AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE	
			A. BUILDING:		-	COMF	LETED
·		NVS3268HOS1	B. WING				
AME OF P	ROVIDER OR SUPPLIER						09/2013
			ADDRESS, CITY, STATE		Electro		
PRING !	MOUNTAIN TREATMENT	CENTER 1 AS VE	EST SPRING MOUN GAS, NV 89117	ITAIN ROAD	Aug 13	2015	10:55
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			Tracie	<u>K. Lind</u>	<u>leman</u>
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CAUSS-REFERE	S PLANTON CORRECT COTIVE ACTION SHOW NCED TO THE APPRO DEFICIENCY)	PRIATE	eme C
S 153	Continued From page	e 5	S 153				
	house until the nation	nt retreived the debit card,					
	then drive the patient	to the new apartment.					
	On 7/9/13 at 11:34 At	M, LSW #2 explained the					
	lamily member should	be contacted prior to the					ĺ
	patients discharge to	assure the family was	1				}
	aingnt with the patien	t returning home. The LSW					
}	acknowledged the pa	tient's father should have					
	patient being discharg	e facility staff prior to the ged.					
	Four additional discha	rged medical records were					
	reviewed,						
	Patient #5						
1	Patient #5 was admitte	ed to the facilty on 6/4/13				i	
1 .	and discharged on 6/1 major depressive disc	8/13, with a diagnosis of					
	There was no docume	nted evidence the social					
,	worker/Case Manager	notified the family of the					
- 11	patients discharge. Th	ere was no documented				- 1	
] •	evidence the family wa	IS educated on the notion to				[
	vas no family contact t	up care needed. There					
v	vorker/Case Manager	after 6/6/13.					
	Continuing Care Plan [Discharge Planning.					
) 11	nterdisciplinary Policy ocumented:	#PC.067, revised 4/13,					
P	rocedure:						
۳.	4.0 In developing the	continuing care plan, the					
10	ollowing is evaluated be ersonal support syster	V the Case Manager 4 o					
, n	5.0 Continuing care r	plans are communicated					
to	ule Dallent and famil.	/guardian, as appropriate,					i

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Division of Public and Behavioral Health FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 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 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 153 Continued From page 6 \$ 153 and documented in the medical record..." Severity: 2 Scope: 1 Complaint #NV00035655 S 602 NAC 449.394 Psychiatric Services S 602 SS≃D 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 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 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. On 5/3/13 at 12:00 PM, the Comprehensive Assessment Tool documented patient had multiple scab areas on his legs. The Comprehensive Assessment Tool documented the patient's father stated the patient's wounds were self inflicted with a sharp object.

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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DIVISION	of Public and Behavior				FU	KM APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SHRVEY
		IDENTIFICATION NUMBER:	A. BUILDING: _			PLETED
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VAME OF D	PROVIDER OR SUPPLIER	NVS3268HOS1	B, WING		07	/09/2013
			DDRESS, CITY, STAT			
PRING I	NOUNTAIN TREATMENT	CENTER 7000 WE	ST SPRING MOUI	NTAIN ROAD		
(X4) ID	SUMMARY OT	ATEMENT OF DEFICIENCIES	GAS, NV 89117			
PRÉFIX	LEACH DEFICIENC	Y MUST RE PRECEDED BY EUR	PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION	(205)
ואט	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETE DATE
5 602	Continued From page			DEFICIENC	OY)	
	Committee From page	17	\$ 602			
	On 5/6/42 -4 0-40 Dee	Lena				
ĺ	Weapons were at the	LSW #1 documented				
-	not at the nation's fat	patient's mothers home, but hers home. The LSW did				
	not identify what wear	ons were at the patient's				
	mouners nome. There	Was no documented	}			
	evidence the patient's	mother was contacted to				
- 1	verify where the weap	ons were located.	1			1
	Patient Continuing Car	re Plan, dated 5/14/13,				
- 1	identified safety conce	ms, including weapons in				
ļ	trie patients nome wer	the eldspillerenon 9				
- 1	ventied by the patient's	father. There was no	1 1			
	contacted for verification	the patient's father was				
- 1	couracted for AeUlication	n.				
	On 5/14/13 at 2:30 PM	, the MA documented the				
	patient asked the MA if	the taxi would he able to				
-) 1	take the patient to the r	nother's house effer the				
	pacent went to the fath	er's house. The MA	1			
	laxi after being dropped	t would have to pay for any				
	and being dropped	off at the father's house.				
(On 7/9/13 at 8:49 AM, t	he Risk Manager			į	
0	confirmed the LSW did	not follow up on				
140	dentifying what weapor	ns and if the nationt had				
٩	access to the weapons	prior to discharge.	}			
C	Continuing Care Plan D	Ischarge Planning				
	mercisciplinary Policy #	PC.067, revised 4/13,				
d	ocumented:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1			
775	8.0 Securing Mosnama	0				į
ir	itiates attempts to sec	Social Services staff			1	
0	btaining permission an	d contacting any person				
Į U	iat may be able to local	le and secure the				
110	emsWeapons are not	Considered secured until			_	
V	ennication has been rec	eived that the task is			}	
CC	ompleted"					ļ
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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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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	[N2] 244	E SURVE
	·	DETTICION NUMBER:	A. BUILDING:		COM	e surve (Pleted
		1				
		NVS3268HOS1	B. WING		- 1	
NAME OF P	ROVIDER OR SUPPLIER				0.	7/09/20
		STREET	ADDRESS, CITY, STATI	E, ZIP CODE		
orning h	OUNTAIN TREATMENT	T CENTER 7000 WI	EST SPRING MOUI	NTAIN ROAD		
(X4) ID	SIIMMADV	LAS VE	GAS, NV 89117			
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0.000				DEFICIENCY)	
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	Complaint #NV00035	5655				1
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27 28 IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK

LEE E. SZYMBORSKI,

Plaintiff(s),

VS.

SPRING MOUNTAIN TREATMENT CENTER; DARRYL DUBROCA,

Defendant(s),

Case No: A-14-700178-C Dept No: XXXI

CASE APPEAL STATEMENT

- 1. Appellant(s): Lee E. Szymborski
- 2. Judge: Joanna Kishner
- 3. Appellant(s): Lee E. Szymborski

Counsel:

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

4. Respondent (s): Spring Mountain Treatment Center; Darryl Dubroca

Counsel:

Michael Prangle, Esq. 1160 N. Town Center Dr., Ste. 200 Las Vegas, NV 89144

5. Appellant(s)'s Attorney Licensed in Nevada: N/A Permission Granted: N/A Respondent(s)'s Attorney Licensed in Nevada: Yes Permission Granted: N/A 6. Appellant Represented by Appointed Counsel In District Court: No 7. Appellant Represented by Appointed Counsel On Appeal: N/A 8. Appellant Granted Leave to Proceed in Forma Pauperis**: Yes, May 20, 2014 **Expires 1 year from date filed Appellant Filed Application to Proceed in Forma Pauperis: N/A 9. Date 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 Appealed: 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 August 2014.

Steven D. Grierson, Clerk of the Court

Leodieu Las

Teodora Jones, Deputy Clerk 200 Lewis Ave

PO Box 551601

Las Vegas, Nevada 89155-1601

(702) 671-0512

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. 1	Lec E. Selambosski	٠
2	4605 Black Stallian Avenue.	
3	North LAS Vegas NV. 8903/	
4	(City, State, Zip)	
5	leeszumkorski @ artook.com	
6	(E-mail Addr (1)	
7	Plaintiff/ Defendant, In Proper Person	
8	EIGHTH JUDICIAL DISTRICT COURT	
9	CLARK COUNTY, NEVADA	
10		
11	LEE E Symbols Ki Case No.: A-14-700/78	?- C
12	Plaintiff(s), Dept. No.:	
13	VS. Spring MOUNTAIN TREATMENT (ENTER	
14	Dogey Outgood whis OFFICIAL COPACITY	
15	DOES 1-XX Notusive AND	
16	ROE COCPOCATION X INCIVIVE	
17	Average 1 MOTION FOR ADDENOUM TO	ı
18	MOTION FOR RECONSIDERATION OF whe	
19	AHECNATIVE MOTION TO SET ASIDE. (Insert Title of Motion)	
20	1	
21		
22	appearing in proper person, submits this	
23	motion based upon the following Memorandum of Points and Authorities; the pleadings and	ı I
24	papers on file in this case; the attached exhibits hereto, if any; and the argument allowed by the	
25	Court at the time of hearing. DATED: 916, 2014.	
26	DATED: 916 20/4.	ı
27		
28	(Signature)	
	Page 1 of 5 CREVISED OUT 5/2011) Self-Help Center APPELLANT 210	ĺ

3 4 5 6 7 X 8 9 10	Spary Mountain Treatment Center Darry Dubloch NOTICE OF MOTION Not will be not on the local of Nonmoving Party's Attorney) (NOTE: Sign below, but DO NOT insert date and time for hearing. The court clerk will complete upon filing.) YOU AND EACH OF YOU take notice that on the 19 day of September. 2014, at the hour of 3 o'clock A.m., of said day, the above MOTION FOR RECONSIDERATIVE MOTION TO SET ASIDE will be heard in Department of the above-entitled Court. DATED: 9/6 (Signature) Plaintiff) Defendant, In Proper Person
12	MEMORANDUM OF POINTS AND AUTHORITIES
13	UNDER RULE 60/2) NEWLY Discovered
14	ELIDENCE
15	Ottoches is the expert AFFIDAVITH Exhibit D
16	As required By NRS 4/A.07/
17	0 101 0 100
18	Doot NE Houth + Human Services
19	The state of the s
20	Division OF Public AND Behavioral Health
21	STOTE OF NEVADA BODN SANDOVAL GOVERNOR
22	Michael J. Willow DiRector Richard White. MS Apprinting
23	TRACEY V. Green M. D. Chief Medical Officer
24	
25	(Check if continued on attached pages)
26	DATED: 9 16 20/4.
27	
28	(Signature)
© 2011 Cla	Page 3 of 5 Page 3 of 5 Page 3 of 5 Revised 04/15/2011) APPELLANT 21

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 NV00035685

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, are 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,

Kyle Devine, Bureau Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIP IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		NVS3268HO81	B. WING		07/	09/2013	
AME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE,			
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(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S 000	Initial Comments		\$ 000				
	a result of a complain 6/25/13, and finalized accordance with Neva Chapter 449, Hospital	e of the investigation was					
		655 was substantlated with se Tags S0146, S0153 and			¥		
	by the Health Division prohibiting any crimina actions or other claims	clusions of any investigation shall not be construed as al or civil investigations, s for relief that may be under applicable federal,			3		
S 146 SS=D	NAC 449.332 Dischar	ge Planning	S 146				
	to discharge planning ilmitation, consideration, consideration, consideration and the provinces and the avail (b) The capacity of the (c) The possibility of more previous care setting appropriate placement discharge. This Regulation is not Based on interview, respectively.	an of: natient for postoperative ability of those services; patient for self-care; and eturning the patient to a or making another t of the patient after t met as evidenced by: coord review and document and to assure the patient was environment for 1 of 5		i i			

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QO) DATE

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 7000 WEST SPRING MOUNTAIN ROAD SPRING MOUNTAIN TREATMENT CENTER LAS VEGAS, NV 89117 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 146 Continued From page 1 S 146 Findings include: Patient #1 Patient #1 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. On 5/13/13 at 1:00 PM, 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. On 5/14/13 at 2:30 PM, the Masters of Art (MA) documented the 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 the patient's debit card prior to going to the new apartment. 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. Patient Continuing Care Plan, dated 5/14/13, identified the patient was to go to the father's home first then on to an address in North Las Vegas. The Acute Physician Discharge Progress Note, on 5/14/13 at 8:50 AM, documented the patient did not want to return to the patient's fathers home due to on-going conflict. The note

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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Division	of Public and Behaviors	l Health			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE	
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	T		AS, NV 89117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE
S 146	Continued From page	2	S 146		
	documented the patie planning to find housing	nt participated in treatment ng.			
	The Risk Manager inv				
		documented placement to			
	On 7/9/13 at 8:49 AM,				
	the identified apartmen	not follow up on verifying nt.		8	
	(LSW) #2 explained m were left by the patien state the patient could	I, Licensed Social Worker sultiple telephone messages t's father. The father would return to the father's home.			
	would demand the pat	essage from the father ient not be discharged to			
	did not speak directly	LSW acknowledged she with the patient's father. uring the first meeting with			
	the patient, the patient	expressed a willingness to			
		rom the father's home. The			
		case load, the LSW had to ils and discharge planning	}		
	own placement, the LS	nen a patient identified their SW would try to obtain as			
		he apartrment. If the LSW			
	was unable to verify pli would be notified prior facility.	acement, the physician to discharge from the			
	Continuing Care Plan I Interdisciplinary Policy documented:	Discharge Planning, #PC.067, revised 4/13,			

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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Division	of Public and Behavior	al Health		FOR	WAPPROVED	
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İ			A DOLDING	,		
		NVS3268HOS1	B. WING		07/09/2013	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET AS			TATE, ZIP CODE		
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETE DATE
S 146	Continued From page	3	S 146			
	Procedure:	9				
	"4.0 In developing the continuing cere plan, the following is evaluated by the Case Manager: 4.4 Housing needs and/or placement issues;4.8 Personal support systems" "5.0 Continuing care plans are communicated to the patient and family/guardian, as appropriate, and documented in the medical record5.2 Where and with whom the patient will live following discharge"					
					;	
	completed for every pa	ncludes, but is not limited			:	
	Severity: 2	Scope: 1				
	Complaint #NV000356	355				
S 153 SS=D	NAC 449.332 Discharg	ge Planning	S 163			
	for the patient must be	person involved in caring provided with such prepare them for		s. "		
		cord review and document d to notify 2 of 5 sampled				

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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 7000 WEST SPRING MOUNTAIN ROAD SPRING MOUNTAIN TREATMENT CENTER LAS VEGAS, NV 89117 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 153 S 153 Continued From page 4 Findings include: Patient #1 Patient #1 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. On 5/10/13 at 9:00 AM, the LSW #2 documented the case manager received a voice mail from the patient's father saying the patient was not to return to his home. The LSW documented the case manager would assist the patient with alternative placement. On 5/10/13 at 11:15 AM, the MA documented the patient's father wanted the patient to return to his home, but not to be discharged "today". There was no further documented evidence the patient's father was contacted to confirm discharge to the patient's father's home. On 5/14/13 at 2:30 PM, the MA documented the MA met with the patient. The patient requested the father's telephone number and told the father of being discharged and a taxi would transport the patient to the father's home. The Risk Manager Investigated a telephone complaint from the patient's father. The Administrative Review documented the discharge was not coordinated with the family. Documentation with the father on the day of discharge was not documented. On 7/9/13 at 9:50 AM, the Risk Manager acknowledged the facility should have arranged for the taxi driver to wait at the patient's father's

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 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 7000 WEST SPRING MOUNTAIN ROAD SPRING MOUNTAIN TREATMENT CENTER LAS VEGAS, NV 89117 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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 airight 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 worker/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.

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If continuation sheet 6 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: _ B. WING NVS3268HOS1 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7000 WEST SPRING MOUNTAIN ROAD SPRING MOUNTAIN TREATMENT CENTER LAS VEGAS, NV 89117 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 6 S 153 and documented in the medical record..." Severity: 2 Scope: 1 Complaint #NV00035655 S 602 NAC 449.394 Psychiatric Services S 602 SS=D 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 would have access to the weapons. Findings include: Patient #1 Patient #1 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. On 5/3/13 at 12:00 PM, the Comprehensive Assessment Tool documented patient had multiple scab areas on his legs. The Comprehensive Assessment Tool documented the patient's father stated the patient's wounds were self inflicted with a sharp object.

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 7 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: B, WING NVS3268HOS1 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7000 WEST SPRING MOUNTAIN ROAD **SPRING MOUNTAIN TREATMENT CENTER** LAS VEGAS, NV 89117 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 5 602 Continued From page 7 S 602 On 5/6/13 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. identified 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. On 5/14/13 at 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 went to the father's house. The MA documented the patient would have to pay for any taxl after being dropped 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 identifying what weapons and if the patient had access to the weapons prior to discharge. Continuing Care Plan Discharge Planning, Interdisciplinary Policy #PC.067, revised 4/13, documented: *8.0 Securing Weapons...Social Services staff initiates attempts to secure the weapons. obtaining permission and contacting any person that may be able to locate and secure the items...Weapons are not considered secured until verification has been received that the task is completed..."

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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DISTRICT COURT
CLARK COUNTY, NEVADA

LEE SZYMBORSKI;

PLAINTIFF(S),

VS.

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SPRING MOUNTAINT TREATMENT CENTER, et al.,

DEFENDANT(S).

Case No.: A-14-7001e7606 Gically Filed

09/23/2014 02:04:52 PM

Dept. No.: XXXI

CLERK OF THE COURT

ORDER DENYING PLAINTIFF'S MOTION FOR RECONSIDERATION, OR IN THE ALTERNATIVE, MOTION TO SET ASIDE

This matter came on for hearing on September 19, 2014, before

Department XXXI's Chamber's Calendar on Plaintiff's Motion for

Reconsideration, or in the Alternative, Motion to Set Aside. Having reviewed the papers, pleadings, documents and file, oral arguments of counsel at the June 24, 2014, hearing on the underlying motion, the supplemental pleading and all applicable statues and case law, the Court finds as follows:

FINDINGS OF FACT

1. On May 2, 2014, Plaintiff filed his Complaint alleging negligence, professional negligence, malpractice, gross negligence, negligence per se and negligent hiring, supervision and training against Spring Mountain Treatment Center and Darryl Dubroca, in his official capacity as CEO/Managing Director of Spring Mountain Treatment Center. Attached to the Complaint was a letter from

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

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

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

- 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

1. In the instant case, on August 25, 2014, Plaintiff filed a Notice of Appeal regarding the Court's ruling, Granting Defendants' Motion to Dismiss.

Thus, prior to determining the propriety of the instant Motion for Reconsideration, the Court needs to determine whether it has jurisdiction to hear the Motion given the purported appeal. Pursuant to *Mack-Manley v. Manley*, 122 Nev. 849, 855, 138 P.3d 525, 529-30 (2006), a properly filed notice of appeal vests jurisdiction in the Supreme Court, and the district court is divested of jurisdiction to consider any issues that are pending before Supreme Court on appeal. *Mack-Manley v. Manley* states:

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

JOANNA S. KISHNER DISTRICT JUDGE DEPARTMENT XXXI LAS VEGAS, NEVADA 19133

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

- 2. 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.

JOANNA S. KISHNER DISTRICT JUDGE DEPARTMENT XXXI LAS VEGAS, NEVADA 19155

- 6. Here, Plaintiff has not provided any new facts or evidence and has not shown that the prior decision was clearly erroneous, nor is there any showing of any mistake, inadvertence, surprise, or excusable neglect. Instead, the Motion for Reconsideration points to the attachments to the Complaint to attempt to 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 that when there is a claim for medical malpractice such as in the instant case, an affidavit from a medical expert must be attached to the Complaint. Plaintiff failed 19 to attach any affidavit compliant with the statute. Specifically, the purported documents from the Department of Health and Human Services, Health Division which were attached to the Complaint do not meet the affidavit requirement. Indeed, the Court previously held that the documents provided by Plaintiff are clearly not compliant with the statute.
 - 7. In the present case, although Plaintiff failed to submit new law or facts, making the motion procedurally deficient, the Court still evaluated its prior decision to determine whether the Motion to Dismiss was properly granted. After

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- 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)
- It is clear that the allegations in the Complaint all fall under the 10. 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 16 treating a patient which resulted in harm to Plaintiff. Nowhere in the statute is 17] medical malpractice defined in such a way that the harms resulting must be felt 18 only by the patient in order to be considered malpractice. As such, although Plaintiff was not a patient, the damages sought still fall under the definition of medical malpractice.
 - 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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ordinary negligence, and did not claim that a conforming affidavit was ever attached to the Complaint.

- 12. As the Court finds that its previous Order was legally sound and in accordance with applicable statutes and caselaw, the instant Motion for Reconsideration, or in the Alternative, to Set Aside, is appropriately DENIED.
- 13. Furthermore, although leave to amend the Complaint was not requested, it would not be appropriate as noncompliance with Nev. Rev. STAT. § 41A.071 renders a complaint *void ab initio*, and no subsequent amendments can cure the defect. *Washoe Medical Center v. Second Judicial District Court*, 122 Nev. 1298, 148 P.3d 790 (2006).

<u>ORDER</u>

Based upon the foregoing, It is hereby ORDERED, ADJUDGED, AND DECREED, that Plaintiff's Motion for Reconsideration, or in the Alternative, to Set Aside, is DENIED as set forth herein.

Dated this 19th day of September, 2014.

JOANNA S. KISHNER
DISTRICT COURT JUDGE

JOANNA S. KISHNER DISTRKTI JUDGE DEPARTMENT XXXI LAS VEGAS, NEVADA 89155

CERTIFICATE OF SERVICE

I hereby certify that on or about the date filed, a copy of this Order was 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 Order was placed in the attorney's file located at the Regional Justice Center:

LEE SZYMBORSKI 4605 E BLACK STALLION AVE NORTH LAS VEGAS, NV 89031

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KERRY DOYLE HALL PRANGLE & SCHOONVELD, LLC

JUDICIAL EXECUTIVE ASSISTANT

JOANNA S, KISHNER DISTRICT JUDGE DEPARTMENT XXXI

1 TRAN 2 **CLERK OF THE COURT** 3 4 5 DISTRICT COURT 6 CLARK COUNTY, NEVADA 7 8 LEE SZYMBORSKI. 9 CASE NO. A700178 10 Plaintiff, DEPT. XXXI VS. 11 SPRING MOUNTAIN TREATMENT 12 CENTER. 13 Defendant. 14 BEFORE THE HONORABLE JOSEPH T. BONAVENTURE, DISTRICT COURT 15 JUDGE **TUESDAY, JUNE 24, 2014** 16 17 TRANSCRIPT OF PROCEEDINGS: 18 DEFENDANT SPRING MOUNTAIN TREATMENT CENTER'S MOTION TO **DISMISS** 19 DARRYL DUBROCA'S JOINDER TO SPRING MOUNTAIN TREATMENT **CENTER'S MOTION TO DISMISS** 20 21 APPEARANCES: 22 For the Plaintiff: IN PROPER PERSON 23 For the Defendant: KERRY J. DOYLE, ESQ. 24 25 RECORDED BY: RACHELLE HAMILTON, Court Recorder

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TUESDAY, JUNE 24, 2014, AT 9:26 A.M.

THE COURT: Lee Szymborski versus Spring Mountain Treatment Center; who's here on that?

MR. DOYLE: Kerry Doyle for Spring Mountain Treatment Center and Darryl Dubroca, but apparently plaintiff filed an opposition.

THE COURT: Come here.

MR. DOYLE: Do you want me to approach, Your Honor?

THE COURT: No, no, no, just make a record. I don't -- so go ahead, what do you want to say?

MR. DOYLE: Apparently plaintiff filed an opposition which he didn't serve on us and we found out yesterday and was able to get it off the internet. Some --! would assume that he's going to appear if he took the time to oppose.

THE COURT: I would assume too. It's not 9:30 yet.

MR. DOYLE: Yeah, I don't know what he looks like or anything.

THE COURT: Are you requesting a continuance?

MR. DOYLE: No Your Honor, we're prepared to go forward.

THE COURT: Is that him?

MR. DOYLE: I don't know, I've never seen him before.

THE COURT: Mr. Szymborski?

MR. SZYMBORSKI: Yes.

THE COURT: Okay. This is on as to A-14-700178-C, Lee Szymborski versus Spring Mountain Treatment Center and Darryl Dubroca. Who's Darryl Dubroca?

MR. DOYLE: He's the CEO of the facility.

THE COURT: You're representing him also? MR. DOYLE: Yes, Your Honor. Kerry Doyle on behalf of Spring Mountain Treatment Center and Darryl Dubroca. THE COURT: All right Spring Mountain filed a motion to dismiss this Mr. Szymborski; you have a copy of that? MR. SZYMBORSKI: Yes. THE COURT: Now you filed an opposition but you've got to serve the other party. I mean you've got to serve the other party so he comes into court without you having properly served your opposition to that. MR. SZYMBORSKI: I didn't realize that. I filed it in court but, you know, I thought that was, you know --THE COURT: Well you've got to serve the party. That's part of the law. That's why you need lawyers on these things. MR. SZYMBORSKI: Yeah, well. THE COURT: I mean I'm looking at the case --MR. SZYMBORSKI: Yeah. THE COURT: -- and you filed some sort of a complaint and the -- your son is involved. Are you seeking any damages on behalf of your son or just --MR. SZYMBORSKI: No --THE COURT: -- property damage? MR. SZYMBORSKI: This is strictly a negligence case. THE COURT: It's a medical malpractice case the defendant is saying. MR. SZYMBORSKI: They're misrepresenting my complaint. THE COURT: Well you're not -- you're not -- you're not seeking any claims for your son at all, just you?

1 MR. SZYMBORSKI: No. 2 THE COURT: And what are you claiming? I'm just curious. Property 3 damage, is that what it is? 4 MR. SZYMBORSKI: It's property damage. I suffered physical injury. 5 THE COURT: You did; you suffered? 6 MR. SZYMBORSKI: Yes. Yes. 7 THE COURT: And what else? 8 MR. SZYMBORSKI: And extreme mental trauma. 9 THE COURT: You? MR. SZYMBORSKI: Yes. THE COURT: Okay. All right. MR. SZYMBORSKI: And I have many exhibits of that, pictures and so --THE COURT: All right, well we have to get to the crux of it right now. You filed a motion to dismiss, counsel? MR. DOYLE: Correct, Your Honor. THE COURT: Now there's something about a press here. I don't know if there's any press here or not but I'm not going to worry about that, there's nobody here so. I signed it already but it's subject to me vacating it, but I'm not going to worry about it now. It's a simple issue you're saying; they didn't file a medical affidavit? MR. DOYLE: That's correct, Your Honor. The entire case stems on whether or not his -- I believe it's his son; Sean Szymborski was -- whether or not he was properly discharged from --

MR. DOYLE: --the facility. In his complaint he alleges that because of this

THE COURT: Right.

improper discharge his son went to his home and caused damage to the residence.

So really the case -- the crux of the case is whether or not he was properly discharged. Discharge requires a doctor to make the decision as to --

THE COURT: Tell me a little about Spring Mountain Treatment. What kind of a facility is it and is a --

MR. DOYLE: It's a mental health facility.

THE COURT: And they have doctors of course --

MR. DOYLE: Yes.

THE COURT: -- and nurses.

MR. DOYLE: Correct, Your Honor.

THE COURT: And they have, you know, certified doctors, MD's, right?

MR. DOYLE: Right.

THE COURT: And they're -- what's their field?

MR. DOYLE: Well in this case it's mental health. I believe they also deal with other drug addictions and things like that, but the course of the patient's stay is directed by a physician. There's nurses; they have the ability to run tests and get lab work and all the things that would expect from a larger hospital. They just focus more on mental health type issues.

In this case the plaintiff's son was admitted for -- at least according to the complaint he was admitted for spice abuse and I believe he had some other psychiatric disorder such as paranoid schizophrenia.

THE COURT: I notice somebody setting up there. Do you want to say anything about it or just -- we'll just proceed?

MR. DOYLE: Well Your Honor we did receive the request yesterday and we attempted to file an opposition or an objection to their presence.

THE COURT: You did file it. I have it. I have it here.

MR. DOYLE: Right but I guess it wasn't signed or --

THE COURT: Well I mean I can -- why do you want me to exclude the press?

MR. DOYLE: Well the issues in this case -- for two reasons. The main reason is that Sean Szymborski was a patient at the facility. Today we're here talking about his diagnosis and his treatment. He is not here to consent so the release of his medical information in a public forum like that and the plaintiff is not a guardian of an adult, or at least he hasn't represented that he's the guardian of Mr. Szymborski, and he doesn't have the authority to waive his HIPPA rights. So that's the first issue.

The second issue this case involves allegations of improper discharge of a mental health patient which has been all over the news recently with the Rawson-Neal allegations at that federal facility of patient dumping. It's a hot button issue. I think that it's a very complicated issue. It's difficult to discuss in this forum let alone to have it put on the news in a minute to a minute and a half segment. It potentially taints the -- a jury pool.

So those are the two issues why we objected to the media presence.

THE COURT: All right. The Court reviewed it and I don't think this is the type of forum where they get deeply into the medical diagnosis; it's just a motion to dismiss. Perhaps at another hearing if you have other, you know, evidentiary hearing you want renew that, but as of right now I'm going to deny it and just hear this brief issue about why he should filed a affidavit -- medical affidavit --

MR. DOYLE: Understand, Your Honor.

THE COURT: -- pursuant to the statute to determine whether they have to

do that or it should be dismissed. That's really I want to hear. I don't want to hear medical diagnosis. You know, in the general terms we're going to talk about it briefly, but go ahead.

MR. DOYLE: Okay, I understand Your Honor. So with respect to the medical malpractice claim again the entire crux of his case centers around whether or not Sean Szymborski was properly discharged from the facility. That requires a doctor's decision with inputs from nurses and case workers, but ultimately it's up to the physician. And if you look at point of complaint he himself specifically points out in his allegations that -- that the facility had a duty to render proper medical treatment and they breached that duty by improperly discharging his son.

He also points to several administrative codes that deal with discharge of patients and they all center around is the patient medically safe to be discharged. It's medical determination. As a result he's required under the statute to file an affidavit with his complaint, which he failed to do.

THE COURT: And you cite the statutes --

MR. DOYLE: Correct, Your Honor.

THE COURT: -- 41A071: if an action for medical malpractice is filed in district court, the district court shall -- it doesn't say could or would or maybe -- it said shall dismiss an action, without prejudice though, right?

MR. DOYLE: Correct.

THE COURT: 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 and at the time of the alleged malpractice.

MR. DOYLE: Correct, Your Honor.

THE COURT: And you cite the *Washoe Medical Center v. Second Judicial* Supreme Court case where it says since a void complaint does not legally exist it cannot be amended. So I couldn't say well this is [indiscernible], why don't you amend this and file an affidavit with an amended complaint. The Supreme Court specifically says to me as a district court judge you can't give leave to amend, it has to be dismissed without prejudice.

MR. DOYLE: That's correct, Your Honor, and I had an opportunity to reply to the -- to his opposition I would have added as well that the Nevada Supreme Court has also held that the maintenance of medical records is a proper medical malpractice allegation. So if the Nevada Supreme Court is willing to go as far as the maintenance of medical records being a medical malpractice action certainly the decision to discharge a patient would fall under that as well.

THE COURT: The basic -- 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; is that correct?

MR. DOYLE: Correct, Your Honor.

THE COURT: And you have no doubt that the -- even if you put some codes in there, whatever he wants to do, this basically substantially is a medical malpractice case?

MR. DOYLE: Correct, Your Honor.

THE COURT: Failure to discharge is a medical malpractice case.

MR. DOYLE: That's correct, Your Honor. I mean even the administrative codes he cites all deal with determining the health consequences that a patient would suffer upon discharge.

THE COURT: I guess the reason for the -- the reason for this, Mr.

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Szymborski, is to lower costs, reduce frivolous lawsuits, ensure the medical malpractice actions are filed in good faith based upon competent expert medical opinions. It was designed to streamline and expedite medical malpractice cases, lower overall costs. So that's why the legislature put that into effect, they're saying we don't want every Tom, Dick and Harry to file a medical malpractice case because you just can't -- it will just -- the cost, the medical -- all we require a plaintiff to do -- and it's not a big -- listen to me Mr. Szymborski.

MR. SZYMBORSKI: Yes, I am.

THE COURT: It's not a big deal to get a medical expert in the same field and get -- produce -- it's just like a written affidavit that we do all the time. An affidavit, you sign our name, we swear it is; just a simple -- it's not a big deal. It's not like overly burdensome. You got to get some -- that's what the defendant is saying --

MR. SZYMBORSKI: This is not --

THE COURT: You got to get some medical expert to say you know what, I've reviewed what happened to Mr. Szymborski and he was discharged on such and such a date in -- on May 14, 2013, and I think he -- the discharge was medical malpractice because he shouldn't have done that, for whatever reasons. You know I'm not going to go into the whole case. It's not a burdensome thing.

Now if I do decide to dismiss this, I don't want to give any -- on that law, but I don't know if the statute of limitations has run, probably not, but I can't give you -- but all you have to do is file -- is go get a little medical affidavit, file another complaint, attach it, that's it. I mean it's not overly burdensome but I'm going to listen to what you want to say briefly.

MR. SZYMBORSKI: Okay. This is an action of negligence. It has nothing to do medical malpractice on me.

THE COURT: Failure to discharge or discharging a patient willfully?

MR. SZYMBORSKI: There's no -- it has nothing to do with their failure to discharge. It -- I'm the public. They have a duty to protect the public. I have no doctor-patient relationship with them, okay? They perpetrated a felony crime against the state of Nevada, against the public of which I am the victim. Nothing in

my -- I filed negligence, professional negligence, and they're misrepresenting this

as a medical malpractice action.

They have a duty to protect the public and their failure was reckless and grossly negligent. Now I have suffered over \$21,000 in property damage, physical injuries and extreme mental torment which I am under doctor's care. It should be held to strict liability. This is a public facility licensed by the state of Nevada. I spoke with Chief Deputy Attorney General Linda Anderson. She agreed with me and she instructed me to put a request for prosecution.

What they did is I demanded my son not be released to my home. I said -- I left several messages which were substantiated by Direct Willden's office which led an investigation into the hospital which resulted in nine pages of substantiated charges where they broke Nevada laws, violated codes -- nine pages. So these are not allegations or whimsical types of arguments, these are based on substantiated charges.

This case firmly hangs on the three prongs of negligence where they knew, should have known they had a duty. Where they had a duty to the injured person, their act was not reasonable, I think it's reckless and I've suffered injuries. Three prongs of negligence.

The reason my son went into Spring Mountain Treatment Center was that he was violent in my home and started to destroy my home, and he started to

get violent with me. I need a plate put in my head; I have several skull fractures, so I ran outside. That's' the reason he went in, and they knew that. So they knew not to send him to my home. I demanded that. So -- but they did it anyway and that's reckless disregard for public safety, and if this allowed to continue we're going to have more of this. The police are tied up chasing their responsibility, the court systems are overloaded with these criminal cases that naturally flow from these types of crimes. So the theme in my complaint rests solidly the prima facie, the theme, is on the three prongs of negligence. And so, you know, they need to be held accountable for public safety.

THE COURT: Well thank you sir. Any response to that, counsel?

MR. DOYLE: With all due respect to the plaintiff, the fact of the matter is he still has to have someone -- if this case were to go to trial he's going to have an expert -- he's going to have a medical expert to come up there and discuss why or why not his son was properly or improperly discharged from the facility. It's a medical decision made by a physician and it's a medical malpractice case.

Your Honor, I also got a little ahead of myself. Mr. Dubroca, we filed a joinder on his behalf. Other than in the caption and a statement at the beginning of the complaint over jurisdiction there's not a single allegation against Mr. Dubroca --

THE COURT: Okay.

MR. DOYLE: -- and so for that reason he should be dismissed from this case regardless of what Your Honor's decision is with respect to medical malpractice.

THE COURT: All right well, again I've been dealing with it for a long time and most recently as a senior judge I handle numerous medical malpractice cases in settlement conferences and a lot of them have to do with early discharge from hospitals, infants or cancer patients or -- whatever the early discharge that

shouldn't have happened is it's medical malpractice. I mean I've handled dozens of these types of cases in settlement conferences. I've read a lot of law on it and I just -- I sympathize with you Mr. Szymborski but it's not an unreasonable burden for you to get a medical affidavit, and you could proceed with this, so the motion to dismiss is granted. Plaintiff does not cite any legal basis to consider this a negligence action instead of medical malpractice action. As there's no affidavit attached to the complaint, the complaint is void ab initio and must be dismissed without prejudice and leave to amend is improper. So -- but you still have a remedy but as of right now this case is dismissed both as to Spring Mountain and defendant Dubroca because I'm allowing him -- I'm granting the joinder and dismissing as to him also, all right? But thank you.

MR. DOYLE: Your Honor, do you want me to prepare the order?

THE COURT: Yeah you prepare the order.

MR. DOYLE: Send it to Mr. Szymborski?

THE COURT: Yeah.

MR. DOYLE: Thank you, Your Honor.

MR. SZYMBORSKI: Thank you, Your Honor.

[Proceeding concluded at 9:44 a.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video recording in the above-entitled case to the best of my ability.

RACHELLE HAMILTON
Recorder/Transcriber

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