STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	290045		C 07/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ROSE DOMINICAN HOSPITAL - SIENA CAMPUS	3001 ST ROSE PARKWAY HENDERSON, NV 89052

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A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Complaint Validation Survey conducted at your facility from 7/13/09 through 7/17/09. The survey was conducted in accordance with 42 CFR Part 482 - Hospitals. The census on the first day of the survey was 189. 25 clinical records were reviewed. The Condition of Participation was not met for CFR 482.55 Emergency Services. The Complaint #NV00021996 was investigated and found to be substantiated, see Tag A1100. 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 regulatory deficiencies were identified.	A 000		
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide acceptable standards of practice such as administering medications and treatments, proper	A1100		11/19/09

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

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.

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A1100	Continued From page 1 assessments, and providing a safe environment for emergency room patients for 8 of 25 sampled patients (#16, #21, #24, #14, #15, #22, #13, #4) and one unsampled patient. Findings include: Patient #16 Patient #16 was treated in the emergency department (ED) on 5/16/09 for abdominal pain. The ED Treatment Record revealed patient #16 was complaining of right lower quadrant pain for 3 days. The physician ordered Morphine 4 mg (milligrams) and Zofran 4 mg IVP (intravenous push). Next to the order documented: -"...not given, no IV in waiting room..." On 7/17/09 in the morning, Patient #16 was contacted by phone. The patient indicated that she was suffering from severe abdominal pain and her physician instructed her to go to the ED for treatment. The patient indicated when she entered the ED the nurse was asking her personal questions and started examining her in the triage open area next to the waiting room. The patient requested for some privacy and she was instructed to wait in the waiting area. The patient indicated she waited for another hour with severe abdominal pain before she was assessed. The patient indicated she was discharged and was never given any pain medication. She indicated she left the ED with the same amount of pain. The patient indicated she was billed for medication she never received from the ED. The patient stated, "I will never come back to that ED."	A1100		

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A1100	Continued From page 2 Patient #21 Patient #21 presented to the ED for right leg open wound and leg pain. The ED Treatment Record dated 5/16/09 ordered for Zosyn, Vancomycin, and normal saline to be given intravenously to Patient #21. Documented next to the order: -"...Not given in Lobby..." The St. Rose Dominican Hospital, Siena campus' "Admit Emergency Room Report" dated 5/16/09, and completed by the physician revealed the physician ordered antibiotics for Patient #21. The report indicated the patient was to be admitted to the San Martin campus or the Siena campus. The patient misunderstood and drove herself to the San Martin ED. The St. Rose Dominican Hospital, San Martin campus' "Admit Emergency Room Report" dated 5/16/09, and completed by the physician documented Patient #21 was medicated with Zosyn and Vancomycin at the Siena campus. There was no documented evidence Patient #21 was administered the initial dose of Zosyn and Vancomycin. There was no documented evidence the Siena or San Martin physicians were informed Patient #21 did not receive the ordered initial antibiotics. Patient #24 Patient #24 presented to the ED on 7/9/09 via ambulance. The patient was intubated due to being found unresponsive by his wife.	A1100		

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A1100	Continued From page 3 Patient #24 was intubated, on a ventilator, sedated and restraints were ordered. The patient was admitted to the intensive care unit (ICU) and was awaiting for an ICU bed while in the ED. The patient improved throughout the night and was extubated, per facility documents. The Admit ED Report dated 7/9/09 documented: -"...His wife states that he has been upset about the death of his mother, but she is "sure" that this was not a suicide attempt...." -"...At this point, the patient's altered level of consciousness seems most likely secondary to overdose, but it is still uncertain whether or not this was intentional or accidental..." The Case Management Note dated 7/9/09 documented: -"...PT (patient) ADMITTED WITH UNINTENTIONAL OVERDOSE OF MEDICATIONS. HAD BEEN INTUBATED AND NOW EXTUBATED. ALERT/RESPONSIVE. PT HAD NOT BEEN PLACED ON LEGAL HOLD. PER NURSING PT IS NOW LEAVING AMA (Against Medical Advice) AND PRIMARY MD (Medical Doctor) was notified." On 7/17/09 in the morning, the Clinical Psychologist indicated Patient #24 should have been psychologically evaluated and recommendations would be made to the physician prior to discharging the patient home. There was no documented evidence a phychiatric or psychological evaluation was ordered to	A1100		

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A1100	Continued From page 4 determine if a Legal 2000 hold was needed due to the recent death of his mother. Note: A Legal 2000 is the state of Nevada's process of civil (psychiatric) commitment. Initial Tour Observations related to actual and potential Legal 2000 Patients: During the initial tour on 7/14/09 in the morning, the psychiatric hold area located on the second floor (also known as 2 North) had 6 hospital beds in the area. Two beds were located inside the nursing station area and four were located in the area in front of the nursing station. One bed blocked an unlocked door that led to the hallway. There was no sink in the room and the bathroom was located across the hallway from the room. The area staffed one nurse and one certified nurse assistant (CNA). The CNA would sometimes be left alone when the nurse had to retrieve medications from the pharmacy. Documented on Patient #1's suicide Observation form dated 7/7/09 was a signature of a patient sitter working on the second floor hold unit from 7:00 pm to 7:00 am. The facility's job description for a patient sitter did not require basic life support and first aid training. Additional observations to the hold area revealed the registered nurses were leaving the area to do other tasks such as obtaining medications from the pharmacy and faxing documents. When the nurse left the area the patient sitter, who was not certified in basic life support, would have to contact the ED (on the first floor) for assistance. Patient #14 Patient #14 was a 28 year old male brought to the	A1100		

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A1100	Continued From page 5 Emergency Department (ED) on 5/14/09 at 12:39 PM, by ambulance with diagnoses to include Acute Psychosis, Hallucinations, Homicidal and Suicidal Ideations. He was assessed for a Legal 2000 at the hospital. The "ED Treatment Record" (no date) for Patient #14, indicated he was placed in room #7 on suicide precautions with restraints at 1315 (1:15 PM). An "Application , Certification and Medical Clearance for Emergency Admission of an Allegedly Mentally Ill Person to a Mental Health Facility" dated 5/14/09 at 1450 (2:50 PM), indicated Patient #14 was medical cleared to be transferred to a mental health facility when a bed became available. The "Suicide Observation Form" for Patient #14 dated 5/14/09 at 1530 (3:30 PM), indicated he was transferred to the second floor holding room from the ED and placed in bed 4 on 2 North. On 5/15/09, a note on the Patient #14's Suicide Observation Form indicated the patient wants to leave. The Suicide Observation Form dated 5/16/09, for Patient #14 contained a note on the back of the form with no date or signature that stated, "Dr. (name) states that mother (of Patient) informed her He (Patient) can get violent and tried to run." The Suicide Observation Form dated 5/17/09, indicated prior to his elopement Patient #14 was pacing and anxious. The form indicated he, "Left the unit @ 1300 (1:00 PM) by the door behind bed 4. Charge nurse notified. HPD	A1100		

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A1100	Continued From page 6 (Henderson Police Department) notified." The Observation Record dated 5/17/09, indicated the Patient eloped and was missing from 1:00 PM until 1:45 PM, when he was returned by the Police. Patient #15 Patient #15 was a 19 year old male brought in by ambulance on a Legal 2000 to the ED on 5/14/09 at 2219 (10:19 PM), with diagnoses to include Bi Polar Disorder, Polysubstance Abuse and ETOH (ethanol alcohol) Intoxication. The Patient indicated to the Police that he was feeling violent toward others. The "Suicide Observation Form" for Patient #15 dated 5/15/09 at 5:15 AM, indicated he was transferred to the 2 North holding area from the ED. The "Suicide Observation Form" dated 5/17/09, indicated he escaped through the door in back of bed 4 at 1:00 PM. The notes indicated the Patient was found 1/2 a mile away at a department store and was returned to the hospital at 2:00 PM by the Police. The Observation Record forms for Patients #14 and #15 indicated both patients eloped from the door behind bed 4 on 5/17/09 at approximately 1:00 PM. On 7/15/09 at 5:15 PM, There were 4 patients, and one visitor in the holding area on 2 North. There was one Certified Nursing Assistant present. She indicated the nurse in charge went to fax something.	A1100		

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A1100	Continued From page 7 Patient #22 Patient #22 was a 29 year old male who was triaged in the ED on 5/11/09 at 2:00 PM, with diagnoses to include ETOH (Ethanol alcohol) Poisoning, Nausea, Vomiting and Tremors and Hypertension. The "Emergency Department Treatment Record" for Patient #22 dated 5/11/09, indicated a Computerized Axial Tomography (CAT) was ordered by the physician who initially assessed the Patient. The Emergency Note indicated the CAT scan was ordered because the Patient had bumped his head. Patient #22 was discharged without having the CAT scan by a Physician's Assistant (PA). The Emergency Room Note dated 5/11/09, indicated after the patient was discharged the PA was notified by radiology that the patient had a pending CAT scan ordered. The note indicated the patient left before getting the imaging done. During a telephone call with Patient #22 on 7/16/09 in the afternoon, he indicated he was seen at the front desk, waited in the lobby, was given some medicine and discharged. He indicated he was discharged by a different doctor then the one who admitted him. He indicated he was never informed that he needed a CAT scan. Support Information for Patients #13 and #4: On July 16, 2009, The Director of Quality Management indicated an algorithm was created that explained the meanings of the letters in the upper right hand corner of the Patient's	A1100		

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A1100	Continued From page 8 Emergency Department (ED) Treatment Records. The letters represented admission criteria into the emergency department. The following information was documented: "A" indicated an immediate bed admission. "B" indicated next available bed (the Physician noted why the bed is needed (example: intravenous infusion, pelvic, etc.). "C" May keep in the lobby for workup, Physician to disposition patient. "RMA" May keep in lobby for workup, Midlevel to disposition patient. Patient # 13 Patient #13 was a 41 year old female triaged at 11:54 AM on 5/26/09, with diagnoses to include Right Cervical and Axillary Lymphadenopathy. The Emergency Note dated 5/26/09, indicated the Patient had been given antibiotics two weeks prior when she was in the ED and was diagnosed with possible cervical node infection. The note indicated she returned to the ED due to concerns with swelling in her right axilla. The Emergency Department Treatment Record dated 5/26/09, had the letter "B" in the upper right hand corner of the form. The physician documented "B" for IVF (intravenous fluids) Patient #13's Emergency Department Treatment Record dated 5/26/09, contained an order written at 1416 (2:16 PM) for one liter of Normal Saline to be infused intravenously. The documentation indicated the fluid was never given, the patient never went into a room and remained in "triage her entire stay."	A1100		

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A1100	Continued From page 9 Patient #13 indicated during a telephone conversation in the afternoon of 7/16/09, that she never went into a room in the Emergency Department. She was sent to x-ray from the lobby and was discharged at the front desk which is open to the lobby. She was told to see her personal physician. Patient #4 Patient #4 was a 61 year old female who came to the emergency room on 5/14/09 with diagnoses to include, Chest Pain, Shortness of Breath, Wheezing, Chronic Obstructive Lung Disease, Fibromyalgia, Vomiting and Sweating. On the, "Emergency Department Treatment Record" a "B" was in the right hand corner of the form. The Patient's History and Physical dated 5/15/09, indicated the physician was worried she might have Pneumonia and she was worked up accordingly with blood work, and Electrocardiogram (EKG) and a Nebulizer Treatment. The notes indicated, the Patient eloped before she received her chest x-ray. Patient #4 indicated on 7/17/09, by telephone that she never made it to the inside of the Emergency Room. She indicated, her vital signs and medical history were taken at the front desk. She had blood work and an EKG performed in a small room (triage room) located behind the front desk. She indicated she told the person at the front desk she was tired of waiting and was going to leave. She then indicated she left. The Patient indicated she was not given a form to sign out against medical advice.	A1100		

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A1100	Continued From page 10 Unsampled Observation and Interview One unsampled female Patient was observed sitting in the lobby with her husband at 11:30 PM on 7/13/09. The Patient was given discharge instructions by a Physician in the waiting room. There were six other individuals also sitting in the waiting room. The Patient indicated after she was discharged that the care was excellent, however the privacy could have been better. She indicated she and her husband were spoken to in the waiting room by staff several times about personal matters.	A1100		