STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 06 - OUTPATIENT & ADMINISTRATIVE B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 39, EXISTING Business Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Outpatient Buildings include: Building #1: West Charleston Clinic (Administrative and Outpatient Services); Single story, Type V (000) without fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146. Building #2: Pharmacy Services; Single story, Type V (000) with fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146. Dietary Building: Single story, Type V (000) with fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146. East Las Vegas Clinic (Outpatient Services): Two Story, Type V (000) without fire sprinkler system; Located at 1785 East Sahara Blvd., Las Vegas, Nevada 89121. Henderson Clinic (Outpatient Services): Single story, Type V (000) without fire sprinkler system; Located at 1590 West Sunset Road, Henderson,	{K 000}		

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

Charles Klang | Hospital Administrator | 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING **06 - OUTPATIENT & ADMINISTRATIVE** B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	**6161 W CHARLESTON BLVD LAS VEGAS, NV 89146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 Nevada 89014. 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. No deficiencies were identified with these outpatient buildings. No further action is necessary with the Statement of Deficiencies (SOD). Please retain this SOD for your records.	{K 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 02 - 3 B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 19, EXISTING Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Building #3 - Two Story, Type II (111) with fire sprinkler system (undergoing extensive remodeling, currently no patient occupants). 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. This building was not in service at the time of the survey due to construction.	{K 000}		

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

Chelsea Klany | Hospital Administrator | 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 18, NEW Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Building 3 - Single Story, Type II (111) with fire sprinkler system; North Building (Sections A, B, C and D) of the Rawson Neal Complex. 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:	{K 000}		
K 022	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022	Tag K022: The exit sign in question near room B171 was removed. The maintenance department performs monthly rounds to verify exit lights and signs are appropriate and operating properly. The Facility Supervisor monitors monthly/quarterly reports. The Facilities Director is responsible for this item.	11/6/13

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

Hospital Chelsea Klany — Hospital Administrator — 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 022	Continued From page 1 This STANDARD is not met as evidenced by: NFPA 101, 7.10.2 Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. Based on observation, the facility failed to ensure that all exit signs were provided with directional indicators. Findings include: On 10/5/13 at 3:05 PM, an exit sign was observed to be tacked to a wall near room number B 171. This sign was not provided with a directional arrow. The true path of egress was to the left of the sign (No arrow suggested that egress was directly ahead).	K 022		
{K 062}	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: NFPA 13 (1996 ed.) 4-5.5 Obstructions to Sprinkler Discharge. 4-5.5.2 Obstructions to Sprinkler Discharge Pattern Development. 4-5.5.2.1 Continuous or noncontinuous obstructions less than 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with this section.	{K 062}	Tag K062: The light fixtures that impeded the clearance of the sprinkler heads were lowered to the appropriate level. (Attachment A) Environment rounds are performed monthly. Reports are submitted to the facility supervisor. The Facilities Director is responsible for this item.	11/21/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 062}	Continued From page 2 Based on observation the facility failed to insure that there were no obstructions 18 in. or less below the sprinkler deflector. Findings include: Observed on 10/5/13 at 3:00 PM, were suspended light fixtures hung below sprinkler heads with a clearance of ten inches or less. The rooms in which sprinkler patterns could have been affected were: B173, B178, B179, B169, B168, B167, B168b, B187, B164, B163.	{K 062}		
{K 066}	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4	{K 066}	Tag K066: The ashtrays at the designated staff smoking area and the visitor smoking area have been replaced with appropriate ashtrays. (Attachment B) Environment rounds are performed monthly. Reports are submitted to the facility supervisor. The Facilities Director is responsible for this item.	11/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 066}	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that smokers utilized only ashtrays of safe design. Findings include: On 11/5/13 at 3:40 PM, it was observed that in the designated staff smoking area, between Buildings D and B, there was a picnic table with an open, ten-inch diameter, metal bowl with a rock in the center of it to hold it down. The bowl was being used as an ashtray. Remnants of cigarettes were not protected from being blown out of the bowl by the wind. On 11/7/13 at 7:00 AM, it was observed that in the visitor smoking area, north of the main entrance, there was a similar metal bowl located on top of a picnic table. This area was covered by a small canopy which provided little protection from the wind.	{K 066}		
K 136	NFPA 101 LIFE SAFETY CODE STANDARD Procedures for laboratory emergencies are developed. Such procedures include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2.	K 136	Tag K136: The citation indicated that through interview, the staff members indicated that there was no written policies and procedures for handling laboratory emergencies. 1. The laboratory is part of the physical plant of Rawson-Neal Psychiatric hospital, therefore will follow under any Agency Emergency Operations for Rawson Neal	12/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 136	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.	K 136	Hospital. The laboratory had in place the Laboratory Safety Plan –Under policy and procedure, effective October 2006 "Laboratory Safety 001". In section D-Instrument and Equipment Safety, #9 and #10 state: #9. In case of fire, electrical outages, all of the electrical laboratory equipment is on "hospital generator power", and will continue to run as normal. # 10. Each instrument has a 4 hour "back-up battery", that will automatically continue providing power to instruments.	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads	K 144	This window allows enough time to complete any pending assays, and to shut down the instrument manually and if necessary, or for the hospital generators to activate. 2. This policy was reviewed and updated on January 10, 2014 to reflect command tree, and integrated into the Agency's Emergency Planning Operations. Plan Responsibilities: (Attachment C) 1. Medical Director: The Director of Laboratories maintains overall responsibility for all safety programs under his or her direction. 2. Administrative Laboratory Director: a. The Administrative Laboratory Director is the safety officer for the laboratory, and the representative to the Environment of Care (Safety) Committee. b. Implements the plan and ensures compliance by staff of all the appropriate safety policies in the laboratories.	12/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 136	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.	K 136	c. Develops, implements, coordinates, and monitors the on-site operations of the laboratory safety program, including this plan. d. Ensures that their staff members are properly informed trained and is complying with the provisions of this plan. 3. The technical and professional staff members are responsible for following the provisions of this plan and carrying out their "day to day" responsibilities in a safe manner. 4. Director of Facility Services 5. Chair of the Environment of Care Committee 6. Chair of the Emergency Planning Committee The Laboratory General Safety was implemented in October, 2006. The policy was reviewed bi-annually thereafter. The most recent revision was done on December 4, 2013, and renamed, Laboratory Emergency Preparedness Plan and General Safety Procedures. (Attachment C) 1. This procedure is found under Laboratory Procedures in Policies and Procedures on the SNAMHS Share folder on the agency's intranet. It is also found in the printed copy of the Laboratory Procedures in the Laboratory Procedures Manual kept in the laboratory. 2. Compliance is monitored through initial and annual department safety in-services for all laboratory staff.	12/4/13
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 136	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.	K 136	3. This action is monitored through documentation in each staff's employee's file in the Administrative Laboratory Director's office. 4. Documentation of compliance can also be found in the Annual Competency documentation in the Policies and Procedures manual in the laboratory. 5. This is also monitored through the EMPLOYEE APPRAISAL & DEVELOPMENT REPORT, work performance standard: Job Element #4: Laboratory Safety: Adheres to all laboratory safety protocols. 6. The compliance is 100% on initial hire, and annually thereafter.	12/4/13
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 136	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.	K 136		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads	K 144	Tag K144: The contracted vendor performed the appropriate load bank test per NFPA 110 on 12/5/13. (Attached D) Monthly reports are submitted by the contractor to the facility supervisor. The Facilities Supervisor is responsible for this item.	12/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 03 - NORTH (ABCD) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. Based on record review, the facility failed to ensure that the required, annual load bank test met the requirements of the Code. Findings include: On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 5/29/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 01 - 3A B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 19, EXISTING Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Building 3A - Single Story, Type V (000) with fire sprinkler system (undergoing extensive remodeling, currently no patient occupants). 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. This building was not in service at the time of the survey due to construction.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chuseck Klany — TITLE: Hospital Administrator — (X6) DATE: 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 04 - SOUTH (EFG) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 18, NEW Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Building 4 - Single Story, Type II (111) with fire sprinkler system; South Building (Sections E, F, and G) of the Rawson Neal Complex. 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.	{K 000}		
K 022	The following deficiencies were identified: NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022	Tag K022: The exit sign in question in building F was removed on 11/6/13. The maintenance department monthly performs rounds to verify exit lights and signs are appropriate and operating properly. Facility supervisor monitors monthly/quarterly reports.	11/6/13

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

Chelsea Klany | Hospital Administrator | 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 04 - SOUTH (EFG) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 022	Continued From page 1 This STANDARD is not met as evidenced by: NFPA 101, 7.10.2 Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. Based on observation, the facility failed to ensure that all exit signs were properly located and correctly indicated the true direction of egress. Findings include: On 10/5/13 at 12:20 PM, it was observed that one door in Building F had exit signage installed on both sides of this same door, presenting opposing directions of egress. On one side of the door was an enclosed courtyard, on the other side of the door was a corridor between Buildings G and E. Directly across from the aforementioned door was another door with an exit sign directing occupants to a public way. Note: On 10/6/13 during the afternoon, one of the two exit signs over the door between the courtyard and the corridor had been removed, and the remaining sign directed building occupants to a true exit.	K 022		
{K 144}	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	{K 144}	Tag K144: The contracted vendor performed the appropriate load bank test per NFPA 110 on 12/5/13. (Attached D) Monthly reports are submitted by the contractor to the facility supervisor.	12/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 04 - SOUTH (EFG) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 144}	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. Based on record review, the facility failed to ensure that the required, annual load bank test met the requirements of the Code. Findings include: On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 5/29/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.	{K 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 04 - SOUTH (EFG) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 147}	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70, ARTICLE 408 Switchboards and Panelboards, 408.38 Enclosure. Panelboards shall be mounted in cabinets, cutout boxes, or enclosures designed for the purpose and shall be dead front. NFPA 70, 408.7 Unused Openings. Unused openings for circuit breakers and switches shall be closed using identified closures, or other approved means that provide protection substantially equivalent to the wall of the enclosure. Based on observation, the facility failed to ensure that open spaces in an electrical panel box were properly covered. Findings include: On 11/6/13 at 9:30 AM, it was observed that one electrical panel box (Panel L1) had open space from slot #32 through slot #40.	{K 147}	Tag 147: Appropriate filler plates (covers) have been placed over slots 32 through 40 on Panel L1. The facilities supervisor is responsible for this item. Environmental rounds are performed monthly. Reports are submitted to the facility supervisor.	11/6/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 05 - WEST (H) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13. Your facility was surveyed using Chapter 18, NEW Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code. Building 5 - Single Story, Type II (111) with fire sprinkler system; West Building (Section H) of the Rawson Neal Complex. 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.	{K 000}		
K 144	The following deficiencies were identified: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144	Tag K144: The contracted vendor performed the appropriate load bank test per NFPA 110 on 12/5/13. (Attachment D) Monthly reports are submitted by the contractor to the facility supervisor.	12/5/13

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

Chris McKenny — Hospital Administrator — 1-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING 05 - WEST (H) RAWSON NEAL B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES	6161 W CHARLESTON BLVD LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 1 NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. Based on record review, the facility failed to ensure that the required, annual load bank test met the requirements of the Code. Findings include: On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 5/29/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.	K 144		