IN THE SUPREME COURT OF THE STATE OF NEVADA

LEE E. SZYMBORSKI, Appellant(s),

VS.

SPRING MOUNTAIN TREATMENT CENTER; AND DARRYL DUBROCA, IN HIS OFFICIAL CAPACITY, Respondent(s), Case N<u>o</u>: A700178 SC Case No: 66398

Electronically Filed Dec 15 2014 10:57 a.m. Tracie K. Lindeman Clerk of Supreme Court

RECORD ON APPEAL

ATTORNEY FOR APPELLANT LEE E. SZYMBORSKI, PROPER PERSON 4605 BLACK STALLION AVE. N. LAS VEGAS, NV 89031 ATTORNEY FOR RESPONDENT MICHAEL PRANGLE, ESQ. 1160 N. TOWN CENTER DR., STE. 200 LAS VEGAS, NV 89144

A-14-700178-C Lee Szymborski, Plaintiff(s) vs. Spring Mountain Treatment Center, Defendant(s)

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√ 5 52	1 2 3 70 4	LEE E. SZYMBORSKI 4605 Black Stallion Ave N. Las Vegas, NV 89031 (702) 609-6762 Plaintiff in Proper Person	FILED MAY 0 2 2014
	70 ⁴ 15	DISTRICT (COURT
050 V	417 ₆ F	CLARK COUNT	ΓY, NEVADA
Ύ	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	LEE E. SZYMBORSKI, Plaintiff, ys. SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive, Defendants. COMPLA COMES NOW, Plaintiff, named above, and <u>GENERAL ALL</u> 1. Plaintiff, at all times relevant hereto Nevada, County of Clark. Jurisdiction and Venue a 2. Defendant DARRYL DUBROCA is MOUNTAIN TREATMENT CENTER.	Case No. A-14-700128-C Dept No. XXX/ EXEMPT FROM ARBITRATION SUMS IN EXCESS OF \$50,000 AINT d for cause of action, alleges as follows: LEGATIONS has been and is now, a resident of the State of are appropriate in Clark County, Nevada. the CEO/Managing Director of SPRING and on that basis alleges, that Defendants
	23 24	SEAN T. SZYMBORSK1 for treatment and dischar	rged him in violation of Nevada Law.
6	25	• • • •	ther individual, corporate, associate or
	MAY 6	otherwise, of the Defendant sued herein as DOES I	I through XX, inclusive, and ROES I through
CLERK OF THE COURT		Page	
JURT			21

:

fictitiously named Defendants is in some way liable to Plaintiff on the causes of action below and
 therefore sues these defendants by such fictitious names. Plaintiff believes said fictitious
 Defendants assisted, devised, schemed, planned or took part in the actions set forth hereinbelow.
 Plaintiff will move to amend this Complaint and insert the true names and capacities of
 fictitiously named Defendants when the same have been ascertained.

5. Plaintiff is informed and believes, and thereon alleges, that at all times herein
mentioned, each actually and fictitiously names Defendant was the principal, agent, co-venturer,
partner, surety, guarantor, officer, director and/or employee of each co-defendant and in doing the
things herein alleged, was acting within the scope of authority and with the permission of each
co-defendant or took some part in the acts and omissions hereinafter set forth, and by reason
thereof, each of said Defendants is liable to Plaintiff for the relief prayed.

6. That on or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING
 MOUNTAIN TREATMENT CENTER, 7000 W. Spring Mountain Road, Las Vegas, Nevada
 89117, due an "UNAUTHORIZED UNSAFE DISCHARGE" of a mentally ill adult patient, to
 wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. See
 Exhibit "1".

7. That said SEAN T. SZYMBORSKI was provided a taxi ride, released without any
money; without appropriate medication, without the ability to care for himself, and being a
danger to both himself and other.

8. Defendant SPRING MOUNTAIN TREATMENT CENTER was directed by
 KATHLEEN BUCHANAN to provide a Guardianship for Defendant SEAN T. SZYMBORSKI,
 and failed to do so.

9. Defendant SPRING MOUNTAIN TREATMENT CENTER Caseworker
"REBECCA" was directed NOT to release SEAN T. SZYMBORSKI to the residence of
Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed
windows, walls, doors, furniture, and completely destroyed the interior of the residence, before
going missing for three weeks. (A missing persons report was filed by NLVPD.)
Page 2

1 10. An investigation by the Division of Public and Behavioral Health substantiated that
 2 Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332,
 3 Discharge Planning, based upon evidence by interview of staff, record review and document
 4 review.

5 11. It was determined that the facility failed to assure the patient was discharged to a safe
6 environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with
diagnoses including psychosis not otherwise specified and spice abuse.

b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much
trepidation about going back to the father's home. The patient was restless when talking about
the father.

c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the
address of the apartment. The MA documented the patient was vague about the address. The
patient needed to stop by the father's home to pick up patient's debit card prior to going to the
new apartment.

d. Review of the Social Services Discharge Note revealed the patient would live in an
apartment upon discharge. There was no documented evidence of an address for the apartment.
There was no documented evidence the Case Manager confirmed the patient had made
arrangements to live in the apartment.

e. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to
father's home first then on to an address in North Las Vegas, Nevada.

f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the
patient did not want to return to the patient's father's home due to ongoing conflict. The note
documented the patient participated in treatment planning to find housing.

g. The Risk Manager investigated a telephone complaint from the patient's father. The
Administrative Review documented placement to the apartment was not verified.

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h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on
verifying the identified apartment.

i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone
messages were left by the patient's father. The father would state the patient could return to the
home; the next telephone message from the father would demand the patient not be discharged to
the father's home. The LSW acknowledged she did not speak directly with the patient's father.
The LSW stated due to the large number of patients on the LSW's caseload, the LSW had to
delegate telephone calls and discharge planning to the MA.

j. The LSW indicated when a patient identified their own placement, the LSW would try
to obtain as much information as possible regarding the address and name of the apartment. If
unable to verify placement, the physician would be notified prior to discharge from the facility.

k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented
the patient did not want to return to his father's home due to ongoing conflict. The note
documented the patient participated in treatment planning to find housing.

15 12. An evaluation of the needs of a patient relating to discharge planning must include,16 without limitation, consideration of:

a. The needs of the patient for postoperative services and the availability of thoseservices.

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b. The capacity of the patient for self-care; and

c. The possibility of returning the patient to a previous care setting or makinganother appropriate placement of the patient after discharge.

13. Defendant SPRING MOUNTAIN TREATMENT CENTER is in violation of NAC
449.394, Psychiatric Services, which requires that a hospital shall develop and carry out policies
and procedures for the provision of psychiatric treatment and behavioral management services
that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and
services are safely and appropriately used. The hospital shall ensure that the policies and
procedures protect the safety and rights of the parties - and the public at large.

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14. That Defendant SPRING MOUNTAIN TREATMENT CENTER has failed to met these statutes and regulations, for the reasons set forth above.

15. That due to the failure to meet these responsibilities, SEAN T. SZYMBORSKI, was
driven by taxi to the home of Plaintiff, and dropped off, at the expense of the Defendant SPRING
MOUNTAIN TREATMENT CENTER, where he proceeded to cause significant property
damage to Plaintiff's residence, and go missing.

7 16. That when SEAN T. SZYMBORSKI was located, he had sustained wounds from a
8 self inflicted injuries with a sharp object, using weapons obtained at the home of his mother; and
9 not at the home of his father.

10 17. The patient care plan, dated 5/14/13 indicated that safety concerns, including
11 weapons, in the patient's home were non-applicable and verified by the patient's father. There
12 was no documented evidence the patient's father was contacted for verification. Furthermore,
13 Defendant SPRING MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a
14 home for SEAN T. SZYMBORSKI, therefore, even confirming no weapons in father's home was
15 not reasonable to consider this non-applicable.

16 18. In violation of the stated statutes, it was determined that the LSW did not follow up
on identifying what weapons and if the patient had access to weapons prior to discharge. (8.0
Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining
permission and contacting any person that may be able to located and secure items...Weapons are
not considered secured until verification has been received that the task is completed...")

19. Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER,
 SEAN T. SZYMBORSKI was convicted of criminal charges related to the property destruction at
 the home of Plaintiff, rather than receiving treatment for his known mental illness.

24 20. Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless
25 disregard of SEAN T. SZYMBORSKI's psychiatric condition in pre-paying for a taxi to dump
26 him at an verified location [Plaintiff's residence], without notice to occupants, without money,
27 and without the ability to provide care for himself due to long standing mental illness.

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21. The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver
 the statutory mandated care to patients in their custody and control resulted in systematic
 disregard of the serious psychological and medical conditions and resulted in adverse
 consequences, which predictably flow from such failures, and caused damages to patients and
 others, who became victims of such disregard.

22. Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit
corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS
(\$2,000,000,000).

FIRST CLAIM FOR RELIEF

(NEGLIGENCE)

23. Plaintiff realleges and incorporates by reference all of the previous allegations of
this Complaint at this point as if set forth fully herein.

13 24. Nevada recognizes negligence claims, where a Plaintiff establishes: (1) the
14 existence of a duty of care (2) breach of that duty; (3) legal causation; and (4) damages.

15 25. Defendants, in the exercise of reasonable care had a duty to know, or should have
16 known, that they are required to comply with NAC 449.332, regarding DISCHARGE PLAN of
17 Patients; and with NRS 449.765 to 449.786.

Defendants breached their duty by failing to carefully investigate, monitor and/or
 oversee discharge activities at SPRING MOUNTAIN TREATMENT CENTER, including but
 not limited to, the development, implementation, and supervision of discharge policies and
 practices.

22 27. That Defendants negligently and/or carclessly, permitted the dumping of SEAN T.
23 SZYMBORSKI, by taxi to the home of Plaintiff, without notice to Plaintiff, in violation of their
24 own internal policies; NAC 449.332; and NRS 449.865 to 449.786.

25 28. Defendants knew or should have known that patients, including SEAN T.
26 SZYMBORSKI are members of the class of patients that could foreseeably suffer injury to
27 themselves, and/or inflict injury on others, as a result of Defendants' failure to exercise

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reasonable care in the discharge of their statutorily imposed duties, and/or common-law duties of
 care.

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3	29. As a direct and proximate result of the negligence and carelessness of Defendants,
4	Plaintiff has suffered extreme emotional and mental distress, further issues and conflict in the
5	family unit, in addition to approximately \$20,000 in physical damage to the residence, including
6	smashed windows, which required immediate action to secure assets in the residence, and other
7	damages the full extent of which shall be provided through discovery.
8	30. As a direct and proximate result of Defendants' acts or omissions, Plaintiff has
9	suffered punitive, general and special damages.
10	SECOND CLAIM FOR RELIEF
11	(Professional Negligence)
12	(Negligent act or omission to act by a provider of health care in rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death,
13	NRS 41A.015)
14	31. Plaintiff realleges and incorporates by reference all of the previous allegations of
15	this Complaint at this point as if set forth fully herein.
16	32. Defendants in the capacity of a for profit hospital providing medical care to the
17	public, government agencies overseeing the hospital's operations, licensed social workers,
18	registered nurses, psychiatrists, and the hospital administrator owed Plaintiff a duty to employ
19	medical staff adequately trained in the care and treatment of patients consistent with the degree
20	of skill and learning possessed by competent medical personnel practicing in the United States of
21	America under the same or similar circumstances; and a duty to comply with Nevada statutes,
22	including NRS 41A.015.
23	33. Defendants breached its duty of care by failing to function as a patient advocate by
24	providing proper care to the patients at the time of discharge, and specifically causing physical,
25	mental and emotional pain and suffering to the patient; as well as physical, mental and emotional
26	pain and suffering to the public at large, and specifically in this matter, to the Plaintiff.
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28	Page 7

THIRD CLAIM FOR RELIEF (Malpractice, Gross Negligence, Negligence Per Se) 3 34. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein. 35. "Malpractice" in the practice of social work means conduct which falls below the standard of care required of a licensee under circumstances which proximately causes damage. "Gross Negligence" in the practice of social work means conduct which represents an extreme departure from the standard required of a licensee under the circumstances and which proximately caused damage. NAC 641B.225, pursuant to 42 C.F.R.§ 482.61, Defendants had a

10 duty to properly discharge patients in compliance with NAC 449.332, relating to discharge 11 planning.

12 36. That Defendants including JOHN DOE 1 in the capacity of Licensed Social Worker 13 (LSW) is entrusted to provide medical care owed to patients and a duty to provide adequate 14 medical treatment, to protect the patient and the public at large. Said Defendant breached the 15 duty of care by discharging the patient, paying for a taxi only to Plaintiff's address (although the patient asked to pick up a debit card, then be transported to another residence), in violation of 16 17 discharge policies and procedures, pursuant to NAC 449.332. As a proximate result of the 18 negligence of Defendants, the patient and public at large are subject to physical, mental and 19 emotional pain, in addition to financial loss, such as Plaintiff has sustained.

20 37. The conduct of Defendants was in wanton, extreme and total disregard of the legal 21 and statutory obligations to patients and the public at large, and constitutes gross, reckless, 22 oppressive and/or outrageous disregard for the consequences of their actions. As a proximate 23 result of the negligence of Defendants, Plaintiff has suffered physical, mental and emotional pain, 24 in addition to financial damages.

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Page 8

1 FOURTH CLAIM FOR RELIEF 2 (Negligent Hiring, Supervision and Training) 3 38. Plaintiff realleges and incorporates by reference all of the previous allegations of 4 this Complaint at this point as if set forth fully herein. 39. At the times mentioned herein, Defendants knew, or in the exercise of reasonable 5 care should have known, that the provisions of medical care and treatment was of such a nature 6 7 that, if it was ot properly given, it was likely to injure the persons to whom it was given. 8 Defendants owed a duty to its patients, and the community at large, to hire, train, and/or 9 supervise competent medical and staff personnel, including supervisors, and LSW, to provide 10 care and treatment to its patients. 11 40. Defendants breached that duty of care by failing to adequately provide competent employees, in the performance of the job, as it appears dumping patients is an ongoing problem. 12 13 41. At all times herein mentioned, Defendants established and/or followed, unsafe 14 medical practices, including "dumping" patients without complying with discharge instructions. 42. As a result of the lack of medical care and treatment provided by Defendant, 15 16 Defendants breached their duty to Plaintiff and the members of the class by failing to protect 17 them from foreseeable harm, resulting in a lack of mental health treatment for Plaintiff and the 18 public at large. 19 43. As a direct and proximate result of the negligence and carelessness of Defendants, 20 Plaintiff has been injured financially, as well as mentally and emotionally in this matter. 21 44. Defendants conduct demonstrated a conscious disregard of known accepted procedures, protocols, care and treatment, all with the knowledge or utter disregard that such 22 23 conduct could or would expose Plaintiff to harm as set forth herein. 24 45. Defendants conduct was willful, reckless, malicious, and in total disregard to the 25 health and safety of not only the patient, but the public at large, thereby justifying an award of 26 punitive damages. 27 28 Page 9

1	46. As a direct and proximate result of the conduct of Defendants, Plaintiff has suffered
2	mental and emotional pain and suffering, in addition to financial loss.
з	WHEREFORE, Plaintiff prays judgement as follows:
4	1. For a temporary restraining order and/or preliminary injunction and permanent
5	injunction enjoining and restraining Defendants from continuing or repeating the unlawful
6	polices, practices and conduct complained of herein;
7	2. For declaratory judgment against Defendants' policies, practices and conduct as
8	alleged herein in violation of patient rights, and the safety of the public at large;
9	3. For compensatory damages according to proof;
10	4. For punitive damages in consideration of the annual income in excess of
11	\$2,000,000,000.
12	5. For emotional distress caused by the violations herein.
13	6. For costs of suit, including attorney fees, and other costs.
14	7. For such other and further relief as the Court may deem appropriate.
15	DATED this day of, 2014.
16	(Are)
17	LEE E. SAY MBORSKI Plaintiff in Proper Person
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EXHIBIT 1

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MICHAEL J. WILLDEN Director



RICHARD WHITLEY, MS Administrator

TRACEY D. GREEN, MD State Health Officer

STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH DIVISION

Health Fadilities/Lab Services 727 Fair/New Dr, Suite E Carson City, Nevada 89701 (775) 684-1030 Fax: (775) 684-1073

Heefth Facilities/Lab Services 4220 S. Maryland Parkway Sulte B10, Building D Las Veges, NV 89119 (702) 486-5515 Fax: (702) 488-6520

Radiation Control 4150 Technology Way Suite 300 Carson Cty, Nevada 89706 (775) 687-7550 Fox: (775) 687-7552

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 2080 €. Flamingo
 Suite 319
 Las Vegas, Nevada 89119
 (702) 486-5280
 Fax: (702) 486-5024

Child Care Licensing 727 Feinkew Dr, Suito E Carson City, Nevada 89701 (775) 584-4463 Fax: (775) 684-4464

Child Cere Licensing 4180 S. Pecos, Ste 150 Las Vegas, Nevada 89121 (702) 485-7918 Fax: (702) 485-6560

Child Care Licensing 1010 Ruby Vista, Ste 101 Elko, Nevoda 89801 (775) 753-1237 Fax: (775) 753-1336 May 22, 2013

Lee Szymborski 4605 Black Stallion Avenue North Las Vegas, NV 89032

RE: Complaint # NV00035655

Dear Mr. Szymborski,

Thank you for alerting us about your dissatisfaction with Spring Mountain Treatment Center. We understand your concerns about admission, transfer and discharge, quality of care-responsible party not notified of patients change in condition, patient not assessed after change in condition, patient's medications improperly administered.

Our team of investigators will review your specific concerns, and evaluate the facility's actions, to determine if the facility is in compliance with state and/or federal regulations. Please refer to the enclosed fact sheet that describes the investigation process.

We will inform you of the investigation results, and send you a copy of the report. If you want to know the status of your complaint, please call the team supervisor, Rosemary Palladino-Marcus, HFI III, and refer to the complaint number listed above.

Please know that the Nevada State Health Division takes all complaints very seriously. By reporting your concerns, you play an important role in promoting the safety of health care recipients and improving the quality of care and services that facilities provide. We thank you.

Sincerely,

Mei Ax.

Johna Thacker, AAII/Complaint Intake Coordinator

cc: Rosemary Palladino-Marcus, Health Facilities Inspector III

Encl: 1 Page Complaint Process Fact Sheet

Public Health Working for a Safer and Healthier Nevada

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		NVS3268HOS1	8. WING	07	7/09/2013	
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PRING N	OUNTAIN TREATMENT	CENTER	EST SPRING MOUN	TAIN ROAD		
(X4) ID	SUMMARY ST		GAS, NV 89117	PROVIDER'S PLAN OF	CORRECTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(XS) Comple Date
S 000	Initial Comments		S 000			
:	a result of a complain 6/25/13, and finalized	ficiencies was generated as t investigation initiated on i in your facility on 7/9/13, in ada Administrative Code, I.				
7	The census at the tim 63. Five discharged n reviewed.	e of the investigation was nedical records were				
	•	655 was substantiated with ee Tags S0148, S0153 and				
-	by the Health Division prohibiting any crimin actions or other claim	clusions of any investigation a shall not be construed as al or civil investigations, s for relief that may be under applicable federal,				
S 146 SS=D	NAC 449.332 Discha	rgə Planning	S 146			
	to discharge planning limitation, consideration	e needs of a patient relating must include, without on of: patient for postoperative				
	services and the avai (b) The capacity of th	ability of those services; e patient for self-care; and eturning the patient to a				
	appropriate placemen discharge. This Regulation is no	it of the patient after it met as evidenced by:				
	Based on interview, n	ecord review and document ed to assure the patient was environment for 1 of 5				

STATE FORM

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If continuation sheet 1 of 9

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
NVS3268HOS1		B. WING		07	/09/2013	
AME OF PI	ROVIDER OR SUPPLIER	STREET #	DDRESS, CITY, STATE	ZIP CODE		
PRING N	OUNTAIN TREATMENT	CENTER	EST SPRING MOUN GAS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
S 146	Continued From page	e 1	S 146			
	Findings include:					
	Patient #1					
		ted to the facility on 5/3/13 14/13 with diagnoses				
		ot otherwise specified and				
	On 5/13/13 at 1:00 P Note documented the	M, the Nu <i>r</i> sing Progress e patient had much				
		ng back to the father's home. ess when talking about the				
		M, the Masters of Art (MA) mel with the patjent to				
	confirm the address of	of the apartment. The MA ent was vague about the				
		needed to stop by the	· · · · · ·			
		up the patient's debit card				
		Services Discharge Note				
	-	vould live in an apartment re was no documented	[[
ľ		ss for the apartment. There				
		evidence the Case Manager				
	confirmed the patient live in the apartment.	had made arrangements to				
		are Plan, dated 5/14/13,				[
		was to go to the father's				
	home first then on to Vegas.	an address in North Las				Ì
		Discharge Progress Note,				2
1		A, documented the patient				
[home due to on-going	to the patient's fathers				

STATE FORM

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If continuation shoet 2 of 9

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	f of deficiencies Of correction	(X1) PROVIGER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			SURVEY PLETED
		NVS3268HOS1	B. WING	07	/09/2013	
IAME OF PI	ROVIDER OR SUPPLIER	STREET /	NDORESS, CITY, STATE	, ZIP CODE		
PRING N	IOUNTAIN TREATMENT	CENTER	EST SPRING MOUN GAS, NV 89117	TAIN ROAD		
(X4) ID		ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF C	ORRECTION	(03)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTA CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLE" DATE
S 146	Continued From page	e 2	S 146	<u> </u>		
	documented the patie planning to find hous	ent participated in treatment ing.				
	complaint from the pa					
	Administrative Review documented placement to the apartment was not vertiled. On 7/9/13 at 8:49 AM, the Risk Manager confirmed the MA did not follow up on verifying					
	the identified apartme	·				
		M, Licensed Social Worker multiple telephone messages				
	were left by the patie	nt's father. The father would				
		d return to the father's home. nessage from the father				
	would demand the pa	atlent not be discharged to				
ŀ		e LSW acknowledged she				
		Juring the first meeting with				
		nt expressed a willingness to				
Í		home and would work on from the father's home. The				
		o the large number of				
	patient's on the LSW	's case load, the LSW had to				Í
	delegate telephone c to the MA.	alls and discharge planning				
	•	when a patient identified their				
		SW would try to obtain as possible regarding the				
		the apartment. If the LSW				
	was unable to verify p	placement, the physician				
	would be notified prior facility.	r to discharge from the				Ì
l l	Continuing Care Plan					
	Interdisciplinary Polic documented:	y #PC.067, revised 4/13,				

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BLALDING:		(X3) DATE SURVEY COMPLETED		
	NV53268HO51		B. WING		07	/09/2013
AME OF PR	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE		
PRING M	IOUNTAIN TREATMENT	CENTER	ST SPRING MOUN GAS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (OF CORRECTION	(X6)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
S 146	Continued From pag	e 3	S 146			
	Procedure:					
	following is evaluated	the continuing care plan, the d by the Case Manager 4.4 or placement issues;4.8 stems*		-		
	to the patient and far					
	completed for every (Includes, but is not limited				
	Severity: 2	Scope: 1				
	Complaint #NV00035	5655				
S 153 SS=D	NAC 449.332 Discha	rge Planning	S 153			
	patient and any other for the patient must b	nbers of the family of the person involved in caring the provided with such essary to prepare them for the patient.				
	Based on Interview, r review, the facility fai	ot met as evidenced by: ecord review and document led to notify 2 of 5 sampled r to discharge (Patient #1				

encies are clied, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. if de 6899

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If continuation sheet 4 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. GUILDING:			e survey Pleted
		NVS3266HOS1	8. WING		07	/09/2013
AME OF PI	ROVIDER OR SUPPLIER		NDORESS, CITY, STATE EST SPRING MOUN			
PRING N	IOUNTAIN TREATMENT	CENTER	GAS, NV 89117			
(X4) ID PRIEFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE	(XS) COMPLET QATE
S 153	Continued From pag	e 4	S 153			
	Findings include:					
	Patient #1					
		Ited to the facility on 5/3/13				
		/14/13 with diagnoses not otherwise specified and				
	spice abuse.					
		M, the LSW #2 documented				
	•	ceived a voice mail from the				
		The LSW documented the				
	case manager would	l assist the patient with				ļ
	alternative placemer	nt.				
	On 5/10/13 at 11:15	AM, the MA documented the				
	•	ed the patient to return to his				
	home, but not to be	discharged "today".				
		r documented evidence the				
	patient's father was discharge to the pati					
	discrizige to the pau	onto lautoro ficinio.				
		M, the MA documented the				
		ent. The patient requested e number and told the father				
	•	and a taxi would transport				
	the patient to the fail	her's home.				
	The Risk Manager in	vestigated a telephone				
	complaint from the p					
	Administrative Revie was not coordinated	w documented the discharge with the family.				
		the father on the day of				
	discharge was not d	ocumented.				
	On 7/9/13 at 9:50 AM					
	acknowledged the fa	cility should have arranged				

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if continuation sheet 5 of 9

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Olvision o	of Public and Behavior	al Health				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING: "		COMPLETED	
		NVS3268HC81	B. WING	·····	07/01	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STA			
		7000 WÉ	ST SPRING MO			
SPRING N	IOUNTAIN TREATMENT	CENTER	GAS, NV 89117			
Q4) (D	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N Í	(7.5)
PREFIX	-	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORT OR (SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HIATE	DATE
			·			
S 153	Continued From page	95	S 153			
	house until the patien	t retreived the debit card,			ļ	
	then drive the patient	to the new apartment.				
		M, LSW #2 explained the	1			
		t be contacted prior to the essure the family was	l i		ł	
		t returning home. The LSW	1		[
	T	tient's father should have				
		e facility staff prior to the				
	patient being discharg	ged.				
		arged medical records were				
	reviewed,					
	Patient #5					
Į						
	Patient #5 was admitt	ed to the faciity on 6/4/13				
		18/13, with a diagnosis of				
[major depressive disc	order.				
	There was no docum	ented evidence the social				
		r notified the family of the				
		here was no documented			1	
		as educated on the patient's				
		w up care needed. There			Í	
	was no family contact					
	worker/Case Manage	r after 6/6/13.				
	Continuing Care Plan	Diechome Planning	1			
		y #PC.067, revised 4/13,				
ĺ	documented:	,,				
	Procedure:					
	• <u>404</u>					
		he continuing care plan, the by the Case Manager4.8	!			
	Personal support syst					
ĺ						i
	"5.0 Continuing care	e plans are communicated				
		ily/guardian, as appropriate,				
d officiencies a	an alter have an annual alter a	of connection must be returned within 40.		lable at how and all all all all and a		

icles are cited, an approved plan of correction must be ratemed within 10 days after receipt of this statement of deficiencies, ORM 00KP11

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If continuation sheet 6 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CA	DNSTRUCTION	(X3) DATE COMPI	
	NVS3268HOS1	B. WING		87/	09/2013
ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
OUNTAIN TREATMEN	T CENTER		TAIN ROAD		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 6	S 153	· · · · ·		
and documented in	the medical record"				
Severity: 2	Scope: 1				
Complaint #NV0003	35655				
NAC 449.394 Psych	niatric Services	S 602			
and procedures for treatment and beha that are consistent inclusive, to ensure services are safely hospital shall ensure	the provision of psychiatric vioral management services with NRS 449.765 to 449.786, that the treatment and and appropriately used. The e that the policies and				
Based on interview, review, the facility fa were at Patient #1's	record review and document ailed to identify what weapons mother's home and if the				
Findings include:					:
Patient #1					
and discharged on a	5/14/13 with diagnoses				
Assessment Tool do multiple scab areas Comprehensive Ass	ocumented patient had on his legs. The ressment Tool documented stated the patient's wounds				
	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER IOUNTAIN TREATMEN SUMMARY'S (EACH DEFICIEN REGULATORY OF Continued From para and documented in Severity: 2 Complaint #NV0003 NAC 449.394 Psych 3. A hospital shall d and procedures for treatment and beha that are consistent with inclusive, to ensure services are safely i hospital shall ensure procedures protect is patient. This Regulation is a Based on interview, review, the facility favore at Patient #1's patient would have i Findings include: Patient #1 Patient #1 Patient #1 Patient #1 Patient #1 Patient 12:00 I Assessment Tool do multiple scab areas Comprehensive Asse	F CORRECTION IDENTIFICATION NUMBER: NV53268HOS1 NV53268HOS1 ROVIDER OR SUPPLIER STREET/ NOUNTAIN TREATMENT CENTER 7000 WI LAS VE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 and documented in the medical record" Severity: 2 Scope: 1 Complaint #NV00035655 NAC 449.394 Psychiatric Services 3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility failed to identify what weapons were at Patient #1's mother's home and if the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility failed to identify what weapons were at Patient #1's mother's home and if the patient would have access to the weapons. Findings include: Patient #1 Patient #1 Patient #1	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: NV53268HOS1 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT CENTER 7000 WEST SPRING MOUNLAS VEGAS, NV 89117 Image: Supplier in the state of the	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: NV53268HOS1 B. WING ROWDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2P CODE NUMARY STATEMENT CENTER TOO WEST SPRING MOUNTAIN ROAD LAS VEGAS, NV 80117 SUMMARY STATEMENT OF DEPICIENCES (#Ach DEFICIENCY MUST BE PRECEDEN BY FAIL D REGULTION OR LS: DEMTIFYING INFORMATION D Continued From page 6 \$ 153 and documented in the medical record* Severity: 2 Severity: 2 Scope: 1 Complaint #NV000035655 S 602 3. A hospital shall develop and carry out policies and procedures for the provision of psychlatric treatment and behavioral management services at safety and appropriately used. The hospital shall ensure that the treatment and behavioral management services are safety and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. This Regulation is not met as evidenced by: Based on interview, necord review and document review. Patient #1 Patient #1 Patient #1 Patient #1 Patient #1 Patient #1 was admitted to the facility on 5/3/13 and discharged on 5/14/13 with diagnoases including psychosis not otherwise specified	PE CORRECTION IDENTIFICATION NUMBER: A BUILDING:

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If continuation sheet 7 of 9

STATEMENT OF GERIGENCIES RM PROVIDER OR SUPPLIEVUAL DESTINCTION NUMBER: COLUME TORUSTON A BULDING COLUME TORUSTON A BULDING COLUME TORUSTON A BULDING COLUME TORUSTON A BULDING COLUME TORUSTON COLUME TORUSTON TORUSTON SUPPLIER STREET COLUMES; TORUSTON TORUSTON TORUSTON TORUSTON SUPPLIER STREET COLUMES; TORUSTON TORUSTON TORUSTON TORUSTON SUPPLIER STREET COLUMES; TORUSTON TORUSTON TORUSTON SUPPLIER STREET COLUMES; TORUSTON SUPPLIER STREET COLUMES; TORUSTON SUPPLIER D STREET COLUME SUPPLIER STREET COLUMES; TORUSTON SUPPLIER D STREET COLUME SUPPLIER D STREET COLUME SUPPLIER <th>Division g</th> <th>of Public and Behavion</th> <th>al Health</th> <th></th> <th></th> <th>· · · · · · · · · · · · · · · · · · ·</th>	Division g	of Public and Behavion	al Health			· · · · · · · · · · · · · · · · · · ·
NAME OF ROMORER OR SUPPLIER Introduction Unitial statement Unitial statement SPRING MOUNTAIN TREATMENT CENTER Introduction Introduct	· · · · · · · · · · · · · · · · · · ·					
SPRING MOUNTAIN TREATMENT CENTER TODA WEST SPRING MOUNTAIN ROAD LAS VEDAS, NV BYIT PAY ID PRETRY TAC SUMMARY STATEMENT OF SPRICEUDS PLAN (EACH CORRECTION CALLS) THE PRECEDED BY FULL REGULTORY ON USC DENTIFYING INFORMATION) The PRETRY TAC PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIC ACTION SHOLD BE CORRECTION TO SHOLD BE CORRECTION TO SHOLD BE CORRECTION TO SHOLD BE CORRECTION TO LEACH CORRECTION TO SHOLD BE CORRECTION TO INFORMATION ON USC DENTIFYING INFORMATION) The PRETRY TAC PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION THE ACTION SHOLD BE CORRECTION TO LEACH CORRECTION TO INFORMATION ON USC DENTIFYING INFORMATION) The PRETRY TAC PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION THE ACTION SHOLD BE CORRECTION THE ACTION TO LEACH CORRECTION TO INFORMATION ON USC DENTIFYING INFORMATION) The PRETRY TAC PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION THE AST CORRECTION SHOLD BE CORRECTION TO INFORMATION OF THE DESCRIPTION OF THE AST ONTED THE AST ONTE DESCRIPTION OF THE AST ONTED THE ACTION TO THE AST ONTED THE ACTION TO INFORMATION OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST OF THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTED THE AST ONTE			NVS3268HOS1	B. WING		07/09/2013
SPRING MOUNTAIN TREATMENT CATER LAS VEGAS, NV 59117 (x) (b) PRETX TAS SUMMARY STATEMENT OF ZEPCIENCIES (EXCH CORRECTIVE AUXTER MERCIPER BY FLAM REGULTORY DATA IS 2 DENTIFYING BEFORMATION REGULTORY PRETX (EXCH CORRECTIVE AUX OF CORRECTION REGULTORY) ON SECONDENTIFYING BEFORMATION REGULTORY Continued FOR DENTIFYING CONDENTIFYING	NAME OF P	ROMDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CAS VEGAS, NV 59117 Operation Description PREFIX REGULTORY ON DEFICIENCIES Display REGULTORY ON LECTORY ON DEFICIENCIES Display PREFIX TAG REGULTORY ON LECTORY ON LECT			CENTER 7000 WE	ST SPRING MOU	INTAIN ROAD	
Prefer (EACH DEFIDENCY MUST RE PRECEDD BY FULL REGULATORY OR LISC DENTIFYING NFORMATION) Prefer To To (EACH CORRECTIVE ACTION BROMBUTON) Configuration Configuration <thconfiguration< th=""> Configuration</thconfiguration<>			LAS VEG	AS, NV 89117		
On 56/13 at 2:42 PM, LSW #1 documented weapons were at the patient's mothers home, but not at the patient's fathers home. The LSW did not identify what weapons were at the patient's mothers home. There was no documented evidence the patient's mother was contacted to verify where the weapons were located. Patient Continuing Care Plan, dated 5/14/13, lidentified safety concerns, including weapons in the patient's home were non-applicable and varified by the patient's father was no documented evidence the patient's father was contacted for verification. On 5/14/13 et 2:30 PM, the MA documented the patient asked the MA if the taxi would be able to take the patient to the mother's house. On 7/14/13 et 2:30 PM, the MA documented the patient went to the father's house. On 7/14/13 et 2:40 AM, the Risk Manager confirmed the patient would have to pay for any taxi after being dropped off at the father's house. On 7/19/13 at 8:49 AM, the Risk Manager confirmed the LSW did not follow up on identifying what weapons and if the patient had access to the weapons, prior to discharge. Continuing Care Plan Discharge Planning, ittardsciplinary Policy #PC.067, revised 4/13, documented: "8.0 Securing WeaponsSocial Services staff initiates attempts to secure the weapons, obtaining permission and contacting any person that may be able to locate and secure the ltermsWeapons are not considered secured until verification has been received that the tax is is	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPROP	BE COMPLETE
 weapons were at the patient's mothers home, but not at the patient's fathers homs. The LSW did not identify what weapons were at the patient's mothers home. There was no documented evidence the patient's mother was contacted to verify where the weapons were located. Patient Continuing Care Plan, dated 5/14/13, identified safety concerns, including weapons in the patient's mothers applicable and verified by the patient's father. There was no documented evidence the patient's father was contacted for verification. On 5/14/13 et 2:30 PM, the MA documented the patient asked the MA if the taxi would be able to take the patient to the mother's house after the patient wask to the father's house. The MA documented the patient would have to pay for any taxi after being dropped off at the father's house. On 7/8/13 at 8:49 AM, the Risk Manager confirmed the LSW did not follow up on identifying what weapons and if the patient had access to the weapons prior to discharge. Continuing Care Plan Discharge Planning, Interdisciptionry Pelicy #PC.087, revised 4/13, documented: *8.0 Securing WeaponsSocial Services staff initiates attempts to secure the weapons, obtaining permission and contacting any person that may be able to locate and secure the lemsWeapons are not considered secured until verification has been received that the tax is is 	S 602	Continued From page	97	S 602		
		weapons were at the not at the patient's fait not identify what wear mothers home. There evidence the patient's verify where the weap Patient Continuing Ca- identified safety conc the patient's home we verified by the patient documented evidence contacted for verificat On 5/14/13 et 2:30 Pf patient asked the MA take the patient to the patient asked the MA take the patient to the patient went to the fail documented the patient taxi after being dropp On 7/9/13 at 8:49 AM confirmed the LSW dI identifying what weap access to the weapor Continuing Care Plan Interdisciplinary Polic documented: "8.0 Securing Weapol initiates attempts to si obtaining permission that may be able to lo itemsWeapons are verification has been	patient's mothers home, but thers home. The LSW did pons were at the patient's a was no documented s mother was contacted to pons were located. are Plan, dated 5/14/13, erns, including weapons in ere non-applicable and t's father. There was no e the patient's father was tion. W, the MA documented the if the taxi would be able to e mother's house after the ther's house. The MA ant would have to pay for any ed off at the father's house. I, the Risk Manager id not follow up on tons and if the patient had ts prior to discharge. Discharge Planning, y #PC.067, revised 4/13, nsSocial Services staff ecure the weapons, and contacting any person to ate and secure the not considered secured until			

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

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If continuation sheet, 8 of 9

If continuation sheet 9 of 9

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Division of	Division of Public and Behavioral Health					1.0720
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			
AND FLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			8. WING			
	······································	NVS3268HOS1			07/09/2013	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
SPRING N	IOUNTAIN TREATMENT	CENTER	EST SPRING MOUN GAS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO		
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FILED APPL 1 Zymborski Illion Ave. MAY 0 2 2014 2 NAME 3 COURT 4 5 6 TELEPHONE 7 ÌN PROPER PERSON 8 9 DISTRICT COURT **CLARK COUNTY, NEVADA** 10 =. Szymbocsk Plaintifi 11 lee 12 <u>-700</u>178-C Case No. 13 (eAT ment e Tee Dept. No. Spring Mourner 14 IN his OFFICIAL CAPACITY 15 Defendant / , Notusive aND ROE Corporations 16 ATION TO PROCEED INFORMA PAUPERIS 17 (Filing Fees/Service Only) 18 RS 12.015, and based on the following Affidavit, I request 19 permission from this Court to proceed without paying court costs or other costs and fees 20 as provided in NRS 12.015, because I lack sufficient financial ability. 21 22 23 24 25 26 A-14-700178-C 27 PIFP Application to Proceed in Forma Paoperis 02 20H Clark County Civil Resource Center ALL RIGHTS RESERVED 1 Civil-IFP Costs/Fees u:\CRC\fee_w aiver\packet_8\appfeewaiver_0501.wpd

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CLERK OF THE COURT

1	AFFIDAVIT	
2	STATE OF NEVADA	
3) ss. COUNTY OF CLARK)	
4		
5	I, lee E, Szymbol (Kafter being duly sworn, depose and state as follows:	
6	I wish to file with this Court the pleading submitted with this Application. I cannot	
7	pay the filing fees and costs of this action because I lack sufficient income, assets, or	
8	other resources. Including myself, there are adults and children	
9	age(s) if my household. My total monthly income is: $2/68$ (O	
10	My total monthly income is: 27.68 , ∞	
11 12	From all sources including employment, self-employment, social security, child	
12	From all sources including employment, self-employment, social security, child support, etc Any other household income from another member of the household is $s \underline{400}, \underline{00} (\text{-th} \cdot s \text{-mosth}), \text{-mosth}, \text{-mosth}), \text{-mosth}, \text{-mosth}), \text{-mosth}, \text{-mosth}), $	\mathbf{h}
14	NOT Dege viole	Ι
15	My employer is <u>permononty</u> Disa Ben located at	
16	, my job title i	
17	The following represents a list of all of my assets and their value:	
18	· · · · · · · · · · · · · · · · · · ·	
19 20	Automobile Value Loan Balance 1978 0 9 YEAR, MAKE, AND MODUE \$ 200	
21	Mobile Home, House or Other Real Estate	
22	25TOR4 (abrul 1989, 125,000 5	
23	SIZE, TYPE, AND YEAR	
24	Bank Accounts Value Loan Balance	
25	NAME OF BANK AND TYPE OF ACCOUNT \$ \$	
26	NAME OF BANK AND TYRE OF ACCOUNT \$ \$	
27	Other	
28	DESCRIPTION \$\$	
	© Clark County Civil Resource Center 2 ALL RIGHTS RESERVED Civil-IFP Costs/Fees u:\CRC\fee_w aiver\packet_8\appfeewaiver_0501.wpd	
	Civil-IFP Costs/Fees u:\CRC\fee_w aiver\packet_8\appfeewaiver_0501.wpd	

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	e.		<u>م</u>		
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2		<u> </u>	*		
3	The following represents my total monthly ex	penses:			
4	Rent or Mortgage		\$_720.37	<u> 75</u> ¥]
5	Phone, Gas, Electricity, and Other Utilities	· · · · · · · · · · · · · · · · · · ·	\$ 3 \$5, 5	/	1
6	Food		\$_500-00		-
7	Child Care	<u> </u>	\$		-
8	Insurance		\$_20,~0		
9	Medical		\$_140,00		1
10	Transportation		\$ 280 0	,	1
11	Other: Auto Insurance		\$		
12	None	-	\$ 220,00	NOMP	in er.
13		Øxe s I	\$ 2823.	73/]
14	TOTAL MONTHLY EXPENSES				ļ
15	I request the Court hold a hearing on this Ap	plication if the	Court is inclined	to denv	
16	same, so that I may testify as to my indigent				
17	that the foregoing is true and correct.	_			
18		$\langle \rangle$	ろく		
19	·		<u> </u>		
20			ature/		
21		1			
22		V			
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24					
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	© Clark County Civil Resource Center 3 Civil-IFP Costs/Fees	u: \CRC\fe	ALL RK e_w aiver\packet_8\appfed	SHTS RESERVED	

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			FILED 24 MAY 2 0 2014
·	1		MAY 2 U ZUIY
	2	ORDR	CLERK OF COURT
	3		AL DISTRICT COURT
	4	CLARK CO	UNTY, NEVADA
	5 6	LEE SZYMBORSKI Plaintiff,	
	7	VS.	Case No. A-14-700178
	8	Spring Mountain Treatment Center	Dep't No. XXXI
	9	Defendant.	
	10		
	11		PART PETITIONER'S APPLICATION TO PROCEED IN
	12		Lee Szymborski's Application to Proceed In Forma
	13	Pauperis and all information therein submitted	
	14	ORDERS the Application GRANTED I	
	15		, Petitioner contacted Department IX chambers to
	16		ount of \$270.00 that Petitioner paid on May 2, 2014. ¹
	17	•	unds of filing fees paid, and this Court cannot issue a
	18	nunc pro tunc order in this situation. The \$270	.00 fee therefore stands paid, and Petitioner's request
	19	for a refund is DENIED. However, in light of	of Petitioner's income amount, and after taking into
	20 E	consideration the expensive nature of protracted	l litigation, this Court GRANTS the Application as to
0 ₹	BUDO	all future fees.	
elved 0 2014	THEN	1	
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OGLLA UDGE NT IX		1	
JENNIFER TOGLIATTI DISTRICT JUDGE MAY 2 0 2014 DEPARTMENT IX	2 7	This Court notes that Department IX staff attempted to	communicate the contents of this order to Petitioner on May
JENN Diste Depa	28		ioner's application. Despite several attempts, no phone contact
			A – 14 – 700178 – C ORDG Order Granting
			1 3817199

Therefore, IT IS HEREBY ORDERED that Petitioner's Application to Proceed In Forma Pauperis is GRANTED IN PART and DENIED IN PART. F _ of May, 2014. DATED this _ Deglant INIFER GLIATTI CHIEF DISTRICT COURT JUDGE JENNIFER TOGLIATTI DISTRICT JUDGE DEPARTMENT IX

· . ·		
	1	CERTIFICATE OF SERVICE
	2	The undersigned hereby certifies that on or about the date filed, she served the foregoing
	3	Order Denying In Part Granting in Part the Application to Proceed in Forma Pauperis by
	4	mailing a copy to Defendant as listed below:
	5	LEE E. SZYMBORSKI
	6	4605 BLACK STALLION AVE NORTH LAS VEGAS NV 89031
	7	
	8	Kose Nyew
	9	ROSE NAJERA JEA, DEPARTMENT IX
	10	
	11	
	12	
	13	AFFIRMATION Pursuant to NRS 239B.030
	14	The undersigned does hereby affirm that the preceding <u>Decision and Order</u> filed in District Court case number <u>A-14-700178-C</u> DOES NOT contain the social security number of any person.
	15	/s/ ROSE NAJERA Date 5/20/14
	16	Judicial Executive Assistant
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JENNIFER TOGLIATTI Distruct Judge Department IX	27	
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ILE & SCHOONVELD, LLC Rth Town Center Drive Sutte 200 Vegas, Nevada 89144 89-6400 Facsmille: 702-384-6025	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	Electronically Filed 05/22/2014 03:05:27 PM IAFD Michael Prangle, Esq. Nevada Bar No. 8619 CLERK OF THE COURT Kerry J. Doyle, Esq. CLERK OF THE COURT Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC HAD Nown Center Dr., Ste. 200 CLERK OF THE COURT Las Vegas, NV 89144 Cross SCHOONVELD, LLC (702) 389-6400 – Office Cross School - Office (702) 384-6025 – Facsimile Email: mprangle@hpslaw.com Email: kdoyle@hpslaw.com Email: kdoyle@hpslaw.com Attorneys for Defendant Spring Mountain Treatment Center DISTRICT COURT CLARK COUNTY, NEVADA LEE E. SZYMBORSKI, CASE NO.: A-14-700178-C Plaintiff, Vs. SPRING MOUNTAIN TREATMENT CASE NO.: XXXI
RANG 160 No Las 702-8	16 17	official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,
HALL PI 1 Telephone:	18	Defendants.
H III	19	DEFENDANT SPRING MOUNTAIN TREATMENT CENTER'S
	20	INITIAL APPEARANCE FEE DISCLOSURE
	21	Pursuant to NRS Chapter 19, as amended by Senate Bill 106, filing fees are submitted for
	22	parties appearing in the above entitled action as indicated below:
	23	
	24	
	25 26	///
	26 27	///
	28	
		Page 1 of 2

1	Name of Defendant: Spring Mountain Treatment Center \$223.00
2	Total Remitted: \$223.00
3	Dated this 22 nd day of May, 2014.
4	HALL PRANGLE & SCHOONVELD, LLC
5	/s/: Kerry J. Doyle, Esq.
6 7	Michael Prangle, Esq. Nevada Bar No. 8619
8	Kerry J. Doyle, Esq. Nevada Bar No. 10571
9	1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144
10	Attorneys for Defendant Spring Mountain Treatment Center
11	<u>CERTIFICATE OF SERVICE</u>
12 13	I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC;
13	that on the <u>22</u> day of May, 2014, I served a true and correct copy of the foregoing
15	
16	
17	<u>APPEARNACE FEE DISCLOSURE</u> attached hereto in a sealed envelope, via U.S. Mail, first-
18	class postage pre-paid to the following parties at their last known address:
19	Lee E. Szymborski 4605 Black Stallion Avenue
20 21	Las Vegas, Nevada 89031 Plaintiff in Proper Person
22	Audrey teplanske-
23	An employee of HALL PRANGLE & SCHOONVELD, LLC
24	
25	4813-3212-8027, v. 1
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27 28	
	Page 2 of 2

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

Electronically Filed 05/22/2014 03:06:46 PM



FACSIMILE: 702-384-6025 HALL PRANGLE & SCHOONVELD, LLC 1160 NORTH TOWN CENTER DRIVE LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400 FACSIMULE: SUITE 200

1	This Motion is made and based on the following Points and Authorities, pleadings and
1	papers on file herein and any arguments of counsel at the time of hearing of this matter.
3	Dated this 22 nd day of May, 2014.
4	HALL PRANGLE & SCHOONVELD, LLC
5	
6	<u>/s/: Kerry J. Doyle, Esq.</u> Michael Prangle, Esq.
7	Nevada Bar No. 8619 Kerry J. Doyle, Esq.
8	Nevada Bar No. 10571 1160 N. Town Center Dr., Ste. 200
9	Las Vegas, NV 89144
10	Attorneys for Defendant Spring Mountain Treatment Center
11	NOTICE OF MOTION
12	PLEASE TAKE NOTICE that the undersigned will bring the foregoing DEFENDANT
13	
14	SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS for hearing beforeJUNE9:30Athe above entitled court on the 24 day of, 2014 at the hour ofa.m. in Department
15 16	the above entitled court on the $\frac{4}{2}$ day of, 2014 at the hour ofa.m. in Department
17	No. XXXI, or as soon thereafter as counsel can be heard.
18	Dated this 22 nd day of May, 2014.
19	HALL PRANGLE & SCHOONVELD, LLC
20	/s/: Kerry J. Doyle, Esq.
21	Michael Prangle, ESQ. Nevada Bar No. 8619
22	Kerry J. Doyle, Esq. Nevada Bar No. 10571
23	1160 N. Town Center Dr., Ste. 200
24	Las Vegas, NV 89144 Attorneys for Defendant
25	Spring Mountain Treatment Center
26	
27	///
28	
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HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 LAS VEGAS, NEVADA 89144 Telebeone: 702-889-6400 Facsimile: 702-384-6025

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

Plaintiff's Complaint against Defendant, Spring Mountain must be dismissed because the claims asserted therein are medical malpractice allegations and the Complaint fails to attach an expert affidavit as required by statute. Although Plaintiff attempts to side-step the affidavit requirement by alleging general negligence as well as medical malpractice, it is clear that this case is based solely on an alleged act of medical malpractice. Therefore, Spring Mountain respectfully requests that the Complaint be dismissed.

II.

STATEMENT OF FACTS

14 This is a medical malpractice action arising out of the care and treatment rendered to 15 Sean Szymborski at Spring Mountain. According to Plaintiff's complaint, Sean Szymborski, a 16 mentally ill patient, was improperly discharged from Spring Mountain to Lee Szymborski's 17 (Plaintiff) home in violation of NAC 449.332. See Plaintiff's Complaint, hereinafter Exhibit A. 18 Further, as a result of this improper discharge, Sean Szymborski smashed the windows, walls, 19 20 doors, furniture, and completely destroyed the interior of the residence before going missing for 21 three weeks. Id. As a result of the alleged improper discharge, Plaintiff has filed suit against 22 Spring Mountain for the damages to his residence as well as emotional distress suffered by 23 Plaintiff. However, no expert affidavit supporting his claims was attached. Accordingly, 24 Defendant Spring Mountain respectfully requests that Plaintiff's Complaint be dismissed, 25

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LEGAL STANDARD

NRCP 12(b) states in part:

[E]very defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion:

(5) failure to state a claim upon which relief can be granted.

On a motion to dismiss for failure to state a claim for relief, the trial court, and the Supreme Court must construe the pleading liberally and draw every fair intendment in favor of the plaintiff. *Merluzzie v. Larson*, 96 Nev. 409, 411-12, 610 P.2d 739, 741 (1980) overruled on other grounds by *Smith v. Clough*, 106 Nev. 568, 796 P.2d 592 (1990). A complaint should not be dismissed unless it appears to a certainty that the plaintiff could prove no set of facts that would entitle him or her to relief. *Zalk-Josephs Co. v. Wells Cargo, Inc.*, 81 Nev. 163, 169, 400 P.2d 621, 624 (1965).

As set forth below, Plaintiff has failed to state a claim for relief for medical malpractice since Plaintiff did not attach an expert affidavit as required by statute.

IV.

<u>ARGUMENT</u>

A. <u>Plaintiff's Complaint must be dismissed because it is not supported by an Expert</u> <u>Affidavit.</u>

Dismissal of Plaintiff's Complaint is required by NRS 41A.071 because Plaintiff's claims

are for medical malpractice but are not supported by an expert affidavit. NRS 41A.071 states:

[i]f an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit, supporting the allegations contained in the action,

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submitted by a medical expert who practices or has practiced in an area that is 1 substantially similar to the type of practice engaged in at the time of the alleged malpractice. 2 3 The Nevada Supreme Court has held that "under NRS 41A.071, a complaint filed without 4 a supporting expert affidavit is void ab initio and must be dismissed." Washoe Med. Ctr. v. 5 Second Judicial Dist. Court, 122 Nev. 1298, 1300, 148 P.3d 790, 792 (2006). And since "a void 6 complaint does not legally exist, it cannot be amended." Id. In Washoe, the Court reasoned that: 7 8 "shall" is mandatory and does not denote judicial discretion. The Legislature's choice of the words "shall dismiss" instead of "subject to dismissal" indicates that 9 the legislature intended that the court have no discretion with respect to dismissal and that a complaint filed without an expert affidavit would be void and must be 10 automatically dismissed. 11 Id. at 1303, 148 P.3d at 793-94. Moreover, the Court discussed the legislative intent underlying 12 NRS 41A.071, stating that the 13 14 legislative history further supports the conclusion that a complaint defective under NRS 41A.071 is void NRS 41A.071 was adopted as part of the 2002 15 medical malpractice tort reform that abolished the Medical-Legal Screening Panel. NRS 41A.071's purpose is to "lower costs, reduce frivolous lawsuits, and 16 ensure that medical malpractice actions are filed in good faith based upon 17 competent expert medical opinion." According to NRS 41A.071's legislative history, the requirement that a complaint be filed with a medical expert affidavit 18 was designed to streamline and expedite medical malpractice cases and lower overall costs, and the Legislature was concerned with strengthening the 19 requirements for expert witnesses. 20 Id. at 1304, 148 P.3d at 794. Accordingly, the Supreme Court has made it very clear that any 21 medical malpractice case must be dismissed if it is filed without an expert affidavit. 22 23 Here, Plaintiff is asserting that the Spring Mountain negligently discharged Sean 24 Szymborski in violation of NAC 449.332. It is clear that Plaintiff failed to file an expert 25 affidavit in support of his claims. Thus, the only question remains is whether this is a medical 26 malpractice claim. 27 28

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HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suffe 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025 1

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NRS 41A.009 defines "medical malpractice" as "the failure of a physician, hospital or employee of a hospital, in rendering services to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." The decision to discharge is a medical decision and clearly falls under the definition of a hospital rendering services as set forth in NRS 41A.009. Thus, Plaintiff's allegations clearly fall under the requirements of NRS 41A.071.

NAC 449.332, the administrative code that Plaintiff relies on to support his claim, further demonstrates that the decision to discharge is a medical decision. NAC 449.332 states in part:

3. A hospital shall, at the earliest possible stage of hospitalization, identify each patient who is likely to <u>suffer adverse health consequences upon discharge</u> if the patient does not receive adequate discharge planning. The hospital shall provide for an evaluation of the needs related to discharge planning of each patient so identified.

NAC 449.332 (emphasis added). Thus, the decision to discharge requires medical care providers to identify whether a patient will need additional health care based upon their diagnosis and current medical status.

Plaintiff himself also acknowledges that the allegations in this case are medical in nature.
He specifically alleges that Defendants were "entrusted to provide medical care owed to patients
and a duty to provide adequate medical treatment..." Ex A at para 36. Plaintiff goes on to state
that "Defendant breached the duty of care by discharging the patient...in violation of discharge
policies and procedures, pursuant to NAC 449.332." Plaintiff's entire theory of liability is based
upon the allegation that Spring Mountain breached a duty owed to Plaintiff to provide his son
with medical treatment by improperly discharging him.

As a result of the above, it is undisputed that Plaintiff's Complaint is based solely on allegations of medical malpractice and each cause of action relies solely on whether the

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HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 FacSimle: 702-384-6025 4

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discharge of Sean Szymborski was medically negligent. Therefore, having failed to comply with
 NRS 41A.071 by attaching an expert affidavit to the Complaint, Plaintiff's Complaint must be
 dismissed.

B. <u>Plaintiff's claim for Punitive Damages fails as Plaintiff has not alleged facts that</u> warrant punitive damages against an employer under NRS § 42.007.

As Plaintiff's causes of action are all based in medical malpractice, any claims for punitive damages also must be dismissed. However, even if those claims survive, Plaintiff has asserted no facts that support a claim for punitive damages against Spring Mountain.

Plaintiffs' are not entitled to punitive damages against Spring Mountain because Plaintiff's Complaint merely alleges negligence by the hospital's employees; yet, it does not allege any independent wrong-doing or ratification by the hospital itself as is required by law. NRS § 42.007 governs an award of punitive damages against an employer for the conduct of employees as follows:

Except as otherwise provided in subsection 2, in an action for the breach of an obligation in which exemplary or punitive damages are sought pursuant to subsection 1 of NRS 42.005 from an employer for the wrongful act of his or her employee, the employer is not liable for the exemplary or punitive damages unless:

(a) The employer had advance knowledge that the employee was unfit for the purposes of the employment and employed the employee with a conscious disregard of the rights or safety of others;

(b) The employer expressly authorized or ratified the wrongful act of the employee for which the damages are awarded; or

(c) The employer is personally guilty of oppression, fraud or malice, express or implied.

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If the employer is a corporation, the employer is not liable for exemplary or punitive damages unless the elements of paragraph (a), (b) or (c) are met by an officer, director or managing agent of the corporation who was expressly authorized to direct or ratify the employee's conduct on behalf of the corporation.

|| Nev. Rev. Stat. § 42.007(1).

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In this case, Plaintiff is requesting punitive damages against a corporation, Spring Mountain, for the actions of its employees in treating Sean Szymborski's condition. While Plaintiff does list Darryl Dubroca in his official capacity in the caption of the Complaint, there are no allegations of any wrongdoing on his part or that he was aware or ratified any of the alleged acts. In fact, the only mention of Mr. Dubroca in the Complaint is that he is the CEO/Managing Director of Spring Mountain. Ex. A, at para. 2. Consequently, to succeed in this request under NRS § 42.007, Plaintiffs must allege and prove one of the following:

- That an officer/director/managing agent of Spring Mountain had advance knowledge that the employees attending to Sean Szymborski were unfit for their employment, but nonetheless were employed with a conscious disregard of the safety of others;
- That an officer/director/managing agent of Spring Mountain "expressly authorized or ratified" the negligent treatment of Sean Szymborski; or
- That an officer/director/managing agent of Spring Mountain was himself/herself guilty of "oppression, fraud or malice."

Here, there are no such allegations in the Complaint. On the contrary, Plaintiff merely concludes that the alleged "negligent" treatment by Spring Mountain's *employees* warrants punitive damages. Therefore, Plaintiffs' claims for punitive damages are insufficient as a matter of law, and must be dismissed.

Moreover, as set forth above, Plaintiff's allegations against the hospital staff are for negligence, which is not a permissible basis for a punitive damage claim. See NRS 42.005

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1 guilty of oppressions, fraud or malice ...," to warrant punitive damages). "A plaintiff is never 2 3 entitled to punitive damages as a matter of right." Dillard Department Stores v. Beckwith, 115 4 Nev. 372, 380, 989 P.2d 882, 887 (1999) (quoting Ramada Inns v. Sharp, 101 Nev. 824, 826, 5 711 P.2d 1, 2 (1985). "[E]ven unconscionable irresponsibility will not support a punitive 6 damages award." Maduike v. Agency Rent-A-Car, 114 Nev. 1, 5-6, 953 P.2d 24, 27 7 (1998)(quoting First Interstate Bank v. Jafros Auto Body, 106, Nev. 54, 57, 787 P.2d 765, 767 8 9 (1990)). The Nevada Supreme Court has further stated that "[s]ince its language plainly requires 10 evidence that a defendant acted with a culpable state of mind, we conclude that NRS 42.001(1) FACSIMILE: 702-384-6025 11 denotes conduct that, at a minimum, must exceed mere recklessness or gross negligence." 12 **160 NORTH TOWN CENTER DRIVE** LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400 FACSIMILE: Countrywide v. Thitchener, 124 Nev. 725, 743, 192 P.3d 243 (2008). 13 14 15

Thus, notwithstanding Plaintiff's inability to overcome the employer specific hurdles under NRS 42.007, Plaintiffs' allegations of negligent medical treatment are insufficient as a matter of law to warrant punitive damages. Therefore, Plaintiff's claim for punitive damages should be dismissed.

(stating that a plaintiff must, by clear and convincing evidence, prove "the defendant has been

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HALL PRANGLE & SCHOONVELD, LLC

Page 9 of 10

1	V.
2	CONCLUSION
3	Based upon the foregoing, Spring Mountain respectfully requests this Honorable Court
4	issue an Order Dismissing, Plaintiffs' Compliant.
5	Dated this 22 nd day of May, 2014.
6	HALL PRANGLE & SCHOONVELD, LLC
7	
8 - 9	<u>/s/: Kerry J. Doyle, Esq.</u> Michael Prangle, Esq.
10	Nevada Bar No. 8619 Kerry J. Doyle, Esq.
10	Nevada Bar No. 10571 1160 N. Town Center Dr., Ste. 200
11	Las Vegas, NV 89144
12	Attorneys for Defendant Spring Mountain Treatment Center
14	CERTIFICATE OF SERVICE
15	I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC;
16	
17	that on the 22 day of May, 2014, I served a true and correct copy of the foregoing
18	DEFENDANT SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS
19	attached hereto in a sealed envelope, via U.S. Mail, first-class postage pre-paid to the following
20	parties at their last known address:
21	Lee E. Szymborski
22	4605 Black Stallion Avenue Las Vegas, Nevada 89031
23	Plaintiff in Proper Person
24 25	An employee of HALL PRANCLE & SCHOONVELD, LLC
26	
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28	4821-1809-2059, v. 1
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EXHIBIT A

1 2	LEE E. SZYMBORSKI 4605 Black Stallion Ave N. Las Vegas, NV 89031 (702) 609-6762	FILED
3	Plaintiff in Proper Person	MAY 0 2 2014
4	2 2 2	CLERK OF COURT
5	DISTRICT CO	JURT
6	CLARK COUNTY,	NEVADA
7		
8	LEE E. SZYMBORSKI,)	Case No. Dept No.
9	Plaintiff,)	-
10	ýs. ()	
11	SPRING MOUNTAIN TREATMENT CENTER,) DARRYL DUBROCA, in his official capacity,)	
12	DOES I-XX, inclusive, and ROE) CORPORATIONS I-XX, inclusive,)	EXEMPT FROM ARBITRATION SUMS IN EXCESS OF \$50,000
13) Defendants.	
14)	
15	COMPLAIN	
16	COMES NOW, Plaintiff, named above, and fo	
17	<u>GENERAL ALLEC</u>	
18		s been and is now, a resident of the State of
19	Nevada, County of Clark. Jurisdiction and Venue are	
20	2. Defendant DARRYL DUBROCA is the	CEO/Managing Director of SPRING
21	MOUNTAIN TREATMENT CENTER.	,
22	3. Plaintiff is informed and believes, and e	on that basis alleges, that Defendants
23	SPRING MOUNTAIN TREATMENT CENTER is a r	nental treatment hospital, who admitted
24	SEAN T. SZYMBORSKI for treatment and discharge	d him in violation of Nevada Law.
25	4. The true names and capacities, whether	individual, corporate, associate or
26	otherwise, of the Defendant sued herein as DOES I thr	ough XX, inclusive, and ROES I through
27	XX, inclusive, are unknown to Plaintiff, who is inform	ed, believes and alleges that each of these
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fictitiously named Defendants is in some way liable to Plaintiff on the causes of action below and
 therefore sues these defendants by such fictitious names. Plaintiff believes said fictitious
 Defendants assisted, devised, schemed, planned or took part in the actions set forth hereinbelow.
 Plaintiff will move to amend this Complaint and insert the true names and capacities of
 fictitiously named Defendants when the same have been ascertained.

5. Plaintiff is informed and believes, and thereon alleges, that at all times herein mentioned, each actually and fictitiously names Defendant was the principal, agent, co-venturer, partner, surety, guarantor, officer, director and/or employee of each co-defendant and in doing the things herein alleged, was acting within the scope of authority and with the permission of each co-defendant or took some part in the acts and omissions hereinafter set forth, and by reason thereof, each of said Defendants is liable to Plaintiff for the relief prayed.

12 6. That on or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING
13 MOUNTAIN TREATMENT CENTER, 7000 W. Spring Mountain Road, Las Vegas, Nevada
14 89117, due an "UNAUTHORIZED UNSAFE DISCHARGE" of a mentally ill adult patient, to
15 wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. See
16 Exhibit "1".

7. That said SEAN T. SZYMBORSKI was provided a taxi ride, released without any
 money; without appropriate medication, without the ability to care for himself, and being a
 danger to both himself and other.

8. Defendant SPRING MOUNTAIN TREATMENT CENTER was directed by
 KATHLEEN BUCHANAN to provide a Guardianship for Defendant SEAN T. SZYMBORSKI,
 and failed to do so.

9. Defendant SPRING MOUNTAIN TREATMENT CENTER Caseworker
"REBECCA" was directed NOT to release SEAN T. SZYMBORSKI to the residence of
Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed
windows, walls, doors, furniture, and completely destroyed the interior of the residence, before
going missing for three weeks. (A missing persons report was filed by NLVPD.)

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10. An investigation by the Division of Public and Behavioral Health substantiated that Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332, Discharge Planning, based upon evidence by interview of staff, record review and document review.

11. It was determined that the facility failed to assure the patient was discharged to a safe environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with diagnoses including psychosis not otherwise specified and spice abuse.

b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much trepidation about going back to the father's home. The patient was restless when talking about the father.

c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the address of the apartment. The MA documented the patient was vague about the address. The patient needed to stop by the father's home to pick up patient's debit card prior to going to the new apartment.

d. Review of the Social Services Discharge Note revealed the patient would live in an apartment upon discharge. There was no documented evidence of an address for the apartment. There was no documented evidence the Case Manager confirmed the patient had made arrangements to live in the apartment.

e. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to father's home first then on to an address in North Las Vegas, Nevada.

f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the patient did not want to return to the patient's father's home due to ongoing conflict. The note documented the patient participated in treatment planning to find housing.

g. The Risk Manager investigated a telephone complaint from the patient's father. The Administrative Review documented placement to the apartment was not verified. 26

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h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on verifying the identified apartment.

3 i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone messages were left by the patient's father. The father would state the patient could return to the home; the next telephone message from the father would demand the patient not be discharged to 5 the father's home. The LSW acknowledged she did not speak directly with the patient's father. The LSW stated due to the large number of patients on the LSW's caseload, the LSW had to delegate telephone calls and discharge planning to the MA.

j. The LSW indicated when a patient identified their own placement, the LSW would try 9 to obtain as much information as possible regarding the address and name of the apartment. If 10 unable to verify placement, the physician would be notified prior to discharge from the facility. 11

12 k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented the patient did not want to return to his father's home due to ongoing conflict. The note 13 14documented the patient participated in treatment planning to find housing.

15 An evaluation of the needs of a patient relating to discharge planning must include, 12. without limitation, consideration of: 16

17a. The needs of the patient for postoperative services and the availability of those 18 services.

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b. The capacity of the patient for self-care; and

20 c. The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. 21

13. Defendant SPRING MOUNTAIN TREATMENT CENTER is in violation of NAC 22 449.394, Psychiatric Services, which requires that a hospital shall develop and carry out policies 23 and procedures for the provision of psychiatric treatment and behavioral management services 24 that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and 25 services are safely and appropriately used. The hospital shall ensure that the policies and 26 procedures protect the safety and rights of the parties - and the public at large. 27

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14. That Defendant SPRING MOUNTAIN TREATMENT CENTER has failed to met these statutes and regulations, for the reasons set forth above.

15. That due to the failure to meet these responsibilities, SEAN T. SZYMBORSKI, was driven by taxi to the home of Plaintiff, and dropped off, at the expense of the Defendant SPRING MOUNTAIN TREATMENT CENTER, where he proceeded to cause significant property damage to Plaintiff's residence, and go missing.

16. That when SEAN T. SZYMBORSKI was located, he had sustained wounds from a
self inflicted injuries with a sharp object, using weapons obtained at the home of his mother; and
not at the home of his father.

10 17. The patient care plan, dated 5/14/13 indicated that safety concerns, including
 weapons, in the patient's home were non-applicable and verified by the patient's father. There
 was no documented evidence the patient's father was contacted for verification. Furthermore,
 Defendant SPRING MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a
 home for SEAN T. SZYMBORSKI, therefore, even confirming no weapons in father's home was
 not reasonable to consider this non-applicable.

16 18. In violation of the stated statutes, it was determined that the LSW did not follow up
on identifying what weapons and if the patient had access to weapons prior to discharge. (8.0
Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining
permission and contacting any person that may be able to located and secure items...Weapons are
not considered secured until verification has been received that the task is completed...")

19. Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER,
 SEAN T. SZYMBORSKI was convicted of criminal charges related to the property destruction at
 the home of Plaintiff, rather than receiving treatment for his known mental illness.

24 20. Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless
25 disregard of SEAN T. SZYMBORSKI's psychiatric condition in pre-paying for a taxi to dump
26 him at an verified location [Plaintiff's residence], without notice to occupants, without money,
27 and without the ability to provide care for himself due to long standing mental illness.

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21. The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver
 the statutory mandated care to patients in their custody and control resulted in systematic
 disregard of the serious psychological and medical conditions and resulted in adverse
 consequences, which predictably flow from such failures, and caused damages to patients and
 others, who became victims of such disregard.

22. Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS (\$2,000,000,000).

FIRST CLAIM FOR RELIEF

(NEGLIGENCE)

23. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein.

13 24. Nevada recognizes negligence claims, where a Plaintiff establishes: (1) the
14 existence of a duty of care (2) breach of that duty; (3) legal causation; and (4) damages.

25. Defendants, in the exercise of reasonable care had a duty to know, or should have
known, that they are required to comply with NAC 449.332, regarding DISCHARGE PLAN of
Patients; and with NRS 449.765 to 449.786.

26. Defendants breached their duty by failing to carefully investigate, monitor and/or
 oversee discharge activities at SPRING MOUNTAIN TREATMENT CENTER, including but
 not limited to, the development, implementation, and supervision of discharge policies and
 practices.

22 27. That Defendants negligently and/or carelessly, permitted the dumping of SEAN T.
23 SZYMBORSKI, by taxi to the home of Plaintiff, without notice to Plaintiff, in violation of their
24 own internal policies; NAC 449.332; and NRS 449.865 to 449.786.

25 28. Defendants knew or should have known that patients, including SEAN T.
26 SZYMBORSKI are members of the class of patients that could foreseeably suffer injury to
27 themselves, and/or inflict injury on others, as a result of Defendants' failure to exercise

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reasonable care in the discharge of their statutorily imposed duties, and/or common-law duties of care.

3 29. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered extreme emotional and mental distress, further issues and conflict in the 4 family unit, in addition to approximately \$20,000 in physical damage to the residence, including 5 smashed windows, which required immediate action to secure assets in the residence, and other 6 damages the full extent of which shall be provided through discovery.

30. As a direct and proximate result of Defendants' acts or omissions, Plaintiff has 8 suffered punitive, general and special damages. 9

SECOND CLAIM FOR RELIEF

(Professional Negligence)

(Negligent act or omission to act by a provider of health care in rendering of professional 12 services, which act or omission is the proximate cause of a personal injury or wrongful death, NRS 41A.015)

1431. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein. 15

16 32. Defendants in the capacity of a for profit hospital providing medical care to the public, government agencies overseeing the hospital's operations, licensed social workers, 17 registered nurses, psychiatrists, and the hospital administrator owed Plaintiff a duty to employ 18 medical staff adequately trained in the care and treatment of patients consistent with the degree 19 20 of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances; and a duty to comply with Nevada statutes, 21 22 including NRS 41A.015.

23 33. Defendants breached its duty of care by failing to function as a patient advocate by providing proper care to the patients at the time of discharge, and specifically causing physical, 24 25 mental and emotional pain and suffering to the patient; as well as physical, mental and emotional 26 pain and suffering to the public at large, and specifically in this matter, to the Plaintiff.

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Page 7

THIRD CLAIM FOR RELIEF

(Malpractice, Gross Negligence, Negligence Per Se)

34. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein.

35. "Malpractice" in the practice of social work means conduct which falls below the standard of care required of a licensee under circumstances which proximately causes damage. "Gross Negligence" in the practice of social work means conduct which represents an extreme departure from the standard required of a licensee under the circumstances and which proximately caused damage. NAC 641B.225, pursuant to 42 C.F.R.§ 482.61, Defendants had a duty to properly discharge patients in compliance with NAC 449.332, relating to discharge planning.

36. That Defendants including JOHN DOE 1 in the capacity of Licensed Social Worker (LSW) is entrusted to provide medical care owed to patients and a duty to provide adequate medical treatment, to protect the patient and the public at large. Said Defendant breached the duty of care by discharging the patient, paying for a taxi only to Plaintiff's address (although the patient asked to pick up a debit card, then be transported to another residence), in violation of discharge policies and procedures, pursuant to NAC 449.332. As a proximate result of the negligence of Defendants, the patient and public at large are subject to physical, mental and emotional pain, in addition to financial loss, such as Plaintiff has sustained.

37. The conduct of Defendants was in wanton, extreme and total disregard of the legal
and statutory obligations to patients and the public at large, and constitutes gross, reckless,
oppressive and/or outrageous disregard for the consequences of their actions. As a proximate
result of the negligence of Defendants, Plaintiff has suffered physical, mental and emotional pain,
in addition to financial damages.

Page 8

FOURTH CLAIM FOR RELIEF

(Negligent Hiring, Supervision and Training)

38. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein.

39. At the times mentioned herein, Defendants knew, or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was ot properly given, it was likely to injure the persons to whom it was given. Defendants owed a duty to its patients, and the community at large, to hire, train, and/or supervise competent medical and staff personnel, including supervisors, and LSW, to provide care and treatment to its patients.

40. Defendants breached that duty of care by failing to adequately provide competent
 employees, in the performance of the job, as it appears dumping patients is an ongoing problem.

41. At all times herein mentioned, Defendants established and/or followed, unsafe
 medical practices, including "dumping" patients without complying with discharge instructions.

42. As a result of the lack of medical care and treatment provided by Defendant,
Defendants breached their duty to Plaintiff and the members of the class by failing to protect
them from foreseeable harm, resulting in a lack of mental health treatment for Plaintiff and the
public at large.

43. As a direct and proximate result of the negligence and carelessness of Defendants,
Plaintiff has been injured financially, as well as mentally and emotionally in this matter.

44. Defendants conduct demonstrated a conscious disregard of known accepted
procedures, protocols, care and treatment, all with the knowledge or utter disregard that such
conduct could or would expose Plaintiff to harm as set forth herein.

45. Defendants conduct was willful, reckless, malicious, and in total disregard to the
health and safety of not only the patient, but the public at large, thereby justifying an award of
punitive damages.

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1	46. As a direct and proximate result of the conduct of Defendants, Plaintiff has suffered
2	mental and emotional pain and suffering, in addition to financial loss.
3	WHEREFORE, Plaintiff prays judgement as follows:
4	1. For a temporary restraining order and/or preliminary injunction and permanent
5	injunction enjoining and restraining Defendants from continuing or repeating the unlawful
6	polices, practices and conduct complained of herein;
7	2. For declaratory judgment against Defendants' policies, practices and conduct as
8	alleged herein in violation of patient rights, and the safety of the public at large;
9	For compensatory damages according to proof;
10	4. For punitive damages in consideration of the annual income in excess of
11	\$2,000,000,000.
12	5. For emotional distress caused by the violations herein.
13	6. For costs of suit, including attorney fees, and other costs.
14	7. For such other and further relief as the Court may deem appropriate.
15	DATED this day of, 2014
16	
17	LEE E. SZYNBORSKI Plaintiff in Proper Person
18	r hannen proper r erson
19	V
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23	
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26	
27	
28	Page 10

*

EXHIBIT 1

BRIAN SANDOVAL Governor

MICHAEL J. WILLDEN Director



TRACEY D. GREEN, MD State Health Officer

STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH DIVISION

Health Facilities/Lab Services 727 Fairview Dr. Suite E Carson City, Nevada 89701 (775) 684-1030 Fax: (775) 684-1073

Health Facilities/Lab Services 4220 S. Maryland Parkway Suite 810, Building D Las Vegas, NV 89119 (702) 486-8515 Fax: (702) 486-6520

□ Radiation Control 4150 Technology Way Suite 300 Carson City, Nevada 69706 (775) 687-7550 Fax: (776) 687-7552

Radiation Control 2080 E. Flamingo Suite 319 Las Vegas, Nevada 89119 (702) 486-5280 Fax: (702) 486-5024

Child Care Licensing 727 Fairview Dr, Suite E Carson City, Nevada 89701 (775) 684-4463 Fax: (775) 684-4464

Child Care Licensing 4180 S. Pecos, Ste 150 Les Veges, Nevada 89121 (702) 486-7918 Fax: (702) 486-6660

Child Care Licensing 1010 Ruby Vista, Ste 101 Elko, Nevada 89801 (775) 753-1237 Fax: (775) 753-1336 May 22, 2013

Lee Szymborski 4605 Black Stallion Avenue North Las Vegas, NV 89032

RE: <u>Complaint # NV00035655</u>

Dear Mr. Szymborski,

Thank you for alerting us about your dissatisfaction with Spring Mountain Treatment Center. We understand your concerns about admission, transfer and discharge, quality of care-responsible party not notified of patients change in condition, patient not assessed after change in condition, patient's medications improperly administered.

Our team of investigators will review your specific concerns, and evaluate the facility's actions, to determine if the facility is in compliance with state and/or federal regulations. Please refer to the enclosed fact sheet that describes the investigation process.

We will inform you of the investigation results, and send you a copy of the report. If you want to know the status of your complaint, please call the team supervisor, Rosemary Palladino-Marcus, HFI III, and refer to the complaint number listed above.

Please know that the Nevada State Health Division takes all complaints very seriously. By reporting your concerns, you play an important role in promoting the safety of health care recipients and improving the quality of care and services that facilities provide. We thank you.

Sincerely,

Johna Thacker, AAII/Complaint Intake Coordinator

cc: Rosemary Palladino-Marcus, Health Facilities Inspector III

Encl: 1 Page Complaint Process Fact Sheet

Public Health Working for a Safer and Healthier Nevada

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION RECTION IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		NVS3268HOS1	8. WING		0	7/09/2013
WE OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRING M	IOUNTAIN TREATMENT	UEN IER	ST SPRING MOUN AS, NV 89117	TAIN ROAD		
(X4) ID		ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CO		(XS)
Prefix Tag		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLET DATE
S 000	Initial Comments		S 000			
	a result of a complain 6/25/13, and finalized	ficiencies was generated as t investigation initiated on in your facility on 7/9/13, in ada Administrative Code, I.				
	The census at the tim 63. Five discharged n reviewed.	e of the investigation was redical records were				
ļ	Complaint #NV00035 deficiencies cited. (Se S0602)	655 was substantiated with se Tags S0146, S0153 and				
	by the Health Division prohibiting any crimina actions or other claims	dusions of any investigation shall not be construed as al or civil investigations, s for relief that may be under applicable federal,				
S 146 SS=D	NAC 449.332 Dischar	ge Planning	S 146			
	to discharge planning limitation, consideration	on of:				
	services and the avail (b) The capacity of the	atient for postoperative ability of those services; a patient for self-care; and				
	previous care setting of appropriate placement	etuming the patient to a or making another t of the patient after				
	Based on interview, re	t met as evidenced by: cord review and document				
	review, the facility faile discharged to a safe e sampled patients (Pati	ed to assure the patient was nvironment for 1 of 5 ient #1).				

łf -LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

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If continuation sheet 1 of 9

Division of	of Public and Behavior	al Health			FURMAPPRI	JVCL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	••
	ST CONTRECTION	IDENTIFICATION NUMBER;	A. BUILDING:		COMPLETED	
		NVS3268HOS1	B, WING		07/09/2013	i
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	E. ZIP CODE		- 1
		7000 1/2	EST SPRING MOUN			
SPRING N	IOUNTAIN TREATMENT	CENTER	GAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPL	ÚETE
S 146	Continued From near			DEFICIENCY)		
- 140	Continued From page	3 1	S 146			
	Findings include:					
	Patient #1					
	Patient #1 was admiti	led to the facility on 5/3/13				
i	and discharged on 5/	14/13 with diagnoses				
	including psychosis n	ot otherwise specified and				
	spice abuse.					
	On 5/13/13 at 1:00 PI	M, the Nursing Progress				
	Note documented the	patient had much				
ļ	trepidation about goir	ig back to the father's home.	ļ			
ſ	father.	ess when talking about the				
	On 5/14/13 at 2:30 P/	V, the Masters of Art (MA)				
		net with the patient to				
	confirm the address of	f the apartment. The MA				
	documented the patie	ent was vague about the				
	address. The patient	needed to stop by the				
	prior to going to the n	up the patient's debit card ew apartment.				
	Review of the Social	Services Discharge Note				
	revealed the patient w	vould live in an apartment				
	upon discharge. Ther	e was no documented				
4	evidence of an addres	ss for the apartment. There			ļ	
	was no documented e	evidence the Case Manager				
		had made arrangements to			l l	
	live in the apartment.					
	Patient Continuing Ca	re Plan, dated 5/14/13,				
ļ	identified the patient v	vas to go to the father's				
	home first then on to a	an address in North Las	ļ			
	Vegas.					
	The Acute Physician I	Discharge Progress Note,				
		, documented the patient				
		to the patient's fathers				
	home due to on-going	conflict. The note			ļ	
ficiencies a	re cited, an approved plan o	of correction must be returned within 10	teva after receipt of th	is statement of deficiencies	<u>_</u>	

STATE FORM

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If continuation sheet 2 of 9

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED
		NVS3268HOS1	B. WING		07	/09/2013
VAMË OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·····	
SPRING A	OUNTAIN TREATMEN	T CENTER 7000 WE	ST SPRING MOUN BAS, NV 89117			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF	CORRECTION	000
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE	(X5) COMPLE DATE
S 146	Continued From pag	ge 2	S 146			
	documented the pat planning to find hous	ient participated in treatment sing.				
	The Risk Manager in complaint from the p	nvestigated a telephone patient's father. The				1
	Administrative Revie the apartment was n	ew documented placement to				
	On 7/9/13 at 8:49 At	M, the Risk Manager				
	the identified apartm	d not follow up on verifying ient.				
	On 7/9/13 at 11:20 A (LSW) #2 explained	M, Licensed Social Worker multiple telephone messages				
	were left by the patie state the patient cou	ent's father. The father would id return to the father's home.				
	would demand the p	message from the father atlent not be discharged to				
	did not speak directly	he LSW acknowledged she y with the patient's father.				
ļ	the patient, the patie	during the first meeting with nt expressed a willingness to home and would work on				
	finding an apartment	t from the father's home. The to the large number of				
	patient's on the LSW	s case load, the LSW had to calls and discharge planning				ļ
2	The LSW explained a	when a patient identified their				
	much information as	LSW would try to obtain as possible regarding the f the apartrment. If the LSW				
	was unable to verify would be notified price	placement, the physician pr to discharge from the				
ĺ	facility.					
	Continuing Care Plar Interdisciplinary Polic documented:	n Discharge Planning, sy #PC.067, revised 4/13,				

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If continuation sheet 3 of 9

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS3268HOS1	8. WING		07/09/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		<u> </u>
	IOUNTAIN TREATMEN	7000 WE	ST SPRING MOUN	TAIN ROAD		
		LAS VE	GAS, NV 89117			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	۱D	PROVIDER'S PLAN OF CO	RRECTION	(X5)
TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLE
· · · · · · · · · · · · · · · · · · ·	······································	·		DEFICIENCY)		
S 146	Continued From page	je 3	S 146			
	Procedure:					
	" 40 in developing	the continuity of the second second				
	following is evaluate	the continuing care plan, the of by the Case Manager 4,4				
	Housing needs and/	or placement issues;4,8				
	Personal support sy	stems"				
	"	re plans are communicated				
	to the patient and fa	mily/guardian, as appropriate,				
	and documented in t	the medical record5.2				
		m the patient will live				
	following discharge.					
	"6.0 The Social Se	rvices Discharge Note is				
ĺ	completed for every	patient at the time of				
	discharge. This note	includes, but is not limited				Ì
	to: 6:1 Living arrange	ements"				
	Severity: 2	Scope: 1				
	Complaint #NV0003	5655				
S 153 SS=D	NAC 449.332 Discha	arge Planning	S 153			
	11. The patient, mer	nbers of the family of the				
	patient and any othe	r person involved in caring				
	for the patient must l	be provided with such				
ļ	Information as is neo	essary to prepare them for				
Í	the post-hospital can	e or the patient.				
	This Regulation is n	ot met as evidenced by:				Ļ
	Based on interview, I	record review and document				
ļ	review, the facility fai	iled to notify 2 of 5 sampled				
ļ	patients families photo and #5).	r to discharge (Patient #1				
						1

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If continuation sheet 4 of 9

	FOF DÉFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
		NVS3268HOS1	B. WING		07	/09/2013
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRING N	OUNTAIN TREATMENT	7000 WE	ST SPRING MOUN	ITAIN ROAD		
		LAS VEC	SAS, NV 89117			
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	THE APPROPRIATE	COMPLET DATE
S 153	Continued From pag	e 4	S 153			-
	Findings include:					
	Patient #1					
	Patient #1 was admi	tted to the facility on 5/3/13				
	and discharged on 5	/14/13 with diagnoses				
	including psychosis spice abuse.	not otherwise specified and				
	On 5/10/13 at 9:00 A	M, the LSW #2 documented				5
	the case manager re	ceived a voice mail from the				
ļ	return to his home. T	g the patient was not to he LSW documented the				
1		assist the patient with				
	alternative placement					
	On 5/10/13 at 11:15	AM, the MA documented the				
ļ	home, but not to be o	ed the patient to return to his discharged "today".				
	There was no further	documented evidence the				
	patient's father was o	contacted to confirm				
ļ	discharge to the patie	ent's father's home.				
ĺ	On 5/14/13 at 2:30 P	M, the MA documented the				
	MA met with the patie	ent. The patient requested				
	the father's telephone	e number and told the father				
		and a taxi would transport				
	the patient to the fath	ers nome.	-			
1	The Risk Manager in	vestigated a telephone				ļ
	complaint from the pa	atient's father. The				
	Administrative Review	w documented the discharge				
	was not coordinated -	with the family. he father on the day of				1
	discharge was not do					
	On 7/9/13 at 9:50 AM	, the Risk Manager				
ĺ	acknowledged the fac	ility should have arranged				
	for the taxi driver to w re cited, an approved plan	ait at the patient's father's				

7 i eceih 5899 00KP11

If continuation sheet 5 of 9

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
	NVS3268HOS1		B. WING		07	/09/2013
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
SPRING N	OUNTAIN TREATMENT	CENTER	ST SPRING MOUN SAS, NV 89117	ITAIN ROAD		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(%5)
PREFIX TAG	(EACH DEFICIENT REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETS
S 153	Continued From pag	je 5	S 153		·····	
	house until the patie then drive the patien	nt retreived the debit card, It to the new apartment.				
	On 7/9/13 at 11:34 A	M, LSW #2 explained the				
	family member shou	Id be contacted prior to the				
	alright with the patie	o assure the family was nt returning home. The LSW				[
	acknowledged the pa	atient's father should have				
1	been contacted by the patient being dischart	ne facility staff prior to the rged.				
	Four additional disch reviewed.	narged medical records were				
	Patient #5					
	Patient #5 was admin and discharged on 6 major depressive dis	tted to the faciity on 6/4/13 /18/13, with a diagnosis of order.				
	There was no docurr worker/Case Manage	ented evidence the social or notified the family of the				
	patient's discharge. T	There was no documented				2
	evidence the family v medications and follo	vas educated on the patient's ow up care needed. There				
	was no family contac	t from the social				
Ì	worker/Case Manage	er after 6/6/13.				
	Continuing Care Plar Interdisciplinary Polic	n Discharge Planning, w #PC.067, revised 4/13,				
ļ	documented:	- ·····				
ļ	Procedure:					
	"4.0 In developing t following is evaluated	the continuing care plan, the I by the Case Manager4.8				
	Personal support sys	tems.,."				Ì
i I	"5.0 Continuing car	e plans are communicated				
	to the patient and fan	nily/guardian, as appropriate, of correction must be returned within 10 d				

STATE FORM

days after receipt of this statement of deficiencies. 6839 00KP11

If continuation sheet 6 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS3268HOS1	B. WING	07	/09/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	······	
	IOUNTAIN TREATMEN	2000 1445	ST SPRING MOUN			
		LAS VEC	GAS, NV 89117			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLE
S 153	Continued From pa	ge 6	S 153			
ſ	and documented in	the medical record"				
	Severity: 2	Scope: 1				
	Complaint #NV000	35655				
S 602 SS=D	NAC 449.394 Psyc	hiatric Services	S 602			
	and procedures for treatment and beha that are consistent inclusive, to ensure services are safely hospital shall ensur	levelop and carry out policies the provision of psychiatric avioral management services with NRS 449.765 to 449.786, that the treatment and and appropriately used. The e that the policies and the safety and rights of the				
	Based on interview, review, the facility fa were at Patient #1's	not met as evidenced by: , record review and document ailed to identify what weapons s mother's home and if the access to the weapons.				
	Findings include:					
	Patient #1					
	and discharged on !	itted to the facility on 5/3/13 5/14/13 with diagnoses not otherwise specified and				
	Assessment Tool do multiple scab areas Comprehensive Ass	essment Tool documented stated the patient's wounds				

6899 00KP11

If continuation sheet 7 of 9

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM		(X2) MULTIPLE C A. BUILDING:			e survey Pleted
		NVS3268HOS1	B. WING		0	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SPRING MOUNTAIN TREATMENT CENTER 7000 WEST SPRING MOUNTAIN ROAD						
SPRING N		7000 WE	ST SPRING MOUN	TAIN ROAD		
		LAS VEC	AS, NV 89117			
(X4) ID		TATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET
S 602	Continued From page	je 7	S 602			· · · · · · · · · · · · · · · · · · ·
		M, LSW #1 documented				1
	weapons were at the	e patient's mothers home, but				
	not at the patient's fa	athers home. The LSW did				
	not identify what we	apons were at the patient's				ļ
	mouners nome. The	e was no documented				
	verify where the wea	's mother was contacted to apons were located.				
	Patient Continuing C	Care Plan, dated 5/14/13,				
	identified safety con	cems, including weapons in				
	the patient's home w	ere non-applicable and				
	verified by the patier	it's father. There was no				
i	documented evidend	the patient's father was				
	contacted for verifica	ation.				
	On 5/14/13 at 2:30 F	M, the MA documented the				
	patient asked the MA	A if the taxi would be able to				
{	take the patient to the	e mother's house after the				
	documentation the net	ather's house. The MA				
	taxi after being dropp	ent would have to pay for any bed off at the father's house.				
	On 7/9/13 at 8:49 AM	<i>I</i> , the Risk Manager				8
	confirmed the LSW c	id not follow up on				
l	Identifying what weap	pons and if the patient had				
	access to the weapo	ns prior to discharge.				
ĺ	Continuing Care Plan	n Discharge Planning,				
	Interdisciplinary Polic	cy #PC.067, revised 4/13,				
	documented:					
	"8.0 Securing Weapo	nsSocial Services staff				
1	initiates attempts to s	ecure the weapons,				
	obtaining permission	and contacting any person				
	that may be able to k	poate and secure the				
	itemsWeapons are	not considered secured until				
	venfication has been	received that the task is				1
	completed"		-			
						1

6899 00KP11

If continuation sheet 8 of 9

Division	of Public and Behavior				FOR	MAPPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		15160
		NV53268HOS1	B. WING		07	/09/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE		05/2013
SPRING A	OUNTAIN TREATMENT	CENTER 7000 W	EST SPRING MOUN			
		LAS VE	GAS, NV 89117			
(X4) ID PREFIX TAG	EACH DEFICIENC	TATEMENT OF DEFICIENCIES 27 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 602	Continued From pag	e 8	S 602		,,,	
	Severity: 2	Scope: 1				
	Complaint #NV00036	6655				
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iclencies ar E FORM	e cited, an approved plan o	f correction must be returned within 10 c	lays after receipt of thi	s statement of deficiencies.		L.,
			⁶⁸⁹⁹ 00K		lí continu	vation sheet 9

IAFD		
¹ Michael Prangle, Esq.		
2 Nevada Bar No. 8619		
Kerry J. Doyle, Esq. Nevada Bar No. 10571	Electronically Filed 05/29/2014 03:55:10 PM	
HALL PRANGLE & SCHOON	VELD, LLC	
1160 N. Town Center Dr., Ste. 2 Las Vegas, NV 89144	Alun & Chim	
(702) 889-6400 – Office	CLERK OF THE COURT	
⁶ (702) 384-6025 – Facsimile Email: mprangle@hpslaw.com		
7 Email: <u>kdoyle@hpslaw.com</u>		
8 Attorneys for Defendant Spring	Mountain Treatment Center	
9 and Darryl Dubroca		
10		
	DISTRICT COURT CLARK COUNTY, NEVADA	
¹² LEE E. SZYMBORSKI,	CASE NO.: A-14-700178-C DEPT. NO.: XXXI	
11 12 13 14 11 LEE E. SZYMBORSKI, Plaintiff,		
s 15 vs.		
 15 16 SPRING MOUNTAIN TREAT CENTER, DARRYL DUBROC official capacity, DOES I-XX, i ROE CORPORATIONS I-XX, 		
CENTER, DARRYL DUBROC		
Defender	nts	
20 DEFENDANT DARRYL DUBROCA'S		
21		
22 Pursuant to NRS Chapte	r 19, as amended by Senate Bill 106, filing fees are submitted for	
²³ parties appearing in the above e	ntitled action as indicated below:	
24 25		
		26
27		
28 ///		
	Page 1 of 2	

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Sufte 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

Name of Defendant: Darryl Dubroca	\$223.00
Total Remitted:	\$223.00
Dated this 29 th day of May, 2014.	
	HALL PRANGLE & SCHOONVELD, LLC
	/s/: Kerry J. Doyle, Esq.
	Michael Prangle, Esq.
	Nevada Bar No. 8619 Kerry J. Doyle, Esq.
	Nevada Bar No. 10571
	1160 N. Town Center Dr., Ste. 200
	Las Vegas, NV 89144
	Attorneys for Defendant
	Spring Mountain Treatment Center
CERTIF	FICATE OF SERVICE
I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVEI	
LLC; that on the 29 th day of May, 2014, I served a true and correct copy of the forego	
IIC; that on the 29 th day of May 20	
	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA	
DEFENDANT DARRYL DUBROCA	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address:	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address:	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue	14, I served a true and correct copy of the fore
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 Plaintiff in Proper Person	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 Plaintiff in Proper Person	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 Plaintiff in Proper Person	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 <i>Plaintiff in Proper Person</i> /s/:	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
DEFENDANT DARRYL DUBROCA attached hereto in a sealed envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 <i>Plaintiff in Proper Person</i> / <u>/s/:</u> An employ	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
DEFENDANT DARRYL DUBROCA attached hereto in a scaled envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 <i>Plaintiff in Proper Person</i> 4813-3212-8027, v. 1	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
DEFENDANT DARRYL DUBROCA attached hereto in a scaled envelope, via parties at their last known address: Lee E. Szymborski 4605 Black Stallion Avenue Las Vegas, Nevada 89031 <i>Plaintiff in Proper Person</i> 4813-3212-8027, v. 1	14, I served a true and correct copy of the fore, A'S INITIAL APPEARNACE FEE DISCLOS a U.S. Mail, first-class postage pre-paid to the follo Audrey Ann Stephanski
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HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vecas, Nevada 89144 Telebhone: 702-889-6400 FacSimilie: 702-384-6025

1 2 3 4 5 6 7	JOIN Michael Prangle, Esq. Nevada Bar No. 8619 Kerry J. Doyle, Esq. Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144 (702) 889-6400 – Office (702) 384-6025 – Facsimile Email: <u>mprangle@hpslaw.com</u>	Electronically Filed 05/29/2014 03:56:03 PM Mun J. Lourn CLERK OF THE COURT				
8	Email: <u>kdoyle@hpslaw.com</u> Attorneys for Defendant Spring Mountain Treatment Center and Darryl Dubroca					
10	DISTRICT COURT CLARK COUNTY, NEVADA					
11 12	LEE E. SZYMBORSKI, Plaintiff,	CASE NO.: A-14-700178-C DEPT. NO.: XXXI				
13 14	VS.					
15 16 17	SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,					
18	Defendants.					
19 20 21	DEFENDANT DARRYL DUBROCA'S JOINDER TO SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS					
22	Hearing Date: June 24, 2014 Hearing Time: 9:30 am					
23 24	COMES NOW, Defendant, Darryl Dubroca, by and through his attorneys, Hall Prangle &					
25	Schoonveld, LLC, and respectfully submits this Joinder to Defendant Spring Mountain					
26	Treatment Center's Motion to Dismiss as follows:					
27 28	///					
	Page	1 of 3				

HALL PRANGLE & SCHOONVELD, LLC 1160 NORTH TOWN CENTER DRIVE SUITE 200 LAS VEGAS, NEVADA 89144 Telephone: 702-889-6400 FACSIMILE: 702-384-6025

That Defendant, Darryl Dubroca, adopts, as though fully set forth herein, the points and 1 2 authorities, and arguments contained in said Defendant Spring Mountain Treatment Center's Motion to Dismiss. 3 Additionally, Plaintiff has set forth no allegations against Mr. Dubroca in the entire 4 Complaint. As a result, Plaintiff has failed to state a claim upon which relief can be granted 5 6 against Mr. Dubroca. 7 WHEREFORE, Defendant Darryl Dubroca, pray that Defendant Spring Mountain 8 Treatment Center's Motion to Dismiss be GRANTED. 9 Dated this 29th day of May, 2014. 10 11 HALL PRANGLE & SCHOONVELD, LLC 12 /s/: Kerry J. Doyle, Esq. 13 Michael Prangle, Esq. Nevada Bar No. 8619 14 Kerry J. Doyle, Esq. 15 Nevada Bar No. 10571 1160 N. Town Center Dr., Ste. 200 16 Las Vegas, NV 89144 17 Attorneys for Defendant Spring Mountain Treatment Center 18 and Darryl Dubroca 19 20 21 22 23 Ш 24 25 26 III27 28 III

Page 2 of 3

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suffe 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

	1	CERTIFICATE OF SERVICE
	2	I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD,
	3	LLC; that on the 29 th day of May, 2014, I served a true and correct copy of the foregoing
	4	DEFENDANT DARRYL DUBROCA'S JOINDER TO SPRING MOUNTAIN
	5	TREATMENT CENTER'S MOTION TO DISMISS attached hereto in a sealed envelope, via
	6	
	7	U.S. Mail, first-class postage pre-paid to the following parties at their last known address:
	8	Lee E. Szymborski
	9	4605 Black Stallion Avenue Las Vegas, Nevada 89031
S	10	Plaintiff in Proper Person
FACSIMILE: 702-384-6025	11	/s/: Audrey Ann Stephanski
: 702-3	12	An employee of HALL PRANGLE & SCHOONVELD, LLC
SIMILE	13	
(ELEPHONE: 702-889-6400 FACS	14	4822-6110-7995, v. 1
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		Page 3 of 3

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144

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CLERK OF THE COURT

LEE E. SZYMBORSKI 1 4605 Black Stallion Ave N. Las Vegas, NV 89031 2 (702) 609-6762 Plaintiff in Proper Person 3 4 DISTRICT COURT 5 6 CLARK COUNTY, NEVADA 7 LEE E. SZYMBORSKI, Case No. A-14-700178-C 8 Dept No. XXXI Plaintiff, 9 vs. 10 SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, 11 DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive, 12 13 Defendants. 14**OPPOSITION TO MOTION TO DISMISS COMPLAINT** 15 COMES NOW, Plaintiff, and files this Opposition to Motion to Dismiss, indicating as 16follows: 171. That Defendant take nothing by way of its motion. 18 2. That the court acknowledge Defendant SPRING MOUNTAIN TREATMENT CENTER 19was found to be in violation of its own policies as well as laws and codes, as set forth in the 20 Complaint; and set forth herein. 21 3. That the court acknowledge the Complaint addresses negligence on the part of 22 defendants, and each of them. 23 4. That the court acknowledge Plaintiff's claim of "Malpractice, Gross Negligence, 24 Negligence Per Se" is not medical malpractice, but malpractice that occurs after the discharge of a 25 patient, but other employees of Spring Mountain Treatment Center, as detailed herein.

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This Opposition and Countermotion is made and based upon the pleadings and files herein, the affidavit of Plaintiff, and any oral argument that may be adduced at the time of trial.

Dated this day of LEE E. SZYM**R** SKJ Plaintiff in Prope

I. INTRODUCTION

This is an action of NEGLIGENCE on the part of SPRING MOUNTAIN TREATMENT CENTER, FOR PROFIT business that has violated codes and statutes pertaining to the safe release of patients, and NOT medical issues relation to its former patients. Plaintiff does set forth a cause of action for "Malpractice, Gross Negligence, Negligence Per Se." Nothing in Plaintiff's complaint seeks a judgment for MEDICAL malpractice; and the motion to dismiss should be summarily denied.

Defendants herein desire this action to be classified as "medical malpractice" solely to find fault with the Complaint. It is clearly negligence and there has been malpractice, but the malpractice is in the area of social work, and the court should acknowledge the same.

"Malpractice" in the practice of social work means conduct which falls below the standard
of care required of a licensee under circumstances which proximately causes damage. In fact, this
definition itself is in the Complaint. Thus, Defendant's allegations that this matter should be
procedurally dismissed is meritless. In this matter, there is clearly "malpractice" - but it is NOT
medical malpractice; not in the process of a surgery or operation, but in the context of the mandatory
social work that is required - and EXPECTED of a "for profit" psychological facility that earns in
excess of TWO BILLION DOLLARS ANNUALLY.
II. STATEMENT OF FACTS

On or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING MOUNTAIN TREATMENT CENTER, provided an unauthorized, unsafe discharge of a mentally ill adult patient, to wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. Exhibits are provided attached to the Complaint.

That the adult patient was provided a taxi ride, released without any money; without appropriate medication, without the ability to care for himself, and being a danger to both himself and other.

SPRING MOUNTAIN TREATMENT CENTER was directed by KATHLEEN BUCHANAN to provide a Guardianship for the patient but failed to do so.

SPRING MOUNTAIN TREATMENT CENTER was directed NOT to release the patient to the residence of Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed windows, walls, doors, furniture, and completely destroyed the interior of the residence, before going missing for three weeks. (A missing persons report was filed by NLVPD.)

An investigation by the Division of Public and Behavioral Health substantiated that Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332, Discharge Planning, based upon evidence by interview of staff, record review and document review.

It was determined, by the Division of Public and Behavioral Health. that the facility failed to assure the patient was discharged to a safe environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with diagnoses
 including psychosis not otherwise specified and spice abuse.

b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much
trepidation about going back to the father's home. The patient was restless when talking about the
father.

c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the address of the apartment. The MA documented the patient was vague about the address. The patient

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needed to stop by the father's home to pick up patient's debit card prior to going to the new apartment.

d. Review of the Social Services Discharge Note revealed the patient would live in an apartment upon discharge. There was no documented evidence of an address for the apartment. There was no documented evidence the Case Manager confirmed the patient had made arrangements to live in the apartment.

e. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to father's home first then on to an address in North Las Vegas, Nevada.

f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the patient did not want to return to the patient's father's home due to ongoing conflict. The note documented the patient participated in treatment planning to find housing.

g. The Risk Manager investigated a telephone complaint from the patient's father. The Administrative Review documented placement to the apartment was not verified.

h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on verifying the identified apartment.

i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone messages were left by the patient's father. The father would state the patient could return to the home; the next telephone message from the father would demand the patient not be discharged to the father's home. The LSW acknowledged she did not speak directly with the patient's father. The LSW stated due to the large number of patients on the LSW's caseload, the LSW had to delegate telephone calls and discharge planning to the MA.

j. The LSW indicated when a patient identified their own placement, the LSW would try to obtain as much information as possible regarding the address and name of the apartment. If unable to verify placement, the physician would be notified prior to discharge from the facility.

k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented the patient did not want to return to his father's home due to ongoing conflict. The note documented the

patient participated in treatment planning to find housing.

An evaluation of the needs of a patient relating to discharge planning must include, without
limitation, consideration of:

a. The needs of the patient for postoperative services and the availability of those
5 services.

b. The capacity of the patient for self-care; and

c. The possibility of returning the patient to a previous care setting or making another
appropriate placement of the patient after discharge.

9 SPRING MOUNTAIN TREATMENT CENTER violated NAC 449.394, Psychiatric 10 Services, which requires that a hospital shall develop and carry out policies and procedures for the 11 provision of psychiatric treatment and behavioral management services that are consistent with NRS 12 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately 13 used. The hospital shall ensure that the policies and procedures protect the safety and rights of the 14 parties - and the public at large. Defendant SPRING MOUNTAIN TREATMENT CENTER has 15 failed to met these statutes and regulations, and the issue of negligence set forth in the Complaint 16 is appropriate.

Due to the failure to meet these responsibilities, the patient, was driven by taxi to the home of Plaintiff, and dropped off ("dumped"), at the expense of the SPRING MOUNTAIN TREATMENT CENTER, where he proceeded to cause significant property damage to Plaintiff's residence, and then, go missing.

When the patient was located, he had sustained wounds from a self inflicted injuries with a sharp object, using weapons obtained at the home of his mother, which was not where he was "dumped."

The patient care plan, dated 5/14/13 indicated that safety concerns, including weapons, in the patient's home were non-applicable and verified by the patient's father. There was no documented evidence the patient's father was contacted for verification. Furthermore, Defendant SPRING

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MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a home for the patient, therefore, even confirming no weapons in father's home was not reasonable to consider this nonapplicable.

In violation of the stated statutes, it was determined that the LSW at SPRING MOUNTAIN TREATMENT CENTER did not follow up on identifying what weapons and if the patient had access to weapons prior to discharge. ("8.0 Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining permission and contacting any person that may be able to located and secure items...Weapons are not considered secured until verification has been received that the task is completed...")

Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER, and failure to protect its patients, due directed to the patient "dumping". SEAN T. SZYMBORSKI was convicted of criminal charges related to the property destruction at the home of Plaintiff, rather than receiving treatment for his known mental illness.

Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless disregard of the patient's psychiatric condition in pre-paying for a taxi to dump him at an verified location [Plaintiff's residence], without notice to occupants, without money, and without the ability to provide care for himself due to long standing mental illness.

The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver the statutory mandated care to patients in their custody and control resulted in systematic disregard of the serious psychological and medical conditions and resulted in adverse consequences, which predictably flow from such failures, and caused damages to patients and others, who became victims of such disregard.

Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS (\$2,000,000,000). There has undoubtedly been negligence on the part of Defendant. Plaintiff has presented a prima facia case in his Complaint and herein for negligence.

III. LEGAL STANDARD

Defendant seeks to dismiss this matter, allegedly for failure to provide an Affidavit in support of an alleged claim for medical malpractice, or the standard 'failure to state a claim upon which relief can be granted.'.

In fact, as detailed above, this is not an action for medical malpractice, but for malpractice in the area of social work, as stated in the very cause of action in the complaint; and as set forth herein.

If the court feels in any measure, that the facts are not pled with specificity, or that Plaintiff needs to obtain other documents, Plaintiff requests leave of the court to amend the complaint, instead of dismissing the Complaint.

Given that Defendant's motion to dismiss misrepresents this as an action for medical malpractice, which it is not, Plaintiff believes the motion should be summarily denied. As for the allegation of failure to state a claim, Plaintiff believes the motion stands on its own, but if it pleases the court, he will seek leave to amend the complaint, rather than dismissing the complaint. This court has the authority to allow leave to amend rather than dismissal in this matter.

The purpose of summary judgment is to obviate trials when they would serve no useful purpose. <u>Short v. Hotel Rivera, Inc.</u>, 79 Nev. 94; 378 P.2d 979 (1963); <u>Corey v. Hom.</u>, 87 Nev. 32, 482 P.2d 814 (1971), <u>Olson v. Iacometti</u>, 91 Nev. 241, 533 P.2d 1360 (1975).

Summary judgment is applicable only where it is quite clean that no genuine issues remain for trial. NRCP 56(a) and (c).

Any presence of real and material issue of fact precludes summary judgment. The presence of real and material issues of fact precludes further consideration of motion for summary judgment under N.R.C.P. 56, because it is not sufficient that court may not credit evidence to be offered or that weight of evidence is clearly in favor of one party. Under such circumstances parties are entitled to trial by jury to determine facts. Plaintiff does not expect Defendant to pay on an alleged contract when the contract cannot be produced. Parman v. Petricciani, 70 Nev. 427, 272 P.2d

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492 (1954), cited, Bynum v. Frisby, 70 Nev. 535, at 538, 276 P.2d 487 (1954), McColl v. Scherer, 73 Nev. 226, at 231, 315 P 2d 807 (1957), Magill v. Lewis, 74 Nev. 381, at 385, 333 P.2d 717 (1958), Zalk-Josephs Co. v. Wells Cargo, Inc., 77 Nev. 441, at 445, 366 P.2d 339 (1961), Dredge Corp. v. Husite Co., 78 Nev 69, at 86, 369 P.2d 676 (1962), Short v. Hotel Riviera, Inc., 79 Nev. 94, at 96, 378 P.2d 979 (1963), Dredge Corp. v. Wells Cargo, Inc., 80 Nev. 99, at 103, 389 P.2d 394 (1964), Tomiyasu v. Golden, 81 Nev. 140, at 161, 400 P.2d 415 (1965), dissenting opinion, Shockey v. Harden Ins. Agency, Inc., 98 Nev. 138, at 140, 643 P.2d 849 (1982), Sawyer v. Sugarless Shops, Inc., 106 Nev. 265, at 269, 792 P.2d 14 (1990), see also Plaza v. City of Reno, 111 Nev. 814, 898 P.2d 114 (1995)

The pleadings and proof offered in a motion for summary judgment are construed in the light most favorable to the non-moving party. <u>Hoopes v. Hammargren</u>, 102 Nev. 425, 729, 725, P.2d 238, 241 (1986). "Once the movant has shown the absence of dispute as to material facts, the burden shifts to the non-movant who must 'set forth specific facts demonstrating the existence of a genuine issue for trial or have summary judgment entered against him." <u>Garvey v. Clark County</u>, 91 Nev. 127, 532 P.2d 269 (1975).

In this circumstance, the case is a negligence case; not a medical malpractice action. While Defendant was entrusted to provide medical care to patients and a duty to provide adequate medical care, they were also required by duty to provide adequate and appropriate social and legal obligations, such as preparing a guardianship as directed that was not done. The context of these statements in his complaint were to provide the facts and details surrounding the negligence, which is clearly the theme and concern set forth in Plaintiff's complaint.

A Litigant has right to trial where slightest doubt zs to facts exists. Clearly, there is a doubt to the facts herein.

IV. ARGUMENT

NRS 41A.009 defines "medical malpractice" as "the failure of a physician, hospital or employee of a hospital, in rendering services to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." Defendant alleges the decision to discharge a patient is a medical decision. Arguably so; however, after that decision is made, the proper procedures for a discharge are out of the doctors scope of duty or authority. He gives the order to release, and it is social workers and staff that are required to provide transportation, assure the patient is being released to a suitable environment, etc. This is not what the doctor does, and patient dumping is not malpractice of the doctor to use the skill he is trained to use. It is the lack of follow through of the doctors discharge which is at issue herein. With annual profits in excess of TWO MILLION DOLLARS, the appropriate staff should be available to comply with laws and regulations to render services after the doctor has authorized the discharge.

Plaintiff agrees that the medical decision to discharge then others are required to provide care to coordinate matters based upon the medical diagnosis and current medical status, but is does not require a doctor to prepare a guardianship, or call and pay for a taxi for the patient. However, those that are involved are required to comply with regulations. In fact, Plaintiff believes there are social workers on staff, and others to coordinate other than medical needs for the patients.

All negligence herein occurred AFTER the release of the patient from the doctors care, and is NOT medical malpractice. Defendant making the allegation this is a medical malpractice case simply does not make it so. Moreover, Defendant completely ignores the issues of negligence in this matter.

As a result it is undisputed that Plaintiff's Complaint is NOT based solely on allegations of medical malpractice, but of negligence without a facility that makes more than TWO MILLION DOLLARS in annual income, to meet the guidelines for release of patients back into society after they are DISCHARGED from the facility.

Plaintiff made a claim for punitive damages due to the significant and overwhelming

evidence of negligence on the part of Defendants, and Plaintiff is entitled to punitive damages. If the court does not feel Plaintiff pled this cause with specificity, he requests leave of the court to amend as to this cause of action. He feels the facts herein warrant punitive damages. Under NRS 42.001 et. seq., Defendant's clearly had a conscious disregard for the welfare of patients who had been released from their facility - and the general public they were released into. The actions detailed in the claim and herein clearly demonstrate the same, and Plaintiff is entitled to plead this cause at the time of trial.

Further, Defendant's and all of them, were required to follow the statutes and guidelines they ignored in releasing a patient. This is enough evidence to provide that Defendant's knew or should have known, that the manner in which the patient at issue herein was release could certainly cause harm.

Plaintiff will request leave to amend to name specific employees as this matter progresses and discovery provides more information. However, at this time, there is no cause in dismissing any portion of this Complaint.

V. CONCLUSION

Based upon the foregoing, Plaintiff respectfully requests this Honorable Court issue and order DENYING in its entirety, Defendant's motion to dismiss Plaintiff's complaint.

Dated this 13 day of June

LEE E. MYMBORSKI Plaintiff in Proper Person

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RICT COURT ADMIN			AL DISTI OUNTY, NEV		COURT	CLERK OF THE C
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-VS-) DEB.1)	NO: _	<u> </u>	
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Dennis Neuha	ausel _d	name), of KL	AS-TV		[111]	edia organization),
hereby requests permiss				edings in 1	the above-suticled o	ase in
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EIGHTH JUDICIAL DISTRICT COURT CLARK COUNTY, NEVADA

Lee Szymborski

PLAINTIFF

-VS-

Spring Mountain Treatment Center

DEFENDANT

CASE NO: <u>A-14-700178-C</u> dept. no: <u>31</u>

NOTIFICATION OF MEDIA REQUEST

TO: COUNSEL OF RECORD IN THE ABOVE-CAPTIONED CASE:

•	pursuant to Supreme Court Rule	es 229-246, inclusive, that	media representatives
from KLAS	have requested to	o obtain permission to broa	dcast, televise, record or
take photographs of all hearings in	n this case. Any objection should	ld be filed at least 24 hours	prior to the subject
hearing.			
DATED this 23 day	, of	14 Eighth	Judicial District Court
CERTIFICA	TE OF SERVICE BY FAC	CSIMILE TRANSMISS	SION
I hereby certify that on the	ne 23 day of June	,20 <mark>_14</mark> ,s	ervice of the foregoing
was made by facsimile transmission	on only, pursuant to Nevada Su	preme Court Rules 229-24	5, inclusive, this date by
faxing a true and correct copy of t	he same to each Attorney of Re	cord addressed as follows:	

Plaintiff

Pro Se

Defendant

Michael Prangle

702-384-6025

Eighth/Judicial Distr

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COS 1 Michael Prangle, Esq. **CLERK OF THE COURT** Nevada Bar No. 8619 2 Kerry J. Doyle, Esq. 3 Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 4 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144 5 (702) 889-6400 - Office 6 (702) 384-6025 - Facsimile Email: efile@hpslaw.com 7 Attorneys for Defendant Spring Mountain Treatment Center 8 and Darryl Dubroca 9 DISTRICT COURT 10 **CLARK COUNTY, NEVADA** 11 LEE E. SZYMBORSKI, CASE NO .: A-14-700178-C 12 DEPT, NO.: XXXI Plaintiff, 13 14 vs. 15 SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his 16 official capacity, DOES I-XX, inclusive, and 17 ROE CORPORATIONS I-XX, inclusive, 18 Defendants. 19 CERTIFICATE OF SERVICE VIA HAND DELIVERY OF 20 DEFENDANT SPRING MOUNTAIN TREATMENT CENTER AND DARRYL DUBROCA'S MOTION BAR MEDIA PRESENCE 21 **DURING PRETRIAL HEARINGS** ON ORDER SHORTENING TIME 22 23 24 25 /// 26 111 27 28 111

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

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Page 1 of 2

1	I HEREBY CERTIFY that I am an employee of Hall Prangle & Schoonveld, LLC; that
2	on the 23 rd day of June, 2014, 1 served a true and correct copy of DEFENDANT SPRING
3	MOUNTAIN TREATMENT CENTER AND DARRYL DUBROCA'S MOTION BAR MEDIA
4	PRESENCE DURING PRETRIAL HEARINGS ON ORDER SHORTENING TIME in a sealed
5	envelope, by hand delivery via runner service, to the following parties at their last known
6	address:
7	
8	Lee E. Szymborski 4605 Black Stallion Avenue
9	Las Vegas, Nevada 89031 Plaintiff in Proper Person
0	
2	An employee of Hall Prangle & Schoonveld, LLC
3	An employee of Hall Prangle & Schoonveld, LLC
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	Page 2 of 2

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	1	AFFT						
		Michael Prangle, Esq.						
	2	Nevada Bar No. 8619						
	3	Kerry J. Doyle, Esq. Nevada Bar No. 10571						
		HALL PRANGLE & SCHOONVELD, LLC						
	4	1160 N. Town Center Dr., Ste 200						
	5	Las Vegas, NV 89144 702-889-6400 office						
	6	702-384-6025 fax						
	0	Email: <u>efile@hpslaw.com</u>						
	7	Attorneys for Defendant						
	8	Spring Mountain Treatment Center and Darryl Dubroca						
	Ŭ							
	9	DISTRICT COURT						
	10	CLARK COUNTY, NEVADA						
		LEE E. SXYMBORSKI,) CASE NO.: A-14-700178-C						
	11) DEPT. NO.: XXXI						
	12	Plaintiff,)						
<u>.</u>	10	vs.						
	13							
PROCESS LICENSE #389 LAS VEGAS, NV (702)384-0305	14	SPRING MOUNTAIN TREATMENT) CENTER, DARRYL DUBROCA, in his)						
	15	official capacity, DOES I-XX, inclusive						
JAL WINUS OCESS LICENSE LAS VECAS, NV (702)384-0305	10	and ROE CORPORATONS I-XX, inclusive,						
E E SO	16	Defendants.						
มีย	17	Detenuants.						
	18	AFFIDAVIT OF EDWARD J. KIELTY RE: LEE E. SZYMBORSKI						
	19	STATE OF NEVADA)						
	20) ss. COUNTY OF CLARK)						
	20	COUNT OF CLARK)						
	21	Edward J. Kielty, being duly sworn deposes and says: that at all times herein affiant was						
	22	and is a citizen of the United States, over 18 years of age, licensed to serve civil process in the						
		state of Nevada under license #389, and not a party to or interested in the proceeding in which						
	23	this affidavit is made.						
	24							
		That affinit received a corrue of the DECEIDE OF CODY OF DEFENDANT OPDING						
	25	That affiant received a copy of the RECEIPT OF COPY OF DEFENDANT SPRING						
	26	MOUNTAIN TREATMENT CENTER AND DARRYL DUBROCA'S MOTION BAR MEDIA PRESENCE						
	27	DURING PRETRIAL HEARINGS ON ORDER SHORTENING TIME on June 23, 2014.						
	21							
	28							
		-1-						
		- •-						

That affiant attempted to deliver a copy of said documents to the Plaintiff, Lee E. Szymborski at 4605 Black Stallion Ave., Las Vegas, Nevada 89031, on June 23, 2014 and received no answer. Affiant posted a copy of said documents to the door.

J. Kielty Edward

Licensee# 389 Legal Wings, Inc. 1118 Fremont St. Las Vegas, NV 89101

Subscribed and Sworn to Before me this DRD day of June, 2014

γP Notarv TAMARA S. CONWAY Notary Public State of Nevada No. 98-4334-1 My Appt. Exp. August 22, 2014

LEUAL WINUS, INU. PROCESS LICENSE #389 LAS VEGAS, NV (702)384-0305 1

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CLERK OF THE COURT

DISTRICT COURT CLARK COUNTY, NEVADA

Lee Szymborski, Plaintiff(s) vs. Spring Mountain Treatment Center, Defendant(s) CASE NO.: A-14-700178-C

TO BE HELD AT CLC

DATE OF HEARING: August 12, 2014 TIME OF HEARING: 1:00 pm

ORDER SETTING MEDICAL/DENTAL MALPRACTICE STATUS CHECK AND TRIAL SETTING CONFERENCE

YOU ARE HEREBY ORDERED TO APPEAR at the Complex Litigation Center, 333 South Sixth Street, on August 12, 2014 at 1:00 pm to provide a status of the procedural posture and discovery status of this matter and for setting confirmation of a firm trial date. Trial counsel is required to be present at the conference. Failure of the designated trial attorney or any party appearing in proper person to attend may result in sanctions and/or dismissal.

Ennif P. Jogliatti DATED this 24th day of June, 2014

JENNIFER TOGLIATTI, CHIEF JUDGE

Certificate of Service

I hereby certify that on the date filed I placed the Order in the attorney folders in the Clerk's Office and/or mailed the order by first-class mail to any addressee listed below:

Lee É Szymborski, Pro Se 4605 black Stallion Ave. N. Las Vegas, NV 89031

Michael E. Prangle

Rose Najera, Judicial Executive Assistant

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	2	DISTRICT	CLERK OF THE COURT				
	3	CLARK COUNTY,					
	4	,					
	5	LEE SZYMBORSKI; ET AL.,	Case No.; A-14-700178-C				
	6	PLAINTIFF(S),					
	8	vs.	Dept. No.: XXXI				
	9	SPRING MOUNTAIN TREATMENT CENTER; ET AL.,					
	10 11	DEFENDANT(S).					
	12						
	13	ORDER SCHEDULING	<u>S STATUS CHECK</u>				
	14	TO: All Parties:					
۰.٨	15	YOU ARE HEREBY ORDERED TO APPEAR, in person, in District Court,					
h	16	Department XXXI, located at 200 Lewis Avenue, on JULY 29, 2014, at 9:00					
40	17	a.m., Courtroom 12B, for a Status Check reg	arding the non-compliance of				
	18	EDCR 7.21 by timely submitting the Order reg	arding: Motion for NRCP 54(b)				
	19 20	Certification heard June 24, 2014.					
	21	Failure to appear may result sanctions	s up to, and including, dismissal of				
	22	this action.					
A	₽ ²³	DATED t	nis 15 TH day of July, 2014				
2014	524		16				
RECEIVED		JOANNA	S. KISHNER				
		DISTRIC	T COURT JUDGE				
	28 J						
JOANNA KISI DISTRICT IUI DEPARTMENT LAS VEGAS, NEVA	HENER DGE XXXI	1					

1 2	CERTIFICATE OF SERVICE
3	I hereby certify that on or about the date filed, a copy of this Order was provided
4	to all counsel, and/or parties listed below via one, or more, of the following
5	manners: via email, via facsimile, via US mail, via Electronic Service if the
6	Attorney/Party has signed up for Electronic Service, and/or a copy of this Order was placed in the attorney's file located at the Regional Justice Center:
7	was placed in the attorney's the located at the Regional Justice Center.
8	LEE E. SZYMBORSKI
9	4605 BLACK STALLION AVENUE LAS VEGAS, NV 89031
10	LAS VEGAS, NV 05051
11	MICHAEL PRANGLE, ESQ.
12	KERRY J. DOYLE, ESQ. HALL, PRANGLE & SCHOONVELD, LLC
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17	TRACY L CORDORA
18 19	TRACY L. CORDOBA JUDICIAL EXECUTIVE ASSISTANT
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JOANNA KISHNER District Judge Department XXXI As Vegas, Nevada 89135	2

TRANSMISSION VERIFICATION REPORT

TIME : 07/16/2014 11:33 NAME : DEPT 31 FAX : 7023661412 TEL : 7026713634 SER.# : 000K0N596534





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ORĐR 1 Michael Prangle, Esq. CLERK OF THE COURT Nevada Bar No. 8619 2 Kerry J. Dovle, Esq. 3 Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 4 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144 5 (702) 889-6400 – Office 6 (702) 384-6025 – Facsimile Email: efile@hpslaw.com 7 Attorneys for Defendant Spring Mountain Treatment Center 8 and Darryl Dubroca 9 DISTRICT COURT 10 CLARK COUNTY, NEVADA 11 LEE E. SZYMBORSKI, CASE NO.: A-14-700178-C 12 DEPT. NO.: XXXI Plaintiff, 13 14 ORDER ON DEFENDANT SPRING VS. **MOUNTAIN TREATMENT CENTER** 15 SPRING MOUNTAIN TREATMENT AND DARRYL DUBROCA'S MOTION CENTER, DARRYL DUBROCA, in his TO DISMISS 16 official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive, 17 before Sr. Judge Joseph Bonaveniture, sitting For 18 Defendants. 19 20ORDER Defendants Spring Mountain Treatment Center and Darryl Dubroca's Motion to Dismiss, 2122 having come on regularly for hearing on June 24, 2014, in Department XXXI, the Honorable 23 Joanna S. Kishner presiding; LEE E. SZYMBORSKI appeared pro se, KERRY J. DOYLE, 24 ESQ., appeared on behalf of Defendants, SPRING MOUNTAIN TREATMENT CENTER, and 25 DARRYL DUBROCA; the Court having considered the pleadings on file and having heard oral 26 argument from the parties, good cause appearing therefore, the Court finds and orders as follows: 27 IT IS ORDERED, ADJUDGED, AND DECREED that, Defendant Spring Mountain 28 Treatment Center, and Darryl Dubroca's Motion to Dismiss is GRANTED. Mr.

FACSIMILE: 702-384-6025

89144

LAS VEGAS, NEVADA SUITE 200

FELEPHONE: 702-889-6400

HALL PRANGLE & SCHOONVELD, LL

1160 NORTH TOWN CENTER DRIVE

Page 1 of 2

07-73-14 Add:19 1

Szymborski's claims are based upon allegations of medical malpractice. As a result, the
 Complaint is required to be supported by a medical expert affidavit pursuant to NRS 41A.071.
 Mr. Szymborski failed to provide the requisite affidavit and as a result, both Spring Mountain
 Treatment Center and Mr. Dubroca are hereby dismissed from the instant action.

IT IS SO ORDERED.

DATED this $2l_{day of July, 2014.}$

JOANNA S. KISHNER T COURT JUDGE

Submitted By:

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HALL PRANGLE & SCHOONVELD, LLC KENNETH M. WEBSTER, ESO. Nevada Bar No.: 7205

KERRY J. DOYLE, ESQ.

¹⁴ Nevada Bar No.: 10571

15 || 1160 N. Town Center Dr., Ste. 200 || Las Vegas, NV 89144

Attorneys for Defendants Summerlin Hospital

4844-0011-1900, v. 1

Page 2 of 2

HALL, PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 FacSimile: 702-384-6025

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4	DISTRICT COURT
5	CLARK COUNTY, NEVADA
6	LEE SZYMBORSKI, PLAINTIFF(S) CASE NO.: A-14-700178-C
7	SPRING MOUNTAIN TREATMENT DEPARTMENT 31
8	CENTER, DEFENDANT(S)
9	CIVIL ORDER TO STATISTICALLY CLOSE CASE
10	Upon review of this matter and good cause appearing, IT IS HEREBY ORDERED that the Clerk of the Court is hereby directed to
11	statistically close this case for the following reason:
12	DISPOSITIONS:
13	Default Judgment Judgment on Arbitration
14	Stipulated Judgment
15	Involuntary Dismissal
16	Motion to Dismiss by Defendant(s)
17	Voluntary Dismissal
18	Non-Jury – Disposed After Trial Starts
19	Non-Jury – Judgment Reached
· 20	Jury – Verdict Reached Other Manner of Disposition
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	DATED this 22nd day of July, 2014.
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	DISTRICT COURT JUDGE
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	I 2 3 4 5 6 7 8	NEOJ Michael Prangle, Esq. Nevada Bar No. 8619 Kerry J. Doyle, Esq. Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144 (702) 889-6400 – Office (702) 384-6025 – Facsimile Email: <u>efile@hpslaw.com</u> Attorneys for Defendant Spring Mountain Treatment Center and Darryl Dubroca	Electronically Filed 07/30/2014 11:55:52 AM Man to During CLERK OF THE COURT				
	9		T COURT NTY, NEVADA				
-6025	10	LEE E. SZYMBORSKI,	CASE NO.: A-14-700178-C				
ADA 89144 Facsimile: 702-384-6025	11 12	Plaintiff,	DEPT. NO.: XXXI				
	13		NOTICE OF ENTRY OF ORDER ON				
EVADA FACS	14	VS.	NOTICE OF ENTRY OF ORDER ON DEFENDANT SPRING MOUNTAIN				
LAS VECAS, NEVADA 89144 02-889-6400 FACSIMILE	15	SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his	TREATMENT CENTER AND DARRYL DUBROCA'S MOTION TO DISMISS				
Las VECAS, 702-889-6400	16	official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,					
HONE:	17	Defendants.					
TELEPI	18 19	Please take notice that an Order granting Defendants Spring Mountain Treatment Center					
	20	and Darryl Dubroca's Motion to Dismiss was er	stered in the above entitled Court on the 23 rd day				
	21	of July, 2014, a copy of which is attached hereto	•				
	22	DATED this 30 th day of July, 2014.					
	23	HALL PRA	ANGLE & SCHOONVELD, LLC				
	24		Doyle, Esq.				
	25	Nevada Ba	DOYLE, ESQ. r No.: 10571				
	26	1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144					
	27	Attorneys for Defendants Summerlin Hospital					
	28						
		Page	1 of 2				

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suffe 200



HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

	1 2 3 4 5 6 7 8 9	ORDR Michael Prangle, Esq. Nevada Bar No. 8619 Kerry J. Doyle, Esq. Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144 (702) 889-6400 – Office (702) 384-6025 – Facsimile Email: <u>efile@hpslaw.com</u> Attorneys for Defendant Spring Mountain Treatment Center and Darryl Dubroca	Electronically Filed 07/23/2014 04:42:55 PM CLERK OF THE COURT
IA I	10	DISTRIC	
SCHOONVELD, LLC wn Center Drive iez 200 Nevlaa 89144 Facsimile: 702-384-6025	11 12 13	CLARK COUN LEE E. SZYMBORSKI, Plaintiff,	NTY, NEVADA CASE NO.: A-14-700178-C DEPT. NO.: XXXI
HALL PRANCLE & SCHOO 1160 North Town Centi Suffe 200 Las Vegas, Neyada 4 Stlephone: 702-889-6400 Facsi	14 15 16 17	vs. SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,	ORDER ON DEFENDANT SPRING MOUNTAIN TREATMENT CENTER AND DARRYL DUBROCA'S MOTION TO DISMISS
HALL	18	Defendants.	before SR. Judge Joseph Bonaventure, sitting for
	19 20		DER
	21		Center and Darryl Dubroca's Motion to Dismiss,
	22		24, 2014, in Department XXXI, the Honorable
	23	Joanna S. Kishner presiding; LEE E. SZYMB	ORSKI appeared pro se, KERRY J. DOYLE,
	24	ESQ., appeared on behalf of Defendants, SPRIN	IG MOUNTAIN TREATMENT CENTER, and
	25	DARRYL DUBROCA; the Court having consid	lered the pleadings on file and having heard oral
	26 27	argument from the parties, good cause appearing	therefore, the Court finds and orders as follows:
	27	IT IS ORDERED, ADJUDGED, AND Treatment Center, and Darryl Dubroca's	DECREED that, Defendant Spring Mountain Motion to Dismiss is GRANTED. Mr.
		Page	1 of 2 07-13-14 208:19 18 TA 3

Szymborski's claims are based upon allegations of medical malpractice. As a result, the
 Complaint is required to be supported by a medical expert affidavit pursuant to NRS 41A.071.
 Mr. Szymborski failed to provide the requisite affidavit and as a result, both Spring Mountain
 Treatment Center and Mr. Dubroca are hereby dismissed from the instant action.

IT IS SO ORDERED.

DATED this 2 day of July, 2014.

HALL PRANGLE & SCHOONVELD, LLC

KENNETH M. WEBSTER, ESQ.

Nevada Bar No.: 7205

JOANNA S. KISHNER

CT COURT JUDGE

Submitted By:

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FACSIMILE: 702-384-6025 HALL PRANGLE & SCHOONVELD, LLC 1164 North Town Center Drive LAS VEGAS, NEVADA 89144 SUITE 200 l'ELEPHONE: 702-889-6400

KERRY J. DOYLE, ESQ. 14 Nevada Bar No.: 10571 1160 N. Town Center Dr., Ste. 200 15 Las Vegas, NV 89144 16 Attorneys for Defendants Summerlin Hospital 17 18 4844-0011-1900, v. 1

Page 2 of 2

	1	CODE		Ŷ					
	2	LEE É SZYMBORSKI 4605 Black Stallion Avenue	FI	-6					
		North Las Vegas, Nevada 89031							
	4	702-609-6762 PLAINTIFF IN PROPER PERSON	Aug 7 2 2	e PH 'I⊿					
	5	DISTRICT	COURT Sin to Left TY, NEVADA	, .					
	6	CLARK COUN	TY, NEVADA	COURT					
	7								
	8	LEE E SZYMBORSKI							
	9	Plaintiff,							
	10	-VS-	CASE NO.A-14-700178-C						
	11	SPRING MOUNTAIN TREATMENT	DEPT. NO.XXX1						
	12	CENTER, DARRYL DUBROCA, in his official							
	13	capacity,DOES 1-XX,inclusive,and ROE	A - 14 - 700178 - C Mrch						
	14	CORPORATIONS 1-XX, inclusive,	Motion to Reconsider 4110908 011000010000000000000000000000000						
	15	Defendant(s).							
	16	· ·							
	17	MOTION FOR RECONSIDERATION, OR	IN THE ALTERNATIVE, MOTION TO SET						
	18	ASI	<u>DE</u>						
	19	HEARIN HEARIN							
	20		BORSKI in the above entitled action						
	21	and hereby files the instant Motion For Re	econsideration, or in the Alternative,						
	22	Motion to Set Aside, Pursuant to E.D.C.R.	2.24 and N.R.C.P.60,of this Courts Order						
	23	of June 24,2014.							
	24	ARGUMENT							
Ō	25	A. LEGAL STANDARD FOR A MOTIC	ON FOR RECONSIDERATION AND						
	26 A	MOTION TO SET ASIDE							
CLERK OF THE COURT	20 AUS 0 7 2014	Plaintiff Lee E. Szymborski respectfully r	requests that this Court reconsider its June						
T	22014	24, 2014 Order. Plaintiff makes this requ	lest, pursuant to EDCR 2.24, which allows						
U RI				32					

this Court to set a matter for re argument or resubmission and hence ; render a new or amended order. A motion for reconsideration should concisely ,and without argument, direct the courts attention to a controlling matter that was overlooked misapprehended specifically that the correct document was submitted in the Complaint under "EXHIBIT1" .because under NRS 41A.100 Required evidence; exceptions Rebuttable presumption of negligence. "the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to demonstrate the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury"In (EXHIBIT 1) are the 9 pages of substantiated charges by The State Of Nevada Department Of Health And Human Services . This is the regulating body and experts in determining what an unsafe discharge is and this is The Controlling Matter in The Complaint. There is no better expert and that the results of "The Bureau Of Health Care Quality Control And Compliance investigation is the best certification you can get in determining a safe of an unsafe discharge, see (EXHIBIT A) RULE 1.SCOPE AND APPLICATION OF **RULES** Spring Mountain Treatment Center Is A Licensed Hospital with The State Of Nevada and since they are guilty of breaking Nevada Laws Rules and Procedures and their unsafe discharge perpetrated a Felony Crime against The State Of Nevada of which I (The Public) am a victim and therefore the Defendants are held to "Strict Liability" and that I as a permanently disabled victim am being put under duress and am forced to sue for damages because they "think they are above the law and show an "evil mind" and refuse to accept their obvious Liability to The Public. Since this case also involves PUBLIC SAFETY, THE COURT SHALL MAKE SUCH ORDER AS THE INTERESTS OF JUSTICE REQUIRE.

Additionally, Under Nevada Rule of Civil Procedure 60(b) Mistakes; Inadvertence; Excusable Neglect, I Hereby Motion that my "Opposition" be heard because although it was timely filed by "All States Paralegal Services" the Paralegal I hired to type the" Opposition"I did not discover t my "Opposition" wasn't served until it was revealed by The Judge at the June 24 2014 hearing, or else "I would have served it"; therefore; "mistakes; inadvertence; surprise or excusable neglect; applies (see EXHIBIT B") Under RULE 60 (2)NEWLY DISCOVERED EVIDENCE; Governor Sandovals Office has notified me on August 5, 2014 that Mike Wilden Chief Of Staff is aware of my "Request for Prosecution " as instructed by Chief Deputy Attorney General Linda C.Anderson .see(EXHIBIT C) and is actively seeking a resolution .Therefore, I Pray for Just and Honorable Relief from this Court

Lee E Baymborski 4605 Black Stallion Avenue North/Las Vegas Nevada

EXHIBIT A

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EXHIBIT 1

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BRIAN SANDOVAL Governor

MICHAEL J. WILLDEN Director



TRACEY D. GREEN, MD Chief Medicel Officer

STATE OF NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Hea'th Facilities/Lab Service3 727 Fainfew Dr, Sulle E Carson City, Nevada 89701 (775) 884-1030 Faz: (775) 684-1073

Health Facilities/Lab Services 4220 S. Maryland Parkway Suite 810, Building D Fas: (702)480-0510 Fas: (702)480-0510 Fas: (702)480-0510 Fas: (702)480-0510 Fas: (702)480-0510 Carson Coly, NewNey Say Fas: (776) 687-7552

³¹ Radiation Control 2080 E. Framingo Sulte 319 Las Vegas, Nevada 89119 (702) 486-5280 Fax: (702) 486-5024

Child Care Ucensing 727 FairMew Dr. Suite E Carson City, Nevade 89701 (776) 584-4463 Fax: (775) 684-4484

Chid Care Licensing 4160 S. Pecos, Sie 140 Las Vegas, Nevada 89121 (702) 486-7918 Fex: (702) 486-6650

Child Care Licensing 1010 Ruby Viste, Sie 101 Elko, Nevada 89801 (775) 753-1237 Fex: (775) 753-1336 August 19, 2013

Lee Szymborski 4605 Black Stallion Avenue North Las Vegas, NV 89032

Re: Complaint Number NV00035655

Dear Mr. Szymborski,

With reference to your complaint against Spring Mountain Treatment Center, an unannounced inspection was completed on 07/09/2013 to investigate your concerns about admission, transfer and discharge, quality of care responsible party not notified of resident's change in condition and resident safety.

During the investigation, the State Inspector interviewed patients/residents, reviewed their records, interviewed staff, and made observations while the facility or agency was in operation. The facility's or agency's actions were evaluated using applicable state and/or federal rules and regulations to determine if they were in compliance.

Based on the completed investigation, it was concluded that the facility or agency was not in compliance with rules and/or regulations. The Bureau will take appropriate measures to ensure the facility/agency is well-informed of the specifics of non-compliance, and that they will exercise their due diligence in preventing similar incidents in the future.

You may access the investigation results on our website following these steps:

- Go to http://health.nv.gov/HCQC.htm
- On the right bar under Facility Services,
- Select Individual Health Facilities Inspection and Survey Results
- Select the facility type from the five categories
- Enter the facility name, provider type and click Start Search
- Select the facility; then select the survey date you want to review

Thank you for reporting your concerns. Please know that your voice will help improve the services of health facilities and agencies. If we can be of further assistance, please contact the investigator, Debra Seeger, at 702-486-6515.

Sincerely, Sheche w

For: Julie Bell, Health Facilities Manager

Public Health Working for a Safer and Healthier Nevada

Division of Public and Behavioral Health						
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE SURVEY COMPLETED	
	NVS3268HOS1		B. WING		07/09/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		7000 WES	T SPRING M	OUNTAIN ROAD		
SPRING	MOUNTAIN TREATMI	ENT CENTER LAS VEG	AS, NV 8911	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OEFICIENCY)	D BE COMPLETE	
S 000	Initial Comments		S 000			
	a result of a compla 6/25/13, and finaliz accordance with No Chapter 449, Hosp The census at the f 63. Five discharged reviewed. Complaint #NV000 deficiencies cited. (S0602) The findings and co by the Health Divis prohibiting any crim actions or other cla	Deficiencies was generated as aint investigation initiated on ed in your facility on 7/9/13, in evada Administrative Code, ital. time of the investigation was d medical records were 35655 was substantiated with (See Tags S0146, S0153 and onclusions of any investigation ion shall not be construed as hinal or civil investigations, tims for relief that may be rty under applicable federal,				
S 146 SS=D	 An evaluation of to discharge planni limitation, consider The needs of the services and the at (b) The capacity of (c) The possibility of previous care setting appropriate placent discharge. This Regulation is Based on interview review, the facility to discharged to a satisfy 	f the needs of a patient relating ing must include, without ation of: ne patient for postoperative vailability of those services; the patient for self-care; and of returning the patient to a ng or making another ment of the patient after not met as evidenced by: v, record review and document failed to assure the patient was fe environment for 1 of 5				
If deficiencie LABORATOR	sampled patients (s are cited, an approved y DIRECTOR'S OR PROVI		hin 10 days aft NATURE	er receipt of this statement of deficiencies. TITLE	(X6) DATE	

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	<u>of Public and Behavi</u>	ioral Health	<u> </u>			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SU COMPLET	
MINU FLAM	1 CONTECTION		A, BUILDING:			
	•	NVS3268HOS1	B. WING		07/09/2	2013
				ITATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER					
SPRING			AS, NV 8911	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE 🔍 🤇	(X5) COMPLETE DATE
S 146	Continued From pa	nge 1	S 146			
	Findings include:					
1	Patient #1					:
	and discharged on	nitted to the facility on 5/3/13 5/14/13 with diagnoses s not otherwise specified and				
	Note documented trepidation about g	PM, the Nursing Progress the patient had much oing back to the father's home stless when talking about the				
	documented the M confirm the addres documented the pa address. The patie	PM, the Masters of Art (MA) A met with the patient to is of the apartment. The MA atient was vague about the int needed to stop by the ck up the patient's debit card e new apartment.				
	revealed the patier upon discharge. The vidence of an add was no documente	ial Services Discharge Note ht would live in an apartment here was no documented dress for the apartment. There ed evidence the Case Manager ent had made arrangements to nt.				
-	identified the patie	Care Plan, dated 5/14/13, nt was to go to the father's to an address in North Las				
	on 5/14/13 at 8:50 did not want to ret	an Discharge Progress Note, AM, documented the patient urn to the patient's fathers ping conflict. The note				
II deficienci	es are cited, an approved	plan of correction must be returned v	vithin 10 days ai 6899	Iter receipt of this statement of deficiencie	s. If continuation	on sheet 2 of !

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Division	of Public and Behav	ioral Health			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(-) ··· + = · · · · ·		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:		
			B. WING		07/09/2013
	<u> </u>	NVS3268HOS1			
NAME OF F	ROVIDER OR SUPPLIER				
SPRING	MOUNTAIN TREATM				
			AS, NV 8911		ON 1 100
(X4) ID	SUMMARY \$TA (FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	LO BE COMPLETE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
			<u> </u>		<u></u>
S 146	Continued From pa	age 2	S 146		
	documented the pa	atient participated in treatment			
	planning to find hou				
	The Diels Menance	investigated a talaphoes			
		investigated a telephone patient's father. The			
	Administrative Rev	iew documented placement to			
	the apartment was	not verified.			
		the Dick Menogor			
	On 7/9/13 at 8:49 A	AM, the Risk Manager did not follow up on verifying			
	the identified apart				
	· ·				
	On 7/9/13 at 11:20	AM, Licensed Social Worker			
	(LSW) #2 explaine	d multiple telephone messages tient's father. The father would			1
	state the patient co	ould return to the father's home			i i
	The next telephone	e message from the father	1		
	would demand the	patient not be discharged to	,		
	the father's home.	The LSW acknowledged she ctly with the patient's father.			
	The LSW explaine	d during the first meeting with			
	the patient, the pat	tient expressed a willingness to			
	return to the father	's home and would work on			i I
	finding an apartme	ent from the father's home. The c'to the large number of			
	natient's on the LS	Wis case load, the LSW had to	,		
		e calls and discharge planning			
,	to the MA.				
ĺ	The LEW evolution	d when a patient identified thei	-		
		e LSW would try to obtain as			
	much information	as possible regarding the			
	address and name	of the apartrment. If the LSW			
	was unable to veri	fy placement, the physician prior to discharge from the			
	facility.	nor to discharge it ont the			ĺ
1					
	Continuing Care P	lan Discharge Planning,	ł		
į		olicy #PC.067, revised 4/13,	1		
If deficienci	documented:	I plan of correction must be returned w	ilhin 10 days af	ter receipt of this statement of deficiencies	<u> </u>
IT Deliciencie STATE FOR				00KP11	If continuation sheet 3 of 9

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	<u>if Public and Behavi</u>	ioral Health	<u> </u>			(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING:			(X3) DATE SURVEY COMPLETED		
AND MLAN L	- CORRECTION			A, BUILDING, _			ļ
	•			B. WING		07//)9/2013
	·	NVS3268HC	DS1				<u>13/2013</u>
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	IATE, ZIP CODE		
					OUNTAIN ROAD		1
SPRING	MOUNTAIN TREATMI		LAS VEGA	AS, NV 8911			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 146	Continued From pa	ige 3		S 146			
	Procedure: "4.0 In developing	a the continuing a	care plan, the				
	following is evaluat Housing needs and Personal support s	ed by the Case M d/or placement is:	/lanager: 4.4				
	"5.0 Continuing of to the patient and f and documented in Where and with wh following discharge	iamily/guardian, a n the medical reco nom the patient w	is appropriate, prd5.2				
	"6.0 The Social S completed for even discharge. This no to: 6.1 Living arran	ry patient at the til te includes, but is	me of				
	Severity: 2	Scope: 1					
	Complaint #NV000	035655					
S 153 SS=D	NAC 449.332 Disc	charge Planning		S 153			
	11. The patient, <u>n</u> patient and any of for the patient <u>mu</u> information as is r the post-hospital of	her person involv st be provided wit necessary to prep	ed in caring th-such are them for				
	This Regulation is Based on Interviev review, the facility patients families p and #5).	w, record review a failed to notify 2	and document of 5 sampled			·	
If deficiencia		d plan of correction m	nust be returned w	ithin 10 days at	ter receipt of this statement of 00KP11	deficiencies. If conti	uation sheet 4 of \$

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN		IDENTIFICATION NUMBER:	A. BUILDING:		COM CLICK	
		NVS3268HOS1	B, WING		07/09/2013	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SPRING	MOUNTAIN TREATM	ENT CENTED				
			AS, NV 891			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL		
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR		
170				DEFICIENCY)		
0.453			S 153			
S 153	Continued From pa	ige 4				
	Findings include:			1		
	Patient #1		1			
		We die Are feelûneen E/2/42				
		nitted to the facility on 5/3/13 5/14/13 with diagnoses				
	and discharged on	s not otherwise specified and			-	
C	spice abuse.	s not only may opeomore and				
			1			
1	On 5/10/13 at 9:00	AM, the LSW #2 documented				
	the case manager	received a voice mail from the				
	patient's father say	ing the patient was not to			1	
		The LSW documented the				
		Id assist the patient with	ļ			
	alternative placem	ent.		2 2 1		
	On 5/10/13 of 11/1	5 AM, the MA documented the				
		nted the patient to return to his				
		e discharged "today".				
		_				
		er documented evidence the				
		s contacted to confirm				
	discharge to the pa	atient's father's home.				
	0 . 5H 4/40 -1 0:00	Did the Mit desumanted the				
) PM, the MA documented the atient. The patient requested				
1	the father's teleph	one number and told the father				
		d and a taxi would transport				
	the patient to the fa					
			[
	The Risk Manager	investigated a telephone				
		patient's father. The				
		view documented the discharge	e	i.		
	was not coordinate	ed with the tamily.				
	discharge was not	th the father on the day of				
	uscharge was not					
	On 7/9/13 at 9:50	AM, the Risk Manager				
	acknowledged the	facility should have arranged				
	for the taxi driver to	o wait at the patient's father's				
lí deficiencie	s are cited, an approved	plan of correction must be returned w	ithin 10 days a	fter receipt of this statement of deficiencle	3.	
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	of Public and Behav	ioral Hea <u>lth</u>			(X3) DATE	
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1112 1 2 11						
		NVS3268HOS1	B. WING		07/0	9/ <u>2013</u>
	PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, S	TATE, ZIP CODE		
		7000 WE	ST SPRING M	IOUNTAIN ROAD		
SPRING			AS, NV 8911			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S 153	Continued From pa	ige 5	S 153		•	
	house until the pati then drive the patie	ent <u>retreived the debit ca</u> rd, int to the new apartment.				1
À.	family member sho patient's discharge alright-with the pati acknowledged the been contacted by patient being disch					
	Four additional dis reviewed. Patient #5	charged medical records were				
	Patient #5 was add and discharged on major depressive of	nitted to the faciity on 6/4/13 6/18/13, with a diagnosis of disorder.				
	worker/Case Mana patient's discharge evidence the famil medications and for	umented evidence the social ager notified the family of the a. There was no documented y was educated on the patient ollow up care needed. There lact from the social ager after 6/6/13.	S			
	Continuing Care F Interdisciplinary Pe documented:	lan Discharge Planning, blicy #PC.067, revised 4/13,				
	Procedure:	,				l İ
	"4.0 In developin following is evalua Personal support	ng the continuing care plan, the ited by the Case Manager4.5 systems"	3			
	to the natient and	care plans are communicated family/guardian, as appropriate	e,		08	
If deficienci STATE FO		d plan of correction must be returned t	within 10 days at 6899	fter receipt of this statement of deficienci 00KP11	ça. If continu	uation sheet 6 d

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	of Public and Behav	ioral Hea <u>lth</u>			(X3) DATE SURVEY
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		NVS3268HOS1	B. WING	·	07/09/2013
		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SPRING			AS, NV 8911	7 PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE I COMPLETE
S 153	Continued From pa	age 6	S 153		
	and documented in	the medical record"			
	Severity 2	Scope: 1	•		5
	Complaint #NV000	35655			
S 602 SS=D	NAC 449.394 Psyc	chiatric Services	S 602		
	and procedures fo treatment and beh that are <u>consistent</u> inclusive, to ensur- services are safely hospital shall ensu procedures protec patient. This Regulation is Based on interview review, the facility were at Patient #1 patient would have	develop and carry out policies r the provision of psychiatric avioral management services with NRS 449.765 to 449.786, e that the treatment and y and appropriately used. The me that the policies and t the safety and rights of the s not met as evidenced by: w, record review and document failed to identify what weapons 's mother's home and if the e access to the weapons.			
	Findings include: Patient #1				
	and discharged of	Imitted to the facility on 5/3/13 n 5/14/13 with diagnoses is not otherwise specified and			
	Assessment Tool multiple scab area Comprehensive A the patient's fathe were self inflicted	0 PM, the Comprehensive documented patient had as on his legs. The assessment Tool documented er stated the patient's wounds with a sharp object.			
If deficienc	ies are cited, an approve	d plan of correction must be returned a	vithin 10 days a 6899	after receipt of this statement of deficiencies	s. If continuation sheet

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE			CONSTRUCTION		LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NU		A. BUILDING: _			
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		NVS3268HOS1	ļ	B. WING		07/0	9/2013
NAME OF F	ROVIDER OR SUPPLIER				ATE, ZIP CODE		
					OUNTAIN ROAD		
SPRING	MOUNTAIN TREATM		LAS VEGA	S, NV 89117			
	SUMMARY STA	ATEMENT OF DEFICIENCIE	s	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5) COMPLETE
(X4) ID PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY	FULL		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ROPRIATE	DATE
TAG	REGULATORY OR U	SC IDENTIFYING INFORM		1/10	DEFICIENCY)		
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	On 5/6/13 at 2:42 F	PM, LSW #1 docume	ented				1
	weanone were at fl	he patient's mothers	home, but	i İ			ļ
	not at the natient's	fathers home. The L	SW did				
	not identify what w	eapons were at the p	patient's				
	mothers home. Th	ere was no documer	nted				1
	evidence the patie	nt's mother was cont	acted to				· ·
	verify where the w	eapons were located	•				
		· · · · - ·					
	Patient Continuing	Care Plan, dated 5/	14/13,				
	identified safety co	ncerns, including we	apons in				1
	the patient's home	were non-applicable	auo po				
1	ventied by the pati	ent's father. There w	25 10				
	contacted for verifi	nce the patient's fath	lei was				
	Contacted for verin						1
	On 5/14/13 at 2:30	PM, the MA docum	ented the				
	i natient asked the	MA if the taxi would t	be able to				
	take the patient to	the mother's house	after the	1			
	patient went to the	a father's house. The	MA				
	documented the p	atient would have to	pay for any				
	taxi after being dro	opped off at the fathe	er's house.	ţ ŀ			
I	1			1			
	On 7/9/13 at 8:49	AM, the Risk Manag	er)				1
	confirmed the LSV	V did not follow up o	L)	1			
	identifying what w	eapons and if the pa			· · · · · · · · · · · · · · · · · · ·		
	access to the wea	pone prior to dischal	.ge.				
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1	Interdiscipling Care P	olicy #PC.067, revise	ed 4/13	1			
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	8.0 Securina We	aponsSocial Servic	ces staff		ĺ		
	initiates attempts	to secure the weapo	ns,	1			
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	that may be able t	to locate and secure	the				1
	itemsWeapons	are not considered s	ecured until				l
	verification has be	een received that the	task is	F	1		Į.
	completed"			1			
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If deficiencies are clied, an approved plan of correction must be returned within 10 days after receipt of this statement of de STATE FORM 6699 00KP11 00KP11

STATE FORM

Division	of Public and Behav	iora <u>l Health</u>	-			·
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANU PLAN	4			<u></u>		
	•	NVS3268HOS1	B. WING		07/09/2013	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
SPRING	MOUNTAIN TREATM			OUNTAIN ROAD		
			GAS, NV 8911	PROVIDER'S PLAN OF CORRECT	ON (X5)	
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EXHIBIT B

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1 2 3 4	LEE E. SZYMBORSKI 4605 Black Stallion Ave N. Las Vegas, NV 89031 (702) 609-6762 Plaintiff in Proper Person	Electronically Filed 06/13/2014 01:37:27 PM
5	DISTRICT COU	RT
6	CLARK COUNTY, N	EVADA
7 8 9 10 1,1 12	LEE E. SZYMBORSKI, Plaintiff, vs. SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,	Case No. A-14-700178-C Dept No. XXXI
13) Defendants.	
14 15 16	OPPOSITION TO MOTION TO DI COMES NOW, Plaintiff, and files this Opposit	
	follows:	
17 18	1. That Defendant take nothing by way of its mo	tion.
19	2. That the court acknowledge Defendant SPRING	B MOUNTAIN TREATMENT CENTER
20	was found to be in violation of its own policies as we	I as laws and codes, as set forth in the
21	Complaint; and set forth herein.	
22	3. That the court acknowledge the Complai	nt addresses negligence on the part of
23	defendants, and each of them.	
24	4. That the court acknowledge Plaintiff's cla	
25	Negligence Per Se" is not medical malpractice, but malpr	
26	patient, but other employees of Spring Mountain Treatme	ent Center, as detailed herein.
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This Opposition and Countermotion is made and based upon the pleadings and files herein, the affidavit of Plaintiff, and any oral argument that may be adduced at the time of trial.

Dated this day of hove LEE E. SZYMBOL Plaintiff in Proper

I. INTRODUCTION

8 This is an action of NEGLIGENCE on the part of SPRING MOUNTAIN TREATMENT 9 CENTER, FOR PROFIT business that has violated codes and statutes pertaining to the safe release 10 of patients, and NOT medical issues relation to its former patients. Plaintiff does set forth a cause 11 of action for "Malpractice, Gross Negligence, Negligence Per Se." Nothing in Plaintiff's complaint 12 seeks a judgment for MEDICAL malpractice; and the motion to dismiss should be summarily 13 denied.

Defendants herein desire this action to be classified as "medical malpractice" solely to find fault with the Complaint. It is clearly negligence and there has been malpractice, but the malpractice is in the area of social work, and the court should acknowledge the same.

⁷ "Malpractice" in the practice of social work means conduct which falls below the standard of care required of a licensee under circumstances which proximately causes damage. In fact, this definition itself is in the Complaint. Thus, Defendant's allegations that this matter should be procedurally dismissed is meritless. In this matter, there is clearly "malpractice" - but it is NOT medical malpractice; not in the process of a surgery or operation, but in the context of the mandatory social work that is required - and EXPECTED of a "for profit" psychological facility that earns in excess of TWO BILLION DOLLARS ANNUALLY.

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II. STATEMENT OF FACTS

On or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING MOUNTAIN TREATMENT CENTER, provided an unauthorized, unsafe discharge of a mentally ill adult patient, to wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. Exhibits are provided attached to the Complaint.

That the adult patient was provided a taxi ride, released without any money; without appropriate medication, without the ability to care for himself, and being a danger to both himself and other.

SPRING MOUNTAIN TREATMENT CENTER was directed by KATHLEEN BUCHANAN to provide a Guardianship for the patient but failed to do so.

SPRING MOUNTAIN TREATMENT CENTER was directed NOT to release the patient to the residence of Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed windows, walls, doors, furniture, and completely destroyed the interior of the residence, before going missing for three weeks. (A missing persons report was filed by NLVPD.)

An investigation by the Division of Public and Behavioral Health substantiated that Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332, Discharge Planning, based upon evidence by interview of staff, record review and document review.

It was determined, by the Division of Public and Behavioral Health. that the facility failed to assure the patient was discharged to a safe environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with diagnoses including psychosis not otherwise specified and spice abuse.

b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much trepidation about going back to the father's home. The patient was restless when talking about the father.

c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the address of the apartment. The MA documented the patient was vague about the address. The patient

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needed to stop by the father's home to pick up patient's debit card prior to going to the new
apartment.

d. Review of the Social Services Discharge Note revealed the patient would live in an
apartment upon discharge. There was no documented evidence of an address for the apartment.
There was no documented evidence the Case Manager confirmed the patient had made arrangements
to live in the apartment.

c. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to father's
home first then on to an address in North Las Vegas, Nevada.

9 f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the
10 patient did not want to return to the patient's father's home due to ongoing conflict. The note
11 documented the patient participated in treatment planning to find housing.

g. The Risk Manager investigated a telephone complaint from the patient's father. The
 Administrative Review documented placement to the apartment was not verified.

h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on
verifying the identified apartment.

i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone
messages were left by the patient's father. The father would state the patient could return to the
home; the next telephone message from the father would demand the patient not be discharged to
the father's home. The LSW acknowledged she did not speak directly with the patient's father. The
LSW stated due to the large number of patients on the LSW's caseload, the LSW had to delegate
telephone calls and discharge planning to the MA.

j. The LSW indicated when a patient identified their own placement, the LSW would try to obtain as much information as possible regarding the address and name of the apartment. If unable to verify placement, the physician would be notified prior to discharge from the facility.

k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented the patient did not want to return to his father's home due to ongoing conflict. The note documented the

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1 patient participated in treatment planning to find housing.

An evaluation of the needs of a patient relating to discharge planning must include, without
limitation, consideration of:

a. The needs of the patient for postoperative services and the availability of those services.

b. The capacity of the patient for self-care; and

c. The possibility of returning the patient to a previous care setting or making another a
appropriate placement of the patient after discharge.

9 SPRING MOUNTAIN TREATMENT CENTER violated NACT449.394. Psychiatric 10 Services, which requires that a hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 11 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately 12 used. The hospital shall ensure that the policies and procedures protect the safety and rights of the 13 14 parties - and the public at large. Defendant SPRING MOUNTAIN TREATMENT CENTER has 15 failed to met these statutes and regulations, and the issue of negligence set forth in the Complaint is appropriate. 16

Due to the failure to meet these responsibilities, the patient, was driven by taxi to the home
of Plaintiff, and dropped off ("dumped"), at the expense of the SPRING MOUNTAIN
TREATMENT CENTER, where he proceeded to cause significant property damage to Plaintiff's
residence, and then, go missing.

When the patient was located, he had sustained wounds from a self inflicted injuries with a sharp object, using weapons obtained at the home of his mother, which was not where he was "dumped."

The patient care plan, dated 5/14/13 indicated that safety concerns, including weapons, in the
 patient's home were non-applicable and verified by the patient's father. There was no documented
 evidence the patient's father was contacted for verification. Furthermore, Defendant SPRING

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MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a home for the patient,
 therefore, even confirming no weapons in father's home was not reasonable to consider this non applicable.

In violation of the stated statutes, it was determined that the LSW at SPRING MOUNTAIN TREATMENT CENTER did not follow up on identifying what weapons and if the patient had access to weapons prior to discharge. ("8.0 Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining permission and contacting any person that may be able to located and secure items... Weapons are not considered secured until verification has been received that the task is completed...')

10Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER, and11failure to protect its patients, due directed to the patient "dumping". SEAN T. SZYMBORSKI was12convicted of criminal charges related to the property destruction at the home of Plaintiff, rather than13receiving treatment for his known mental illness.

Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless disregard of the patient's psychiatric condition in pre-paying for a taxi to dump him at an verified location [Plaintiff's residence], without notice to occupants, without money, and without the ability to provide care for himself due to long standing mental illness.

The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver the statutory mandated care to patients in their custody and control resulted in systematic disregard of the serious psychological and medical conditions and resulted in adverse consequences, which predictably flow from such failures, and caused damages to patients and others, who became victims of such disregard.

Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS (\$2,000,000,000). There has undoubtedly been negligence on the part of Defendant. Plaintiff has presented a prima facia case in his Complaint and herein for negligence.

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III. LEGAL STANDARD

2 Defendant seeks to dismiss this matter, allegedly for failure to provide an Affidavit in support of an alleged claim for medical malpractice, or the standard 'failure to state a claim upon which relief can be granted.'.

In fact, as detailed above, this is not an action for medical malpractice, but for malpractice 5 in the area of social work, as stated in the very cause of action in the complaint; and as set forth 6 7 herein.

If the court feels in any measure, that the facts are not pled with specificity, or that Plaintiff 8 needs to obtain other documents, Plaintiff requests leave of the court to amend the complaint, instead 9 10 of dismissing the Complaint.

Given that Defendant's motion to dismiss misrepresents this as an action for medical 11 malpractice, which it is not, Plaintiff believes the motion should be summarily denied. As for the 12 allegation of failure to state a claim, Plaintiff believes the motion stands on its own, but if it pleases 13 the court, he will seek leave to amend the complaint, rather than dismissing the complaint. This 14 court has the authority to allow leave to amend rather than dismissal in this matter. 15

16 The purpose of summary judgment is to obviate trials when they would serve no useful purpose. Short v. Hotel Rivera, Inc., 79 Nev. 94; 378 P.2d 979 (1963); Corey v. Hom., 87 Nev. 32, 17 482 P.2d 814 (1971), Olson v. Jacometti, 91 Nev. 241, 533 P.2d 1360 (1975). 18

Summary judgment is applicable only where it is quite clean that no genuine issues remain for trial. NRCP 56(a) and (c).

Any presence of real and material issue of fact precludes summary judgment. The presence of real and material issues of fact precludes further consideration of motion for summary judgment under N.R.C.P. 56 because it is not sufficient that court may not credit evidence to be offered or that weight of evidence is clearly in favor of one party. Under such circumstances parties are entitled to trial by jury to determine facts. Plaintiff does not expect Defendant to pay on an alleged contract when the contract cannot be produced. Parman v. Petricciani, 70 Nev. 427, 272 P.2d

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492 (1954), cited, Bynum v. Frisby, 70 Nev. 535, at 538, 276 P.2d 487 (1954), McColl v. Scherer, ŀ 73 Nev. 226, at 231, 315 P2d 807 (1957), Magill v. Lewis, 74 Nev. 381, at 385, 333 P.2d 717 2 (1958), Zalk-Josephs Co. v. Wells Cargo, Inc., 77 Nev. 441, at 445, 366 P.2d 339 (1961), Dredge 3 Corp. v. Husite Co., 78 Nev! 69, at 86, 369 P.2d 676 (1962), Short v. Hotel Riviera, Inc., 79 Nev. 94, at 96, 378 P.2d 979 (1963), Dredge Corp. v. Wells Cargo, Inc., 80 Nev. 99, at 103, 389 P.2d 394 (1964), Tomiyasu v. Golden, 81 Nev. 140, at 161, 400 P.2d 415 (1965), dissenting opinion, Shockey 6 v. Harden Ins. Agency, Inc., 98 Nev. 138, at 140, 643 P.24 849 (1982), Sawyer v. Sugarless Shops, Inc., 106 Nev. 265, at 269, 792 P.2d 14 (1990), see also Plaza v. City of Reno, 111 Nev. 814, 898 د. اچک د زه P.2d 114 (1995)

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10 The pleadings and proof offered in a motion for summary judgment are construed in the light 11 most favorable to the non-moving party. Hoopes v. Hammargren, 102 Nev. 425, 729, 725, P.2d 238, 12 241 (1986). "Once the movant has shown the absence of dispute as to material facts, the burden 13 shifts to the non-movant who must 'set forth specific facts demonstrating the existence of a genuine 14 issue for trial or have summary judgment entered against him." Garvey v. Clark County, 91 Nev. 15 127, 532 P.2d 269 (1975).

16 In this circumstance, the case is a negligence case, not a medical malpractice action. While 17 Defendant was entrusted to provide medical care to patients and a duty to provide adequate medical 18 care, they were also required by duty to provide adequate and appropriate social and legal 19 obligations, such as preparing a guardianship as directed that was not done. The context of these 20 statements in his complaint were to provide the facts and details surrounding the negligence, which is clearly the theme and concern set forth in Plaintiff's complaint. 21

22 A Litigant has right to trial where slightest doubt as to facts exists. Clearly, there is a 23 doubt to the facts herein.

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IV. ARGUMENT

NRS 41A.009 defines "medical malpractice" as "the failure of a physician, hospital or employee of a hospital, in rendering services to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." Defendant alleges the decision to discharge a patient is a medical decision. Arguably so; however, after that decision is made, the proper procedures for a discharge are out of the doctors scope of duty or authority. He gives the order to release, and it is social workers and staff that are required to provide transportation, assure the patient is being released to a suitable environment, etc. This is not what the doctor does, and patient dumping is not malpractice of the doctor to use the skill he is trained to use. It is the lack of follow through of the doctors discharge which is at issue herein. With annual profits in excess of TWO MILLION DOLLARS, the appropriate staff should be available to comply with laws and regulations to render services after the doctor has authorized the discharge.

Plaintiff agrees that the medical decision to discharge then others are required to provide care to coordinate matters based upon the medical diagnosis and current medical status, but is does not require a doctor to prepare a guardianship, or call and pay for a taxi for the patient. However, those that are involved are required to comply with regulations. In fact, Plaintiff believes there are social workers on staff, and others to coordinate other than medical needs for the patients.

All negligence herein occurred AFTER the release of the patient from the doctors care, and is NOT medical malpractice. Defendant making the allegation this is a medical malpractice case simply does not make it so. Moreover, Defendant completely ignores the issues of negligence in this matter.

As a result it is undisputed that Plaintiff's Complaint is NOT based solely on allegations of medical malpractice, but of negligence without a facility that makes more than TWO MILLION DOLLARS in annual income, to meet the guidelines for release of patients back into society after they are DISCHARGED from the facility.

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Plaintiff made a claim for punitive damages due to the significant and overwhelming

evidence of negligence on the part of Defendants, and Plaintiff is entitled to punitive damages. If
the court does not feel Plaintiff pled this cause with specificity, he requests leave of the court to
amend as to this cause of action. He feels the facts herein warrant punitive damages. Under NRS
42.001 et. seq., Defendant's clearly had a conscious disregard for the welfare of patients who had
been released from their facility - and the general public they were released into. The actions
detailed in the claim and herein clearly demonstrate the same, and Plaintiff is entitled to plead this
cause at the time of trial.

Further, Defendant's and all of them, were required to follow the statutes and guidelines they
ignored in releasing a patient. This is enough evidence to provide that Defendant's knew or should
have known, that the manner in which the patient at issue herein was release could certainly cause
harm.

Plaintiff will request leave to amend to name specific employees as this matter progresses
and discovery provides more information. However, at this time, there is no cause in dismissing any
portion of this Complaint.

V. CONCLUSIÓN

Based upon the foregoing, Plaintiff respectfully requests this Honorable Court issue and order DENYING in its entirety, Defendant's motion to dismiss Plaintiff's complaint.

18	Dated this 13 day of	JINC ,2014
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20		LEE E. STYMBORSKI
21		Plaintiff in Proper Person
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EXHIBIT C

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6 67 / 14 DEAR CATERINE CORTEZ MASTO "Provest FOR Prosention D Neuson Chief Deputy Attorney General Linda C. ANDESON INSTRUCTOR TO UNTE - HIS LATER ON 3/24/14 Agreeing That my cose warrans prosecution although sole goin ist AN" Isolateo CASE" DNOCABOUT 11/04/13 Ispoke AT length with NevADA Division OF Heatth and Human Serioes Director mike Wilpen Spring Mountain Treaments Cerree livensing outhority Devala BIREAN DE HEATHCARE QUALITY GERREL OPNO Compliance Ligar Coursel Stice Frieston She urged me to 1º Press The Issue That with P. FACILITY like Spang COONTOIN TREATMENT CENTER HS All ABOUT The motion where it should be about The Quality of Cre VOONE Sould be Treated likettis Toype Soin Stecon Steep pT Might Knowing the OWN DAUGHTER IS SOFE AND AT & PSUCH FACILITY She was Spanled That Spring Mountain Faibotd Forber The GOODIENDARC INSTRUCTIONS TO FILLONT the "Certificate OF Mettel INCAPACITY" (Centing " Boseo an the muttiple incrudents of atterpres Suicide his trade Record its UREY DBUIOUS SEON CONNOT

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Name zymborski Т FILED Address Hallion Avenue. 2 4605 City State AUG 7 2 31 PH 14 903 3 pour look com Email nhoski 4 Som & loh Telephone 5 <u>60</u>9. 67 x of 6 DISTRICT COURT 7 CLARK COUNTY, NEVADA 8 Case No.: A-14-705 178-C 9 XXXI Dept No: 10 24 m Bosck 11 Plaintiff, NOTICE OF MOTION 12 0- BrowsieconbN MOTION ٧S. 13 HELMATIVE OCIN The Por mon : 14 BOTA 10TON OFFICIAL COPACITY DOES 15 16 1-XX INCLUSIVE DOCATION 17 18 Please take notice that the hearing on 19 (XX) -12-Floor ____ Courtroom 20 Will be heard on _ in Department CHAMBERS at the hour of ____ AM/PM. 21 JOK Dated this _____ day of 22 A-14-700178-C NOTM 23 Notice of Motion By: 4110917 24 CLERK OF THE COURT 25 AUG 0 7 2014 RECE Summary of Pleading - 11

1 FILED Sumbors 1 (Name) Avenve_ 2 Aug 25 12 52 PM 14 3 State 7in 1.15 4 CLERN OF 5 Plaintiff/ 🛛 Defendant, Pro Se A-14-700178-C CERT 6 Certificate of Mailing 1172557 EIGHTH JUDICIAL DISTRICT COURT 7 CLARK COUNTY, NEVADA 8 9 <u>60 178- C</u> Case No.; Dept. No.: 10 Plaintiff(s). (BATTY WIT 11 ς 12 3-12-14 Date of Hearing: 13 Time of Hearing: Defendant(s). 14 CHAMBERS CERTIFICATE OF MAILING 15 I HEREBY CERTIFY that on the 11 day of Hocust 20/4, I placed a true 16 RECONSIDERATION and correct copy of the following document: 17 FER OTTON AHECNATIVE OCINTA 18 ASIDE COTaddressed to the following: FT CA Dostago prepaid, 19 in the United States Mail, with first-00 NVE D 20 NUTTE 200 60 21 22 CLEAK OF THE COURT 28 Per NRS 53.045, I declare under penalty of perjury that the foregoing is true and correct. (signature) BOSSKI (print name) ŝ Defendant, Pro Se Page 1 C 2009 Civil Law Self-Help Center Clark County, Nevada



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1 2 3 4 5 6 7	LEE E SZYMBORSKI 4605 Black Stallion Avenue North Las Vegas,Nevada 89031 702-609-6762 PLAINTIFF IN PROPER PERSON DISTRICT CLARK COUN	OFFRE DE COORT
8	LEE E.SZYMBORSKI,	
9	PLAINTIFF IN PROPER PERSON	CASE NO.A-14-700178-C
10	-VS-	DEPT. NO.XXX1
11	SPRING MOUNTAIN TREATMENT	
12	CENTER, DARRYL DUBROCA, in his official	
13	capacity,DOES 1-XX,inclusive,and ROE	A = 14 - 700178 - C
14	CORPORATIONS 1-XX, inclusive,	NOAS Notice of Appeal 4174120
15	Defendant(s).	
16	NOTICE OI	- APPEAL
17		
18	Notice is hereby given that LEE E SZYMBOI	RSKI., PLAINTIFF IN PROPER PERSON,
19	hereby appeals to the Supreme Court of Nev	ada from NOTICE OF ENTRY OF ORDER
20	ON DEFENDANT SPRING MOUNTAIN TRE	
21	DUBROCA'S MOTION TO DISMISS ENTER	RED ON The 23 rd Day of July, 2014
22		AX AX
23		
24 25		SIGNATURE Lee E.Szymbørski 4605 Black Station Avenue
25		North Las Vegas,Nevada 89031
27		
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	l l	

1 ORDR 2 EIGHTH JUDICIAL DISTRICT COURT 3 CLARK COUNTY, NEVADA 4 5 LEE SZYMBORSKI 6 Plaintiff. 7 VS. Case No. A-14-700178 8 SPRING MOUNTAIN TREATMENT CENTER Dep't No. XXXI g Defendant. 10 ORDER GRANTING IN PART AND DENVING IN PART PETITIONER'S APPLICATION TO PROCEED IN 11 Forma Pauperis 12 The Court, having reviewed Petitioner Lee Szymborski's Application to Proceed In Forma 13 Pauperis and all information therein submitted to this Court, 14 ORDERS the Application GRANTED IN PART AND DENIED IN PART. 15 In addition to the instant Application, Petitioner contacted Department IX chambers to 16 request a refund of the civil filing fee in the amount of \$270.00 that Petitioner paid on May 2, 2014.¹ 17 Unfortunately, this Court is unable to issue refunds of filing fees paid, and this Court cannot issue a 18 nunc pro tunc order in this situation. The \$270.00 fee therefore stands paid, and Petitioner's request 19 for a refund is DENIED. However, in light of Petitioner's income amount, and after taking into 20 consideration the expensive nature of protracted litigation, this Court GRANTS the Application as to BLERK ORTHERCOURT all future fees. 26 27 This Court notes that Department IX staff attempted to communicate the contents of this order to Petitioner on May 9th, 12th, and 13th via the phone number provided on Petitioner's application. Despite several attempts, no phone contact 28 could be made with Petitioner. 1

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DISTRUCT JUDGE DEPARTMENT IX

JENNIFER TOGLIATTI

2 -	
	CERTIFICATE OF SERVICE
:	The undersigned hereby certifies that on or about the date filed, she served the foregoing
3	Order Denying In Part Granting in Part the Application to Proceed in Forma Pauperis by
4	mailing a copy to Defendant as listed below:
ţ	
(4605 BLACK STALLION AVE NORTH LAS VEGAS NV 89031
7	
8	
9	ROSE NAJERA JEA, DEPARTMENT IX
10	
11	
12	
13	Pursuant to NRS 239B.030
14	The undersigned does hereby affirm that the preceding <u>Decision and Order</u> filed in District Court case number <u>A-14-700178-C</u> DOES NOT contain the social security number of any person.
15	
-	/s/ ROSE NAJERA Date 5/20/14
16	/s/ ROSE NAJERA Date 5/20/14 Judicial Executive Assistant
16 17	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21 22	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21 22 23	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21 22 23 24	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21 22 23 24	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
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16 17 18 19 20 21 20 21 20 21 22 23 24 25 23 24 25 23 24 25 27	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant
16 17 18 19 20 21 20 21 20 21 22 23 24 25 23 24 25 23 24 25 27	/ <u>s/ ROSE NAJERA</u> Date <u>5/20/14</u> Judicial Executive Assistant

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		OPPS	Alman S. Ehrman		
	1	Michael Prangle, Esq.	CLERK OF THE COURT		
	2	Nevada Bar No. 8619 Kerry J. Doyle, Esq.			
	3	Nevada Bar No. 10571			
	4	IIALL PRANGLE & SCHOONVELD, LLC 1160 N. Town Center Dr., Ste. 200			
	5	Las Vegas, NV 89144			
	6	(702) 889-6400 – Office (702) 384-6025 – Facsimile			
	7	cfile@hpslaw.com			
	8	Attorneys for Defendant Spring Mountain Treati and Darryl Dubroca	Attorneys for Defendant Spring Mountain Treatment Center		
	9	DISTRIC	T COURT		
U 28	10		T COURT NTY, NEVADA		
.Т. D, LLC ve 702-384-6025	11	LEE E SZYMDODSZI	CASE NO.: A-14-700178-C		
ELD. ave : 702-	12	LEE E. SZYMBORSKI,	DEPT. NO.: XXXI		
HOONVE Center Dri 00 Pacsmile: Pacsmile:	13	Plaintiff,			
NGLE & SCHOONVELD, North Town Center Drive Sufte 200 as Vegas, Nevada 89144 2-889-6400 Facsimile: 702-3	14	vs.			
3 2 2 2 2 9	15	SPRING MOUNTAIN TREATMENT			
(ANGLE & 60 NORTH TO SUI LAS VEGAS, 702-889-6400	16	CENTER, DARRYL DUBROCA, in his			
199 - 18	17	official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,			
HALJ. PR 11 Telephone:	18				
НАІЛ		Defendants.			
	19	DEFENDANT SPRING MOUNTAIN T	REATMENT CENTER AND DARRYL		
	20		FF'S MOTION FOR RECONSIDERATION E MOTION TO SET ASIDE		
	21				
	22	0	ptember 12, 2014 : In Chambers		
	23				
	24	COMES NOW, Defendant Spring Mour	ntain Treatment Center (hereinafter referred to as		
	25	"Spring Mountain") and Darryl Dubroca, by	and through their attorneys, Hall Prangle &		
	26	Schoonveld, LLC, and respectfully submits	s this Opposition to Plaintiff's Motion for		
	27	Reconsideration or in the Alternative Motion to	Set Aside.		
	28				

Page 1 of 13

This Opposition is made and based on the following Points and Authorities, pleadings 1 and papers on file herein and any arguments of counsel at the time of hearing of this matter. 2 Dated this 25th day of August, 2014. 3 4 HALL PRANGLE & SCHOONVELD, LLC 5 /s/: Kerry J. Doyle, Esq. 6 Michael Prangle, Esq. Nevada Bar No. 8619 7 Kerry J. Doyle, Esq. Nevada Bar No. 10571 8 1160 N, Town Center Dr., Ste. 200 9 Las Vegas, NV 89144 Attorneys for Defendant 10 Spring Mountain Treatment Center and Darryl Dubroca 11 12 MEMORANDUM OF POINTS AND AUTHORITIES 13 Ĭ. 14 **INTRODUCTION** 15 Plaintiff filed his Complaint against Defendant, Spring Mountain and Daryl Dubroca on 16 17 May 2, 2014. Defendants filed a Motion to Dismiss which was heard in Department XXXI with 18 the Honorable Senior Judge Joseph Bonaventure presiding on June 24, 2014. Prior to the 19 hearing, Plaintiff apparently filed an Opposition to Defendants' Motion to Dismiss and it was 20served only on the Court. Defendants' counsel received the Opposition the evening before the 21 hearing and when asked by the Court if Defendants would like to move the hearing, Defendants 22 23 declined. Thus, Plaintiff's Opposition was received and considered by the Court in making its 24 decision to grant Defendants' Motion. The Notice of Entry of Order was filed on July 30, 2014, 25 and served the same day. Plaintiff now seeks to have the Court reconsider its decision. 26 However, Plaintiff has not set forth a proper basis to support his Motion as required under NRCP 27 60(b). Therefore, Defendants respectfully requests that the Plaintiff's Motion be Denied. 28

Page 2 of 13

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suffe 200 Las Vecas, nevada 89144 Telephone: 702-389-6400 Facsimile: 702-384-6025

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II.

STATEMENT OF FACTS

This is a medical malpractice action arising out of the care and treatment rendered to Sean Szymborski at Spring Mountain. According to Plaintiff's complaint, Sean Szymborski, a mentally ill patient, was improperly discharged from Spring Mountain to Lee Szymborski's (Plaintiff) home in violation of NAC 449.332. See Plaintiff's Complaint, hereinafter **Exhibit A**. Further, as a result of this improper discharge, Sean Szymborski smashed the windows, walls, doors, furniture, and completely destroyed the interior of the residence before going missing for three weeks. *Id*. As a result of the alleged improper discharge, Plaintiff has filed suit against Spring Mountain for the damages to his residence as well as emotional distress suffered by Plaintiff. However, no expert affidavit supporting his claims was attached. Accordingly, Defendants filed a Motion to Dismiss Plaintiff's Complaint which was granted and the order was entered on July 30, 2014. See Notice of Entry of Order, hereinafter **Exhibit B**, and Motion to Dismiss hereinafter **Exhibit C**.

Plaintiff has now filed a Motion for Reconsideration on the grounds that (1) this case does not require an expert affidavit under NRS 41A.100. Plaintiff also appears to be arguing that the investigation by the Division of Public and Behavioral Health is sufficient to meet the expert affidavit requirement. In the alternative, Plaintiff also argues that (2) he inadvertently failed to serve Defendants with his Opposition and as a result, the Order Dismissing his Complaint should be reconsidered. As fully set forth below, Plaintiff's arguments are not sufficient to support a Motion for Reconsideration and are otherwise insufficient to overcome Defendants' underlying Motion to Dismiss. As a result, Plaintiff's Motion for Reconsideration should be Denied.

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III

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Page 3 of 13

LEGAL STANDARD

2	LEGAL STANDARD
3	Motions for Reconsideration are authorized under EDCR 2.24 and NRCP 60(b). Motions
4	for reconsideration are granted at the discretion of the Court. Gellar v. McCown, 64 Nev. 102,
5 6	108, 178 P.2d 380, 381 (1947). EDCR 2.24 states:
7	(a) No motions once heard and disposed of may be renewed in the same cause, nor may the same matters therein embraced be reheard, unless by leave of the
8 9	court granted upon motion therefor, after notice of such motion to the adverse parties.
10	(b) A party seeking reconsideration of a ruling of the court, other than any order which may be addressed by motion pursuant to N.R.C.P. 50(b), 52(b), 59 or 60,
11	must file a motion for such relief within 10 days after service of written notice of the order or judgment unless the time is shortened or enlarged by order. A motion
12 13	for rehearing or reconsideration must be served, noticed, filed and heard as is any other motion. A motion for reconsideration does not toll the 30-day period for filing a notice of appeal from a final order or judgment.
14	
15	(c) If a motion for rehearing is granted, the court may make a final disposition of the cause without reargument or may reset it for reargument or resubmission or
16	may make such other orders as are deemed appropriate under the circumstances of the particular case.
17 18	Further, NRCP 60(b) states, in pertinent part:
19	On motion and upon such terms as are just, the court may relieve a partyfrom a[n] order, for the following reasons:
20	(1) Mistake, inadvertence, surprise, or excusable neglect;
22	(2) Newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial under Rule 59(b);
23 24	(3) Fraud, misrepresentation or other misconduct of an adverse party[.]
25	As set forth below, Plaintiff has failed to meet the requirements to support granting
26	Plaintiff's Motion for Reconsideration.
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	Page 4 of 13

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IV.

ARGUMENT

A. Plaintiff's Motion for Reconsideration Must Be Denied Because He Does Not Meet the Requirements Under NRCP 60(b).

Motions for reconsideration under Rule 60 are appropriate in three instances (10 when there has been an intervening change of controlling law, (2) new evidence has come to light, or (3) when necessary to correct a clear error or prevent manifest injustice. San Luis & Delta-Mendota Water Authority v. United States Dept. of the Interior, 624 F. Supp.2d 1197, 1207 (E.D. Cal., 2009). See also, Branam v. Crowder, 226 B.R. 45, 2 Cal. Bankr. Ct. Rep. 36 (1998) (Motions for reconsideration which merely revisit same issues already ruled upon...or advance supporting facts that were otherwise available when issues were originally briefed, generally will not be granted).

The Nevada State Court has ruled consistently with the reasoning behind the Federal 15 Court decisions in Moore v. City of Las Vegas, 92 Nev. 402 (1976). In Moore, the Court held 16 that it was appropriate to deny a motion for reconsideration where no new issues of fact or law were raised. Id. Further, the District Court may reconsider a previously decided issue "iff substantially different evidence is subsequently introduced or the decision is clearly erroneous." Masonry 7 Tile Contractors v. Jolley, Urga, & Wirth, 113 Nev. 737 (1997).

In the present matter Plaintiff has not presented any new evidence or any change in 22 23 controlling law which would support his request that this Court hear a Motion for 24 Reconsideration. Plaintiff is attempting to have the Order Dismissing his Complaint overturned 25 arguing that this case does not require an expert affidavit under NRS 41A.100. Plaintiff also 26 appears to be arguing that the investigation by the Division of Public and Behavioral Health is 27 sufficient to meet the expert affidavit requirement. In doing so, it can only be presumed that he 28

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is arguing that the basis of the Motion for Reconsideration is mistake or inadvertence, or newly discovered evidence or law under NRCP 60(b)(1) or (2) respectively, since Plaintiff does not specifically state what he is basing his motion on. Despite having the investigative report in his possession and attaching it to his Complaint prior to the filing of the Motion to Dismiss, he did not make these arguments in his opposition. See Investigative Report contained in Exhibit A and Plaintiff's Motion for Reconsideration. Moreover, Plaintiff fails to even cite any controlling case law and even if he did, this is not new law or evidence to support a ruling in his favor. As a result, he has not set forth a sufficient basis to justify an order granting his motion and it must be denied.

B. Plaintiff's Complaint was Properly Dismissed for Failure to Provide a Supporting Affidavit

1. <u>Plaintiff's</u> claims do not meet the narrow exceptions to the affidavit requirement set forth under NRS 41A.100

If the Court is inclined to review the ruling for clear error, Plaintiff still has not provided 16 any argument that would overcome Defendants' Motion to Dismiss. Exhibit C. In granting Defendants' Motion to Dismiss, the Court determined that Plaintiff's claims were based in medical malpractice and required an expert affidavit. Exhibit B. Plaintiff is not challenging the Court's ruling that this is a medical malpractice case, but is attempting to argue that an expert affidavit is not required under NRS 41A.100, because there is a reasonable presumption of negligence. See Plaintiff's Motion for reconsideration. However, what Plaintiff fails to acknowledge is that NRS 41A.100 sets forth narrow exceptions to the affidavit requirement which do not apply to his case.

NRS 41A.100 sets forth a narrow exception to the expert affidavit requirement and provides in pertinent part:

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1. Liability for personal injury or death is not imposed upon any provider of medical care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises or the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to demonstrate the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury or death, except that such evidence is not required and a rebuttable presumption that the personal injury or death was caused by negligence arises where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances:

(a) A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;

(b) An explosion or fire originating in a substance used in treatment occurred in the course of treatment;

(c) An unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care;

(d) An injury was suffered during the course of treatment to a part of the body not directly involved in the treatment or proximate thereto; or

(c) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

2. Expert medical testimony provided pursuant to subsection 1 may only be given by a provider of medical care who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged negligence.

In interpreting this statute, the Nevada Supreme Court has held that:

"... the plaintiff must present facts and evidence that show the existence of one or more of the situations enumerated in NRS 41A.100(1)(a)-(e). While the dissent disapproves this procedure because it is not specifically set forth in the statute, we believe it is only fair that a plaintiff filing a res ipsa loquitur case be required to show early in the litigation process that his or her action actually meets the <u>narrow</u> res ipsa requirements."

²³ *Szydel v. Markman* 121 Nev. 453, 460-461, 117 P.3d 200, 205 (2005) (emphasis added). As

²⁴ indicated by the Nevada Supreme Court, the res ipsa exceptions are intended to be narrowly

construed. In the instant matter, Plaintiff wishes this Court to exponentially expand the realm of

the NRS 41A.100 exceptions.

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There are no set of facts set forth in Plaintiff's complaint that can be construed to meet any of the narrow exceptions under NRS 41A.100. Moreover, Plaintiff provides no argument in his Motion for Reconsideration as to what exception he feels his case falls under. Even if the Court feels that Plaintiff has met the burden to justify granting his Motion for Reconsideration, its initial Order Granting Defendants' Motion to Dismiss was proper.

2. <u>The investigative report authored by the Nevada Department of Health does</u> not meet the expert affidavit requirement.

Alternatively, Plaintiff appears to be arguing that the investigative report generated by the Nevada Department of Health that he attached to the Complaint in this case is sufficient to meet the expert affidavit requirement set forth under NRS 41A.071.

NRS 41A.071 states:

[i]f an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit, supporting the allegations contained in the action, submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice.

The Nevada Supreme Court has held that "under NRS 41A.071, a complaint filed without

a supporting expert affidavit is void ab initio and must be dismissed." Washoe Med. Ctr. v.

Second Judicial Dist. Court, 122 Nev. 1298, 1300, 148 P.3d 790, 792 (2006). And since "a void

22 complaint does not legally exist, it cannot be amended." *Id.* In *Washoe*, the Court reasoned that:

"shall" is mandatory and does not denote judicial discretion. The Legislature's choice of the words "shall dismiss" instead of "subject to dismissal" indicates that the legislature intended that the court have no discretion with respect to dismissal and that a complaint filed without an expert affidavit would be void and must be automatically dismissed.

Id. at 1303, 148 P.3d at 793-94.

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Page 8 of 13

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Therefore, in *Washoe Medical Center* the Nevada Supreme Court made it clear that a medical malpractice complaint filed without the required affidavit under NRS 41A.071 is "void ab initio" and "must be dismissed."

The Nevada Supreme Court has also recently issued an opinion stating that a declaration signed under penalty of perjury is sufficient to satisfy the affidavit requirement of NRS 41A.071. *Buckwalter v. Eighth Judicial District Court*, 126 Nev. Adv. Op. No. 21 (2010). In doing so, the Nevada Supreme Court indicated that there are two methods of satisfying the affidavit requirement of NRS 41A.071: 1) attaching an actual affidavit, or 2) attaching a sworn declaration which complies with NRS 53.045. *Id.* Neither of which was done in the instant case.

Nevada's definition of what constitutes an affidavit has not changed in over 100 years. "An affidavit is a voluntary, *ex parte* statement formally reduced to writing and sworn to or affirmed before some officer authorized to take it." *Lutz v. Kinney*, 23 Nev. 279, 281, 46 P. 257, 258 (1875), citing 1 *Ency. Of Pleading and Practice*, 309. (emphasis added) "The signature of an affiant can in no case add to or give force to what is sworn, and what is sworn is made to appear authoritatively by the certificate of the officer." *Id.* Further, the certificate, usually called the 'jurat," is essential, not as part of the affidavit, but **as official evidence that the oath was taken before the proper officer**. *Id.* (emphasis added). In the instant matter, investigative report does not set forth any opinions that Defendants fell below the standard of care, or that the opinions are sworn. Nor is there a jurat that would evidence that an oath was actually taken by the author of the report. The investigative report is simply a document that does not comply with NRS 41A.071.

Page 9 of 13

1160 NORTH TOWN CENTER DRIVE SUITE 200 LAS VEGAS, NEVADA 89144 FELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

HALL PRANGLE & SCHOONVELD, LLC

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Morcover, the Nevada Legislature has provided their requirements for an affidavit in NRS 15.010. When mandating that certain pleadings be verified, the Nevada Legislature has provided the following form for affidavits:

Most noticeably, the Nevada Legislature requires that the affidavit to verify pleadings specifically state that the statement is made under the penalties of perjury. When comparing this to the investigative report, there is no corresponding statement that the report is drafted under the penalty of perjury or is sworn. As such, it cannot be considered an affidavit.

Notwithstanding the requirement of sworn testimony, the affidavit must also be made "by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice" and it must support the allegations in Plaintiff's complaint. NRS 41A.071. There is no indication that the person who authored the investigative report is a medical expert or practices in an area substantially similar to Defendants. Moreover, there are no findings that Defendants fell below the standard of care in any respect or that any deviations from the standard of care caused Plaintiff's damages in this case.

It is abundantly clear that the investigative report fails to meet any test to consider it an affidavit. It never states that it was made under oath, and never states that it is signed under the penalty of perjury. Moreover, it was not made by a medical expert that practices in an area substantially similar to Defendants nor does it make any findings of deviations from the standard of care to support Plaintiff's allegations. As such, the investigative report fails to meet the

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statutory requirements of NRS 41A.071. Thus, the Court's order granting Defendants' Motion to Dismiss was proper.

As a result, Plaintiff has failed to meet his burden to show that his Motion for
 Reconsideration is proper under NRCP 60(b) or that the Court's Order Granting Defendants'
 Motion to Dismiss was improper.

C. <u>Plaintiff's Opposition was Considered by the Court and is not a Proper Basis for</u> <u>Reconsideration</u>

Although Plaintiff did fail to serve his Opposition on Defendants, he properly served it upon the Court. The evening prior to the hearing, Defendants' counsel found the Opposition on the Court's online service. At the hearing, the Court acknowledged their receipt of the Opposition and asked Defendants' counsel if the hearing should be moved in order for Defendants to provide a response. Defendants' counsel decided to go forward despite the short notice. Therefore, if anyone was prejudiced by the failure to properly serve the Opposition, it was Defendants. Since the Court still entertained both Plaintiff's Opposition and the oral argument he presented at the hearing, it cannot be a basis to grant his Motion for Reconsideration. As a result, this Motion must be Denied.

Page 11 of 13

V. 1 **CONCLUSION** 2 3 Plaintiff has not met his burden to substantiate a Motion for Reconsideration. Moreover, 4 the Court's ruling Granting Defendants' Motion to Dismiss was proper. Based upon the 5 foregoing, Defendants respectfully requests this Honorable Court issue an Order Denying 6 Plaintiff's Motion for Reconsideration. 7 Dated this 25th day of August, 2014. 8 9 HALL PRANGLE & SCHOONVELD, LLC 10 LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400 KACSDALE: 702-384-6025 <u>/s/: Kerry J. Doyle, Esq.</u> Michael Prangle, Esq. 11 Nevada Bar No. 8619 12 Kerry J. Doyle, Esq. Nevada Bar No. 10571 13 1160 N. Town Center Dr., Ste. 200 14 Las Vegas, NV 89144 Attorneys for Defendant 15 Spring Mountain Treatment Center and Darryl Dubroca 16 17 18 19 20 21 22 23 24 25 26 27 28 ///

HALL PRANGLE & SCHOONVELD, LLC

1160 NORTH TOWN CENTER DRIVE

SUITE 200

Page 12 of 13



HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 1.as Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimle: 702-384-6025

4810-8686-6440, v. 1

EXHIBIT A

	LEE E. SZYMBORSKI 4605 Block Stallion And			FILED		
2 1	4605 Black Stallion Ave N. Las Vegas, NV 89031			MAY 0 2 2014		
3	(702) 609-6762 Plaintiff in Proper Person			CLERK OF COURT		
1						
5	DISTRICT	COURT	٦			
5	CLARK COUNT	Y, NEV	ADA			
3	LEE E. SZYMBORSKI,	}	Case No. Dept No.			
,	Plaintiff,	ξ.				
	ys.	Ś				
1 5	SPRING MOUNTAIN TREATMENT CENTER,)				
l I	DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE)	EXEMPT FROM A			
	CORPORATIONS I-XX, inclusive,)	SUMS IN EXCESS OF \$50,000			
_	Defendants.))				
	COMPLA	/				
	COMES NOW, Plaintiff, named above, and		se of action alleges	as follows:		
	GENERAL ALL			13 10110/03.		
	Nevada, County of Clark. Jurisdiction and Venue a					
	2. Defendant DARRYL DUBROCA is	the CEC)/Managing Director	of SPRING		
	MOUNTAIN TREATMENT CENTER.					
	3. Plaintiff is informed and believes, an	ıd on tha	at basis alleges, that	Defendants		
S	SPRING MOUNTAIN TREATMENT CENTER is	a menta	al treatment hospital,	who admitted		
S	SEAN T. SZYMBORSKI for treatment and dischar	ged him	in violation of Neva	ida Law.		
	4. The true names and capacities, wheth	her indiv	vid ual, corporate, ass	ociate or		
0	otherwise, of the Defendant sucd herein as DOES I					
	KX, inclusive, are unknown to Plaintiff, who is info					
CEIVED	Page 1					
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BLERK OF THE COURT

fictitiously named Defendants is in some way liable to Plaintiff on the causes of action below and
 therefore sues these defendants by such fictitious names. Plaintiff believes said fictitious
 Defendants assisted, devised, schemed, planned or took part in the actions set forth hereinbelow.
 Plaintiff will move to amend this Complaint and insert the true names and capacities of
 fictitiously named Defendants when the same have been ascertained.

5. Plaintiff is informed and believes, and thereon alleges, that at all times herein
mentioned, each actually and fictitiously names Defendant was the principal, agent, co-venturer,
partner, surety, guarantor, officer, director and/or employee of each co-defendant and in doing the
things herein alleged, was acting within the scope of authority and with the permission of each
co-defendant or took some part in the acts and omissions hereinafter set forth, and by reason
thereof, each of said Defendants is liable to Plaintiff for the relief prayed.

12 6. That on or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING
 13 MOUNTAIN TREATMENT CENTER, 7000 W. Spring Mountain Road, Las Vegas, Nevada
 14 89117, due an "UNAUTHORIZED UNSAFE DISCHARGE" of a mentally ill adult patient, to
 15 wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. See
 16 Exhibit "1".

7. That said SEAN T. SZYMBORSKI was provided a taxi ride, released without any
money; without appropriate medication, without the ability to care for himself, and being a
danger to both himself and other.

8. Defendant SPRING MOUNTAIN TREATMENT CENTER was directed by
 KATHLEEN BUCHANAN to provide a Guardianship for Defendant SEAN T. SZYMBORSKI,
 and failed to do so.

9. Defendant SPRING MOUNTAIN TREATMENT CENTER Caseworker
"REBECCA" was directed NOT to release SEAN T. SZYMBORSKI to the residence of
Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed
windows, walls, doors, furniture, and completely destroyed the interior of the residence, before
going missing for three weeks. (A missing persons report was filed by NLVPD.)

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10. An investigation by the Division of Public and Behavioral Health substantiated that
 Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332,
 Discharge Planning, based upon evidence by interview of staff, record review and document
 review.

II. It was determined that the facility failed to assure the patient was discharged to a safe
environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with
diagnoses including psychosis not otherwise specified and spice abuse.

b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much
trepidation about going back to the father's home. The patient was restless when talking about
the father.

c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the
address of the apartment. The MA documented the patient was vague about the address. The
patient needed to stop by the father's home to pick up patient's debit card prior to going to the
new apartment.

d. Review of the Social Services Discharge Note revealed the patient would live in an
apartment upon discharge. There was no documented evidence of an address for the apartment.
There was no documented evidence the Case Manager confirmed the patient had made
arrangements to live in the apartment.

e. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to
father's home first then on to an address in North Las Vegas, Nevada.

f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the
patient did not want to return to the patient's father's home due to ongoing conflict. The note
documented the patient participated in treatment planning to find housing.

g. The Risk Manager investigated a telephone complaint from the patient's father. The
 Administrative Review documented placement to the apartment was not verified.

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h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on verifying the identified apartment.

i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone
messages were left by the patient's father. The father would state the patient could return to the
home; the next telephone message from the father would demand the patient not be discharged to
the father's home. The LSW acknowledged she did not speak directly with the patient's father.
The LSW stated due to the large number of patients on the LSW's caseload, the LSW had to
delegate telephone calls and discharge planning to the MA.

j. The LSW indicated when a patient identified their own placement, the LSW would try
to obtain as much information as possible regarding the address and name of the apartment. If
unable to verify placement, the physician would be notified prior to discharge from the facility.

k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented
the patient did not want to return to his father's home due to ongoing conflict. The note
documented the patient participated in treatment planning to find housing.

15 12. An evaluation of the needs of a patient relating to discharge planning must include,
without limitation, consideration of:

a. The needs of the patient for postoperative services and the availability of those
services.

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b. The capacity of the patient for self-care; and

c. The possibility of returning the patient to a previous care setting or making
 another appropriate placement of the patient after discharge.

13. Defendant SPRING MOUNTAIN TREATMENT CENTER is in violation of NAC
449.394, Psychiatric Services, which requires that a hospital shall develop and carry out policies
and procedures for the provision of psychiatric treatment and behavioral management services
that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and
services are safely and appropriately used. The hospital shall ensure that the policies and
procedures protect the safety and rights of the parties - and the public at large.

14. That Defendant SPRING MOUNTAIN TREATMENT CENTER has failed to met these statutes and regulations, for the reasons set forth above.

15. That due to the failure to meet these responsibilities, SEAN T. SZYMBORSKI, was
driven by taxi to the home of Plaintiff, and dropped off, at the expense of the Defendant SPRING
MOUNTAIN TREATMENT CENTER, where he proceeded to cause significant property
damage to Plaintiff's residence, and go missing.

7 16. That when SEAN T. SZYMBORSKI was located, he had sustained wounds from a
8 self inflicted injuries with a sharp object, using weapons obtained at the home of his mother; and
9 not at the home of his father.

10 17. The patient care plan, dated 5/14/13 indicated that safety concerns, including
11 weapons, in the patient's home were non-applicable and verified by the patient's father. There
12 was no documented evidence the patient's father was contacted for verification. Furthermore,
13 Defendant SPRING MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a
14 home for SEAN T. SZYMBORSKI, therefore, even confirming no weapons in father's home was
15 not reasonable to consider this non-applicable.

16 18. In violation of the stated statutes, it was determined that the LSW did not follow up
on identifying what weapons and if the patient had access to weapons prior to discharge. (8.0
Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining
permission and contacting any person that may be able to located and secure items...Weapons are
not considered secured until verification has been received that the task is completed...")

19. Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER,
 SEAN T. SZYMBORSKI was convicted of criminal charges related to the property destruction at
 the home of Plaintiff, rather than receiving treatment for his known mental illness.

24 20. Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless
25 disregard of SEAN T. SZYMBORSKI's psychiatric condition in pre-paying for a taxi to dump
26 him at an verified location [Plaintiff's residence], without notice to occupants, without money,
27 and without the ability to provide care for himself due to long standing mental illness.

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1	21. The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver
2	the statutory mandated care to patients in their custody and control resulted in systematic
3	disregard of the serious psychological and medical conditions and resulted in adverse
4	consequences, which predictably flow from such failures, and caused damages to patients and
5	others, who became victims of such disregard.
6	22. Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit
7	corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS
8	(\$2,000,000).
9	FIRST CLAIM FOR RELIEF
10	(NEGLIGENCE)
11	23. Plaintiff realleges and incorporates by reference all of the previous allegations of
12	this Complaint at this point as if set forth fully herein.
13	24. Nevada recognizes negligence claims, where a Plaintiff establishes: (1) the
14	existence of a duty of care (2) breach of that duty; (3) legal causation; and (4) damages.
15	25. Defendants, in the exercise of reasonable care had a duty to know, or should have
16	known, that they are required to comply with NAC 449.332, regarding DISCHARGE PLAN of
17	Patients; and with NRS 449.765 to 449.786.
18	26. Defendants breached their duty by failing to carefully investigate, monitor and/or
19	oversee discharge activities at SPRING MOUNTAIN TREATMENT CENTER, including but
20	not limited to, the development, implementation, and supervision of discharge policies and
21	practices.
22	27. That Defendants negligently and/or carelessly, permitted the dumping of SEAN T.
23	SZYMBORSKI, by taxi to the home of Plaintiff, without notice to Plaintiff, in violation of their
24	own internal policies; NAC 449.332; and NRS 449.865 to 449.786.
25	28. Defendants knew or should have known that patients, including SEAN T.
26	SZYMBORSKI are members of the class of patients that could foreseeably suffer injury to
27	themselves, and/or inflict injury on others, as a result of Defendants' failure to exercise
28	Page 6

reasonable care in the discharge of their statutorily imposed duties, and/or common-law duties of
 care.

29. As a direct and proximate result of the negligence and carelessness of Defendants,
Plaintiff has suffered extreme emotional and mental distress, further issues and conflict in the
family unit, in addition to approximately \$20,000 in physical damage to the residence, including
smashed windows, which required immediate action to secure assets in the residence, and other
damages the full extent of which shall be provided through discovery.

30. As a direct and proximate result of Defendants' acts or omissions, Plaintiff has
suffered punitive, general and special damages.

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SECOND CLAIM FOR RELIEF

(Professional Negligence)

(Negligent act or omission to act by a provider of health care in rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death,
 NRS 41A.015)

14 31. Plaintiff realleges and incorporates by reference all of the previous allegations of
15 this Complaint at this point as if set forth fully herein.

32. Defendants in the capacity of a for profit hospital providing medical care to the
public, government agencies overseeing the hospital's operations, licensed social workers,
registered nurses, psychiatrists, and the hospital administrator owed Plaintiff a duty to employ
medical staff adequately trained in the care and treatment of patients consistent with the degree
of skill and learning possessed by competent medical personnel practicing in the United States of
America under the same or similar circumstances; and a duty to comply with Nevada statutes,
including NRS 41A.015.

33. Defendants breached its duty of care by failing to function as a patient advocate by
providing proper care to the patients at the time of discharge, and specifically causing physical,
mental and emotional pain and suffering to the patient; as well as physical, mental and emotional
pain and suffering to the public at large, and specifically in this matter, to the Plaintiff.

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1	THIRD CLAIM FOR RELIEF
2	(Malpractice, Gross Negligence, Negligence Per Se)
3	34. Plaintiff realleges and incorporates by reference all of the previous allegations of
4	this Complaint at this point as if set forth fully herein.
5	35. "Malpractice" in the practice of social work means conduct which falls below the
6	standard of care required of a licensee under circumstances which proximately causes damage.
7	"Gross Negligence" in the practice of social work means conduct which represents an extreme
8	departure from the standard required of a licensee under the circumstances and which
9	proximately caused damage. NAC 641B.225, pursuant to 42 C.F.R.§ 482.61, Defendants had a
10	duty to properly discharge patients in compliance with NAC 449.332, relating to discharge
11	planning.
12	36. That Defendants including JOHN DOE 1 in the capacity of Licensed Social Worker
13	(LSW) is entrusted to provide medical care owed to patients and a duty to provide adequate
14	medical treatment, to protect the patient and the public at large. Said Defendant breached the
15	duty of care by discharging the patient, paying for a taxi only to Plaintiff's address (although the
16	patient asked to pick up a debit card, then be transported to another residence), in violation of
17	discharge policies and procedures, pursuant to NAC 449.332. As a proximate result of the
18	negligence of Defendants, the patient and public at large are subject to physical, mental and
19	emotional pain, in addition to financial loss, such as Plaintiff has sustained.
20	37. The conduct of Defendants was in wanton, extreme and total disregard of the legal
21	and statutory obligations to patients and the public at large, and constitutes gross, reckless,
22	oppressive and/or outrageous disregard for the consequences of their actions. As a proximate
23	result of the negligence of Defendants, Plaintiff has suffered physical, mental and emotional pair
24	in addition to financial damages.
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FOURTH CLAIM FOR RELIEF

(Negligent Hiring, Supervision and Training)

3 38. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein. 4

5 39. At the times mentioned herein, Defendants knew, or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature 6 7 that, if it was ot properly given, it was likely to injure the persons to whom it was given. Defendants owed a duty to its patients, and the community at large, to hire, train, and/or 8 9 supervise competent medical and staff personnel, including supervisors, and LSW, to provide 10 care and treatment to its patients.

11 40. Defendants breached that duty of care by failing to adequately provide competent employees, in the performance of the job, as it appears dumping patients is an ongoing problem. 12

13 41. At all times herein mentioned, Defendants established and/or followed, unsafe medical practices, including "dumping" patients without complying with discharge instructions. 14

15 42. As a result of the lack of medical care and treatment provided by Defendant, Defendants breached their duty to Plaintiff and the members of the class by failing to protect 16 them from foreseeable harm, resulting in a lack of mental health treatment for Plaintiff and the 17 18 public at large.

19 43. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has been injured financially, as well as mentally and emotionally in this matter. 20

21 44. Defendants conduct demonstrated a conscious disregard of known accepted 22 procedures, protocols, care and treatment, all with the knowledge or utter disregard that such conduct could or would expose Plaintiff to harm as set forth herein. 23

45. Defendants conduct was willful, reckless, malicious, and in total disregard to the health and safety of not only the patient, but the public at large, thereby justifying an award of 26 punitive damages.

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1	46. As a direct and proximate result of the conduct of Defendants, Plaintiff has suffered
2	mental and emotional pain and suffering, in addition to financial loss.
3	WHEREFORE, Plaintiff prays judgement as follows:
4	1. For a temporary restraining order and/or preliminary injunction and permanent
5	injunction enjoining and restraining Defendants from continuing or repeating the unlawful
6	polices, practices and conduct complained of herein;
7	2. For declaratory judgment against Defendants' policies, practices and conduct as
8	alleged herein in violation of patient rights, and the safety of the public at large;
9	3. For compensatory damages according to proof;
10	4. For punitive damages in consideration of the annual income in excess of
11	\$2,000,000,000.
12	5. For emotional distress caused by the violations herein.
13	6. For costs of suit, including attorney fees, and other costs.
14	7. For such other and further relief as the Court may deem appropriate.
15	DATED this day of, 2014.
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17	LEE E SZYRBORSKI Plaintiff in Proper Person
18	r iaintin, in priper terson
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28	Page 10

EXHIBIT 1

BRIAN SANDOVAL Governor

MICHAEL J. WILLDEN Director



RICHARD WHITLEY, MS Administrator

TRACEY D. GREEN, MD Chief Medical Officer

STATE OF NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Health Facilities/Lab Services 727 FairMew Dr, Suite E Carson City, Nevada 89701 (775) 684-1030 Fax: (775) 684-1073

Health Facilities/Lab Services 4220 S. Maryland Parkway Suite 810, Building D 1020 Vices NV 85119 (702) 436 4314 Fax: (702) 436 4314

Radieson Control 4150 Teclinology Way Suite 300 Carson City, Nevate 69706 (775) 687-7550 Fax: (775) 687-7552

Radiaton Control 2080 E. Flamingo Suite 319 Las Vegas, Nevade 89119 (702) 486-5280 Fax: (702) 486-5024

Child Care Licensing 727 Pairvew Dr, Suite E Carson City, Nevada 89701 (775) 684-4463 Fax: (775) 584-4464

Child Care Licensing 4180 S. Pecos, Ste 150 Les Vegas, Nevada 89121 (702) 486-7918 Fax: (702) 486-6660

Child Care Licensing 1010 Ruby Vista, Ste 101 Elko, Nevada 89801 (775) 763-1237 Fax: (775) 753-1336 August 19, 2013

Lee Szymborski 4605 Black Stallion Avenue North Las Vegas, NV 89032.

Re: Complaint Number NV00035655

Dear Mr. Szymborski,

With reference to your complaint against Spring Mountain Treatment Center, an unannounced inspection was completed on 07/09/2013 to investigate your concerns about admission, transfer and discharge, quality of care responsible party not notified of resident's change in condition and resident safety.

During the investigation, the State Inspector interviewed patients/residents, reviewed their records, interviewed staff, and made observations while the facility or agency was in operation. The facility's or agency's actions were evaluated using applicable state and/or federal rules and regulations to determine if they were in compliance.

Based on the completed investigation, it was concluded that the facility or agency was not in compliance with rules and/or regulations. The Bureau will take appropriate measures to ensure the facility/agency is well-informed of the specifics of non-compliance, and that they will exercise their due diligence in preventing similar incidents in the future.

You may access the investigation results on our website following these steps:

- Go to http://health.nv.gov/HCQC.htm
- On the right bar under Facility Services,
- Select Individual Health Facilities Inspection and Survey Results
- Select the facility type from the five categories
- Enter the facility name, provider type and click Start Search
- Select the facility; then select the survey date you want to review

Thank you for reporting your concerns. Please know that your voice will help improve the services of health facilities and agencies. If we can be of further assistance, please contact the investigator, Debra Seeger, at $7\bar{0}2$ -486-6515.

Sincerely. spacke OAN

For: Julie Bell, Health Facilities Manager

Public Health Working for a Safer and Healthier Nevada

Division o	of Public and Behavior	al Health			F ORWA	AFFROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A BUILDING:		(X3) DATE SU COMPLET	
		NV53268HOS1	8. WING		07/09	/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
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S 000	Initial Comments		S 000			
	a result of a complair 6/25/13, and finalized accordance with Nev Chapter 449, Hospita	e of the investigation was				
	deficiencies cited. (S S0602) The findings and con by the Health Division prohibiting any crimin actions or other claim	655 was substantiated with se Tags S0146, S0153 and clusions of any investigation a shall not be construed as al or civil investigations, s for relief that may be under applicable federal,				
S 146 SS=D	 An evaluation of the to discharge planning limitation, considerati (a) The needs of the services and the avai (b) The capacity of the (c) The possibility of the previous care setting appropriate placement discharge. This Regulation is not Based on Interview, review, the facility fail discharged to a safe of sampled patients (Particular Schement	the needs of a patient relating must include, without on of: patient for postoperative lability of those services; e patient for self-care; and eturning the patient to a or making another at of the patient after at met as evidenced by: ecord review and document ed to assure the patient was environment for 1 of 5 thent #1).	S 146	· · · · · · · · · · · · · · · · · · ·		
deficiencies a ABORATORY D	re cited, an approved plan DIRECTOR'S OR PROVIDER/	of correction must be returned within 10 o SUPPLIER REPRESENTATIVE'S SIGNATUR	lays after receipt of the	nis statement of deficiencies. יחוונה		X6) DATE

STATE FORM

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If continuation sheet 1 of 9

Division (of Public and Behavior	ai Health			FORM APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
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SPRING N	OUNTAIN TREATMENT	CENTER	GAS, NV 89117		
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		· · · · · · · · · · · · · · · · · · ·		DEFICIENCY)	
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	Findings include:				
	r mango moluce.				
	Patient #1				
	Patient #1 was admit	ted to the facility on 5/3/13			
	and discharged on 5	14/13 with diagnoses			
· .	spice abuse.	not otherwise specified and			
	spice abuse.	. •			
	On 5/13/13 at 1:00 P	M, the Nursing Progress			
	Note documented the	e patient had much			
	trepidation about goin	ng back to the father's home.			
		ess when taiking about the			
	father.				
	On 5/14/13 at 2:30 P	M, the Masters of Art (MA)			
	documented the MA	met with the patient to			
	confirm the address	of the apartment. The MA			
	documented the patie	ent was vague about the			
	address. The patient	needed to stop by the			
	prior to going to the r	up the patient's debit card			
		apatiment.			
	Review of the Social	Services Discharge Note			
	revealed the patient	would live in an apartment			
		re was no documented			
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•		evidence the Case Manager t had made arrangements to			
	live in the apartment.	nad made anangements to			
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	home first then on to	was to go to the father's an address in North Las			
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	u =-				
	The Acute Physician	Discharge Progress Note,			
	on 5/14/13 at 8:50 At	M, documented the patient			
		to the patient's fathers			
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STATE FORM		of correction must be returned within 10		nis statement of deficiencies. KP11	If continuation sineet 2 of 9
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STATE FORM

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	of Public and Behavior	al Health			101	(MAPPROVED			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY				
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	documented the pati planning to find hous	ent participated in treatment ing.							
	The Risk Manager in	vestigated a telephone							
	complaint from the p	atient's father. The							
	Administrative Revie the apartment was n	w documented placement to ot verified.							
	On 7/9/13 at 8:49 AM confirmed the MA did	not follow up on verifying							
	the identified apartm	ent.							
	On 7/9/13 at 11:20 A	M, Licensed Social Worker							
	were left by the patie	multiple telephone messages nt's father. The father would							
	state the patient coul	d return to the father's home.							
	The next telephone n	nessage from the father							
	would demand the pa	atlent not be discharged to							
(did not speak directly	e LSW acknowledged she with the patient's father.				ļ			
	The LSW explained	Juring the first meeting with							
	the patient, the paties	nt expressed a willingness to							
	return to the father's	home and would work on							
	finding an apartment	from the father's home. The							
-	nation's on the LSW	o the large number of s case load, the LSW had to							
4	delegate telephone o	alls and discharge planning							
	to the MA.	and and alocharge plaining							
ļ	The LSW explained v	vhen a patient identified their							
	own placement, the L	SW would try to obtain as							
ĺ	much information as	possible regarding the							
	address and name of	the apartment. If the LSW				-			
	was unable to venty a would be notified prio facility.	placement, the physician r to discharge from the							
•	•								
	Continuing Care Plan	Discharge Planning,							
	documented:	y #PC.067, revised 4/13,		, ,, ,, ,, , , ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,					

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STATEMENT	of Public and Behavior OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		NVS3268HOS1	B. WING		07/	09/2013
AME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE		
PRING N	IOUNTAIN TREATMENT	CENTER 7000 WE	ST SPRING MOUN	TAIN ROAD		
		LAS VEC	BAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Præfix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X6) COMPLE DATE
S 146	Continued From page	ə 3	S 146			
	Procedure:					
	• 4.0 in developing t	he continuing care plan, the				
	following is evaluated	l by the Case Manager: 4.4				
	Housing needs and/o	r placement issues;4.8				1
	Personal support sys	tems"				
		e plans are communicated				
	to the patient and fan	nily/guardian, as appropriate.				
	and documented in th	e medical record5.2				
	Where and with whor following discharge					
	"6.0 The Social Ser	vices Discharge Note is				
	completed for every p discharge. This note	patient at the time of includes, but is not limited				
	to: 6.1 Living arrange	ments*				
	Severity: 2	Scope: 1				
	Complaint #NV00035	655				
S 153 SS=D	NAC 449.332 Discha	rge Planning	S 153			
ł	11. The patient, men	bers of the family of the				
	patient and any other	person involved in caring				
	for the patient must b	e provided with such essary to prepare them for				
İ	the post-hospital care	of the patient.				
	This Regulation is no	t met as evidenced by:	4 1			
	Based on interview, n	ecord review and document				
	review, the facility fail	ed to notify 2 of 5 sampled				
	and #5).	to discharge (Patient #1				
<u> </u>		of correction must be returned within 10 of				

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If continuation sheet 4 of 9

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O			SURVEY
			A. BUILDING:			
		NVS3268HOS1	B. WING		07	/09/2013
VAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SPRING N	OUNTAIN TREATMENT	CENTER 7000 WE	ST SPRING MOUN	TAIN ROAD		
		LAS VEC	GAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 153	Continued From page	e 4	S 153	·····		}
	Findings include:					
	Patient #1					
	Patient #1 was admit	ted to the facility on 5/3/13				
	and discharged on 5,	14/13 with diagnoses				
	spice abuse.	not otherwise specified and				
	On 5/10/13 at 9:00 A	M, the LSW #2 documented				
	the case manager re	ceived a voice mail from the				
	patient's father saying	g the patient was not to				
		he LSW documented the assist the patient with				
	alternative placemen					
	On 5/10/13 at 11:15	AM, the MA documented the				
	patient's father wante home, but not to be c	ed the patient to return to his ilscharged "today".				
	There was no further	documented evidence the				
	patient's father was o	contacted to confirm				
	discharge to the patie	ent's father's home,				
	On 5/14/13 at 2:30 P	M, the MA documented the				
	MA met with the patie	ent. The patient requested				
		e number and told the father				
	the patient to the fath	and a taxi would transport er's home.				
	The Risk Manager In	vestigated a telephone				
· . [complaint from the pa	atient's father. The				
ŀ	Administrative Review	w documented the discharge				
1	was not coordinated				•	
	Documentation with t discharge was not de	he father on the day of cumented.				
	On 7/9/13 at 9:50 AM	l, the Risk Manager				
	acknowledged the fac	cility should have arranged				
		ait at the patient's father's of correction must be returned within 10				

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If continuation sheet 5 of 9

Division of	of Public and Behavior	al Health			PURM APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		NVS3268HOS1	B. WING		07/09/2013
NAME OF P	ROVIDER OR SUPPLIER	STREETA	VODRESS, CITY, STATI	- 71 P CODE	
SPRING	OUNTAIN TREATMENT		EST SPRING MOU		
	CONTRA TREATMENT	LAS VE	GAS, NV 89117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 153	Continued From pag	e 5	S 153		
	house until the patien then drive the patient	it retreived the debit card, to the new apartment.			
	family member shoul patient's discharge to	M, LSW #2 explained the d be contacted prior to the assure the family was			
	acknowledged the pa	It returning home. The LSW Itient's father should have e facility staff prior to the ged.			
	Four additional disch reviewed.	arged medical records were			
	Patient #5				
	Patient #5 was admit and discharged on 6/ major depressive disc	ted to the faciity on 6/4/13 18/13, with a dlagnosis of order.			
	worker/Case Manage patient's discharge. T evidence the family w	ented evidence the social er notified the family of the here was no documented ras educated on the patient's w up care needed. There t from the social er after 6/6/13.			
	Continuing Care Plan Interdisciplinary Polic documented:	Discharge Planning, y #PC.067, revised 4/13,			
	Procedure:				
	"4.0 In developing t following is evaluated Personal support syst	he continuing care plan, the by the Case Manager4.8 tems*			
1	to the patient and fam	e plans are communicated ily/guardian, as appropriate, of correction must be returned within 10 r		la statement of deficiencies	

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Division	of Public and Behavior	al Health			FUR	MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE : COMPL	
		NVS3268HOS1	B. WING		07/	09/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	719 6056		
			EST SPRING MOUN			
SPRING N	OUNTAIN TREATMENT	UENIER	GAS, NV 89117			
(X4) ID		ATEMENT OF DEFICIENCIES	CI	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
S 153	Continued From page	96	S 153			
n.	and documented in ti	ne medical record"				
	Severity: 2	Scope: 1				
	Complaint #NV00035	655				
S 802 SS=D	NAC 449.394 Psychi	atric Services	S 602			
	and procedures for the treatment and behaving that are consistent within the consistent within inclusive, to ensure the services are safely and hospital shall ensure	nd appropriately used. The				
	Based on interview, r review, the facility fail were at Patient #1's r	ot met as evidenced by: ecord raview and document led to identify what weapons nother's home and if the xcess to the weapons.				
	Findings include:					-
	Patient #1					
	and discharged on 5/	ied to the facility on 5/3/13 14/13 with diagnoses ot otherwise specified and				
deficiencies	Assessment Tool doc multiple scab areas o Comprehensive Asse the patient's father sta were self inflicted with	n his legs. The ssment Tool documented ated the patient's wounds				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			isurvey Aleted
		NVS3268HOS1	B. WING		07	/09/2013
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PRING N	OUNTAIN TREATMENT	CENTER 7000 WE	ST SPRING MOUN	ITAIN ROAD		
		LAS VEG	GAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPL DATI
S 602	Continued From pag	e7	S 602			
	On 5/6/13 at 2:42 BL	1, LSW #1 documented				
	Weapons were at the	patient's mothers home, but				
	not at the nationt's fa	thers home. The LSW did				
	not identify what we	pons were at the patient's				
	mothers home. Then	was no documented	1			
	evidence the patient'	s mother was contacted to				
	verify where the wea	pons were located.				
	Patient Continuing C	are Plan, dated 5/14/13,				
ļ	identified safety conc	ems, including weapons in				1
ļ	the patient's home w	ere non-applicable and				
	verified by the patien	t's father. There was no				
	documented avidenc contacted for verifica	e the patient's father was tion.			·	
	On 5/14/13 at 2:30 P	M, the MA documented the				
	patient asked the MA	if the taxi would be able to				
	take the patient to the	e mother's house after the				
ļ	documented the petit	ther's house. The MA ent would have to pay for any				
	taxi after being dropp	ed off at the father's house.				
	On 7/9/13 at 8:49 AM	l, the Risk Manager				
	confirmed the LSW d	id not follow up on				
	identifying what weap	ons and if the patient had				
	access to the weapor	is prior to discharge.				
	Continuing Care Plan	Nischarge Planning				
		y #PC.067, revised 4/13,				
	documented:	2				
	"8.0 Securing Weapo	nsSocial Services staff				
	initiates attempts to s	ecure the weapons,				
	obtaining permission	and contacting any person				
	that may be able to lo	cate and secure the				
	nemsWeapons are	not considered secured until				
		received that the task is				
	completed"		1 1			1

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STATEMEN AND PLAN (EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE PLAN OF CORRECTION IDENTIFICATION NUM		R-		(X3) DATE SURVEY COMPLETED		
	•		A. BUILDING:		CONFLETED		
·		NVS3268HOS1	B. WING		07/	07/09/2013	
IAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE			
PRING N	OUNTAIN TREATMENT		EST SPRING MOUN	ITAIN ROAD			
		LAS VE	GAS, NV 89117				
(X4) ID PREFIX TAG	EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		HOULD BE COMPL		
S 602	Continued From pag	le 8	S 602	<u></u>			
	Severity: 2	Scope: 1					
	Complaint #NV0003	5655					
						Í	
						1	
i							
l							
					:		
dencies a E FORM	re cited, an approved plan of	of correction must be returned within 10 d	ays after receipt of th	is statement of deficiencies.	· . ·		

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4810-8686-6440, v. 1

EXHIBIT B

Electronically Filed 07/30/2014 11:55:52 AM 1.15 NEOJ 1 Michael Prangle, Esq. CLERK OF THE COURT Nevada Bar No. 8619 2 Kerry J. Doyle, Esq. 3 Nevada Bar No. 10571 HALL PRANGLE & SCHOONVELD, LLC 4 1160 N. Town Center Dr., Ste, 200 Las Vegas, NV 89144 5 (702) 889-6400 - Office 6 (702) 384-6025 - Facsimile Email: efile@hpslaw.com 7 Attorneys for Defendant Spring Mountain Treatment Center and Darryl Dubroca 8 9 DISTRICT COURT CLARK COUNTY, NEVADA 10 Las Vegas, Nevada 89144 Las Vegas, Nevada 89144 Facsimile: 702-889-6400 11 LEE E. SZYMBORSKI, CASE NO.: A-14-700178-C DEPT. NO.: XXXI 12 Plaintiff, 13 VS. NOTICE OF ENTRY OF ORDER ON 14 DEFENDANT SPRING MOUNTAIN SPRING MOUNTAIN TREATMENT TREATMENT CENTER AND DARRYL 15 CENTER, DARRYL DUBROCA, in his **DUBROCA'S MOTION TO DISMISS** official capacity, DOES I-XX, inclusive, and 16 ROE CORPORATIONS I-XX, inclusive, 17 Defendants. 18 Please take notice that an Order granting Defendants Spring Mountain Treatment Center 19 and Darryl Dubroca's Motion to Dismiss was entered in the above entitled Court on the 23rd day 20 of July, 2014, a copy of which is attached hereto. 21 DATED this 30th day of July, 2014. 22 HALL PRANGLE & SCHOONVELD, LLC 23 /s/: Kerry J. Doyle, Esq. 24 KERRY J. DOYLE, ESO. 25 Nevada Bar No.: 10571 1160 N. Town Center Dr., Ste. 200 26 Las Vegas, NV 89144 27 Attorneys for Defendants Summerlin Hospital $\parallel \parallel$ 28

HALL PRANGLE & SCHOONVELD, LL(

1160 NORTH TOWN CENTER DRIVE SUITE 200

Page 1 of 2



HALL PRANGLE & SCHOONVELD, LLC

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•			Electronically Filed 07/23/2014 04:42:55 PM				
	1	ORDR Michael Prangle, Esq.	Alter to Burn				
	2	Nevada Bar No. 8619	CLERK OF THE COURT				
	3	Kerry J. Doyle, Esq. Nevada Bar No. 10571					
		HALL PRANGLE & SCHOONVELD, LLC					
	4	1160 N. Town Center Dr., Ste. 200					
	5	Las Vegas, NV 89144 (702) 889-6400 Office					
	6	(702) 384-6025 – Facsimile					
	7	Email: <u>efilc@hpslaw.com</u> Attorneys for Defendant					
	8	Spring Mountain Treatment Center					
	9	and Darryl Dubroca					
	10	DISTRICT COURT					
L.C 6025		CLARK COUNTY, NEVADA					
J.D, I.J.C ve 702-384-6025	11	LEE E. SZYMBORSKI,	CASE NO.: A-14-700178-C				
VEJ, DRIVE 14 UE: 70	12		DEPT. NO.: XXXI				
RANGLE & SCHOONVELD, 1160 North Town Center Drive Suite 200 Las Vegas, Nevado 12389-6400 Facsimule: 702-3	13	Plaintiff,					
(ANGLE & SCHO 60 North Town Cent Sutte 200 Las Vecas, Nevada 702-889-6400 Fact	14	vs.	ORDER ON DEFENDANT SPRING MOUNTAIN TREATMENT CENTER				
E & Sur Sur 6400	15	SPRING MOUNTAIN TREATMENT	AND DARRYL DUBROCA'S MOTION				
NGL NGL As VI 2-889	16	CENTER, DARRYL DUBROCA, in his	TO DISMISS				
L PRANGLE 1160 North 148 VLG	1 7	official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,					
HAUL	18	Defendants.	before Sr. Judge Joseph Bonavaiture, sitting For				
H H	19		sitting for				
	20	OR	DER				
	21	Defendants Spring Mountain Treatment	Center and Darryl Dubroca's Motion to Dismiss,				
	22	having come on regularly for hearing on June	24, 2014, in Department XXXI, the Honorable				
	23	Joanna S. Kishner presiding; LEE E. SZYMBORSKI appeared pro se, KERRY J. DOYLE,					
	24	ESQ., appeared on behalf of Defendants, SPRING MOUNTAIN TREATMENT CENTER, and					
	25	DARRYL DUBROCA; the Court having consid	lered the pleadings on file and having heard oral				
	26	-	therefore, the Court finds and orders as follows:				
	27	IT IS ORDERED, ADJUDGED, AND DECREED that, Defendant Spring Mountain					
	28						
		a Dubroca's	Motion to Dismiss is GRANTED. Mr.				
		Page	1 of 2 07-30-14 403:19 (W				

Szymborski's claims are based upon allegations of medical malpractice. As a result, the 1 2 Complaint is required to be supported by a medical expert affidavit pursuant to NRS 41A.071. 3 Mr. Szymborski failed to provide the requisite affidavit and as a result, both Spring Mountain 4 Treatment Center and Mr. Dubroca are hereby dismissed from the instant action. 5 IT IS SO ORDERED.

DATED this $2l_{day of July, 2014.}$

JOANNA S. KISHNER COURT JUDGE

Submitted By:

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LAS VEGAS, NEVADA 89144 TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

HALL PRANGLE & SCHOONVELD, LLC

1169 NORTH TOWN CENTER DRIVE SUITE 200

HALL PRANGLE & SCHOONVELD, LLC KENNETH M. WEBSTER, ESQ.

Nevada Bar No.: 7205

- 14 KERRY J. DOYLE, ESQ.
 - Nevada Bar No.: 10571
 - 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144
- 16 Attorneys for Defendants Summerlin Hospital

4844-0011-1900, v. 1

Page 2 of 2

4810-8686-6440, v. 1

EXHIBIT C

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	to as
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OTTOWNOULD MALE AND ALL PRANCIE & SCHOONVELD, LLC /// 1 Jated this 22 nd day of May, 2014. 1 HALL PRANCIE & SCHOONVELD, LLC 1/2 /// 1/2 Michael Prangle, Esq. 1/2 Nevada Bar No. 8619 1/2 Kerry J. Doyle, Esq. 1/2 Nevada Bar No. 8619 1/2 Kerry J. Doyle, Esq. 1/2 Nevada Bar No. 8619 1/2 Kerry J. Doyle, Esq. 1/2 Noruce Orthornom Center Dr., Ste. 200 1/2 Las Vegas, NV 89144 1/2 Attorneys for Defindant 1/2 SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS for hearing bef 1/2 JUNE 9: 3 0 A 1/2 Juted this 22 nd day of May, 2014. 1/2 No. XXXI, or as soon thereafter as counsel can be heard. 1/2 Dated this 22 nd day of May, 2014. 1/2 Michael Prangle, ESQ. 1/2 Nevada Bar No. 8619 1/2 Nevada Bar No. 10571 1/3 Nevada Bar No. 10571 1/4 Nevada Bar No. 10571	HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevida 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025
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MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

Plaintiff's Complaint against Defendant, Spring Mountain must be dismissed because the claims asserted therein are medical malpractice allegations and the Complaint fails to attach an expert affidavit as required by statute. Although Plaintiff attempts to side-step the affidavit requirement by alleging general negligence as well as medical malpractice, it is clear that this case is based solely on an alleged act of medical malpractice. Therefore, Spring Mountain respectfully requests that the Complaint be dismissed.

n.

STATEMENT OF FACTS

14 This is a medical malpractice action arising out of the care and treatment rendered to 15 Sean Szymborski at Spring Mountain. According to Plaintiff's complaint, Sean Szymborski, a 16 mentally ill patient, was improperly discharged from Spring Mountain to Lee Szymborski's 17 (Plaintiff) home in violation of NAC 449.332. See Plaintiff's Complaint, hereinafter Exhibit A. 18 Further, as a result of this improper discharge, Sean Szymborski smashed the windows, walls, 19 20 doors, furniture, and completely destroyed the interior of the residence before going missing for 21 three weeks. Id. As a result of the alleged improper discharge, Plaintiff has filed suit against 22 Spring Mountain for the damages to his residence as well as emotional distress suffered by 23 Plaintiff. However, no expert affidavit supporting his claims was attached. Accordingly, 24 Defendant Spring Mountain respectfully requests that Plaintiff's Complaint be dismissed. 25

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Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsimile: 702-384-6025

HALL PRANCLE & SCHOONVELD, LLC

1160 NORTH TOWN CENTER DRIVE

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Page 3 of 10
III. -

LEGAL STANDARD

NRCP 12(b) states in part:

[E]very defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion:

(5) failure to state a claim upon which relief can be granted.

9 On a motion to dismiss for failure to state a claim for relief, the trial court, and the 10 Supreme Court must construe the pleading liberally and draw every fair intendment in favor of the plaintiff. Merluzzie v. Larson, 96 Nev. 409, 411-12, 610 P.2d 739, 741 (1980) overruled on 12 other grounds by Smith v. Clough, 106 Nev. 568, 796 P.2d 592 (1990). A complaint should not 13 14 be dismissed unless it appears to a certainty that the plaintiff could prove no set of facts that 15 would entitle him or her to relief. Zalk-Josephs Co. v. Wells Cargo, Inc., 81 Nev. 163, 169, 400 16 P.2d 621, 624 (1965). 17

As set forth below, Plaintiff has failed to state a claim for relief for medical malpractice since Plaintiff did not attach an expert affidavit as required by statute.

IV.

ARGUMENT

A. Plaintiff's Complaint must be dismissed because it is not supported by an Expert Affidavit.

Dismissal of Plaintiff's Complaint is required by NRS 41A.071 because Plaintiff's claims

are for medical malpractice but are not supported by an expert affidavit. NRS 41A.071 states:

[i]f an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit, supporting the allegations contained in the action,

Page 4 of 10

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LAS VEGAS, NEVADA 89144 Telephone: 702-889-6400 FACSIMILE: 702-384-6025 HALL PRANGLE & SCHOONVELD, LLC **1160 NORTH TOWN CENTER DRIVE** SUITE 200

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submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice.

The Nevada Supreme Court has held that "under NRS 41A.071, a complaint filed without

a supporting expert affidavit is void ab initio and must be dismissed." Washoe Med. Ctr. v.

Second Judicial Dist. Court, 122 Nev. 1298, 1300, 148 P.3d 790, 792 (2006). And since "a void

7 complaint does not legally exist, it cannot be amended." Id. In Washoe, the Court reasoned that:

"shall" is mandatory and does not denote judicial discretion. The Legislature's choice of the words "shall dismiss" instead of "subject to dismissal" indicates that the legislature intended that the court have no discretion with respect to dismissal and that a complaint filed without an expert affidavit would be void and must be automatically dismissed.

I Id. at 1303, 148 P.3d at 793-94. Moreover, the Court discussed the legislative intent underlying

NRS 41A.071, stating that the

legislative history further supports the conclusion that a complaint defective under NRS 41A.071 is void NRS 41A.071 was adopted as part of the 2002 medical malpractice tort reform that abolished the Medical-Legal Screening Panel. NRS 41A.071's purpose is to "lower costs, reduce frivolous lawsuits, and ensure that medical malpractice actions are filed in good faith based upon competent expert medical opinion." According to NRS 41A.071's legislative history, the requirement that a complaint be filed with a medical expert affidavit was designed to streamline and expedite medical malpractice cases and lower overall costs, and the Legislature was concerned with strengthening the requirements for expert witnesses.

21 *Id.* at 1304, 148 P.3d at 794. Accordingly, the Supreme Court has made it very clear that any

22 medical malpractice case must be dismissed if it is filed without an expert affidavit.

Here, Plaintiff is asserting that the Spring Mountain negligently discharged Sean
 Szymborski in violation of NAC 449.332. It is clear that Plaintiff failed to file an expert
 affidavit in support of his claims. Thus, the only question remains is whether this is a medical
 malpractice claim.

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Las Vegas, Nevada Telephone: 702-889-6400 Facs

HALL PRANGLE & SCHOONVELD, LLC

1160 NORTH TOWN CENTER DRIVE

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Page 5 of 10

NRS 41A.009 defines "medical malpractice" as "the failure of a physician, hospital or
employee of a hospital, in rendering services to use the reasonable care, skill or knowledge
ordinarily used under similar circumstances." The decision to discharge is a medical decision
and clearly falls under the definition of a hospital rendering services as set forth in NRS
41A.009. Thus, Plaintiff's allegations clearly fall under the requirements of NRS 41A.071.

NAC 449.332, the administrative code that Plaintiff relies on to support his claim, further demonstrates that the decision to discharge is a medical decision. NAC 449.332 states in part;

3. A hospital shall, at the earliest possible stage of hospitalization, identify each patient who is likely to <u>suffer adverse health consequences upon discharge</u> if the patient does not receive adequate discharge planning. The hospital shall provide for an evaluation of the needs related to discharge planning of each patient so identified.

NAC 449.332 (emphasis added). Thus, the decision to discharge requires medical care providers
 to identify whether a patient will need additional health care based upon their diagnosis and
 current medical status.

Plaintiff himself also acknowledges that the allegations in this case are medical in nature. He specifically alleges that Defendants were "entrusted to provide medical care owed to patients and a duty to provide adequate medical treatment..." Ex A at para 36. Plaintiff goes on to state that "Defendant breached the duty of care by discharging the patient...in violation of discharge policies and procedures, pursuant to NAC 449.332." Plaintiff's entire theory of liability is based upon the allegation that Spring Mountain breached a duty owed to Plaintiff to provide his son with medical treatment by improperly discharging him.

As a result of the above, it is undisputed that Plaintiff's Complaint is based solely on allegations of medical malpractice and each cause of action relies solely on whether the

Page 6 of 10

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suffe 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facsminle: 702-384-6025 7

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discharge of Sean Szymborski was medically negligent. Therefore, having failed to comply with
 NRS 41A.071 by attaching an expert affidavit to the Complaint, Plaintiff's Complaint must be
 dismissed.

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HALL PRANGLE & SCHOONVELD, LLC

1160 NORTH TOWN CENTER DRIVE

SUITE 200

B. <u>Plaintiff's claim for Punitive Damages fails as Plaintiff has not alleged facts that</u> warrant punitive damages against an employer under NRS § 42.007.

As Plaintiff's causes of action are all based in medical malpractice, any claims for punitive damages also must be dismissed. However, even if those claims survive, Plaintiff has asserted no facts that support a claim for punitive damages against Spring Mountain.

Plaintiffs' are not entitled to punitive damages against Spring Mountain because
 Plaintiff's Complaint merely alleges negligence by the hospital's employees; yet, it does not
 allege any independent wrong-doing or ratification by the hospital itself as is required by law.
 NRS § 42.007 governs an award of punitive damages against an employer for the conduct of
 employees as follows:

Except as otherwise provided in subsection 2, in an action for the breach of an obligation in which exemplary or punitive damages are sought pursuant to subsection 1 of NRS 42.005 from an employer for the wrongful act of his or her employee, the employer is not liable for the exemplary or punitive damages unless:

(a) The employer had advance knowledge that the employee was unfit for the purposes of the employment and employed the employee with a conscious disregard of the rights or safety of others;

(b) The employer expressly authorized or ratified the wrongful act of the employee for which the damages are awarded; or

(c) The employer is personally guilty of oppression, fraud or malice, express or implied.

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Page 7 of 10

If the employer is a corporation, the employer is not liable for exemplary or punitive damages unless the elements of paragraph (a), (b) or (c) are met by an officer, director or managing agent of the corporation who was expressly authorized to direct or ratify the employee's conduct on behalf of the corporation.

|| Nev. Rev. Stat. § 42.007(1).

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In this case, Plaintiff is requesting punitive damages against a corporation, Spring Mountain, for the actions of its employees in treating Sean Szymborski's condition. While Plaintiff does list Darryl Dubroca in his official capacity in the caption of the Complaint, there are no allegations of any wrongdoing on his part or that he was aware or ratified any of the alleged acts. In fact, the only mention of Mr. Dubroca in the Complaint is that he is the CEO/Managing Director of Spring Mountain. Ex. A, at para. 2. Consequently, to succeed in this request under NRS § 42.007, Plaintiffs must allege and prove one of the following:

- That an officer/director/managing agent of Spring Mountain had advance knowledge that the employees attending to Sean Szymborski were unfit for their employment, but nonetheless were employed with a conscious disregard of the safety of others;
- That an officer/director/managing agent of Spring Mountain "expressly authorized or ratified" the negligent treatment of Sean Szymborski; or
- That an officer/director/managing agent of Spring Mountain was himself/herself guilty of "oppression, fraud or malice."

Here, there are no such allegations in the Complaint. On the contrary, Plaintiff merely concludes that the alleged "negligent" treatment by Spring Mountain's *employees* warrants punitive damages. Therefore, Plaintiffs' claims for punitive damages are insufficient as a matter of law, and must be dismissed.

Moreover, as set forth above, Plaintiff's allegations against the hospital staff are for negligence, which is not a permissible basis for a punitive damage claim. See NRS 42.005

Page 8 of 10

HALL PRANGLE & SCHOONVELD, LLC 1160 North Town Center Drive Suite 200 Las Vegas, Nevada 89144 Telephone: 702-889-6400 Facismile: 702-384-6025

(stating that a plaintiff must, by clear and convincing evidence, prove "the defendant has been 1 guilty of oppressions, fraud or malice ... " to warrant punitive damages). "A plaintiff is never 2 3 entitled to punitive damages as a matter of right." Dillard Department Stores v. Beckwith, 115 4 Nev. 372, 380, 989 P.2d 882, 887 (1999) (quoting Ramada Inns v. Sharp, 101 Nev. 824, 826, 5 711 P.2d 1, 2 (1985). "[E]ven unconscionable irresponsibility will not support a punitive 6 damages award," Maduike v. Agency Rent-A-Car, 114 Nev. 1, 5-6, 953 P.2d 24, 27 7 (1998)(quoting First Interstate Bank v. Jafros Auto Body, 106, Nev. 54, 57, 787 P.2d 765, 767 8 9 (1990)). The Nevada Supreme Court has further stated that "[s]ince its language plainly requires 10 evidence that a defendant acted with a culpable state of mind, we conclude that NRS 42.001(1) 11 denotes conduct that, at a minimum, must exceed mere recklessness or gross negligence." 12 Countrywide v. Thitchener, 124 Nev. 725, 743, 192 P.3d 243 (2008). 13

Thus, notwithstanding Plaintiff's inability to overcome the employer specific hurdles under NRS 42.007, Plaintiffs' allegations of negligent medical treatment are insufficient as a matter of law to warrant punitive damages. Therefore, Plaintiff's claim for punitive damages should be dismissed.

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HALL PRANGLE & SCHOONVELD, LLC

1160 NORTH TOWN CENTER DRIVE

SUITE 200

Page 9 of 10

		V.
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	2	CONCLUSION
	3	Based upon the foregoing, Spring Mountain respectfully requests this Honorable Court
	4	issue an Order Dismissing, Plaintiffs' Compliant.
	5	Dated this 22 nd day of May, 2014.
	6	HALL PRANGLE & SCHOONVELD, LLC
	7	
	8	<u>/s/: Kerry J. Doyle, Esq.</u> Michael Prangle, Esq.
	9 10	Nevada Bar No. 8619 Kerry J. Doyle, Esq.
LLC -6025	10	Nevada Bar No. 10571 1160 N. Town Center Dr., Ste. 200
LD, LLC Æ 702-384-6025	12	Las Vegas, NV 89144
	13	Attorneys for Defendant Spring Mountain Treatment Center
CENTER DRI CENTER DRI 00 FACSIMILE:	14	CERTIFICATE OF SERVICE
& SCE Town C SUITE 200 AS, NEVA	15	
LANGLE & SCHO 60 NORTH TOWN CENT SUITE 200 LAS VEGAS, NEVADA 702-889-6400 FAC	16	I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC;
HALL PRANGLE 1160 North 1 1 Las Veg 1 Las Veg	17	that on the 22 day of May, 2014, I served a true and correct copy of the foregoing
JALL PR 11 elephone:	18	DEFENDANT SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS
H J	19	attached hereto in a sealed envelope, via U.S. Mail, first-class postage pre-paid to the following
	20	parties at their last known address:
	21	Lee E. Szymborski
	22	4605 Black Stallion Avenue Las Vegas, Nevada 89031
	23	Plaintiff in Proper Person
	24	Audrey Stephanski
·.	25	An employee of HALL PRANCLE & SCHOONVELD, LLC
	26	
	27	4821-1809-2059, v. 1
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		Page 10 of 10

EXHIBIT A

4810-8685-6440, v. 1

1 2 3 4 5	LEE E. SZYMBORSKI 4605 Black Stallion Ave N. Las Vegas, NV 89031 (702) 609-6762 Plaintiff in Proper Person DISTRICT CO	FILED MAY 0 2 2014
6	CLARK COUNTY, 1	NEVADA
7 8 9	LEE E. SZYMBORSKI,) Plaintiff,) ys.	Case No. Dept No.
10 11 12	SPRING MOUNTAIN TREATMENT CENTER, DARRYL DUBROCA, in his official capacity, DOES I-XX, inclusive, and ROE CORPORATIONS I-XX, inclusive,	EXEMPT FROM ARBITRATION SUMS IN EXCESS OF \$50,000
13	Defendants.	
14	COMPLAIN	Γ
15 16	COMES NOW, Plaintiff, named above, and for	-
17	GENERAL ALLEGA	
18		been and is now, a resident of the State of
19	Nevada, County of Clark. Jurisdiction and Venue are ap 2. Defendant DARRYL DUBROCA is the	
20		LEO/Managing Director of SPRING
21	 Plaintiff is informed and believes, and or 	that basis alleges, that Defendents
22	SPRING MOUNTAIN TREATMENT CENTER is a m	
23	SEAN T. SZYMBORSKI for treatment and discharged	
24 25	4. The true names and capacities, whether in	
26	otherwise, of the Defendant sued herein as DOES I through	
27	XX, inclusive, are unknown to Plaintiff, who is informed	
28	Page 1	

fictitiously named Defendants is in some way liable to Plaintiff on the causes of action below and
 therefore sues these defendants by such fictitious names. Plaintiff believes said fictitious
 Defendants assisted, devised, schemed, planned or took part in the actions set forth hereinbelow.
 Plaintiff will move to amend this Complaint and insert the true names and capacities of
 fictitiously named Defendants when the same have been ascertained.

5. Plaintiff is informed and believes, and thereon alleges, that at all times herein
mentioned, each actually and fictitiously names Defendant was the principal, agent, co-venturer,
partner, surety, guarantor, officer, director and/or employee of each co-defendant and in doing the
things herein alleged, was acting within the scope of authority and with the permission of each
co-defendant or took some part in the acts and omissions hereinafter set forth, and by reason
thereof, each of said Defendants is liable to Plaintiff for the relief prayed.

C. That on or about May 14, 2013, at approximately 3:30 p.m., Defendant SPRING
 MOUNTAIN TREATMENT CENTER, 7000 W. Spring Mountain Road, Las Vegas, Nevada
 89117, due an "UNAUTHORIZED UNSAFE DISCHARGE" of a mentally ill adult patient, to
 wit: SEAN T. SZYMBORSKI, in violation of NAC 449.332, to the residence of Plaintiff. See
 Exhibit "1".

7. That said SEAN T. SZYMBORSKI was provided a taxi ride, released without any
 money; without appropriate medication, without the ability to care for himself, and being a
 danger to both himself and other.

8. Defendant SPRING MOUNTAIN TREATMENT CENTER was directed by
 KATHLEEN BUCHANAN to provide a Guardianship for Defendant SEAN T. SZYMBORSKI,
 and failed to do so.

9. Defendant SPRING MOUNTAIN TREATMENT CENTER Caseworker
"REBECCA" was directed NOT to release SEAN T. SZYMBORSKI to the residence of
Plaintiff, however he was transported by taxi directly to the home of Plaintiff, where he smashed
windows, walls, doors, furniture, and completely destroyed the interior of the residence, before
going missing for three weeks. (A missing persons report was filed by NLVPD.)

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10. An investigation by the Division of Public and Behavioral Health substantiated that 1 Defendant SPRING MOUNTAIN TREATMENT CENTER was in violation of NAC 449.332, Discharge Planning, based upon evidence by interview of staff, record review and document review.

5 11. It was determined that the facility failed to assure the patient was discharged to a safe environment due to the following issues in this matter:

a. Patient was admitted to the facility on 5/3/13, and discharged on 5/14/13 with diagnoses including psychosis not otherwise specified and spice abuse.

9 b. On 5/13/13 at 1 p.m. the Nursing Progress Note documented the patient had much trepidation about going back to the father's home. The patient was restless when talking about 10 11 the father.

12 c. On 5/15/13 at 2:0 p.m. the Masters of Art (MA) met with the patient to confirm the 13 address of the apartment. The MA documented the patient was vague about the address. The patient needed to stop by the father's home to pick up patient's debit card prior to going to the 14 15new apartment.

16 d. Review of the Social Services Discharge Note revealed the patient would live in an apartment upon discharge. There was no documented evidence of an address for the apartment. 17 There was no documented evidence the Case Manager confirmed the patient had made 18 19 arrangements to live in the apartment.

20 e. The Patient Continuing Care Plan, dated 5/14/13 identified the parties was to go to father's home first then on to an address in North Las Vegas, Nevada. 21

22 f. The Acute Physician Discharge Progress Note on 5/14/13 at 8:50 a.m. documented the patient did not want to return to the patient's father's home due to ongoing conflict. The note 23 documented the patient participated in treatment planning to find housing. 24

25 g. The Risk Manager investigated a telephone complaint from the patient's father. The 26 Administrative Review documented placement to the apartment was not verified.

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h. On 7/9/13 at 8:49 a.m. the Risk Manager confirmed the MA did not follow up on verifying the identified apartment.

3 i. On 7/9/13 at 11:20 a.m., Licensed Social Worker (LSW) indicated multiple telephone messages were left by the patient's father. The father would state the patient could return to the 4 home; the next telephone message from the father would demand the patient not be discharged to the father's home. The LSW acknowledged she did not speak directly with the patient's father. The LSW stated due to the large number of patients on the LSW's caseload, the LSW had to delegate telephone calls and discharge planning to the MA.

9 j. The LSW indicated when a patient identified their own placement, the LSW would try to obtain as much information as possible regarding the address and name of the apartment. If 10 unable to verify placement, the physician would be notified prior to discharge from the facility. 11

12 k. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 a.m. documented the patient did not want to return to his father's home due to ongoing conflict. The note 13 documented the patient participated in treatment planning to find housing.

15 12. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: 16

17 a. The needs of the patient for postoperative services and the availability of those 18 services.

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b. The capacity of the patient for self-care; and

20 c. The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. 21

22 13. Defendant SPRING MOUNTAIN TREATMENT CENTER is in violation of NAC 449.394, Psychiatric Services, which requires that a hospital shall develop and carry out policies 23 and procedures for the provision of psychiatric treatment and behavioral management services 24 that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and 25 services are safely and appropriately used. The hospital shall ensure that the policies and 26 procedures protect the safety and rights of the parties - and the public at large. 27 28

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14. That Defendant SPRING MOUNTAIN TREATMENT CENTER has failed to met these statutes and regulations, for the reasons set forth above.

3 15. That due to the failure to meet these responsibilities, SEAN T. SZYMBORSKI, was driven by taxi to the home of Plaintiff, and dropped off, at the expense of the Defendant SPRING MOUNTAIN TREATMENT CENTER, where he proceeded to cause significant property damage to Plaintiff's residence, and go missing.

7 16. That when SEAN T. SZYMBORSKI was located, he had sustained wounds from a self inflicted injuries with a sharp object, using weapons obtained at the home of his mother; and 8 9 not at the home of his father.

10 17. The patient care plan, dated 5/14/13 indicated that safety concerns, including weapons, in the patient's home were non-applicable and verified by the patient's father. There 11 was no documented evidence the patient's father was contacted for verification. Furthermore, 12 Defendant SPRING MOUNTAIN TREATMENT CENTER indicated they assisted in obtaining a 13 home for SEAN T. SZYMBORSKI, therefore, even confirming no weapons in father's home was 14not reasonable to consider this non-applicable. 15

16 18. In violation of the stated statutes, it was determined that the LSW did not follow up on identifying what weapons and if the patient had access to weapons prior to discharge. (8.0 17 Securing Weapons...Social Services staff initiates attempts to secure the weapons, obtaining 18 permission and contacting any person that may be able to located and secure items...Weapons are 19 not considered secured until verification has been received that the task is completed ... ") 20

21 19. Due to the inactions of Defendant SPRING MOUNTAIN TREATMENT CENTER, 22 SEAN T. SZYMBORSKI was convicted of criminal charges related to the property destruction at 23 the home of Plaintiff, rather than receiving treatment for his known mental illness.

24 20. Defendant SPRING MOUNTAIN TREATMENT CENTER acted in reckless disregard of SEAN T. SZYMBORSKI's psychiatric condition in pre-paying for a taxi to dump 25 him at an verified location [Plaintiff's residence], without notice to occupants, without money, 26 and without the ability to provide care for himself due to long standing mental illness. 27

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1	21. The failures of Defendant SPRING MOUNTAIN TREATMENT CENTER to deliver
2	the statutory mandated care to patients in their custody and control resulted in systematic
3	disregard of the serious psychological and medical conditions and resulted in adverse
4	consequences, which predictably flow from such failures, and caused damages to patients and
- 5	others, who became victims of such disregard.
6	22. Defendant SPRING MOUNTAIN TREATMENT CENTER is a for profit
7	corporation, whose estimated annual revenue is in excess of TWO BILLION DOLLARS
8	(\$2,000,000,000).
9	FIRST CLAIM FOR RELIEF
10	(NEGLIGENCE)
11	23. Plaintiff realleges and incorporates by reference all of the previous allegations of
12	this Complaint at this point as if set forth fully herein.
13	24. Nevada recognizes negligence claims, where a Plaintiff establishes: (1) the
14	existence of a duty of care (2) breach of that duty; (3) legal causation; and (4) damages.
15	25. Defendants, in the exercise of reasonable care had a duty to know, or should have
16	known, that they are required to comply with NAC 449.332, regarding DISCHARGE PLAN of
17	Patients; and with NRS 449.765 to 449.786.
18	26. Defendants breached their duty by failing to carefully investigate, monitor and/or
19	oversee discharge activities at SPRING MOUNTAIN TREATMENT CENTER, including but
20	not limited to, the development, implementation, and supervision of discharge policies and
21	practices.
22	27. That Defendants negligently and/or carelessly, permitted the dumping of SEAN T.
23	SZYMBORSKI, by taxi to the home of Plaintiff, without notice to Plaintiff, in violation of their
24	own internal policies; NAC 449.332; and NRS 449.865 to 449.786.
25	28. Defendants knew or should have known that patients, including SEAN T.
26	SZYMBORSKI are members of the class of patients that could foresceably suffer injury to
27	themselves, and/or inflict injury on others, as a result of Defendants' failure to exercise
28	Page 6

reasonable care in the discharge of their statutorily imposed duties, and/or common-law duties of
 care.

29. As a direct and proximate result of the negligence and carelessness of Defendants,
Plaintiff has suffered extreme emotional and mental distress, further issues and conflict in the
family unit, in addition to approximately \$20,000 in physical damage to the residence, including
smashed windows, which required immediate action to secure assets in the residence, and other
damages the full extent of which shall be provided through discovery.

30. As a direct and proximate result of Defendants' acts or omissions, Plaintiff has
suffered punitive, general and special damages.

10 11

SECOND CLAIM FOR RELIEF (Professional Negligence)

(Negligent act or omission to act by a provider of health care in rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, NRS 41A.015)

31. Plaintiff realleges and incorporates by reference all of the previous allegations of
 this Complaint at this point as if set forth fully herein.

32. Defendants in the capacity of a for profit hospital providing medical care to the
public, government agencies overseeing the hospital's operations, licensed social workers,
registered nurses, psychiatrists, and the hospital administrator owed Plaintiff a duty to employ
medical staff adequately trained in the care and treatment of patients consistent with the degree
of skill and learning possessed by competent medical personnel practicing in the United States of
America under the same or similar circumstances; and a duty to comply with Nevada statutes,
including NRS 41A.015.

33. Defendants breached its duty of care by failing to function as a patient advocate by
providing proper care to the patients at the time of discharge, and specifically causing physical,
mental and emotional pain and suffering to the patient; as well as physical, mental and emotional
pain and suffering to the public at large, and specifically in this matter, to the Plaintiff.

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1 THIRD CLAIM FOR RELIEF 2 (Malpractice, Gross Negligence, Negligence Per Se) 3 34. Plaintiff realleges and incorporates by reference all of the previous allegations of this Complaint at this point as if set forth fully herein. 4 5 35. "Malpractice" in the practice of social work means conduct which falls below the standard of care required of a licensee under circumstances which proximately causes damage. 6 7 "Gross Negligence" in the practice of social work means conduct which represents an extreme departure from the standard required of a licensee under the circumstances and which 8 9 proximately caused damage. NAC 641B.225, pursuant to 42 C.F.R.§ 482.61, Defendants had a duty to properly discharge patients in compliance with NAC 449.332, relating to discharge 10 11 planning. 12 36. That Defendants including JOHN DOE 1 in the capacity of Licensed Social Worker (LSW) is entrusted to provide medical care owed to patients and a duty to provide adequate 13 medical treatment, to protect the patient and the public at large. Said Defendant breached the 14duty of care by discharging the patient, paying for a taxi only to Plaintiff's address (although the 15 patient asked to pick up a debit card, then be transported to another residence), in violation of 16 17 discharge policies and procedures, pursuant to NAC 449.332. As a proximate result of the negligence of Defendants, the patient and public at large are subject to physical, mental and 18 19 emotional pain, in addition to financial loss, such as Plaintiff has sustained. 20 37. The conduct of Defendants was in wanton, extreme and total disregard of the legal and statutory obligations to patients and the public at large, and constitutes gross, reckless, 21

oppressive and/or outrageous disregard for the consequences of their actions. As a proximate
result of the negligence of Defendants, Plaintiff has suffered physical, mental and emotional pain,
in addition to financial damages.

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1	FOURTH CLAIM FOR RELIEF
2	(Negligent Hiring, Supervision and Training)
3	38. Plaintiff realleges and incorporates by reference all of the previous allegations of
4	this Complaint at this point as if set forth fully herein.
5	39. At the times mentioned herein, Defendants knew, or in the exercise of reasonable
6	care should have known, that the provisions of medical care and treatment was of such a nature
7	that, if it was ot properly given, it was likely to injure the persons to whom it was given.
8	Defendants owed a duty to its patients, and the community at large, to hire, train, and/or
9	supervise competent medical and staff personnel, including supervisors, and LSW, to provide
10	care and treatment to its patients.
11	40. Defendants breached that duty of care by failing to adequately provide competent
12	employees, in the performance of the job, as it appears dumping patients is an ongoing problem.
13	41. At all times herein mentioned, Defendants established and/or followed, unsafe
14	medical practices, including "dumping" patients without complying with discharge instructions.
15	42. As a result of the lack of medical care and treatment provided by Defendant,
16	Defendants breached their duty to Plaintiff and the members of the class by failing to protect
17	them from foreseeable harm, resulting in a lack of mental health treatment for Plaintiff and the
18	public at large.
19	43. As a direct and proximate result of the negligence and carelessness of Defendants,
20	Plaintiff has been injured financially, as well as mentally and emotionally in this matter.
21	44. Defendants conduct demonstrated a conscious disregard of known accepted
22	procedures, protocols, care and treatment, all with the knowledge or utter disregard that such
23	conduct could or would expose Plaintiff to harm as set forth herein.
24	45. Defendants conduct was willful, reckless, malicious, and in total disregard to the
25	health and safety of not only the patient, but the public at large, thereby justifying an award of
26	punitive damages.
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	46. As a direct and proximate result of the conduct of Defendants, Plaintiff has suffered
2	mental and emotional pain and suffering, in addition to financial loss.
3	WHEREFORE, Plaintiff prays judgement as follows:
4	1. For a temporary restraining order and/or preliminary injunction and permanent
5	injunction enjoining and restraining Defendants from continuing or repeating the unlawful
6	polices, practices and conduct complained of herein;
7	2. For declaratory judgment against Defendants' policies, practices and conduct as
8	alleged herein in violation of patient rights, and the safety of the public at large;
9	3. For compensatory damages according to proof;
10	4. For punitive damages in consideration of the annual income in excess of
11	\$2,000,000,000.
12	5. For emotional distress caused by the violations herein.
13	6. For costs of suit, including attorney fees, and other costs.
14	7. For such other and further relief as the Court may deem appropriate.
15	DATED this day of, 2014
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17	LEE E. SKYMBORSKI Plaintiff in Proper Person
18	r mining ar r toper r erson
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20	Page 10

EXHIBIT 1

BRIAN SANDOVAL Governor

MICHAEL J. WILLDEN Director



RICHARD WHITLEY, MS Administrator

TRACEY D. GREEN, MD State Health Officer

STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH DIVISION

Health Facilities/Lab Services 727 Fairview Dr., Suite E Carson City, Neveda 89701 (775) 684-1030 Fax: (775) 684-1073

★ Health Facilities/Lab Services 4220 S. Maryland Parkway Suite 810, Building D Las Vegas, NV 89119 (702) 466-6515 Fax; (702) 486-6520

Rediation Control 4150 Technology Way Suite 300 Carson City, Nevada 89706 (775) 687-7550 Fax: (775) 687-7552

Radiation Control 2030 E. Flamingo Suite 319 Las Vegas, Nevada 89119 (702) 486-5280 Fax: (702) 486-5024

Child Care Licensing 727 Fairview Dr, Suite E Carson City, Nevada 89701 (775) 684-4463 Fax: (775) 684-4464

Child Care Licensing 4180 S. Pecos, Ste 150 Las Vegas, Neveda 89121 (702) 486-7918 Fax: (702) 486-6660

□ Child Care Licensing 1010 Ruby Vista, SIe 101 Eiko, Nevada 89801 (775) 753-1237 Fax: (775) 753-1336 May 22, 2013

Lee Szymborski 4605 Black Stallion Avenue North Las Vegas, NV 89032

RE: Complaint # NV00035655

Dear Mr. Szymborski,

Thank you for alerting us about your dissatisfaction with Spring Mountain Treatment Center. We understand your concerns about admission, transfer and discharge, quality of care-responsible party not notified of patients change in condition, patient not assessed after change in condition, patient's medications improperly administered.

Our team of investigators will review your specific concerns, and evaluate the facility's actions, to determine if the facility is in compliance with state and/or federal regulations. Please refer to the enclosed fact sheet that describes the investigation process.

We will inform you of the investigation results, and send you a copy of the report. If you want to know the status of your complaint, please call the team supervisor, Rosemary Palladino-Marcus, HFI III, and refer to the complaint number listed above.

Please know that the Nevada State Health Division takes all complaints very seriously. By reporting your concerns, you play an important role in promoting the safety of health care recipients and improving the quality of care and services that facilities provide. We thank you.

Sincerely,

Khna Thacker, AAII/Complaint Intake Coordinator

cc: Rosemary Palladino-Marcus, Health Facilities Inspector III

Encl: 1 Page Complaint Process Fact Sheet

Public Health Working for a Safer and Healthier Nevada

	OF DEFICIENCIES # CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPLI	
		NVS3268HOS1	8. WING	07/0	07/09/2013	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ODING U	OUNTAIN TREATMENT		ST SPRING MOUN			
	OUR MAIN IREALMENT	VERICK	SAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS COMPL DAT
S 000	Initial Comments		S 000	, , , , , , , , , , , , , , , , , , ,		Pen
	a result of a complair 6/25/13, and finalized	ficiencies was generated as ht investigation initiated on I in your facility on 7/9/13, in ada Administrative Code, II.				
	The census at the tin 63. Five discharged r reviewed.	ne of the investigation was medical records were		· .		
	Complaint #NV00035 deficiencles cited. (Si S0602)	i655 was substantiated with ee Tags S0146, S0153 and				
	by the Health Division prohibiting any crimin actions or other claim	clusions of any investigation a shall not be construed as al or civil investigations, is for relief that may be under applicable federal,				
S 146 SS=D	NAC 449.332 Discha	rge Planning	S 146			
	to discharge planning limitation, considerati (a) The needs of the j services and the avail	ne needs of a patient relating must include, without on of: patient for postoperative lability of those services; e patient for self-care; and				
	(c) The possibility of r previous care setting appropriate placemen discharge.	eturning the patient to a or making another				
	Based on interview, re	ecord review and document ed to assure the patient was environment for 1 of 5				

STATE FORM

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If continuation sheet 1 of 9

		(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			e survey IPleted
		NVS3268HOS1	B. WING	07	07/09/2013	
AME OF PF	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	, ZIP CODE		
PRING M	OUNTAIN TREATMEN	I GENIER	ST SPRING MOUN 3AS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY B	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(265)
TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
S 146	Continued From page	je 1	S 146		4844	
1	Findings include:					
	Patient #1					
	and discharged on 5	itled to the facility on 5/3/13 5/14/13 with diagnoses				
	including psychosis spice abuse.	not otherwise specified and				
	Note documented th	PM, the Nursing Progress le patient had much				
	trepidation about go The patient was rest father.	ing back to the father's home. dess when talking about the				
	On 5/14/13 at 2:30 F	^D M, the Masters of Art (MA) met with the patient to				
	confirm the address	of the apartment. The MA				
	documented the pat	ient was vague about the				
	address. The patient	t needed to stop by the				
İ	father's home to pick prior to going to the	<up card<br="" debit="" patient's="" the="">new apartment,</up>				
		Services Discharge Note				
	revealed the patient	would live in an apartment				
į	upon olscharge. The	re was no documented				
	was no documented	ess for the apartment. There evidence the Case Manager				
	confirmed the nation	t had made arrangements to				
	live in the apartment					
	Patient Continuing C	are Plan, dated 5/14/13,				
	identified the patient	was to go to the father's				
	home first then on to Vegas,	an address in North Las				
	The Acute Physician	Discharge Progress Note,				
	did not want to roture	M, documented the patient to the patient's fathers				
	home due to on-goin	of correction must be returned within 10 of				

~

ł .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MIATIPLE C A. BUILDING:			e Survey Pleted
		NVS3268HOS1	8. WING		07	//09/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		
SPRING M	OUNTAIN TREATMEN		ST SPRING MOUN			
	CONTRACT INEALMENT	I ACUITU	3AS, NV 89117			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	COMPLE
S 146	Continued From page		S 146			1
	documented the pat planning to find hous	ient participated in treatment sing.				
	The Risk Manager in	vestigated a telephone				
	complaint from the p	atient's father. The				
	Administrative Revie	w documented placement to				
ļ	the apartment was n	ot verified.				
	On 7/9/13 at 8;49 AM	1 the Rick Manager				
	confirmed the MA die	d not follow up on verifying				
	the identified apartm	ent.				
	On 7/9/13 at 11:20 A	M, Licensed Social Worker				
	(LSW) #2 explained	multiple telephone messages				
	were left by the patie	nt's father. The father would				ļ
	state the patient coul	id return to the father's home.				1
	Would demand the m	nessage from the father atlent not be discharged to				
-	the father's home. The	ne LSW acknowledged she				
	did not speak directly	/ with the patient's father.				l l
	The LSW explained (during the first meeting with	1			1
	the patient, the paties	nt expressed a willingness to				
	return to the father's	home and would work on				
	LSW explained due t	from the father's home. The other large number of				
	patient's on the LSW	's case load, the LSW had to				ſ
	delegate telephone o	alis and discharge planning	, i			
	to the MA.	0.1				
	The LSW explained v	when a patient identified their				
-	own placement, the L	SW would try to obtain as				
1	much information as	possible regarding the	l Ì			
	accress and name of	the apartment. If the LSW				
,	Would be notified prin	placement, the physician r to discharge from the				
1	facility.	a to algorith do a gift fild				1
	Continuing Care Plan	Discharge Planning,				
l i	nterdisciplinary Police	y #PC.067, revised 4/13,				
	documented:		1			1

. . .

TATEMENT ND PLAN (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		NVS3268HOS1	B. WING	07/09/2013		
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
PRING M	OUNTAIN TREATMEN		ST SPRING MOUN			
			3AS, NV 89117	······································		
(X4) ID PREFIX	SUMMARY (STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	RECTION	(X5)
TAG	REGULATORY	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPL
			TAG	DEFICIENCY)	SPERCER (MIL	ÇA,
S 146	Continued From page	ge 3	S 146			
1	Procedure:					
	following is evaluate	the continuing care plan, the d by the Case Manager: 4.4				ļ
	Housing needs and	or placement issues;4.8				
	Personal support sy	stems*				
	5.6 Continuing on					
	to the patient and fa	rre plans are communicated mily/guardian, as appropriate,				
	and documented in	the medical record5.2				
ļ	Where and with who	om the patient will live				
	following discharge.	n 				}
	"6.0 The Social Se	rvices Discharge Note is				
	completed for every	patient at the time of				
	discharge. This note	includes, but is not ilmited				l
	to: 6:1 Living arrange	ements*				
	Sevenity: 2	Scope: 1				ļ
ļ	Complaint #NV0003	5655				
S 153 SS=D	NAC 449.332 Discha	arge Planning	S 153			
	11. The patient, mer	nbers of the family of the				
	patient and any othe	r person involved in caring				1
[for the patient must I	e provided with such				
	information as is nec the post-hospital can	essary to prepare them for				
	and host-moshirdi (SI)	e vrule patient,				Í
.	This Degulation 1					
	Based on interview	ot met as evidenced by: record review and document				
[]	review, the facility fai	led to notify 2 of 5 sampled				
1	patients families prior	to discharge (Patient #1				ļ
1	and #5).					
			1			1

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

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If continuation sheet 4 of 9

ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		NVS3268HOS1	B, WING	07	/09/2013	
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			
PRING N	OUNTAIN TREATMEN	T CENTER 7000 WE	ST SPRING MOUN GAS, NV 89117			
(X4))D						
Prefix Tag	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	RD PREFIX TAG	PROVIDER'S PLAN OF CORF (EAGH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
S 153	Continued From page	ge 4	\$ 153	······································		
	Findings include:					
	Patient #1					
	Patient #1 was admi	itted to the facility on 5/3/13				
	and discharged on 5 including psychoosis	V14/13 with diagnoses not otherwise specified and				
ļ	spice abuse,	not otherwise specified and				
	On 5/10/13 at 9:00 A	M, the LSW #2 documented				
	the case manager re Datient's father sovin	eceived a voice mail from the				
	return to his home. T	The LSW documented the				
į	case manager would alternative placemer	assist the patient with				
	On 5/10/13 at 11:15	AM, the MA documented the				ļ
	home, but not to be	ed the patient to return to his discharged "today".				
	There was no further	documented evidence the				
	patient's father was o discharge to the patie	contacted to confirm ent's father's home.				
		M, the MA documented the				
	MA met with the patie	ent. The patient requested				
	of being discharged	s number and told the father and a taxi would transport				1
	the patient to the fath	er's home.				
	The Risk Manager in	vestigated a telephone				
	complaint from the pa Administrative Review	atient's father. The w documented the discharge				1
·	was not coordinated	with the family.				
	Documentation with t	he father on the day of				
	discharge was not do	cumented.				
•	On 7/9/13 at 9:50 AM	, the Risk Manager				
	acknowledged the fac	ility should have arranged				
	or the taxi onver to w	rait at the patient's father's				1

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If continuation sheet 5 of 9

Division of Public and Behavioral Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ NVS3268HOS1 B. WING _ 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SPRING MOUNTAIN TREATMENT CENTER 7000 WEST SPRING MOUNTAIN ROAD LAS VEGAS, NV 89117 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PROVIDER'S PLAN OF CORRECTION PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XIS). COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY> S 153 Continued From page 5 S 153 house until the patient retreived the debit card, then drive the patient to the new apartment. On 7/9/13 at 11:34 AM, LSW #2 explained the family member should be contacted prior to the patient's discharge to assure the family was alright with the patient returning home. The LSW acknowledged the patient's father should have been contacted by the facility staff prior to the patient being discharged. Four additional discharged medical records were reviewed. Patient #5 Patient #5 was admitted to the facility on 6/4/13 and discharged on 6/18/13, with a diagnosis of major depressive disorder. There was no documented evidence the social worker/Case Manager notified the family of the patient's discharge. There was no documented evidence the family was educated on the patient's medications and follow up care needed. There was no family contact from the social worken/Case Manager after 6/6/13. Continuing Care Plan Discharge Planning, Interdisciplinary Policy #PC.067, revised 4/13, documented: Procedure: "...4.0 In developing the continuing care plan, the following is evaluated by the Case Manager...4.8 Personal support systems ... " "...5.0 Continuing care plans are communicated to the patient and family/guardian, as appropriate, If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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If continuation sheet 6 of 9

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
		NVS3268HOS1	B. WING		07/0	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
SPRING N	OUNTAIN TREATMENT	CENTER 7000 W	EST SPRING MOUN	ITAIN ROAD		
<u> </u>		LAS VE	GAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPL DATI
S 153	Continued From page	96	S 153		····· ·· · · · · · · · · · · · · · · ·	
	and documented in th	ne medical record"			•	
	Severity: 2	Scope: 1				
	Complaint #NV00035	655				
S 602 SS≃D	NAC 449.394 Psychia	atric Services	S 602			
	and procedures for th treatment and behavior that are consistent with inclusive, to ensure the services are safely an hospital shall ensure to	d appropriately used. The				
	Based on interview, re review, the facility faile	t met as evidenced by: accord review and document ad to identify what weapons nother's home and if the cess to the weapons.				
	Findings include:					
	Patient #1					
	and discharged on 5/1	ed to the facility on 5/3/13 4/13 with diagnoses t otherwise specified and				
1 1 1	On 5/3/13 at 12:00 PM Assessment Tool docu multiple scab areas on Comprehensive Asses the patient's father stat were self inflicted with	mented patient had his legs. The sment Tool documented led the patient's wounds				

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

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If continuation sheet 7 of 9

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			ITE SURVEY	
		NVS3268HOS1	8. WING		0.	7/09/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			10012010	
SPRING N	OUNTAIN TREATMENT	CENTER 7000 WE	ST SPRING MOUN GAS, NV 89117				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			<u> </u>	·	
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) Comple Date	
S 602	Continued From page	ə7	\$ 602				
	0- 50000						
Í	On 5/6/13 at 2:42 PM	, LSW #1 documented					
	not at the petited	patient's mothers home, but					
	not at the patient's fat	hers home. The LSW did					
	mothem home. These	pons were at the patient's					
	mothers home. There evidence the patient's	was no documented					
ļ	verify where the weap	mother was contacted to cons were located.					
	Patient Continuing Ca	re Plan, dated 5/14/13,					
-	identified safety conce	ms, including weapons in					
ļ	the patient's home we	re non-apolicable and					
	ventied by the patient	s father. There was no				1	
	contacted for verificati	the patient's father was on.					
	On 5/14/13 at 2:30 PM	4, the MA documented the					
	patient asked the MA i	if the taxi would be able to					
	patient went to the fath	mother's house after the					
	documented the nation	it would have to pay for any					
	taxi after being droppe	ed off at the father's house.					
	On 7/9/13 at 8:49 AM,	the Risk Manager					
	confirmed the LSW did	not follow up on				1	
	access to the weapons	ons and if the patient had s prior to discharge.					
ļ	Continuing Care Plan I	Discharge Planning,					
	Interdisciplinary Policy documented:	#PC.067, revised 4/13,					
	8.0 Securing Weapons	sSocial Services staff				ļ	
1	nmates attempts to see	cure the weapons.				Ì	
	obtaining permission ai	nd contacting any person					
. 1	hat may be able to loca	ate and secure the					
	temsWeapons are no	ot considered secured until					
1	remication has been re	ceived that the task is				ĺ	
10	completed"						

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If continuation sheet 8 of 9

SIAIEMEN	of Public and Behavic T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			······································	RM APPROV	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATE SURVEY COMPLETED	
		NVS3268HOS1	B. WING		07	07/09/2013	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE			
PRING N	OUNTAIN TREATMENT	CENTER 7000 W	EST SPRING MOUN				
		LAS VE	GAS, NV 89117				
(X4) ID PREFIX TAG	LEACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PRO ICH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)		
S 602	Continued From pag	e 8	S 602				
	Severity: 2	Scope: 1				2	
	Complaint #NV0003	5665				1	
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		correction must be returned within 10 day					

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if continuation sheet 9 of 9

	Electronically Filed									
	08/28/2014 09:14:00 AM									
1	ASTA Dem to Comm									
2	CLERK OF THE COURT									
3										
4										
5										
6	IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE									
7	STATE OF NEVADA IN AND FOR									
8	THE COUNTY OF CLARK									
9										
10	LEE E. SZYMBORSKI, Case No: A-14-700178-C									
11	Plaintiff(s), Dept No: XXXI									
12	vs.									
13	SPRING MOUNTAIN TREATMENT CENTER; DARRYL DUBROCA,									
14	Defendant(s),									
15										
16										
17 18	CASE APPEAL STATEMENT									
19	1. Appellant(s): Lee E. Szymborski									
20	2. Judge: Joanna Kishner									
21	3. Appellant(s): Lee E. Szymborski									
22	Counsel:									
23	Lee E. Szymborski 4605 Black Stallion Ave.									
24	N. Las Vegas, NV 89031									
25	4. Respondent (s): Spring Mountain Treatment Center; Darryl Dubroca									
26	Counsel:									
27	Michael Prangle, Esq. 1160 N. Town Center Dr., Ste. 200									
28	Las Vogas, NV 89144									
	-1-									

5.	Appellant(s)'s Attorney Licensed in No	evada: N/A			
	Permission Granted: N/A Respondent(s)'s Attorney Licensed in	Nevada: Yes			
	Permission Granted: N/A				
6,	Appellant Represented by Appointed C	Counsel In District Court: No			
7.	Appellant Represented by Appointed Counsel On Appeal: N/A				
8.	Appellant Granted Leave to Proceed in **Expires 1 year from date filed	a Forma Pauperis**: Yes, May 20, 2014			
	Appellant Filed Application to Proceed	1 in Forma Pauperis: N/A			
9.	Date Commenced in District Court: M	commenced in District Court: May 2, 2014			
10.	Brief Description of the Nature of the	Action: NEGLIGENCE - Medical/Dental			
	Type of Judgment or Order Being App	bealed: Judgment			
11.	Previous Appeal: No				
	Supreme Court Docket Number(s): N/A				
12.	. Child Custody or Visitation: N/A				
13,	. Possibility of Settlement: Unknown				
	Dated This 28 day of Aug				
		teven D. Grierson, Clerk of the Court			
	1	Leodice Lars			
		eodora Jones, Deputy Clerk 00 Lewis Ave			
	\mathbf{P}_{i}	O Box 551601			
	L	as Vegas, Nevada 89155-1601			
	(7	702) 671-0512			
	(7	702) 671-0512			
	(7	702) 671-0512			
	(7	702) 671-0512			
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	(7	702) 671-0512			
	(7	702) 671-0512			
	(7	702) 671-0512			
	(7	702) 671-0512			

1 1 4 Name FILED 1 Addres 2 160 ENUR. SEP 17 1 16 PH 4 City 3 02 Email CLERK OF THE COURT 4 androok.com Telephone 5 6 District Court 7 Clark County, Nevada 8 9 ee F szymbacski 1011 Case No.: A-14-700178-Plaintiff, 12 Department: XXX/ IceoThent Center spring Mountain 13 OCA IN his OFFICIAL COPACITY 14 A-14-700178-C ADDM 15 porations 1-XXINCLUSIN \mathcal{O} (\mathcal{O}) Addandum Defendant 4253040 16 17 ADDENDOM Notice of Motion 18 Please take notice that the hearing on ______ DONDUM 19 Reconsideration or in the Attennive Netion to Set Asian $\sim \sim$ 20 will be heard on Sept. , 2014 in Department XXX/ Floor _____ Courtroom 21 at the hour of AM/PM. 22 Dated this 16 day of Sept ___, 201**4** 23 **]** SEP 17 2014 RECEIVED Notice of Motion - 1



Spring MOUNTAIN TRATMENT CENTER DARRY DUBLOCA INHISOFFICIAL COPORTY, DOES 1-XX INCLUSIVE ROE CORPORATIONS /XX TO: Name of Nonmoving Party Inclusive 2 0 + Schoon VelD, LLC (Name of Nonmoving Party's Attorney) 3 (NOTE: Sign below, but DO NOT insert date and time for hearing. The court clark will complete upon filing.) 4 YOU AND EACH OF YOU take notice that on the 197 _day of 💲 POTOMBCA 5 2014, at the hour of 3 o'clock A.m., of said day, the above MOTION FOR Kecon \$ iPerorial 6 MOTION TO SET ASIDE will be heard in Department Alter NATIVE of the above-entitled Court. DATED: 9/16 , 20*14*. 9 10 (Signature) 11 dant, In Proper Person Plaintiff/)Defei 12 13 overed 14 Denle TXhiBiT 15 16 17 Me 18 19 2021 $c\overline{N}$ 22 CAR 23 24 (Check if continued on attached pages) 25 ,20/4. DATED: 26 27 (Signature) 28 Page 3 of 5 (Revised 04/15/2011) © 2011 Clark County Civil Law Self-Help Center

EXHIBIT D

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 727 Fairview Dr., Suite E, Carson City, NV 89701 Telephone: 775-684-1030, Fax: 775-684-1073 www.health.nv.gov

CERTIFIED MAIL#

9171 9690 0935 0037 8520 44

September 12, 2014

Lee Szymborski 4605 Black Stallion Ave. North Las Vegas, NV 89031

Re: Complaint Number <u>NV00035685</u>

Dear Mr. Szymborski,

This letter will follow your telephone conversation with Donna McCafferty, Health Program Manger III, conducted on 8/28/14. This letter, along with the associated Statement of Deficiencies (SOD) enclosed, arc evidence Complaint Number NV00035685 against Spring Mountain Treatment Center was substantiated. The investigator substantiated the allegation the facility failed to ensure a resident was discharged to a safe environment. The investigator substantiated the allegation the facility failed to notify a patient's family member prior to their discharge. The investigator substantiated the allegation the facility failed to identify potential weapons, and access to weapons upon discharge. The enclosed SOD provides additional specific information regarding the substantiated allegations.

During the investigation, the State Inspector interviewed patients/residents, reviewed their records, interviewed staff, and made observations while the facility or agency was in operation. The facility's or agency's actions were evaluated using applicable state and/or federal rules and regulations to determine if they were in compliance.

Based on the completed investigation, it was concluded that the facility or agency was not in compliance with rules and/or regulations.

Thank you for reporting your concerns.

Sincerely. he Bell for Kyle Devine, Bureau Chief

Public Health: Working for a Safer and Healthier Nevada
PRINTED: 09/04/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CA A. BUILDING:			E SURVEY PLETED
		NV53268HO51	B. WING		לח	//09/2013
			DORESS, CITY, STATE			10012.010
		7000 WE	ST SPRING MOUN			
PRING M	IOUNTAIN TREATMENT	CENTER LAS VEG	AS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROBS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
S 000	Initial Comments		S 000			
	a result of a complain 6/25/13, and finalized	ficiencies was generated as it investigation iniliated on i in your facility on 7/9/13, in ada Administrative Code, il.				
	The census at the tin 63. Five discharged r reviewed.	ne of the investigation was nedical records were				
		655 was substantlated with ee Tags S0146, S0153 and				
	by the Health Divisio prohibiting any crimin actions or other clain	clusions of any investigation n shall not be construed as nal or civil investigations, as for relief that may be y under applicable federal,				
S 146 SS=D	NAC 449.332 Discha	rge Planning	S 146			
	to discharge planning limitation, considerat (a) The needs of the services and the ava	patient for postoperative ilability of those services;				
	This Regulation is n Based on interview, review, the facility fai	ot met as evidenced by: record review and document iled to assure the pattent was environment for 1 of 5				
	sampled patients (Pa					
ficiencies DRATORY	ere cited, an approved plan	of correction must be returned within 10	days after receipt of	this statement of deficiencies. TITLE		DATE

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If continuation sheet 1 of 9

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	OF DÉFICIENCIES XF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY 1LETED
		NVS3268HOS1	B. WING			/09/2013
AME OF PI	Rowider or supplier	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
PRING N	OUNTAIN TREATMENT	CENTER	EST SPRING MOUN GAS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		
PREFIX TAG	(EACH DEFICIEN	EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
S 146	Continued From pag	e 1	S 146			
	Findings include:					
	Patient #1					
	and discharged on 5	tted to the facility on 5/3/13 /14/13 with diagnoses not otherwise specified and				
	Note documented the trepidation about goi	M, the Nursing Progress e palient had much ng back to the father's home. less when talking about the				
	documented the MA confirm the address documented the pati- address. The patient	M, the Masters of Art (MA) met with the patient to of the apartment. The MA ent was vague about the needed to stop by the up the patient's debit card new apartment.				
	revealed the patient to upon discharge. The evidence of an addre was no documented	Services Discharge Note would live in an apartment re was no documanted ess for the apartment. There evidence the Case Manager t had made arrangements to				
	identified the patient	are Plan, dated 5/14/13, was to go to the father's an address in North Las				
	on 5/14/13 at 8:50 At	Discharge Progress Note, M, documented the patient to the patient's fathers a conflict. The sete				

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If continuation sheet [2 of 9

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY
	<u> </u>	NVS3268HOS1	B. WING		07	/09/2013
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	, ZIP CODE		
		7000 WE	EST SPRING MOUN	ITAIN ROAD		
	IOUNTAIN TREATMENT	LAS VE	GAS, NV 89117			
(X4) ID		TATEMENT OF DEFICIENCIES	0	PROVIDER'S PLAN		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCEO T DEFICIE	O THE APPROPRIATE	COMPLE DATE
S 146	Continued From pag	e 2	S 146			1
	documented the pati planning to find hous	ent participated in treatment ing.				
	The Risk Manager in complaint from the p	ivestigated a telephone atient's father. The				
	Administrative Revie	w documented placement to				
	the apartment was n	ot venned.				
	On 7/9/13 at 8:49 AM					
	confirmed the MA did the identified apartm	d not follow up on verifying ent.				
	On 7/9/13 at 11:20 A	M, Licensed Social Worker				
		multiple telephone messages				
		ent's father. The father would				
	•	Id return to the father's home. message from the father				
		atient not be discharged to				
		he LSW acknowledged she				
		y with the patient's father.				
		during the first meeting with				
		nt expressed a willingness to				
		home and would work on the father's home. The				
	v •	to the large number of				
		/s case load, the LSW had to				
		calls and discharge planning				
	to the MA.					Ì
	The LSW explained	when a patient identified their				
		LSW would try to obtain as				
		possible regarding the				
		of the apartrment. If the LSW placement, the physician				
		or to discharge from the	1			1
	facility.					-
		n Discharge Planning,				
		cy #PC.067, revised 4/13,				1
	documented:					1

deficiencie ent of deficiencies. cited, an approved plan of correction must be returned 10.089 er recespt 6299

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Division of Public and Behavioral Health

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ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING;			SURVEY Pleted
NVS3268HOS1		B. WING		07	/09/2013	
AME OF PF	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE		
PRING M	OUNTAIN TREATMENT	CENTER	EST SPRING MOUN	TAIN ROAD		
			GAS, NV 89117	··· ···		
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETZ DATE
S 146	Continued From page	3	S 146			
	Procedure:					
	following is evaluated	he continuing care plan, the by the Case Manager: 4.4 r placement issues;4.8 tems,"				
	to the patient and fam	•				
	completed for every p	ncludes, but is not limited				
	Severity: 2	Scope: 1				
	Complaint #NV00035	655				
S 153 SS=D	NAC 449.332 Dischar	rge Planning	S 163			
	patient and any other for the patient must be	essary to prepare them for		• *		a contra c
	Based on Interview, review, the facility fail	t met as evidenced by: ecord review and document ed to notify 2 of 5 sampled to discharge (Patient #1				

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

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if continuation sheet 4 of 9

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STATEMENT	f Public and Behavior OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A BUILDING;	ONSTRUCTION		e survey Pleted	
		NVS3268HOS1	8. WING		07	07/09/2013	
NAME OF P			DDRESS, CITY, STATE	, ZIP CODE			
		7000 WE	ST SPRING MOUN	TAIN ROAD			
SPRING M	OUNTAIN TREATMENT	CENTER LAS VE	GAS, NV 89117				
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE	
S 153	Continued From pag	je 4	S 153				
	Findings include:						
	Patient #1						
	and discharged on 5 including psychosis	itted to the facility on 5/3/13 i/14/13 with diagnoses not otherwise specified and					
	the case manager re patient's father sayir return to his home. 1	AM, the LSW #2 documented aceived a voice mail from the ing the patient was not to The LSW documented the d assist the patlent with					
		nt. AM, the MA documented the ted the patient to return to his				÷	
	home, but not to be	discharged "today".)	
		r documented evidence the contacted to confirm ient's father's home.					
	MA met with the pat the father's telephor	PM, the MA documented the jent. The patient requested ne number and told the father and a taxi would transport ther's home					
	The Risk Manager is complaint from the p Administrative Revie was not coordinated	nvestigated a telephone patient's father. The ew documented the discharge I with the family. the father on the day of					
	On 7/9/13 at 9:50 A acknowledged the fa for the taxi driver to	M, the Risk Manager acility should have arranged wait at the patient's father's n of correction must be returned within 10					

If deficiencies are cited, an approved plan of correction must be returned within 10 days efter receipt of this statement of deficiencies. 6899

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	f of deficiencies DF correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				e Survey Pleted
	·····	NVS3268HOS1	B. WINO		07	/09/2013
IAME OF PI	ROVIDER OR SUPPLIER	SIREETA	DDRESS, CITY, STATE	, ZIP CODE		
SPRING N	OUNTAIN TREATMENT	CENTER	ST SPRING MOUN	TAIN ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	SAS, NV 89117	PROVIDER'S PLAN OF	CORRECTION	
TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) Complet Date
S 153	Continued From page	95	S 153			
		it retreived the debit card, to the new apartment.				
	On 7/9/13 at 11:34 At	M, LSW #Z explained the				
		d be contacted prior to the essure the family was				
		t returning home. The LSW				
		tient's father should have				
	patient being discharg	e facility staff prior to the ged.				
	Four additional dischar reviewed.	arged medical records were				
	Patient #5			-		
		ted to the facility on 6/4/13 18/13, with a diagnosis of order.				
	There was no docum	ented evidence the social				
		r notified the family of the here was no documented				-
		as educated on the patient's				
		w up care needed. There				
	was no family contact worker/Case Manage					1
	Continuing Care Plan Interdisciplinary Polic documented:	Discharge Planning, y #PC.067, revised 4/13,				
	Procedure:					
		he continuing care plan, the by the Case Manager4.8 lems"				
		e plans are communicated illy/guardian, as appropriate,				

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If continuation sheet 6 of 9

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
				· · · · ·		
NVS3268HOS1		B. WING		07	/09/2013	
ame of Pi	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PRING N	IOUNTAIN TREATMENT	I CENTER	EST SPRING MOUN GAS, NV 89117	ITAIN ROAD		
(X4) ID	SUMMARY 5	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	FCORRECTION	()(5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE
S 153	Continued From pag	je 6	S 153			
	and documented in t	the medical record"				
	Seventy: 2	Scope: 1				
	Complaint #NV0003	5655				
S 602 SS≃D	NAC 449.394 Psych	iatric Services	S 602			
	and procedures for t treatment and behave that are consistent w inclusive, to ensure services are safely a hospital shall ensure	evelop and carry out policies the provision of psychiatric vioral management services with NRS 449.765 to 449.786, that the treatment and and appropriately used. The that the policies and the safety and rights of the				
	Based on interview, review, the facility fa were at Patient #1's	not met as evidenced by: record review and document itled to identify what weapons mother's home and if the access to the weapons.				
	Findings include:					
	Patient #1					
	and discharged on 5	itted to the facility on 5/3/13 /14/13 with diagnoses not otherwise specified and				
	Assessment Tool do multiple scab areas Comprehensive Ass	essment Tool documented tated the patient's wounds				

cies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. DRM 6000 00KPf1

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If continuation sheet 7 of 9

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			≝ 6URVEY PLETEO
NV53268HOS1		B. WING	······································		/09/2013	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
SPRING N	OUNTAIN TREATMENT	CENTER	ST SPRING MOUN AS, NV 89117	TAIN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX (TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULO BE THE APPROPRIATE	(X5) Completi Date
S 602	Continued From page	97	S 602			
	weapons were at the not at the patient's fail not identify what weat mothers home. There evidence the patient's verify where the weat Patient Continuing Ca identified safety cond the patient's home we verified by the patient documented evidence contacted for verifical On 5/14/13 at 2:30 PI patient asked the MA take the patient to the patient went to the fail documented the patient	a mother was contacted to cons were located. are Plan, dated 5/14/13, erns, including weapons in ere non-applicable and i's father. There was no e the patient's father was tion. M, the MA documented the if the taxl would be able to a mother's house after the				
	On 7/9/13 at 8:49 AM confirmed the LSW d identifying what weap access to the weapor Continuing Care Plan	ld not follow up on ons and if the patient had is prior to discharge.		- -		
		y #PC.067, revised 4/13,				
	initiates attempts to s obtaining permission that may be able to lo items,Weapons are	and contacting any person				

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If continuation sheet 8 of 9

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		NVS3268HOS1	B. WING		07/	09/2013
NAME OF P	ROWDER OR SUPPLIER	STREET	DDRESS, CITY, ST	ATE, ZIP CODE		
SPRING N	OUNTAIN TREATMENT		ST SPRING MO			
		LAS VE	GAS, NV 89117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	id Prefix TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
S 602	Continued From page	8	S 602			
	Severity: 2	Scope: 1				
	Complaint #NV00035	655				
	-					
deficiencies a	ve cited, an approved plan of	f correction must be returned within 10 c	n a second of the second of the second second second second second second second second second second second s	Ethic statement of differences	· · · · ·	

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Division of Public and Behavioral Health

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FILED <u>am</u>borchi ł Dillon Ave. 2 21 PN 14 SEP 17 2 3 CLERK OF THE COURT 4 5 Plaintiff/ 🗆 Defendant, Pro Se 6 EIGHTH JUDICIAL DISTRICT COURT 7 CLARK COUNTY, NEVADA 8 Szymborsk 9 Case No.: Dept. No .: Sping MOUNTOIN Plaintiff(s), Treat MOUT CONTROL DARGE DUBLOCCA IN his OFFICIAL COPACIT 10 11 DOES 1-XX INCLUSIVE AND ROE 12 CORPORATION 13 Date of Hearing: Defendant(s). Time of Hearing: 14 15 **CERTIFICATE OF MAILING** I HEREBY CERTIFY that on the <u>17</u> day of <u>Get</u> 16 20<u>14</u>, I placed a true 17 and correct copy of the following document: Appendix 18 MOTION KeconSiperonion To Set-HSUI Crinke INTION. in the United States Mail, with first-cla Ø addressed to Nod 19 DOWNTOWN STA LAS VEGAS, Nevada 891019997 3148830008 -0099 (2003000 -0099) 09/17/2014 (702)382-5779 01:39:55 PM Sales Receipt Product Sale Unit Final Description ûty Price Price LAS TEGAS NV 89144-0561 \$16.95 Per NRS 53.045, Vdeclare under penalty of perjury Denorito Mail Express 1-Day 970 oz. USPS Maacking #: that the foregoing is true and correct. USPS Heacking #: ER37 (H933 2010 S Schedwled Delivery Day: Thu 09/18/14 Money Back Guarantee 12:00 (signature) Sholudes \$100 insurance (print name) Plaintiff/ 🖞 Defendant, Pro Se Signa∰re Requested A - 14 - 700178 - Ċ CERT -----Issue Postage: Certificate of Maillog \$16.95 Page 1 4253890 Total: \$16.95 Paidy by :

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		2		
		3	CLARK COUNTY,	NEVADA
		4 5	LEE SZYMBORSKI;	Case No.: A-14-7091e∂6eGically Filed 09/23/2014 02:04:52 PM
			PLAINTIFF(S),	Dept. No.: XXXI
		6 7	VS.	Alun N. Column
		8	SPRING MOUNTAINT TREATMENT CENTER, et al.,	CLERK OF THE COURT
		9	DEFENDANT(S).	
		10		
		11		
		12	ORDER DENYING PLAINTIFF'S MOTION I THE ALTERNATIVE, MOTIO	
		13	This matter came on for hearing on Se	ntember 19, 2014, before
		14 15	Department XXXI's Chamber's Calendar on P	
		16	Reconsideration, or in the Alternative, Motion	
		17	papers, pleadings, documents and file, oral ar	Ĵ
		18		•
		19	2014, hearing on the underlying motion, the s	
		20	applicable statues and case law, the Court fin	
		21	FINDINGS OF	FACT
		22	1. On May 2, 2014, Plaintiff filed hi	s Complaint alleging negligence,
		L E E E E	professional negligence, malpractice, gross ne	egligence, negligence per se and
/ED	2014	E BO	negligent hiring, supervision and training agai	nst Spring Mountain Treatment
RECEIVED	o 2 3	1230	Center and Darryl Dubroca, in his official capa	acity as CEO/Managing Director of
ä	SEP .	GLERK OFTHE DOURI	Spring Mountain Treatment Center. Attached	to the Complaint was a letter from
DISTR DEPART	S. KISHIN BIT JUDGE TMENT XXX S. NEVADA :	28 ER	1	

the State of Nevada, Department of Health and Human Services, Health Division,
which included a "complaint process fact sheet." That letter was signed by Johna
Thacker, AAII/ Complaint Intake Coordinator. The letter and "fact sheet" were
not signed by a medical expert compliant with NEV. REV. STAT. § 41A.071

2. The Complaint, however did not have an affidavit of a medical expert pursuant to NEV. REV. STAT. § 41A.071.

3. The Complaint alleges that Defendants were negligent in providing
treatment to patient Sean Szymborski. Specifically, Plaintiff alleges, *inter alia*,
that the improper discharge of the patient resulted in \$20,000 in damage to
Plaintiff's residence. The Complaint further alleges a failure to provide necessary
medical and psychiatric care for the patient resulted in damage to Plaintiff.

4. On May 22, 2014, Defendant Spring Mountain Treatment Center
filed a Motion to Dismiss Complaint based on the failure to attach an affidavit in
compliance with NEV. REV. STAT. § 41A.071. Defendant Darryl Dubroca joined In
that motion on May 29, 2014.

Plaintiff filed an Opposition to the motion on June 13, 2014. There
was no certificate of service attached.

6. The parties appeared for oral argument on the motion on June 24,
2014, before the Honorable Senior Judge T. Joseph Bonaventure. At the
hearing, counsel for Defendants indicated he had never been served with the
opposition, but had no objection to the Court considering the opposition and
proceeding with oral argument. The Court found that the Motion to Dismiss was
meritorious, and granted the motion. That ruling was reduced to writing in an

28 IOANNA S. KISHNER DISTRICT (JDGR DEPARTMENT XXXI AS VEGAS, NIJVADA 19155

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Order signed on July 21, 2014, and filed by Defendants on July 23, 2014. The 1 2 notice of entry of that Order was filed on July 30, 2014.

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7. On August 7, 2014, Plaintiff filed the instant Motion for Reconsideration, or in the Alternative, to Set Aside. Although the motion did not include a certificate service, an Opposition was filed by both Defendants on August 25, 2014.

8. Also on August 25, 2014, Plaintiff filed a Notice of Appeal to the Nevada Supreme Court of the Order on the Motion to Dismiss.

CONCLUSIONS OF LAW

12 1. In the instant case, on August 25, 2014, Plaintiff filed a Notice of 6 13 Appeal regarding the Court's ruling, Granting Defendants' Motion to Dismiss. 14 Thus, prior to determining the propriety of the instant Motion for Reconsideration, 15 the Court needs to determine whether it has jurisdiction to hear the Motion given 16 17 the purported appeal. Pursuant to Mack-Manley v. Manley, 122 Nev. 849, 855, 18 138 P.3d 525, 529-30 (2006), a properly filed notice of appeal vests jurisdiction in 19 the Supreme Court, and the district court is divested of jurisdiction to consider |⁵ 20 any issues that are pending before Supreme Court on appeal. Mack-Manley v. Manley states: ź2

> This court has consistently explained that "a timely notice of appeal divests the district court of jurisdiction to act and vests jurisdiction in this court" and that the point at which jurisdiction is transferred from the district court to this court must be clearly defined. Although, when an appeal is perfected, the district court is divested of jurisdiction to revisit issues that are pending before this court, the district court retains jurisdiction to enter orders on matters that are

collateral to and independent from the appealed order, *i.e.*, matters that in no way affect the appeal's merits.

122 Nev. 849, 855, 138 P.3d 525, 529-30 (2006).

Additionally, the Nevada Supreme Court in Foster v. Dingwall, 126 Nev. 4 Adv. Op. 5, 228 P.3d 453, 455 (2010) set forth that during pendency of appeal, 5 the district court in considering a motion for relief from order or judgment 6 challenged on appeal retains jurisdiction to direct briefing on the motion, hold a 7 hearing regarding the motion, and enter an order denying the motion, but lacks 8 jurisdiction to enter an order granting such a motion. See also NEV, R. CIV, P. 9 60(b)(2). Pursuant to applicable precedent, the Court finds it has jurisdiction to 10 determine the pending Motion for Reconsideration. 11

As noted herein, a Court has the inherent authority to reconsider its
prior orders. *Trail v. Faretto*, 91 Nev. 401, 403, 536 P.2d 1026, 1027 (1975).
Pursuant to *Masonry & Tile Contractors Ass'n of S. Nevada v. Jolley, Urga & Wirth, Ltd.*, 113 Nev. 737, 941 P.2d 486 (1997), the trial court may reconsider a
previously decided issue if substantially different evidence is subsequently
introduced, or if the prior decision is clearly erroneous.

3. Within the Eighth Judicial District Court, when a party seeks
reconsideration of a Court's previous order, not only must the party comply with
the Nevada Rules of Civil Procedure, the party must also comply with EDCR
2.24(b). EDCR 2.24(b) requires "[a] party seeking reconsideration of a ruling of
the court, other than any order which may be addressed by motion pursuant to
N.R.C.P. 50(b), 52(b), 59 or 60, must file a motion for such relief within 10 days
after service of written notice of the order or judgment[.]" EDCR 2.24(b).

4. Pursuant to EDCR 2.24(b), Plaintiff's Motion for Reconsideration was timely filed.

28 JOANNA S. KISHNER DISTRICT JUDGE DEPARTMENT XXXI AS VEGAS, NEVADA 89155

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5. In evaluating a Motion for Reconsideration, the Court engages in a two-step process. First, the Court determines in accordance with N.R.C.P. 60(b)'s provisions if there is "mistake, inadvertence, surprise or excusable neglect[.]" If the first step is met, then the Court reviews the evidence to determine if a different result should occur. In Nevada, "[o]nly in very rare instances in which new issues of fact or law are raised supporting a ruling contrary to the ruling already reached should a motion for rehearing be granted." *Masonry & Tile Contractors Ass'n of S. Nevada v. Jolley, Urga & Wirth, Ltd.,* 113 Nev. 737, 741, 941 P.2d 486, 489 (1997) (citing *Moore v. City of Las Vegas,* 92 Nev. 402, 405, 551 P.2d 244, 246 (1976)).

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NNA S. KISHNER KSTRET JUDGR PARTMENT XXXI EGAS. NEVADA 89155

 $^{41}_{11}$ 6. Here, Plaintiff has not provided any new facts or evidence and has 12 not shown that the prior decision was clearly erroneous, nor is there any showing 13 of any mistake, inadvertence, surprise, or excusable neglect. Instead, the Motion 14 for Reconsideration points to the attachments to the Complaint to attempt to 15 assert that he was compliant with NEV. REV. STAT. § 41A.071. His attempt to show compliance, however fails. NEV. REV. STAT. § 41A.071 specifically requires lб 10 that when there is a claim for medical malpractice such as in the instant case, an ί8 affidavit from a medical expert must be attached to the Complaint. Plaintiff failed to attach any affidavit compliant with the statute. Specifically, the purported 19 documents from the Department of Health and Human Services, Health Division 20which were attached to the Complaint do not meet the affidavit requirement. 211Indeed, the Court previously held that the documents provided by Plaintiff are 22° clearly not compliant with the statute. 23 1

7. In the present case, although Plaintiff failed to submit new law or facts, making the motion procedurally deficient, the Court still evaluated its prior³ decision to determine whether the Motion to Dismiss was properly granted. After

a full review, the Court finds that the Motion to Dismiss was properly granted as set forth in further detail below.

8. NEV. REV. STAT. § 41A.009 defines medical malpractice as "the
failure of a physician, hospital, or employee of a hospital, in rendering services,
to use the reasonable care, skill or knowledge ordinarily used under similar
circumstances."

9. NEV. REV. STAT. § 41A.071 provides, in part that "If an action for
medical malpractice...is filed in the district court, the district court *shall* dismiss
the action, without prejudice, if the action is filed without an affidavit, supporting
the allegations contained in the action, submitted by a medical expert who
practices or has practiced in an area that is substantially similar to the type of
practice engaged in at the time of the alleged malpractice." (emphasis added)

13 It is clear that the allegations in the Complaint all fall under the 10. 14 definition of medical malpractice as defined by statute. The Complaint alleges 15 failures on the behalf of physicians, a hospital and employees of a hospital in treating a patient which resulted in harm to Plaintiff. Nowhere in the statute is 16 medical malpractice defined in such a way that the harms resulting must be felt 17 only by the patient in order to be considered malpractice. As such, although 18 Plaintiff was not a patient, the damages sought still fall under the definition of 19 medical malpractice. 20

11. There is also nothing in the record to suggest even minimal
compliance with NEV. REV. STAT. § 41A.071. The only document attached to the
Complaint was a letter from a Complaint Intake Coordinator for the Department
of Health. The letter does not claim to support any of the allegations in the
Complaint nor does its author claim to be a medical expert of any kind. In
opposition to the Motion to Dismiss, Plaintiff argued only that the claims were

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1	ordinary negligence, and did not claim that a conforming affidavit was ever
2	attached to the Complaint.
3	12. As the Court finds that its previous Order was legally sound and in
4	accordance with applicable statutes and caselaw, the instant Motion for
5	Reconsideration, or in the Alternative, to Set Aside, is appropriately DENIED.
6	13. Furthermore, although leave to amend the Complaint was not
7	requested, it would not be appropriate as noncompliance with NEV. REV. STAT. §
8	41A.071 renders a complaint <i>void ab initio</i> , and no subsequent amendments can
9	cure the defect. Washoe Medical Center v. Second Judicial District Court, 122
10	Nev. 1298, 148 P.3d 790 (2006).
11	
12	ORDER
١3	Based upon the foregoing, It is hereby ORDERED, ADJUDGED, AND
14	DECREED, that Plaintiff's Motion for Reconsideration, or in the Alternative, to Set
15	Aside, is DENIED as set forth herein.
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17	Dated this 19 th day of September, 2014.
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20	Joanna & Kishner
21	DOANNA S. KISHNER
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28, JOANNA S. KISHNER DISTRICT JUDGE DEPARTMENT XXXI LAS VEGAS, NEVADA 19153	7

1	CERTIFICATE OF SERVICE
2	hereby certify that on or about the date filed, a copy of this Order was
4	provided to all counsel, and/or parties listed below via one, or more, of the following manners: via email, via facsimile, via US mail, via Electronic Service if the Attorney/Party has signed up for Electronic Service, and/or a copy of this
5	Order was placed in the attorney's file located at the Regional Justice Center:
6	LEE SZYMBORSKI
7	4605 E BLACK STALLION AVE NORTH LAS VEGAS, NV 89031
9	
10	HALL PRANGLE & SCHOONVELD, LLC
11	Chan & Martin
12	TRACY CORDOBA
14	JUDICIAL EXECUTIVE ASSISTANT
15	
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28 JOANNA S. KISHNER DISTRICT IJDZIE DEPARTMENT XXXI LAS VEGAS. NEVADA 89155	8

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DISTRICT COURT CLARK COUNTY, NEVADA

Malpractice - Medical/Dental		COURT MINUTES	June 24, 2014			
A-14-700178-C	Lee Szymborski, vs. Spring Mountair	Plaintiff(s) 1 Treatment Center, Defendar	ıt(s)			
June 24, 2014	9:30 AM	All Pending Motions				
HEARD BY:]	Bonaventure, Joseph T.	COURTROOM:	RJC Courtroom 12B			
COURT CLERK: Sandra Harrell						
RECORDER: Rachelle Hamilton						
REPORTER:						
PARTIES PRESENT:	Doyle, Kerry J. Szymborski, Lee E	Attorney Plaintiff				

JOURNAL ENTRIES

- DEFENDANT SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS,...DARRYL DUBROCA'S JOINDER TO SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO DISMISS

Mr. Doyle states he was not served with opposition, happened to notice opposition online late yesterday. Court noted to Mr. Szymborski documents must be properly served. Mr. Doyle argued medical malpractice claim, no affidavit. Mr. Szymborski argued this is an action of negligence, has nothing to do with medical malpractice. Further arguments by Mr. Szymborski. Court stated its findings and ORDERED, Defendant Spring Mountain Treatment Center's Motion to Dismiss and the Joinder thereto are GRANTED; both Spring Mountain Treatment Center and Darryl Dubroca are Dismissed. Mr. Doyle to prepare the order, circulating to Plaintiff. Matter SET for Status Check regarding receipt of proposed order.

7/11/14 STATUS CHECK: ORDER (CHAMBERS)

PRINT DATE: 12/15/2014

Page 1 of 2 Minutes Date: June 24, 2014

DISTRICT COURT CLARK COUNTY, NEVADA

Malpractice - Medical/Dental		COURT MINUTES	September 19, 2014		
A-14-700178-C	Lee Szymborski vs. Spring Mountai	, Plaintiff(s) n Treatment Center, Defendant(s)			
September 19, 2014	3:00 AM	Motion For Reconsideration			
HEARD BY: Kishner, Joanna S.		COURTROOM:			
COURT CLERK: Shelly Landwehr					
RECORDER:					
REPORTER:					
PARTIES PRESENT:					
		JOURNAL ENTRIES			

- Court NOTED a Decision and Order has been filed, denying the motion.

PRINT DATE: 12/15/2014

Page 2 of 2 Minutes Date: June 24, 2014

Certification of Copy and Transmittal of Record

State of Nevada County of Clark SS:

Pursuant to the Supreme Court order dated December 8, 2014, I, Steven D. Grierson, the Clerk of the Court of the Eighth Judicial District Court, Clark County, State of Nevada, do hereby certify that the foregoing is a true, full and correct copy of the complete trial court record for the case referenced below. The record comprises one volume with pages numbered 1 through 233.

LEE E. SZYMBORSKI,

Plaintiff(s),

VS.

SPRING MOUNTAIN TREATMENT CENTER,

Defendant(s),

now on file and of record in this office.

Case No: A700178

Dept. No: XXXI

IN WITNESS THEREOF, I have hereunto Set my hand and Affixed the seal of the Court at my office, Las Vegas, Nevada This 15 day of December 2014.

Steven D. Grierson, Clerk of the Court

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Barbara J. Gutzmer, Deputy Clerk