

Acceptable POC 9/6/12
 EJP

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN871HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2012
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RECEIVED

NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 690 EDISON WAY RENO, NV 89502 SEP 04 2012 BUREAU OF HEALTH CARE QUALITY & COMPLIANCE CARSON CITY, NV
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 8/14/12, in accordance with Nevada Administrative Code, Chapter 449, Hospital.</p> <p>Surveyor #28725</p> <p>Complaint #NV00032660.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The investigation included interviews with the quality manager, nurse manager, charge nurse, staff nurse, a physician and the director of plant operations. The patient's file and facility policies and procedures were reviewed.</p> <p>When the resident alleged overdose, staff responded quickly following facility policies and procedures. It was never determined that the patient actually took an overdose. When the patient ran from the transport vehicle, staff kept her in their line of sight and retrieved her with the help of police. Allegations unsubstantiated.</p> <p>The allegation regarding unsafe housekeeping was substantiated. See tag #S105.</p>	S 000	<p>NAC 449.322 APPROPRIATE CARE OF PATIENT</p> <p>The executive leadership team (the CEO, Director of Plant Operations, CNO, and Director of Performance Improvement) met on 7/23/2012 to review the housekeeping policy and practice of keeping cleaning products inaccessible from patients.</p> <p>ACTION(S) TAKEN:</p> <p>The practice on Cart Control /Patient Room Cleaning was reviewed and revised on 8/27/12 by the Director of Plant Operations (Safety Officer) and Director of Performance Improvement (Patient Safety Officer) to clarify expectations regarding keeping housekeeping cleaning products inaccessible from patients.</p> <p>The new hire orientation for housekeepers was updated and training was provided on 8/22/12 to ensure housekeeping staff is knowledgeable about changes to the policy and procedure</p>	<p>7/23/12</p> <p>8/27/12</p> <p>8/22/12</p>
S 105 SS=D	<p>NAC 449.322 Housekeeping Services</p> <p>1. A hospital shall establish organized housekeeping services planned, operated and maintained to provide a pleasant, safe and</p>	S 105		

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

Audie Jate RN BSN Director of P/I Risk Management
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE 8/31/12

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN671HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2012
NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 690 EDISON WAY RENO, NV 89502		
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S 105	Continued From page 1 sanitary environment. Adequate personnel, using accepted practices and procedures, shall keep the hospital free from offensive odors, accumulations of dirt, rubbish, dust and safety hazards. This Regulation is not met as evidenced by: Based on staff interview, record review and review of facility policies and procedures, the facility failed to keep a safety hazard locked away from a suicidal patient. (Patient #1) Findings include: Patient #1 was a 14 year old child admitted to the facility on 5/24/12. The patient's diagnoses included major depressive disorder with severe psychotic features. The patient had a history of suicidal ideation and command auditory hallucinations telling her to kill herself. Record review revealed that on 7/22/12 around 2:00 PM, Patient #1 took a bottle of 10% bleach off the top of a housekeeping cart parked in the hallway and drank approximately 10 ounces of the solution. The patient was taken via ambulance to the ER. The ER found no injury and discharged her after a few hours of observation. The plant operations manager stated it was against facility policy to leave cleaning products unlocked and accessible to patients. Review of the housekeeping practice and procedures revealed a requirement that all cleaning solution bottles be stored inside the cart's locked compartment.	S 105	MSDS sheets and binders were updated by Ceasar Cornejo Plant Operation Manager in April 2012. Staff was re-educated by Mark St. Germaine on 8/22/12 about the importance of their use and how/where to access the information in the event a patient gains access to cleaning products. This training included how to alert the Charge Nurse and how to contact poison control in the event patient's gain access to cleaning products. Mental health Tech were re-educated on patient room cleaning process by Rick Van Epps Milieu Manager by 9/15/12 The Director of Plant Operations verified all housekeeping staff has operable and keys for the lock on the cart on 7/24/12. PERSON(S) RESPONSIBLE: Director of Plant Operations Chief Nursing Officer Nurse Manager Milieu Manager Director of PI/Risk Management	8/22/12 9/15/12 7/24/12

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If continuation sheet 2 of 2

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