STATE OF NEVADA

BRIAN SANDOVAL
Governor

MICHAEL J. WILLDEN
Director

RICHARD WHITLEY, MS
Administrator

TRACEY D. GREEN, MD
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Southern Nevada Adult Mental Health Services
6161 W. Charleston Boulevard
Las Vegas, Nevada 89146-1148
(702) 486-6000 Fax (702) 486-8397

January 18, 2014

Rufus Arther, Branch Chief
Non-Long Term Care, San Francisco Regional Office
Centers for Medicare and Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Re: EMTALA

Dear Mr. Arther:

Southern Nevada Adult Mental Health Services' (SNAMHS) goal is to meet or exceed all regulatory expectations and best standards of care in treatment and service delivery while also recognizing it is our responsibility to continuously assess and be accountable when we find areas where we can or need to improve.

The Nevada Department of Health and Human Services (NV DHHS) surveyed our hospital on November 12, 2013 based on an allegation of noncompliance with the Emergency Medical Treatment and Labor Act (EMTALA) requirements of 42 C.F.R. § § 489.20 and 489.24.

Please find enclosed the SNAMHS required response for regulatory compliance. Should you require additional information please contact Chelsea Szklany at the above address or at (702) 486-8894.

Thank you for your understanding and support as we work together with our professional staff, patients, and with NV DHHS, to continue to improve and enhance our mental health services.

Sincerely,

Chelsea Szklany

Chelsea Szklany, OTR/L
SNAMHS Administrator

CC: Las Vegas Office, Bureau of Health Care Quality and Compliance

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING _____ B. WING _____	R-C 11/12/2013

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

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{A 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of an EMTALA (Emergency Medical Treatment and Active Labor Act) follow-up survey and a Federal Complaint Investigation which was conducted at your facility from 11/5/13 through 11/12/13, in accordance with 42 Code of Federal Regulations (C.F.R.) Chapter VI Section 489.20 and 489.24. During the initial EMTALA Investigation conducted 5/2/13 through 5/9/13, the Psychiatric Observation Unit (POU) met the EMTALA definition of a dedicated emergency department (DED). After the initial EMTALA survey, the facility opened an out-patient clinic (Out-Patient Clinic #1) which connected to the POU. The new Out-Patient Clinic #1 met the EMTALA definition of a DED. The facility opened Out-Patient Clinic #1, which connected to the POU, on 07/16/13. Out-Patient Clinic #1 hours were 8:00 AM to 5:00 PM Monday and Saturday, 8:00 AM to 9:00 PM Tuesday through Friday and closed on Sunday. The expectation of the facility was to have the clinic open 24 hours a day. The process on how Out-Patient Clinic #1 was operating was obtained through observation, interviews with staff and record reviews. During the follow-up survey the Administrator continued to indicate the facility did not operate a DED and the out-patient clinic did not meet the EMTALA definition of a DED. A detailed report was submitted to CMS (Centers for Medicare and Medicaid Services) explaining how the facility met the EMTALA definition of a DED.	{A 000}	This Agency is committed to improvement and desires to be in compliance with all the Conditions of Participation for The Centers for Medicare and Medicaid Services. Effective 01/24/14 the Rawson Neal Behavioral Health Clinic was closed and the employees were re-assigned to comparable positions in the hospital or in the urban outpatient clinics at the Agency. The Hospital does not have walk-in admissions and receives all admissions via medical transport. The clinic was opened and located within the hospital building with the intent: -to cater to individuals with behavioral needs who have difficulty organizing themselves including their personal schedules, -to co-locate services for individuals that typically do not have resources for independent or public transportation and -to serve a community need. The clinic was not designed to be a DED. The Hospital Administrator is responsible for the oversight of this corrective compliance activity.	01/24/14

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

Hospital Administrator

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.

Chrissa Kislany, OTR/L, Hospital Administrator 01/18/14

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{A 000}	Continued From page 1 The following describes how the out-patient clinic met the EMTALA definition of a DED: Out-Patient Clinic #1 received patients by appointment and walk-ins. The patient's scheduled for appointments were recent discharged patients from the facility's inpatient units. When recently discharged patients were seen at Out-Patient clinic #1, the majority of patients were given return appointments to the other out-patient clinics located through-out the valley. A follow-up appointment at Out-Patient Clinic #1 site was usually not made. Staff indicated 90% of patients seen in Out-Patient Clinic #1 were walk-in patients with no scheduled appointments. There were no visible signs outside the facility or outside Out-Patient Clinic #1 informing the public the facility was not a DED. Security reports and interviews with staff identified incidents when individuals presented themselves to the facility, after hours when the clinic and the hospital lobby was closed, requesting emergency psychiatric care. The facility had no written policy on how to properly report, assess, stabilize and document the after hour emergencies. Three random dates were chosen from Out-Patient Clinic #1's schedule from 8/12/13 - 11/12/13. Reviewing each day in detail, it was identified the criteria exceeded the EMTALA 1/3 definition for a DED. Each reviewed day identified 100% of the patients were out-patient individuals, 90% of the patients presenting to the clinic were walk-in with unscheduled appointments, more than 1/3 of patients seen in a day had a psychiatric emergency medical condition (EMC)	{A 000}	The clinic was opened and located within the hospital building to achieve several goals. One of these goals was to serve individuals with behavioral needs who have difficulty organizing themselves including their personal schedules. Allowing some flexibility could be considered a normal and reasonable accommodation for such diagnosis. For this reason, the clinic scheduled blocks of times rather than clock specific appointments for individuals referred for follow up appointments and from partner facilities. In addition to being more user-friendly for the individuals served, the practice represented efficient and responsive government in a State Agency. The employees knew the individuals were reporting to the clinic for the follow up services and these individuals were therefore scheduled. This practice was discontinued with the closing of the clinic. The hospital has ordered by 01/17/14 and placed signs at all public entrances by 01/24/14 indicating "This facility does not provide emergency services." The agency has amended the website to evidence the closing of the clinic for the public. An email communication to partners organizations and hospitals will be routed by close of business on 01/24/14.	

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{A 000}	Continued From page 2 and received stabilizing treatment or were admitted. The following dates were reviewed: On 09/16/13: 2 out of 3 patients who were admitted to the facility were placed on a Legal 2000 hold (Nevada Process of Civil Commitment) and 1 patient was admitted for severe depression, hallucinations and delusional. On 10/21/13: 3 out of 8 patients were placed on a Legal 2000 hold. On 11/07/13: 5 out of 10 patients were placed on a Legal 2000 hold. With the governing body documenting the facility did not have a DED and the Administrative staff indicating the facility did not have a DED there was no documented evidence the facility attempted to verify the criteria for the EMTALA 1/3 definition of being a DED did not apply to their facility. The facility's expectation was to have Out-Patient Clinic #1 be open 24 hours a day seeing a majority of patients as walk-ins with unscheduled appointments. The staff indicated the community would be aware of the services offered through word of mouth and from patients who were treated at the out-patient clinic. Having identified the facility was operating a DED, there was no documented evidence the facility was taking steps to inform the community Out-Patient Clinic #1 was not a DED and no process change on how the clinic was currently operating as a DED. The following complaint was investigated: Complaint #NV00037375: Allegations regarding lack of emergency assessment and	{A 000}	Effective 12/02/14 a directive was given to the DON 1, DON 2 and to the Agency Medical Director to identify all after hour individuals walking in for or requesting service to be reported on a incident report and to follow the Agency policy OF-COC-17: Walk-in and Call-in. This included completing all forms without leaving blanks. Effective 01/18/2014 the Agency policy - PF-COC-20: After Hours Response (Attachment A) was implemented codifying the same activities for individuals that show up on campus after normal business hours. This policy provides direction for the Security Officers. The governance and the Local Governing Body did engage, participate in and approve the Agency's plan for submission to CMS indicating the belief that the outpatient clinic did not meet the criteria for a DED. The communication was documented in the minutes of the meeting as information rather than approved.. Effective 1/16/14, in the meeting of the Local Governing Body the Commissioners gave direction to the recording secretary to include the action taken and to no longer use the term "information" when "approval" should be the case.	12/02/13 01/18/14 01/16/14

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{A 000}	Continued From page 3 documentation was substantiated (Please see Tag A2405 and A2409). Forty-nine patient records were sampled. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal for civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	{A 000}	Two methodologies were used determining the Agency and in particular the clinic did not meet the one third rule. One methodology used the numbers for hospital daily admissions and the numbers for the outpatient clinic. The second methodology used only the numbers for the outpatient clinic. The methodology also identified the individuals referred from the hospital, other agency clinics, the local County emergency rooms and partner facilities as scheduled patients since the Agency knew they would arriving and were prepared with background information. The numbers used were aggregated on a monthly basis. The Agency did not use a stratified sample based upon days individuals were transferred out of the Agency. In both methodologies used the Agency and the outpatient clinic did not meet the one third rule. The data from these methodologies is included in Attachment B. The same data was collected for December, 2013. The percentage dropped even more in December, 2013 because effective 12/02/13, the clinic no longer accepted L2K's from the local County emergency rooms. All L2K's were processed only through the inpatient units.	
{A2405}	489.20(r)(3) EMERGENCY ROOM LOG [The provider agrees,] in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. §489.24 The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services. This STANDARD is not met as evidenced by: Based on document review, interview, and record review, the facility failed to ensure a central log was maintained to allow tracking of each patient seeking assistance, whether the client or the facility refused treatment and the disposition of the patient; whether they were transferred, admitted and treated, stabilized and	{A2405}		

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{A2405}	Continued From page 4 transferred or discharged for 6 of 6 months (Patient #7). Findings include: The facility policy titled EMTALA (Emergency Medical Treatment and Labor Act) Procedure for L2K (Legal 2000 Nevada Process for Civil Commitment) Patients at RNOPC (Rawson-Neal Outpatient Clinic) effective September 9, 2013 documented: - "Purpose: To insure that a procedure is in place that will allow Rawson Neal Outpatient Clinic (RNOC) to remain in compliance with requirements set forth in the Emergency Treatment and Active Labor Act (EMTALA). It shall be the policy of the RNOC to provide an appropriate medical screening to all patients who present to the clinic for services, regardless of ability to pay, in order to assess whether an individual is experiencing an emergency medical condition. If the RNOC is unable to provide stabilizing treatment, the client will be transferred to the Rawson Neal Inpatient facility or to another hospital as appropriate." The Outpatient Clinic (OP) logs for the months of June 2013 through November 2013 were reviewed. Interviews with the Psychiatric Nurse (PN) in the OP clinic and the Director of OP Services revealed the logs were created when a patient walked into the OP clinic for services. The patient completed the intake form, if they were a new admission. If they were a current patient, they would sign in at the desk and the clerk would pull up the previous information available for the patient. On 11/7/13 at 4:00 PM, the PN House Supervisor	{A2405}	A2405: EMERGENCY ROOM LOG Effective 12/02/14 a directive was given to the DON 1, DON 2 and to the Agency Medical Director to identify all after hour individuals walking in for or requesting service to be reported on a incident report and to follow the Agency policy OF-COC-17: Walk-in and Call-in. This included completing all forms without leaving blanks. The Director of Nursing is responsible for oversight or this corrective compliance activity. Effective 01/18/2014 the Agency policy - PF-COC-20: After Hours Response (Attachment A) was implemented codifying the same activities for individuals that show up on campus after normal business hours. This policy provides direction for the Security Officers. The Hospital Administrator approved the policy and was responsible for this corrective compliance activity. The After Hour Response policy requires employees to complete the log, document the assessment(s), medical stabilize the patient to the level possible, appropriately transfer and document in compliance with the policy and medical record standards whenever the employee has been called upon to intervene or engages the individual.	12/02/13 01/18/13

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{A2405}	Continued From page 5 revealed when a patient showed up at the facility after hours, which referred to after the OP Clinic hours, there was no log maintained. The PN verbalized when a patient presented to the hospital, the security guard would let the house supervisor know. The house supervisor would come to the entrance of the facility and do an assessment of the patient. Based on this assessment, if the patient was determined to be stable and safe, the patient would be sent home. If the PN determined the patient would need additional services, the PN called 911 emergency and had the patient transferred to an acute care facility. The PN indicated she did not document the assessment that was performed and did not document the name of the patient presenting to the facility. The PN indicated the security guard documented the name of the patient presenting to the facility. The PN confirmed there was no log of all patients who presented after hours. The PN indicated there may be 2-3 persons per week or 5-6 a month who present to the facility after hours. On 11/7/13 at 4:10 PM,the security guard (SG) explained when a person presented to the facility and indicated they needed help or appeared in distress, the security guard would notify the house supervisor. The security guard indicated he would open the door and let the person in the facility and wait with the patient while the house supervisor came to see the patient. The SG verbalized he would wait with the person and house supervisor. If the house supervisor determined the person was in crisis and needed	{A2405}	All House Supervisors, hospital medical staff and Security Guard personnel have been trained and deemed competent to implement this policy. The Director of Nursing is responsible for this corrective compliance activity. 100% of all individuals transferred to another medical facility or medical care from inpatient or outpatient services were audited in December, 2013 and weekly for documentation requirements. Immediate coaching, training, and if indicated progressive disciplinary action was taken and will occur for future non-compliance activities. The audit findings are reported to the Executive Leadership and the Division Administration monthly and to the Local Governing Board quarterly. The Director of Nursing is responsible for the oversight of this corrective compliance activity. Complete documentation is also included in the concurrent medical record audit which occurs daily for all inpatient medical records. Immediate coaching, training, and if indicated progressive disciplinary action occurs.	01/18/14

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{A2405}	Continued From page 6 further treatment, 911 emergency would be called and the person transferred to another hospital. The SG added he documented the name of the individuals who presented to the facility after hours on the SG's daily journal. When there was a serious situation, such as a person in crisis who was transferred out to another facility, he would complete an report and submit it along with the daily security log. The security logs for August 2013 through November 2013 were reviewed. The SG Daily Journal and Operations Log dated 9/12/13 at 21:30 (9:30 PM) documented: - "Lady showed up at (name of facility) claiming she needed help. AMR (American Medical Response) was called and took her to (Name) Hospital. More detail in (report) located in completed (report) folder." There was no documentation of the patient's name who presented to the facility. There was no documented evidence of an assessment by any medical personnel, nurse or physician. The SG Daily Journal and Operations Log dated 9/19/13 at 17:10 (5:10 PM) documented: - "Lady came and wanted to be admitted into (name of facility). Advised her they needed to go to ER (Emergency Room) due to (name of facility) being closed." There was no documentation of the name of the person who presented to the facility. There was no documented evidence of an assessment by any medical personnel, nurse or physician.	{A2405}	The audit findings are reported to clinicians and supervisors daily and to the Executive Leadership and Division Administration governance monthly. The analysis, follow up and recommendations are reported to the Local Governing Board quarterly.	

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{A2405}	Continued From page 7 The SG daily log dated 10/1/13 at 1909 (7:09 PM) documented: - " WFA (white female adult) came to lobby doors and advised she was supposed to be admitted tonight. (Staff Name) was contacted and took over." There was no documentation of the name of the person who presented to the facility, either on the SG log, the log in the OP clinic, or Inpatient admissions. On 11/12/13 at 3:00 PM, the Hospital Administrator (Adm) indicated there was no policy in place regarding how to handle after hours emergencies for people who show up at the facility when the clinic was closed and the doors locked. The Adm verbalized when someone showed up requesting services after the clinic was closed, there was no requirement for the nurse to do an assessment. If there was a person needing immediate assistance, 911 emergency should called. There was no log maintained of people who presented to the facility after hours. If 911 emergency was called and there was a determination the patient was a legal 2000, there was no requirement for the nurse to complete a transfer form, as the person was not an admission to the facility. The Adm added, the determination as to which the facility the patient was referred to was totally the decision of the EMS (Emergency Medical Staff). There was no communication between the staff at the facility and the receiving facility. Patient #7	{A2405}		

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{A2405}	Continued From page 8 Patient #7 and a case worker initially presented to the facility on 8/17/13 when the out-patient clinic was closed. The patient and case worker arrived by car from California. A Legal 2000 for poor insight, poor judgement, no social support and unable to care for self was initiated by the house supervisor. AN ambulance transferred the patient toan acute care hospital on 8/17/13. The patient was admitted to the acute care hospital from 8/17/13 to 8/20/13, with diagnosis of psychotic disorder. From 11/7/13 to 11/8/13 several staff members were interviewed regarding Patient #7 presenting on the facility grounds on 8/17/13. There were no staff members who recalled the incident. There was no documented evidence a log was completed for patients requiring emergency medical treatment after the out-patient clinic was closed for the day. On 11/8/13 in the afternoon, it was identified which Registered Nurse (RN) house supervisor was working at the time of Patient #7's incident. The RN house supervisor recalled the incident that occurred on 8/17/13 with Patient #7. The RN house supervisor indicated the patient could not be admitted to the facility since the out-patient clinic was closed. The RN house supervisor confirmed the incident and assessment was not documented. The security guard daily log had no documented evidence on the incident. The RN house supervisor indicated there was no policy regarding handling of patients who show up to the facility when the out-patient clinic was closed. Complaint NV00037375	{A2405}	The case worker identified in this report is from California. The Agency RN in this case told the California caseworker there was no after hour services. The California caseworker left patient #7 in the parking lot of the Agency. The Agency nurse, acting in the capacity of a licensed nurse, contacted 911. The emergency medical staff personnel would not accept Pt. #7 without an L2K. The After Hour Response policy requires employees to complete the log, document the assessment(s), medically stabilize the patient to the level capable, appropriately transfer and document in compliance with the policy and medical record standards whenever the employee has been called upon to intervene or engages the individual. 100% of all individuals transferred to another medical facility or medical care from inpatient or outpatient services are audited weekly for documentation requirements. Immediate coaching, training, and if indicated progressive disciplinary action occurs. The audit findings are reported to the Executive Leadership and Division Administration monthly and to the Local Governing Board quarterly.	

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{A2400}	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on findings at A2405, A2406 and A2409, the facility failed to ensure compliance with C.F.R. (Code of Federal Regulations) 489.20 and 489.24.	{A2400}	Complete documentation is also included in the concurrent medical record audit daily for all inpatient medical records. Immediate coaching, training, and if indicated progressive disciplinary action occurs. The audit findings are reported to clinicians and supervisors daily and to the governance monthly.	
{A2406}	489.24(r) and 489.24(c) MEDICAL SCREENING EXAM Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must (i) provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2)	{A2406}	A2406 MEDICAL SCREEN EXAM The Agency policy PF-COC-17: Walk-in Call-in requires nursing and medical staff employees to document a medical screening. PF-COC-20: The After Hour Response policy requires the nursing and Medical Staff to conduct and document the medical screening, stabilization and document in compliance with the policy and medical record standards whenever the employee has been called upon to intervene or engages the individual. The Agency Medical Director and the Director of Nursing are responsible for the oversight of this corrective compliance activity. 100% of all individuals transferred to another medical facility or medical care from inpatient or outpatient services are audited weekly for documentation requirements. The House Supervisors and outpatient Clinic Directors are responsible for this corrective compliance activity.	01/18/14

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

Hospital Administrator

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.

Chelsea Kilany, QIRL, Hospital Administrator 01/18/14

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{A2406}	Continued From page 1 of this section. (2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act. (c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all patient who presented to the facility with possible psychiatric emergencies received consistent care including screening, stabilization, admission and/or	{A2406}	Immediate coaching, training, and if indicated progressive disciplinary action occurs. The audit findings are reported to the governance monthly and to the Local Governing Board quarterly. Complete documentation is also included in the concurrent medical record audit daily for all inpatient medical records. Immediate coaching, training, and if indicated progressive disciplinary action occurs. The audit findings are reported to clinicians and supervisors daily and to the governance monthly.	

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{A2406}	Continued From page 2 transfer. Findings include: The facility opened an Out-Patient Clinic connected to the Psychiatric Observation Unit (POU) on 07/16/13. The out-patient clinic hours were 8:00 AM to 5:00 PM Monday and Saturday, 8:00 AM to 9:00 PM Tuesday through Friday and closed on Sunday. The out-patient clinic received patients by appointment and walk-ins. The patient's scheduled for appointments were recent discharged patients from the facility's inpatient untied. The out-patient clinic staff indicated 90% of the patients senn in the clinic were walk-in patients with no scheduled appointments. Three random dates were chosen from the out-patient clinic schedule from 8/12/13 through 11/12/13. One-third of the walk-in patients seen the the out-patient clinic had a psychiatric emergency medical condition. Those patients who were placed on a Legal 2000 hold were either admitted to the facility (if a bed was available) or transferred to an acute care facility for further evaluation. The facillity's expectation was to have the out-patient clinic be open 24 hours a day seeing a majority of paitents as walk-ins with unscheduled appointments. On 11/7/13 at 4:00 PM, the Psychiatric Nurse (PN) House Supervisor revealed when a patient showed up at the facility after hours, which referred to after the OP Clinic hours, the house supervisor would come to the entrance of the facility and do an assessment of the patient. Based on this assessment, if the patient was determined to be stable and safe, the patient	{A2406}		

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{A2406}	Continued From page 3 would be sent home. If the PN determined the patient would need additional services, the PN called 911 emergency and had the patient transferred to an acute care facility. The PN indicated she did not document the assessment that was performed and did not document the name of the patient presenting to the facility. The PN indicated the security guard documented the name of the patient presenting to the facility. The PN confirmed there was no log of all patients who presented after hours. The PN revealed there may be 2-3 persons per week or 5-6 a month who present to the facility after hours. On 11/7/13 at 4:10 PM, the security guard (SG) verbalized he documented the name of the individuals who presented to the facility after hours on the SG's daily journal. When there was a serious situation, such as a person in crisis who was transferred out to another facility, he would complete an report and submit it along with the daily security log. The security logs for August 2013 through November 2013 were reviewed. The SG Daily Journal and Operations Log dated 9/12/13 at 21:30 (9:30 PM) documented: - "Lady showed up at (name of facility) claiming she needed help. AMR (American Medical Response) was called and took her to (name) hospital. More detail in (report) located in completed (report) folder." There was no documentation of the patient's name who presented to the facility. There was no	{A2406}		

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{A2406}	Continued From page 4 documented evidence of an assessment by any medical personnel, nurse or physician. The SG Daily Journal and Operations Log dated 9/19/13 at 17:10 (5:10 PM) documented: - "Lady came and wanted to be admitted into (name of facility). Advised her they needed to go to ER (Emergency Room) due to (name of facility) being closed." There was no documentation of the name of the person who presented to the facility. There was no documented evidence an assessment was completed by any medical personnel, nurse or physician. The facility policy titled Walk-in/Call-in Screening effective date 10/12 documented: -" IV. Procedure: - A. At no time shall a non-clinical staff member attempt to determine whether or not the person should be seen. - B. At no time shall a non-clinical staff member send the person in an emergency or crisis away without being evaluated by a clinician." On 11/12/13 at 3:00 PM, the Hospital Administrator (Adm) indicated there was no policy in place regarding how to handle after hours emergencies for people who show up at the facility when the clinic was closed and the doors locked. The Adm verbalized when someone showed up requesting services after the clinic was closed, there was no requirement for the nurse to do an assessment. If there was a person needing immediate assistance, 911 emergency should called. There was no log maintained of people	{A2406}		

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{A2406} A2409	Continued From page 5 who presented to the facility after hours. 489.24(e)(1)-(2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification	{A2406} A2409	Agency policy PF-COC-02: Inter-hospital Client Transfers and COBRA Compliance requires all employees to complete and document an appropriate transfer. A component of the form requires employee to communicate with the receiving facility and document such. This Agency's employees dictate the receiving facility and communicates this information to the emergency transport personnel and provide their hand-off communications as well as their assessments. Employees in the inpatient and outpatient settings were re-educated to comply with Agency policy. In these cases the nurses specifically involved were coached and required to demonstrate competency for completed medical record documentation because the the appropriate form was initiated but not thoroughly completed by the nurses involved. The Director of Nursing was responsible for this corrective compliance activity.	01/18/14 12/12/13

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A2409	Continued From page 6 described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical	A2409	100% of all individuals transferred to another medical facility or medical care from inpatient or outpatient services are audited weekly for documentation requirements. Immediate coaching, training, and if indicated progressive disciplinary action occurs. The House Supervisors and outpatient Clinic Directors are responsible for this corrective compliance activity. The audit findings are reported to the Executive Leadership and Division Administration monthly and to the Local Governing Board quarterly. The Hospital Administrator is responsible for this corrective compliance activity.	

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A2409	Continued From page 7 records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure transfers were screened and carried out following regulatory requirements as required for 5 of 49 sampled patients (Patient #3, Patient #18, Patient #35, Patient #39, and Patient #7). Findings include: Patient #3 Patient #3 presented to the Outpatient (OP) Clinic on 10/7/13 with complaints of hearing voices telling her to go naked, and everyone was threatening her with knives. Patient #3's skilled nurse's notes from the clinic documented Patient #3 had a previous admission at the facility with an incidence of assault. During the nurse assessment, Patient #3 became violent and started to assault the nurse. Patient #3 was placed on a Legal hold. Since there were no beds available in the facility, 911 emergency was called for transfer to another facility.	A2409		

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A2409	Continued From page 8 Patient #3's COBRA (Consolidated Omnibus Reconciliation Act) transfer form documented: - Receiving Facility - Per Routine - Receiving Physician - Blank - Person Accepting - Blank - Verbal Report Given - Blank - Phone - Blank Patient #3's medical record included a Legal 2000 form which indicated the patient was extremely agitated and assaulted a staff member. There was no documented evidence of any medical record information sent to the receiving facility. There was no documented evidence a verbal report was given to the receiving facility. Patient #18 Patient #18 presented to the Outpatient Clinic on 10/8/13 with complaints of being depressed and suicidal thoughts. The patient was evaluated by the psychiatrist and placed on a Legal 2000. The patient was transferred to another hospital for medical clearance. Patient #18's COBRA (Consolidated Omnibus Reconciliation Act) transfer form documented: - Receiving Facility - Per Routine - Receiving Physician - Blank - Person Accepting - Blank - Verbal Report Given - Blank - Phone - Blank Patient #18's medical record included a Legal 2000 form which indicated the patient was depressed and increased risk for self harm.	A2409		

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A2409	Continued From page 9 There was no documented evidence of any medical record information sent to the receiving facility. There was no documented evidence a verbal report was given to the receiving facility. Patient #35 Patient #35 presented to the Outpatient Clinic on 11/7/13 with complaints of active hallucinations. The patient was seen by a nurse and a psychiatrist. Based on the psychiatric assessment, Patient #35 was placed on a Legal 2000 and transferred to (Name) Hospital by AMR (American Medical Response) ambulance for medical clearance and evaluation, as per the nurse's notes. As per the nurse's note, a copy of the Legal 2000 form was sent with the patient. The form documented the patient was psychotic and could not care for self. There was no documented evidence a COBRA (Consolidated Ominbus Reconciliationc Act) transfer form was completed. There was no documented evidence a report was provided to the receiving facility. There was no documented evidence copies of any additional medical record information was sent with the patient including the most recent vital signs. Patient #39 Patient #39 presented to the Outpatient Clinic on 10/21/13 with complaints of suicidal ideations. The patient was hearing voices to hurt himself. The patient was assessed by the nurse and psychiatrist.	A2409		

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A2409	Continued From page 10 Based on the psychiatric assessment, Patient #39 was placed on a Legal 2000 and transferred to (Name) Hospital by ambulance for medical clearance and evaluation, as per the nurse's notes. The nurse's notes indicated a report was given to a nurse and physician at the receiving hospital. There was no documented evidence a COBRA transfer form was completed. There was no documented evidence copies of the medical record including the assessments by the nurse and psychiatrist were sent with the patient. On 11/12/13 at 3:00 PM, the Hospital Administrator (Adm) verbalized when someone showed up requesting services after the clinic was closed, there was no requirement for the nurse to do an assessment. If there was a person needing immediate assistance, 911 emergency should called. There was no log maintained of people who presented to the facility after hours. If 911 was called and there was a determination the patient was a legal 2000, there was no requirement for the nurse to complete a transfer form, as the person was not an admission to the facility. The Adm added, the determination as to which the facility the patient was referred to was totally the decision of the EMS (Emergency Medical Staff). There was no communication between the staff at facility and the receiving facility. The facility policy titled Interhospital Patient Transfers and COBRA Compliance, review date 5/13 documented: - A. The Patient Transport Form is to be used	A2409		

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A2409	Continued From page 11 anytime a patient from SNAMHS is transferred to another facility including, acute care medical facility for inpatient or emergency department care.... - 1. c. Enter reason for transfer and name of receiving facility. - d. Enter the name of the receiving physician and name of the person authorized to accept the patient... - e. Enter the name of the person receiving your verbal report and the phone number at which this person can be reached." Patient #7 Patient #7 and a case worker initially presented to the facility on 8/17/13 when the out-patient clinic and hospital lobby were closed. The patient and the case worker arrived by car from California. A Legal 2000 was initiated by the house supervisor for poor insight, poor judgement, no social support and unable to care for self. The patient was transferred to an acute care hospital on 8/17/13. The patient was admitted to the acute care hospital from 8/17/13 to 8/20/13, with diagnosis of psychotic disorder. The patient was transferred back to the facility on 8/20/13. The acute care hospital Psychiatric consultation dated 8/18/13, documented: "...History Of Present Illness: This is a psychiatry evaluation for a 26 year-old female with unknown past psychiatric history presenting to the hospital on legal 2000 stating that she is unable to care for herself. The patient states that she was	A2409	The case worker identified in this report is from California. The Agency nurse in this case told the California caseworker there was no after hour services. The California caseworker left patient #7 in the parking lot. The Agency RN, acting in the capacity of a licensed nurse, contacted 911. The emergency medical staff personnel would not accept Pt. #7 without an L2K.	

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A2409	Continued From page 12 essentially dumped here by her case manager yesterday. Is not able to state any reason why she was essentially dumped here by someone. She is very primitively self focused on discharge throughout the interview. She appears very, very guarded and give conflicting information throughout the interview. She does present extremely flat and guarded with very concrete thought process. She states that she has been taking her medications although she states that she takes medications for headaches. She states initially that she has never seen a psychiatrist in the past. However, upon learning that she is not leaving the hospital immediately today she does eventually open up that she has seen a psychiatrist in California just before coming to the hospital here. She states "I have been locked up for 7 months". She persist that she wants to leave the hospital, eventually she states that she wants to leave the hospital so she can "get a beer". She does state that she is taking her medications although she cannot name them off the top of her head. She states that she has been living in a shelter. She states that she has several family and friends in town. However again, she is getting very conflictual information throughout the interview. She denies actual psychotic symptoms at this time including auditory or visual hallucinations or paranoid ideation. However, after the interview she might be possibly responding to internal stimuli in her room. She otherwise denies any suicidal ideation. She denies other pertinent positives on psychiatric review of systems. The patient began asking from her room "please do not mess with my brother"...." From 11/7/13 to 11/8/13 several staff members were interviewed regarding Patient #7 presenting	A2409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING _____ B. WING _____	R-C 11/12/2013

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
A2409	Continued From page 13 on the facility grounds on 8/17/13. There were no staff members who recalled the incident. There was no documented evidence a log was completed for patients requiring emergency medical treatment after the out-patient clinic was closed for the day. On 11/8/13 in the afternoon, it was identified which Registered Nurse (RN) house supervisor was working at the time of Patient #7's incident. The RN house supervisor recalled the incident that occurred on 8/17/13 with Patient #7. The RN house supervisor indicated the patient's case worker dropped the patient off at the facility having the understanding the patient was to be admitted to the facility. The RN supervisor indicated the facility did not receive any information the patient was transferring from a California hospital to their facility. The RN house supervisor indicated the patient could not be admitted to the facility since the out-patient clinic was closed. The RN house supervisor indicated a Legal 2000 was initiated due to his assessment the patient was unsafe and could not be left alone to wander the streets. The RN house supervisor confirmed the incident and assessment was not documented. The security guard daily log had no documented evidence of the incident. The RN house supervisor indicated there was no policy regarding handling of patients who show up to the facility when the out-patient clinic was closed. Complaint NV00037375	A2409		