that the facility was following. The Vice President of Quality and Risk Management confirmed the facility nurses were following the above listed policy and procedure for self harm and risk assessment. The facility's Self Harm Risk Assessment/Suicide Precautions Policy and Procedure included the following: Scope: "All Inpatient Nursing Departments" Purpose: A. "To provide guidelines for Registered Nurse (R.N.) performing suicide assessment." B. "To identify and provide optimal safety for	S 310		

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MOUNTAINVIEW HOSPITAL	3100 N TENAYA LAS VEGAS, NV 89128

(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 310	Continued From page 28 patients at risk for suicide." Policy: A. Emergency Department: "All patients presenting to the emergency department for psychiatric, behavioral, drug or alcohol problems, or with a history of the same, will be assessed for harm/suicide risk by R.N. Documentation will be completed in the T-System harm assessment/suicide screens." 1. "All patients with above noted criteria will be placed on suicide precautions." 2. "Patients found at risk for suicide will be screened further by a Mental Health Assessor." B. Inpatients: "Inpatients exhibiting psychiatric, behavioral, drug or alcohol problems, or history of the same, will be screened by an R.N. utilizing the self harm risk screening tool in Meditech." "All personal items should be removed from the patient. This includes all clothing, colognes, writing instruments, sharps, plastic bags, medications, matches, lighters, and communication equipment. Document items removed and to which secure location they were sent. Belongings will not be returned to patients being transferred to psychiatric facilities, belongings will be given to the transporter at the time of transfer." On 05/21/10 at 10:30 AM, the Chief Nursing Officer provided a second Suicide Risk Policy effective 01/20/08 and last revised 03/13/08. The Chief Nurse indicated the second policy was the policy the nursing staff should follow for suicide risk assessment. The policy included the following: Policy: "All patients presenting to the Emergency department for psychiatric, behavioral, drug or	S 310		

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S 310	Continued From page 29 alcohol problems will be assessed for suicide risk." Procedure: "Utilizing the psychiatric complaint template in the T-System, suicidal and homicidal assessment will be completed. If it is determined that suicidal/homicidal tendencies exist, notify the Physician and place the patient on suicide precautions." "A search and recovery of all potentially harmful items should be conducted by an R.N. in the presence of Security personnel. All clothing should be removed. All sharps, including glass objects, razors, scissors, nail files, etc will be removed. Belts, scarves, matches and plastic bags should be sent home with the family or removed from the patient's room. All medications will be removed from the patient's room and sent to the pharmacy. Cell phones, I pods and electronic/communication equipment will be removed. The results of the search should be documented to include personnel present and all items removed. All items will be placed in the custody of security." "An RN/LPN will check the patient as his/her condition indicates, but no less than once every hour. Assessment of the intensity level of suicidal ideation will be charted each shift. The RN/LPN will notify the physician/psychiatrist of major changes in ideation." On 05/21/10 at 11:00 AM a review Patient #1s medical record revealed no documented evidence that a self harm risk assessment for suicide precautions was completed by emergency room nursing staff and documented in the medical record .	S 310		

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S 310	Continued From page 30 On 05/21/10 at 12:00 PM an interview was conducted with the Director of Emergency Services. The Director confirmed the emergency room nursing staff failed follow the facility's Self Harm Risk Assessment/Suicide Precautions policy and procedure. The Director confirmed the emergency room nursing staff failed to assess Patient #1 for suicide risk and failed to document any psychiatric assessments in the T-System Harm Assessment/Suicide Screen. On 05//21/10 at 10:30 AM, the Chief Nursing Officer reported due to the patient being a fall risk and having psychiatric diagnoses the patient was transferred to the fourth floor and placed in a camera room for 24 hour observation with another patient. Patient #1 was not placed suicide watch. The patients clothing had been taken and secured by security. A monitor technician was assigned to continuously observe 2 monitors that visualized 10 rooms and 12 patients. Some of the patients were on suicide watch. The camera could not visualize patients who entered the bathroom area. The Chief Nursing Officer reported there was no written facility policy or procedure that specified how many minutes could elapse when a patient entered the bathroom out of the visual field of the camera prior to notifying a staff member to check on the patient. The Chief Nursing Officer indicated the camera technicians should notify nursing staff to check on an at risk or suicide watch patients safety within 3 minutes of them entering a bathroom out of the cameras visual field. The patient's physician ordered for a psychiatric evaluation to be completed on the patient. On 05/19/10 an Intake Coordinator from a psychiatric hospital responded and completed a comprehensive psychiatric assessment on the	S 310		

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S 310	Continued From page 31 patient. The Intake Coordinator handed the assessment to the patients Social Worker who placed the packet in the patients chart. The discharge plan included transferring the patient to a psychiatric hospital for psychiatric care. The Chief Nurse acknowledged the Social Worker did not read the Intake Coordinators psychiatric assessment of the patient. The Chief Nursing Officer reported on 05/19/10 at approximately 4:30 PM facility security was called to bring the patients clothing up to the th floor nursing unit in preparation for the patients transfer. The Chief Nurse reported somehow the patient got access to his clothing and changed out of his gown and put his clothing on. The Chief Nursing Officer reported th floor staff on duty that night was questioned and no staff member acknowledged giving the patients his clothing. The Chief Nurse acknowledged Patient #1 was seen by his nurse at 8:00 PM lying in bed with street clothing on. The Chief Nursing officer acknowledged according to facility policy patients being transferred to a psychiatric facility should not have been given access to their street clothes and should have remained in a hospital gown while a patient at the hospital and during transport to a receiving facility. At 11:00 PM the patient was seen by the camera tech getting out of bed and walking into the bathroom. The door was left partially open. At 11:10 PM a CNA entered the patient's room to take vital signs on Patient #2. Patient #2 asked the CNA to check on Patient #1. The CNA then entered the bathroom and found Patient #1 hanging from the shower rod by a belt around his neck. The patients nurse was notified by the CNA and responded and cut the belt from around the	S 310		

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S 310	Continued From page 32 patient's neck and started CPR. (cardiopulmonary resuscitation) The Chief Nursing Officer reported there was a 10 minute window from the time the camera tech saw the patient enter the bathroom to the time the CNA discovered the patient hanging from a belt in the shower. A Nursing care Plan for Patient #1 initiated 05/17/10 included the following: The patients admit was related to an emotional or behavioral disorder. The patient's status was described as confused at times and afraid. The patient had a history of psychiatric care, excessive alcohol or drug abuse and a loss of rational thinking. Problems listed on the patients nursing care plan included the following: Suicide Risk/Ideation: Patient has risk for suicide. Patient will be free from suicidal ideation. On 05/21/10 at 9:50 AM an interview was conducted with CNA Camera Technician #1 on the fourth floor. Camera Technician #1 reported she has been working as a camera technician for 4 years and was never given any written facility policy or procedure regarding the operation or monitoring of patients on camera beds. Camera Technician #1 reported based on her assessment of the patients being monitored and the report given on the patient's diagnosis, no more than 5 minutes should elapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 at 9:45 AM an interview was	S 310		

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S 310	Continued From page 33 conducted with the Director of Medical Surgical floor. The Director reported there should be no more than a 2 to 3 minute time lapse before a staff member should be notified to physically check on a patient at risk or on suicide precautions that has entered the bathroom or left the visible field of the camera. On 05/21/10 the Vice President of Quality and Risk Management reported she could not locate any written policy or procedure for the operation or monitoring of patients on camera beds. A Facility Security Patient Belongings Log indicated Patient #1s clothing was logged into security on 05/17/10, the date the patient was admitted. The log indicated the patients clothing was returned to staff on the th floor on 05/19/10. On 05/21/10 at 2:30 PM an interview was conducted with Security Guard #1. The Security Guard reported on 05/19/10 at 4:20 PM the nursing staff on 4 north requested Patient #1s belongings be brought up from security. The security Guard reported he brought the patients clothing bag and cane to the 4 th floor at 4:30 PM and provided them to CNA Camera Technician #2. The patients clothing bag and cane were placed in the nursing station on the floor by a printer. Patient #1 was outside his room dressed in a hospital gown at the time and asked if he could have his cane. The Security Guard reported he advised the patient his cane and clothes would be given to the ambulance driver who transported him to the receiving facility. The Security Guard reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer.	S 310		

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S 310	Continued From page 34 On 05/21/10 at 3:00 PM an interview was conducted with CNA Camera Technician #2 who confirmed she took possession of the patients clothing bag from security on 05/19/10 at 4:30 PM. Camera Technician #2 reported she was relieved by another camera technician at 5:00 PM and saw that the patients clothing bag was still on the floor in the nursing station by a printer when she left. Camera Technician #2 reported the facility policy required all patients transported to another facility were to be transported in a hospital gown. All clothing was to be given to the person transporting the patient at the time of transfer. Nursing Documentation for 05/19/10 from the patients nurse, RN #1 included the following; 1. 8:00 PM: " Spoke with patient about transfer. He was resting comfortably in street clothes in bed. 2. 9:00 PM: " Rounded, patient medication given." 3. 10:45 PM: " Discovered transfer summary was never completed. Decided patient would have to stay another night. " 4. 10:55 PM: " Called Spring Mountain, informed them patient would not be transported. " 5. 11:00 PM: " Walked to patient room. Noticed him lying in bed. Looked like patient was sleeping. " 6. 11:10 PM: " CNA came down hall and informed she found patient hanging by his neck in bathroom. I ran to room. Found patient hanging by his belt. Cut belt. Lowered patient to the ground. Called code. Patient did not appear to give any warning intentions leading up to this event. "	S 310		

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S 310	Continued From page 35 An Emergency Physician Record dated 05/19/10 at 11:15 PM, indicated the patient hung himself. The patient was last seen at 11:00 PM on his way to a (psychiatric facility). A Respiratory Therapy note dated 05/19/10 at 11:58 PM documented the following: "Patient code 99 on fourth floor. Brought down to ICU. Setting were set by ER doctor. Breath sounds are diminished bilaterally." A Clinical Note dated 05/20/10 indicated Patient #1 had a suicide attempt and was found hanging in his bathroom unresponsive with asystole. The patient was transferred to the ICU. A Nursing Progress Note dated 05/20/10 at 8:26 AM indicated the Patient #1 had a cessation of life signs. The EKG showed flat line. The patient had no pulse or blood pressure. The patient was pronounced dead by R.N. designee. On 05/24/10 at 10:30 Am a telephonic interview was conducted with RN #1. RN #1 reported he was assigned to care for patient #1 on 05/19/10 during the 7:00 PM to 7:00 AM shift on the 4th floor. RN #1 reported when he arrived at 7:00 PM he noticed the patient was dressed in street clothes. RN #1 acknowledged he was aware the patient was being transferred to a psychiatric hospital during his shift but thought only patients on a legal hold were prohibited from wearing street clothing. RN #2 reported the patient did not receive any visitors during the shift. RN #1 reported the patients planned transfer was delayed because the physician had not completed the transfer summary. At 8:00 PM the patient inquired about the delay in his transfer. At 8:00 PM the psychiatric hospital called to inquire as to why the patient had not been transferred.	S 310		

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S 310	Continued From page 36 RN #1 reported he found a note in the patients chart that indicated Physician #1 needed to complete the patients transfer summary. RN #1 acknowledged he did not call Physician #1 to inquire about the completion of the patients transfer summary. RN #1 indicated he met with the charge nurse at 11:00 PM and a decision was made to cancel the patients transfer. RN #1 called the psychiatric hospital and informed them the transfer was canceled. RN #1 informed the patient the transfer was canceled at 11:00 PM. RN #1 reported he left the patients room to obtain equipment to place the patient back on cardiac telemetry. At 11:10 PM a CNA came down hall and informed she found patient hanging by his neck in bathroom. He responded to the patients bathroom and found the patient hanging by his belt from a shower curtain rod. He cut the belt and lowered the patient to the ground and called a code. The patient did not appear to give any warning of suicidal intentions leading up to the event. On 05/21/10 at 9:55 AM an interview was conducted with Patient #2 who was the roommate of Patient #1. Patient #2 reported Patient #1 was in a heavy state of depression [redacted] Patient #2 reported Patient #1 spoke about being transferred to another facility for psychiatric help dealing with his depression. Patient #1s mood went from being depressed to feeling as if things were starting to look up for him due to the help he was going to have dealing with his depression and he was looking forward to his transfer to a mental health facility. Patient #2 reported Patient #1 became increasingly more anxious, agitated	S 310		

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S 310	Continued From page 37 and depressed as the evening progressed due to the delay in his transfer. Patient #2 reported he tried to offer assurance to Patient #1 that he would be transferred and that sometimes there can be delays in completing paper work for the transfer. Patient #2 reported on 05/19/10 at approximately 8:00 PM he saw Patient #1 change out of his gown and put on jeans and a shirt. Patient #2 reported he did not see who brought Patient #1s clothing in to him. Patient #1 was watching television and eating. Patient #2 reported he fell asleep around 10:30 PM. At around 12:00 PM a nurse entered the room to take his vital signs and he asked if the nurse to check on Patient #1 who was in the bathroom. Patient #2 then said he heard a lot of commotion and nursing staff running into the room and though they were performing CPR on Patient #1. Patient #2 reported he was then moved to another room. Patient #2 indicated he later learned Patient #1 had attempted to hang himself in the shower. Severity: 4 Scope: 1 Complaint # 25388	S 310		