(X1) PROVIDER/SUPPLIER/CLIA

050378

DENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

Pacifica Hospital of the Valley

AND PLAN OF CORRECTION

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	3	100	9	50

11

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

10/21/2013

B.VVING STREET ADDRESS, CITY, STATE, ZIP CODE

9449 San Fernando Rd, Sun Valley, CA 91352-1421 LOS ANGELES COUNTY

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC DENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during an inspection visit:			
	Complaint Intake Number: CA00365892-Substantiated		2016 MAR 22 RECE	HEA
			RE	ECT
	Representing the Department of Public Health: Surveyor ID# 22458, HFEN			H FAC
	The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.		PM 2: 54	A TION
	Health and Safety Code Section 1280.3: For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.			8/15/13
	Title 22 DIVS CH1 ARTS - 70215 Planning and Implementing Patient Care.		one (1:1), close observation intervention when significant changes in the patient's ability to navigate or respond to simple	
	(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the timeof admission		directions are observed by the licensed nurse, with immediate physician notification. The Elopement/AWOL policy was reviewed and revised on 8/20/2013 and was revised on Nov 2014 (see attachment 2, policy) to include all other acute departments in the process of patients	8/20/2013
	Title 22 DIVS CH1 ARTS – 70701 Governing Body.		leaving their assigned units without a physician's order.	
	(a) The governing bode shall:			
Event ID:NS	96211 3/8/2016	3	:24:29PM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE mouse man and .

By signing this document. Iam acknowledging receipt of the entire citation packet, Pagels>, 1thru 11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing tis detennined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI DENTIFICATION NUMBER 050378		(X2)MULT A. BUILDIN B.WING		(X3)DATESUR COMPLET 10/2	
NAMEOEDDO	VIDER OR SUPPLIER		EET ADDRESS,		7/0 0005		
	spital of the Valley		-		Valley, CA 91352-1421 LOS ANGELES	COUNTY	
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLANOF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BECROSS-	(X5) COMPLETE DATE
	personnel required patients and shall meet the health needs Title 22 DIVS CH1 Safety and Maintenanc (a)The hospital sha good repair at all include provision a	of the community ARTS – 70837 (a) (a) a ll be clean, sanitary times. Maintenance and surveillance of the safety and well-t	of the ing to General and in shall services		The Director of Education condi- inservices regarding the risk as and the AWOAL policy to the m surgical nursing staff on August and another reinforcement educ started on March 8, 2016 and w completed on by April 1' 2016 (s attachment 3, inservice). The Risk Manager will be the per responsible for monitoring comp the admission risk assessment electronic medical record and w findings to the Quality Council of quarterly basis.	edical edical 15, 2013, cation vill be see erson pliance of in the vill report	4/1/2016
	prevent Patient 1 fr exit door; (2) maint facility's fire exit doo the roof top, in goo provide appropriate personnel required Patient 1 to prevent an On August 10, 2013 p.m., Patient 1 ex (pulled out his intra times), severe dis where he was), unit/room, and was p his room. There between 11:40 p.m.) plan and deliver a com exiting the facili ain the exit alarm for r of Neuro 3 unit lea od repair at all time of physical resource to meet the nee accident or harm. 3, from 8:20 p.m. to chibited increasing avenous/IV access sit orientation (did not wandered out fro bicked up and sent b	care to ity's fire or the ading to es; (3) s and eds of 11:40 agitation te three know om his back to tentation indicate		In addition, the Chief Nursing O be the person responsible to en compliance by conducting rando of each acute care unit. Finding reported to the Safety Committe Council Committee, and Goverr on a quarterly basis for complia	sure om audits s will be e, Quality hing Board	
Event ID:N9	6211	·····	3/8/2016	3.2	24:29PM		

STATEMENT OF DEFICIENCIES AMDRAMON CORRECTION Improvides Regular Line and the state of th			· · · · · · · · · · · · · · · · · · ·	<u> </u>			
059378 B. WING 10/21/2013 NAMEGPERPOYNDERORSUPPLER Practice Hospital of the Valley STREET ADDRESS, CITY STATE, ZP CODE MID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (BCAHORFICENCY MUST REPRECEDED BY FULL TAG D PROVIDERS FLANOF CORRECTION (BCAHORFICENCY MUST REPRECEDED BY FULL TAG D PREVIX TAG PROVIDERS FLANOF CORRECTION (BCAHORFICENCY MUST REPRECEDED BY FULL TAG D PREVIX TAG PROVIDERS FLANOF CORRECTION (BCAHORFICENCY MUST REPRECEDED BY FULL TAG D PREVIX TAG PROVIDERS FLANOF CORRECTION (BCAHORFICENCY MUST REPRECEDED BY FULL TAG D </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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0410 PREFX Tag SUMMARY STATEMENT OF DEFICIENCIES (REAL DEFICIENCY MUST BE PRECEDEDE BY FULL REQUENCIENCY MUST BE PRECEDEDE BY FULL RECENCE TO THE APPROPRIATE BERCIENCY 0000 COMPLETE DATE 0 observe Patient 1 for safety. The policy "Alcohol Withdrawal/Withdrawal from Substances" was reviewed and revised on 10/2/13, and again on 2/16, to provide clinical guidelines in recognizing; the adam of the medical/surgical unit. At 5.45 a.m., the security guard immediately informed LVN 1. When LVN 1 went to the scene, LVN 1 observed Patient 1 on the ground not breathing. According to the police report, Patient 1", entered the stalinvell and gained access to the roof top through the unlocked door (door alarm was not functioning) drooped from the roof top [3/d floor/30 feet tall] landing onto the patio concrete below causing his death." A review of the Coroner Report (medical examination) disclosed: Patient 15 place of death was at the hospital; the maner was an accident; and causewas multiple bluntraumaticinjuries. The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Depation decise Patient 1% as an accident; and causewas multiple bluntraumaticinjuries. The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Depatiment of Medicine Committee, Quality Council, and Governing Board on a quarterly basis. 4/1/2016	NAMEOFPR	OVIDER OR SUPPLIER		•	•		
PRERX TAG REACH DERCEMENT MIST BE PRECEEDED BY FULL RECALCORRECT MEAP ROPEATE DEFICIENCY CAMPLETE TAG CAMPLETE TAG TAG (EACH DERCET THE APPROPRIATE DEFICIENCY) CAMPLETE DATE Observe Patient 1 for safety. TAG The policy "Alcohol Withdrawal/Withdrawal again on 2/16, to provide clinical gain on 2/16, to the group on to breathing. According to the corner Report (medical was an ont functioning) dropped from the roof top 13rd floor/30 feet tall) landing onto the pation concrete below causing his death." A review of the Corner Report (medical examination) disclosed: Patient 1's place of death was at the hospital; the manner was an accident; and cause was multiplebluntraumatichjuries. The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Department of Medicine Committee, Quality Council, and Governing Board on a quarterly basis. On August 16, 2013 at 10:45 a.m., with dignoses that include alcohol withdrawal and alterde level of con	Pacifica H	lospital of the Valley	9449 San Fe	mando Rd, Su	n Valley, ca \91352-1421 LOS ANGELE	ES COUNTY	
PRERX TAG REACH DERCEMENT MIST BE PRECEEDED BY FULL RECALCORRECT MEAP ROPEATE DEFICIENCY CAMPLETE TAG CAMPLETE TAG TAG (EACH DERCET THE APPROPRIATE DEFICIENCY) CAMPLETE DATE Observe Patient 1 for safety. TAG The policy "Alcohol Withdrawal/Withdrawal again on 2/16, to provide clinical gain on 2/16, to the group on to breathing. According to the corner Report (medical was an ont functioning) dropped from the roof top 13rd floor/30 feet tall) landing onto the pation concrete below causing his death." A review of the Corner Report (medical examination) disclosed: Patient 1's place of death was at the hospital; the manner was an accident; and cause was multiplebluntraumatichjuries. The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Department of Medicine Committee, Quality Council, and Governing Board on a quarterly basis. On August 16, 2013 at 10:45 a.m., with dignoses that include alcohol withdrawal and alterde level of con		, 					_
TAG REGULATORY OR LSC DENTIFYING INFORMATION) TAG REFERENCEDTOTHE APPROPRIATE DEFICIENCY) DATE Observe Patient 1 for safety. The policy "Alcohol Withdrawal form Substances" was reviewed and revised on 10/2/13, and again on 2/16, to provide clinical guidelines in recognizing; treating and stabilizing the symptoms relating to alcohol withdrawal (see attachment 4, policy). 10/2/2013 Yind the security guard form the medical/surgical with the security guard immediately informed LVN 1. When LVN 1 (when to the secone, LVN 1 observed Patient 1 on the ground not breathing. According to the police report, Patient 1", entered the stainvell and gained access to the roof top through the unlocked door (door alarm was not functioning) dropped from the roof top [3rd floor/30 feet tall] landing onto the patio concrete below causing his death." A review of the Coroner Report (medical examination) disclosed: Patient 1's place of death was at the hospital; the manner was an accident; and cause was multiple bluntraumatichjuries. The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Department of Medicine Committee, Quality Council, and Governing Board on a quarterly basis. 4/1/2016 A review of Patient 1 % Admission Document disclosed Patient 1 was admitted to the facility on investigate an entity-reported incident involving the death of Patient 1 was admitted to the facility on August 10, 2013, at 12:25 a.m., with diagnoses that include alcohol withdrawal and altered level of consciousness. (Symptoms of alcohol withdrawal and altered level of consciousness. (Symptoms of alcohol withdrawal and altered level of consciousness. (Symptoms of alcohol withdrawal and altered level of consciousness.	(X4)1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	ū	PROVIDER'S PLAN OF CORRE	CTION	
 beserve Patient 1 for safety. Ch August 11, 2013, at 12:50 a.m., Patient 1 was found missing from the medical/surgical unit. At 5x45 am., the security guard found a patient lying by the hospital, inside a brick fence and a steel (metal) gate. The security guard immediately informed LVN 1. When LVN 1 went to the scene, LVN 1 observed Patient 1 on the ground not breathing. According to the police report, Patient 1 " entered the stainveil and gained access to the roof top 13rd floor/30 feet tail] landing onto the patio concrete below causing his death." A review of the Coroner Report (medical examination) disclosed: Patient 1 % Admission Document disclosed Patient 1 % Admission Document disclosed Patient 1. A review of Patient 1's Admission Document disclosed Patient 1's Admis							
observe Patient 1for safety.On August 11, 2013, at 12:50 a.m., Patient 1was found missing from the medical/surgicalunit. At 5:45 a.m., the security guard found apatient lying by the hospital, inside a brickfence and a steel (metal) gate. The securityguard immediately informed LVN 1. When LVNtwent to the scene, LVN 1 observed Patient 1oh the ground not breathing. According to thepolice report, Patient 1", entered the stairwelland gained access to the roof top through theunlocked door (door alarm was notfiloor/30 feet tall] landing onto the patioconcrete below causing his death." A review ofthe correne Reportfindings:On August 16, 2013 at 10:45 a.m., anunannounced visit was made to the facility toinvestigate an entity-reported incident involvingthe death of Patient 1.A review of Patient 1sA review of Consciousness. (Symptoms ofaltered level of consciousness. (Symptoms ofaltered level of consciousness. (Symptoms ofaltered level of consciousness.altered level of consciousness.altered level of consciousness.altered level of consciousness.altered level of consciousness.<	TAG	REGULATORY OR	SC DENTIFYING NFORMATION)	IAG	REFERENCED TO THE AFFROFRIATI	E DEFICIENCY)	DATE
Event ID:N96211 3/8/2016 3:24:29PM		On August 11, 20 was found missin unit. At 5:45 a.m., patient lying by the fence and a steel guard immediately in 1 went to the scene on the ground not police report, Patien and gained access unlocked door functioning) droppon floor/30 feet tall] concrete below cause the Coroner Repond disclosed: Patient 1 hospital; the manner cause was multiple blu Findings: On August 16, unannounced visit investigate an entit the death of Patient 1. A review of Patient disclosed Patient 1 on August 10, 2 diagnoses that incl altered level of ca alcohol withdrawa n e r v o u s n e s s,	13, at 12:50 a.m., Patient g from the medical/surgical the security guard found a the hospital, inside a brick {metal) gate. The security informed LVN 1. When LVN a, LVN 1 observed Patient breathing. According to the nt 1" entered the stairwel to the roof top through the {door alarm was not ed from the roof top [3rd landing onto the patient is place of death was at the er was an accident; and nttraumaticinjuries. 2013 at 10:45 a.m., and was made to the facility to ity-reported incident involving ent 1's Admission Documer was admitted to the facility 013, at 12:25 a.m., witt uded alcohol withdrawal and onsciousness. {Symptoms of al include anxiety of s lur red s peech	II A A A A A A A A A A A A A A A A A A	from Substances" was review revised on 10/2/13, and agair provide clinical guidelines in r treating and stabilizing the sy relating to alcohol withdrawal attachment 4, policy). Staff inservices on Alcohol Withdrawal/Withdrawal from 3 began in October, of 2013 wit education started on March 1 will be completed by April 1, 2 attachment 5, inservice) . The Chief Nursing Officer will responsible for monitoring co conducting random rounds ar any variations to the Departm Medicine Committee, Quality Governing Board on a quarte	ved and o on 2/16, to recognizing; mptoms (see Substances" th re- 5, 2016 and 2016 (see be person mpliance by nd will report ent of Council, and	

(EACH DEFICIENCY REGULATORY OR I tremors/shakiness, symptoms get wors	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC DENTIFYING NFORMATION) and not thinking cleariy	-	ZIP CODE N Valley, CA 91352-1421 LOS ANGE PROVIDER'S PLANOF COR (EACH CORRECTIVE ACTION SHO REFERENCEO TO THE APPROPRIA	LES COUNTY RECTION ULD BE CROSS-	(XS) COMPLETE DATE
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(EACH DEFICIENCY REGULATORY OR I tremors/shakiness, symptoms get wors	MUST BE PRECEEDED BY FULL SC DENTIFYING NFORMATION) and not thinking cleariy	PREFIX	(EACH CORRECTIVE ACTION SHO REFERENCEO TO THE APPROPRIA	ULD BE CROSS-	COMPLETE
symptoms get wors					
tremors/shakiness, and not thinking clearly symptoms get worse in 48 - 72 hours, and may persist for weeks.) A review of the electronic Clinical -Interdisciplinary Notes admission nursing assessment, dated August 10, 2013, at 130			 Roof top cameras were on November 2013 with nig capability and continue to b to monitor activities on the (Attachment, picture of mor attachment 6, pictures). Additional alarms were insta doors including all exists to b 	ht vision e operational roof top. hitor) see illed to all exist the roof top	11/2/201 8/16/201
a.m., indicated Pat but sometimes his sense. The asses patient exhibited bilateral arm tren movement that is The Fall Risk Asse 2013, indicated the falls (total risk score more is a high inc o nt ine n c e, anticonvulsants, an facility's intervention "exit alarms are in plac A review of the Phy 10, 2013, included MP every four ho	ient 1 was awake and alert, answers did not make sment further indicated the intermittent (off and on) nors (involuntary shaking repeated over and over). essment, dated August 10, patient was at high risk for of 9, the score of 5 or risk) due to disorientation, g e n d e r / m a le, t a k ing d mobility. One of the s for fall high risk included e and active". vsician Orders, dated August the following: Ativan 1 mg purs PRN (as necessary) for		8/16/2013 (see attachment The policy and procedure or Procedures – Security" was October of 2015 to emphasi locations for daily rounds for personnel (See attachment The "Hospital and Grounds was reviewed and revised to need for all security personr any malfunctioning of fire ex to the Director of Facilities N	7, pictures) n "Routine revised in ze roof top r security 8, policy). Security"policy o include the nel to report tit door alarms Management	
anxiety medication); night (hypnotic age mg orally every r and Librium 25 mg anxiety medication). included "cardiac m to continuous mor	Ambien 10 mg orally every ent for sleep); Seroquel 25 hight (anti-psychotic medication); orally every six hours (anti- The Physician Orders also ponitor." (Cardiac monitor refers hitoring of the heart activity,				
	a.m., indicated Pat but sometimes his sense. The asses patient exhibited bilateral arm trem movement that is The Fall Risk Asse 2013, indicated the falls (total risk score more is a high inc o nt ine n c e, anticonvulsants, an facility's intervention "exit alarms are in plac A review of the Phy 10, 2013, included MP every four ho alcohol withdrawal, anxiety medication); night (hypnotic age mg orally every mand Librium 25 mg anxiety medication). included "cardiac mon generally by electro	a.m., indicated Patient 1 was awake and alert, but sometimes his answers did not make sense. The assessment further indicated the patient exhibited intermittent (off and on) bilateral arm tremors (involuntary shaking movement that is repeated over and over). The Fall Risk Assessment, dated August 10, 2013, indicated the patient was at high risk for falls (total risk score of 9, the score of 5 or more is a high risk) due to disorientation, inc o nt ine n c e , g e n d e r / m a le , t a k ing anticonvulsants, and mobility. One of the facility's interventions for fall high risk included "exit alarms are in place and active". A review of the Physician Orders, dated August 10, 2013, included the following: Ativan 1 mg MP every four hours PRN (as necessary) for alcohol withdrawal, agitation, and anxiety (anti- anxiety medication); Ambien 10 mg orally every night (hypnotic agent for sleep); Seroquel 25 mg orally every night (anti-psychotic medication); and Librium 25 mg orally every six hours (anti- anxiety medication). The Physician Orders also included "cardiac monitor." (Cardiac monitor refers to continuous monitoring of the heart activity, generally by electrocardiography, EKG, for	a.m., indicated Patient 1 was awake and alert, but sometimes his answers did not make sense. The assessment further indicated the patient exhibited intermittent (off and on) bilateral arm tremors (involuntary shaking movement that is repeated over and over). The Fall Risk Assessment, dated August 10, 2013, indicated the patient was at high risk for falls (total risk score of 9, the score of 5 or more is a high risk) due to disorientation, inc o nt ine n c e , g e n d e r / m a le , t a k ing anticonvulsants, and mobility. One of the facility's interventions for fall high risk included "exit alarms are in place and active". 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		050378		A. BUILDII B. WING	NG	10/2	1/2013
Pacifica H	VDERORSUPPLIER ospital of the Valley	9449 :	ET ADDRESS, CI San Fernando	Rd, Sun	Valley, CA 91352-1421 LOS ANG	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC DENTIFYING NFORMATION)	5	id Prefix Tag	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BECROSS-	(X5) COMPLET DATE
	document, dated A Patient 1 received a 2 p.m., Librium 25 m and 6 p.m.; Seroqu Ambien 10 mg orally at An entry in the C dated August 10, 2 indicated the patier Ativan 2 mg MP "f relief". The primary phys (H&P), dated Augu 8:50 p.m., indica "Patient with tremo the onset is und severe, shaking durationhistory treatment urgency October 8, 2013 telephone interview, she interviewed the August 11, 2013, the was 6 p.m., but the electronically transmitted A review of Patient August 10 - 11, 2 disoriented, ambulated	hand-written Medication August 10, 2013, in dose of Ativan 2 mg ng orally at 6 a.m., 1 iel 25 mg at 9 p.m., t10:30 p.m. Clinical-Interdisciplinary 013, and timed at 6:30 for restlessness with sician history and p ist 10, 2013 and time ted the following irs, confusion, anxiety, certain. The symptom , constant, v unobtainable due or poor historian.' at 12:35 p.m., dur , the risk manager ind the primary physicia the actual assessment the history and physicia	dicated VP at 2 p.m., , and Notes, 0 p.m., e with some hysical ed at entry: , and hysical ed at entry: , and bysical ed at entry: , and hysical ed at entry: , and bysical ed at entry: , and bysical entry: , and entry: , and entry: , and entry: entry: , and entry:		In August of 2013, Education personnel was completed of and Re-education for Secu- on routine procedures bega 14, 2016 with an expected date of April 1, 2016 (see a inservice). The Detex monitoring syste be operational and security conducted every hour. The provides a detailed print-ou security rounds for each ei- example of Detex monitorin out, 11). Education and inservices of and Grounds Security" poli march 9, 2016 and will be of April 1, 2016 (See attachm- inservice). The Director of Security is f person for monitoring comp reports variances to the Sa Committee, Quality Counci Governing Board quarterly.	on 8/21/2013 rity personnel an on March completion attachment 10, em continued to rounds are Detex system at of hourly xit (see ng system print n the "Hospital cy started on completed by ent 12, the responsible pliance and fety 1 and	4/1/2016
Event ID:N	<u> </u>		3/8/2016				l

OBSIZE INVICE INVICE<		OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILD		(X3)DATESUR COMPLET	FED
Pacifice Hospital of the Valley 0449 San Fermande Rd, Sun Valey, CA 91382-1421 LOS ANGELES COUNTY (M4) D SumMARY STATEMENT OF DEPICIENCES RRETK TAG Issue and the statement of the formation of the right forearmwill monitor patientat 22:30 patient pulled out IV access againtelemonitor (cardiac monitor) Image: Department of the patient sequiring elopement, fail precautions or any medical or behavioral concern, including alcohol withdrawal, is implemented as soon as possible upon admission to maintain safety needs of the patient. Some Termende Rd, Sun Valey, CA 91382-1421 LOS ANGELES COUNTY Visition of the right forearmwill monitor patientat 22:30 patient pulled out IV access againtelemonitor (cardiac monitor) wander and vas told to stay in the room at 0b/S0 (August 11)patient was diven A tivan 2 mg IVPfor agitation patient section of IV due to patient siderioritationsafety provided at 23:00 patient wander and was told to stay in the room at 00:50 (August 11)patient was checked by toward Pestignetint (passed by toward Pestignetint (patient 4), passed by toward Pestignetint (passed by toward Pestignetint (patient 4), passed by toward Pestigneting (patient 4), passed by toward Pestigneting (patient 4), patient 4, pastay and disorienteton as incontinent of the patient (patient 4),			050378		B. WING		10/2	1/2013
(K4) D SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MIST REPRECEDED TO PROLIDE REPROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECEDED TO PROLIDE REPROVIDER PERMIT DEPICIENCY NET TAG D PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECEDED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECEDED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICENCY MIST REPRECEDED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECEDED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECEDED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECED TO THE APPROVING REPORTSON DURING THE PROVIDER'S PLANOP CORRECTION (EACH DEPICIENCY MIST REPRECED TO THE APPROVING REPORTSON DURING THE PROVIDER TO THE APPROVING REPORTSON DURING THE PROVIDER TO THE PROVIDER TO THE APPROVING TO THE DEPICIENCY (S) (202013 S/20/2013	NAMEOFPR	DVIDER OR SUPPLIER		STREETADDRESS	S, CITY, STATE	E, ZIP CODE		
PRERX TAG RECULTORY OR ISCORTIFY NOILPORNATION) PRERX TAG RECULTORY CACIDENCE ACTIONS HOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEPICIENCY DATE COMPLETE DATE SEVER discontented does not know where he was, and insisted to go down to buy somethingat 21:00 W access inserted on the right forearmwill monitor patienttat 22:30 patient pulled out IV access againlelemonitor [cardiac monitor] was disconnectedat 23:00 patient was given Ativan 2 mg IVP for agitation patient was given Ativan 2 mg IVP for agitation patient continued to wander and was told to stay in the room at 0b:50 [August 11]patient was checked in the room and was not found a nursestifting in rom 320 saw Patient 1 passed by loward Peds [pediatic] unitsecurity was notified and search was intitatedfom 3rd floor to the basement, patient was ont found. Three was no documentation between 23:40 and 00:50 to indicatePatient 1 twas being monitored for safety.] At 5:50 Patient 1 was found [fing on the patient. At 7:10 the policecame PREFX TAG PREFX TAG A review of LVN 1's written statement for facility's hwestigation, dated August 111 2013, from 7 p.m. to 11 p, a total of three times. He was unsteady and disornet PREFX TAG Recurrence and patient of patients active the patient of patients active the statement for the facility's hwestigation, dated August 111 2013, from 7 p.m. to 11 p.m., a total of three times. He was unsteady and disornet, constantly wandered the hallway, and was incontinent of urine. The statement aiso revealed the patient hp dreceived Ativan 2 mg IVF at 11:40 p.m.	Pacifica H	ospital of the Valley		9449 San Ferna	ndo Rd, Sui	n Valley, CA 91352-1421 LOS ANGELI	ES COUNTY	
 severe disoriented does not know where he was, and insistedto go down to buy something, at 21:00 M access inserted on the right forearmviil monitor patientat 22:30 patient pulled out IV access again.telemonitor (cardiac monitor) was disconnectedat 22:30 opatient wandered down the hallway by the Neuro 3 area and pulled out his IV again RN (registered nurse) picked up the patient and back to his room no further reinsertion of N due to patient's disorientation patient continued to wander and was told to stay in the room at 00:50 [August 11]patient was checked in the room and was not founda nursesitting in room 320 saw Patient 1 passed by toward Peds [pediatic] unitsecurity was notified and search was not foundThere was no documentation between 23:40 and 00:50 to indicatePatient 1 was being monitored for siefely.] At 5:50 Patient 1 was fund lying on the pavement. At 7:101 hepolicecame A review of LVN fs written statement for the facility's investigation, dated August 111 2013, from 7 p.m. to 11 p.m., indicated Patient 1 pulled out his IV line, a total of three times. He was unsteady and disoriented, constantly wandered the hallway, and was incontinent of urine. The statement also revealed the patient here of the hallway, and was incontinent of the received Alivan 2 mg IVP at 11:40 p.m. 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	DBECROSS-	COMPLETE
		was, and insisted somethingat 21:0 the right forearm 22:30 patient p again_telemonit disconnecteda wandered do Neuro 3 area and p [registered nurse] back to his room due to patient's provided at 23:40 mg IVP for agitation wander and was to 00:50 [August 11] room and was no room 320 saw toward Peds [pe was notified initiatedfrom 3rd patient was documentation l indicatePatient 1w safety.] At 5:50 Pa the pavement. At 7:10 A review of LVN facility's investigation from 7 p.m. to 11 pulled out his IV lin was unsteady and wandered the hallw urine. The statemen had received Ativa	to go down to bo W access inse will monitor patient bulled out IV acce or [cardiac monitor] at 23:00 patient won the hallway bulled out his IV picked up the pati no further reinse disorientation s patient was given patient contin bld to stay in the patient was chec t founda nurse Patient 1 passed ediatric] unitsec and search v d floor to the ba not found.[There between 23:40 ar vas being monitore tient 1 was found h 1 the police came 1's written statemen, dated August I p.m., indicated he, a total of three d disoriented, vay, and was inco t also revealed n 2 mg IVP at	o buy erted on itat ss was by the again RN ent and rtion of N afety Ativan 2 ued to room at ked in the sitting in by curity vas asement, was no nd 00:50 to ed for ying on ent for the 111 2013, Patient 1 times. He constantly ontinent of the patient 11:40 p.m.		 was reviewed and revised on ensure one on one acuity staf patients requiring elopement, precautions or any medical or concern, including alcohol witi implemented as soon as poss admission to maintain safety re patient. Several per-diem C.N.As were 2013 to provide one to one of as needed throughout the hose addition, extra security guards to ensure patient safety (see a 13, employees list) All CNAs were trained and ev competency of maintaining sta patient safety while on a 1:1 d orientation and yearly during to skills fair (attachment 14, insee The Director of Security is the person for monitoring complia reports variances to the Safet Committee, Quality Council at 	8/20/13 to fing for fall behavioral hdrawal, is ible upon heeds of the e hired since servations spital. In attachment aluated for aff and uring he annual rvice). responsible nce and	

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CUA DENTIFICATION NUMBER:			(X3)DATESUR COMPLET	
		050378	A. BUILDI B.WING		10/2	1/2013
NAME OF PROVID Pacifica Hosp (X4) ID	ital of the Valley	STREET ADDRESS 9449 San Ferna TEMENT OF DEFICIENCIES		ZIP CODE Valley, CA 91352-1421 LOS ANGELI PROVIDER'S PLANOF CORRE		(XS)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC DENTIFYING NFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATI	DBECROSS-	COMPLETE DATE
th (n ar br nc A 20 fin sig he to bu lec ca ca ca tra	e hospital inside a netal) gate. LVN and found Patient reathing, the ches- ot moving and the eyer review of the pol 013, indicated, the e department p the decedent (F gns of life and w at 0612 (6:12 department para ead and bleeding fit police investig decedent/Patient his hospital onitor, entered ccess to the roof for (door alarm ecedent (Patient 1) uched several ledg iilding, the d the partition wa dge. The deceder roof top [3 landing onto susing his death. review of the camination) disclose eath was at the h ccident; and cau aumatic injuries.	twent to see that person 1 on the ground, not t and abdomen area were swere open. lice report dated August 11, police officer met with the aramedic and found Patient 1) to have no visible vas pronounced deceased am) hours. Thefire medic noted "trauma to room his head". The ation revealed the t 1 walked away from room, removed his heart the stainwell andgained top through the unlocked was not functioning). The walked along the roof and ges, on the east side of the ecedent climbed over all and sat down on the ent dropped from the Brd floor/30 feet tall] the patio concrete below Coroner report (medical ted: Patient 1's place of topsital; the manner was an lise was multiple blunt		After a thorough root cause a comprehensive plan of action submitted to The Joint Comm August 21, 2013 (see attachn report: Organization Plan of A Reduction Strategy) and the S Event Measure of Success w on March 27, 2014 with no fu up action required. All invested parties pursuant titled incident have forever dis future claims resulting from th which occurred on August 11 release of all claims was filed on November 6, 2013 (see at release of all claims).	was ission on hent 15, action Risk Sentinel as accepted rther follow to the above scharged any is incident , 2013. A and closed	8/11/2013
Event ID:N9621	11	3/8/2016	3:	24:29PM		

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA DENTIFICATION NUMBER:		PLECONSTRUCTION	(X3)DATESUR COMPLET	
		050378	A.BUILDIN B. WING		10/21	/2013
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADDRES	S. CITY, STATE, 2		•	
Pacifica I	Hospital of the Valley			√alley, CA 91352-1421 LOS ANGELES	COUNTY	
	hospital of the valley	3449 381 Fena		Valley, CA 91332-1421 EOS ANGELES	COUNTI	
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING NFORMATION)	id PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BECROSS-	(X5) COMPLETE DATE
	videotapes for the unit revealed Patient evening of August interview, a review form (computerized of the security rounds) with the manager, indicated accessed the roo approximately 12:25 a.m., lookingfor Patien At 3:30 p.m. on A interview, the secur not sure if the functioning that ni Maintenance/Enginee rounds of the roof. were no records to was checked on a regu At 4:05 p.m. on A interview, the 3-1 stated he had wo 10, 2013, and the ni for Neuro 3 were r for how long the functioning, the securit anyone who went noticed", then stat	the security personnel had of top exit doors at o a.m., and again at 2:20 ht1. ugust 16, 2013, during an ity director stated he was fire exit door alarms were ight (August 10), and the ering staff made daily He further indicated there o indicate the alarm system ular basis. August 16, 2013, during an 1 p.m. shift security officer rked the evening of August roof access/exit door alarms not functioning. When asked door alarm was not curity officer stated it had two weeks. When asked eported the non-functioning y officer replied, "I think up on the roof would have				
Event (D:N	196211	3/8/2016	3:2	4:29PM		

STATEMENT OF AND PLANOF C		(X1) PROVIDER/SUPPLIER/CUA DENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3)DATE SUR COMPLET	
		050378	B.WNG			1/2013
NAMEOFPROV	DERORSUPPLIER	STREET ADDRESS	, CITY, STATE, ZIP	CODE		
Pacifica Hos	pital of the Valley	9449 San Ferna	ndo Rd, Sun Va	lley, CA 91352-1421 LOS /	ANGELES COUNTY	
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEOED BY FULL SC DENTIFYING NFORMATION)	id Prefix Tag	PROVIDER'S PLANO (EACH CORRECTIVE ACTIC REFERENCED TO THE APPR	N SHOULD BE CROSS.	(XS) COMPLETE DATE
, , , , , , , , , , , , , , , , , , ,	Director stated who access/exit door ala hey were all function initexitdoor. On October 8, 20 elephone interview, 10, 2013, during en tay shift nurse at shivering and shat he day shift nurse at shivering and shat he day shift nurse ike that". As the in- stated Patient 1 was 1:40 p.m., after the V line for the third sharge nurse had go 0 minutes to one ativan, but Patient 1 was asked LVN 1to more busy assisting anot describe Patient 1's RN 4 indicated Patient shable to stand up stra A review of the faci Grounds Security modicated Security responsible for the property within the	2013 at 7:40 a.m., during a , RN 4 stated, she had nitor Patient 1, as she was ther patient. When asked to s gait (manner of walking), ient 1 was a little unsteady, ight, and a little shaky.		29PM		

STATEMENT OF ANO PLANOF C	DEFICIENCIES ORRECTION	(X1) PROVIOER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3)DATESUR COMPLET	
		050378	A. BUILDIN B. WING		10/21	/2013
NAME OF PROV	DERORSUPPLIER	STREET ADDRESS	, CITY, STATE, Z	IPCODE		
Pacifica Hos	pital of the Valley	9449 San Ferna	ndo Rd, Sun V	/alley, CA 91352-1421 LOS ANGELES	COUNTY	
(X4)10 PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEOEO BY FULL SC DENTIFYING NFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BECROSS.	(X5) COMPLETE DATE
F T F iii a t t t t t t t t t t t t t t t t t	revention of accide for functions of prevention of unau- to restricted and and reporting of all unsafe conditions; hspections, tours, and campus to secured. A review of the fac- tiled, "One on One ace quiring suicide precaut ions, close precautions, or any concern. The purpor naintain patent safe patient impulsivity aff he patient, staffor othe a t e d F e b r un Assessment/Reass stipulated all patient per provided with assessment and dentify patient ne esponses to the terventions, asses sused to develop are. The facility's failure	or patrols of the hospital ensure they were properly sility's policy dated May 2011, e Obseivation", stipulated a uity staffing, for patients precautions, elopement e obser v at ion, fall y medical or behavioral se of this policy is to ety or to further assess fecting the safety needs of ers. ility's policy and procedures a r y 2 0 1 3, t i t l e d,	3:24	:29PM		
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050378 INVINO 10/21/2013 NUME OF PROVIDER OR SUPPLER Padifica Hospital of the Valley SUMMARY STATEMENT OF DEFICIENCIES OF INTERT ADDRESS, OTT, STATE, JPECDE OF INTERT ADDRESS, ADDE CORRECTION INTERT ADDRESS, ADDE CORRECTION OF INTERT ADDRESS, ADDE CORRECTION OF INTER	STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA DENTIFICATION NUMBER:	(X2)MULTI		(X3) DATE SUR COMPLET	
Pacifica Hospital of the Valley 9449 San Fernando Rd, Sun Valley, CA 91352-1421 LOS ANGELES COUNTY (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEEOEO BY FULL REGULATORY OR LSC DENTIFYINGINFORMATION) ID PREFIX PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BEPRECEEOEO BY FULL REGULATORY OR LSC DENTIFYINGINFORMATION) 0(3) PREFIX COMMETTE TAG PREFIX COMMETTE ACT care to prevent Patient 1 from exiting the facility's fire exit door; (2) maintain the exit alarm for the facility's fire exit door of Neuro 3 unit leading to the roof top, in good repair at all times; and (3) provide appropriate physical resources and personnel required to meet the needs of Patient 1, is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and SafetyCode Section 1280.1. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and		050378			10/2	1/2013
Pacifica Hospital of the Valley 9449 San Fernando Rd, Sun Valley, CA 91352-1421 LOS ANGELES COUNTY (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEEOEO BY FULL REGULATORY OR LSC DENTIFYINGINFORMATION) ID PREFIX TAG PROVIDER'S PLANOF CORRECTION (EACH DORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMMETE DATE care to prevent Patient 1 from exiting the facility's fire exit door; (2) maintain the exit alarm for the facility's fire exit door of Neuro 3 unit leading to the roof top, in good repair at all times; and (3) provide appropriate physical resources and personnel required to meet the needs of Patient 1, is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and	NAME OF PROVIDER OR SUPPLIER	STREET ADDRES	S, CITY, STATE Z	IPCODE		
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facility's fire exit door; (2) maintain the exit alarm for the facility's fire exit door of Neuro 3 unit leading to the roof top, in good repair at all times; and (3) provide appropriate physical resources and personnel required to meet the needs of Patient 1, is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and						
Event D:N96211 3/8/2016 3:24:29PM	facility's fire exalarm for the fac unit leading to t times; and (3 resources and needs of Patier caused, or is death to the an immediate Health and Safety This facility faile as described al cause, serious i and therefore jeopardy within	it door; (2) maintain the exit ility's fire exit door of Neuro 3 ne roof top, in good repair at all) provide appropriate physical personnel required to meet the t 1, is a deficiency that has ikely to cause, serious injury or batient, and therefore constitutes eopardy within the meaning of Code Section 1280.1. If to prevent the deficiency(ies) ove that caused, or is likely to njury or death to the patient, constitutes an immediate the meaning of Health and on 1280.3(g).				