CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT VINCENT MEDICAL CENTER	2131 W THIRD STREET, Los Angeles, CA 90057-1901 LOS ANGELES COUNTY

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The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number:
CA00513129 - Substantiated

Representing the Department of Public Health:
Surveyor ID # 1276, HFEN

The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.

Health and Safety Code Section 1280.3(g): 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.

Penalty Number: 930014070

Health and Safety Code Section 1280.3(g) 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.

Health and Safety Code Section 1279.1(b)
(5) Environmental events, including the following:
(D) A patient death associated with a fall while being cared for in a health facility.

Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 6/21/18

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 9

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. 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.

APOC 6/21/18

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responsible for the patient of the adverse event by the time the report is made."

The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.

T22, DIV5, CH1 70213 Nursing Service Policies and Procedures
(a)Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.
(b)Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.

T22, DIV5, CH1 70215 Planning and Implementing Patient Care
(a) A registered nurse shall directly provide:
(1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.
(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of

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validated competency, and/or regulation.
(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.
(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 time of admission.
(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.
(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

T22, DIV5, CH1 70217 Nursing Service Staff
(a)(10)The licensed nurse-to-patient ratio in a telemetry unit shall be 1:5 or fewer at all times. Commencing January 1, 2008, the licensed nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times. "Telemetry unit" is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and

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display of cardiac electrical signals. "Telemetry unit" as defined in these regulations does not include fetal monitoring nor fetal surveillance.

Based on interview and record review, the professional nursing staff failed to implement the hospital's written policy and procedure related to fall prevention along with specific nursing interventions consistent with the plan of care. Additionally, the facility failed to maintain a nurse to patient ratio at one to four at all times on the telemetry unit.

As a result, Patient B was able to elope from the fifth floor-nursing unit, and was found approximately 55 minutes later at the bottom of an interior stairwell in cardiac arrest. Efforts to resuscitate Patient B failed.

Findings:

On 12/6/16, the hospital's administration reported to the California Department of Public Health (CDPH) that an 81-year-old patient (Patient B) was missing from an assigned hospital room on the fifth floor.

The written report indicated Patient B was discovered missing on 12/2/16 at 3:05 AM, and a search for the patient was initiated. Patient B was found at the bottom of a hospital interior stairwell at "approximately 3:54 AM" and was without a pulse. The efforts to resuscitate Patient B failed resulting in the death of Patient B.

The subsequent CDPH investigation began 12/16/16.

Preparation and submission of the Plan of Correction does not constitute an admission of guilt or agreement by St. Vincent Medical Center (the "Hospital") of the veracity of facts or conclusion set forth in the Statement of Deficiencies.

The Hospital is submitting this Plan of Correction as required by state and federal regulations.

This Plan of Correction documents the actions taken by the Hospital to address the alleged deficiencies.

The Plan of Correction constitutes credible evidence of compliance with the cited regulations.

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	Per the medical records, Patient B was admitted to the hospital on 11/30/16 at 4:15 PM. A physician history and physical dated 12/1/16 provided that Patient B had experienced a "suspect acute myocardial infarction" (heart attack). The nursing note documentation on 12/1/16 indicated Patient B was assessed at "Risk for Falls" category by RN 1 at 8 PM, and assigned a point total of 13. The applicable hospital policy and procedure (P&P) titled, "Fall Prevention and Management, Adult Patient" revised 3/2012 was reviewed and provided the following direction to the professional nursing staff on page 2, section 3.b. "Interventions: Patients identified at risk for falls will have bed alarm applied and activated." Per the "Fall Prevention and Management, Adult Patient" P&P, the professional nursing staff assessed patients for fall risk utilizing the Adult Fall Risk Assessment (Attachment A in the P&P), and this consisted of a point system with seven categories. When the cumulative point value exceeded 13 points, patients were considered to be at high risk for falls as stated in the procedure. The categories include: 1. Age 2. Fall history 3. Elimination (bowel/bladder function) 4. Medications		A house-wide effort to improve patient care related to fall prevention has been underway since September of 2016. Charge RNs conducted huddles focused on: Review of the fall policy, documentation, post fall documentation, importance of prompt physician notification, use of SBAR, RRT resources, care plan updates, incident reporting and education/involvement of family. A Fall Prevention Team has been formed and is meeting weekly. The Team was initiated on May 14, 2018. This patient's fall risk status at the time of the initial assessment indicated that he was not at risk for falling. In order to better determine which patients are at greater risk for falls, a new Fall Prevention policy has been developed which utilizes the Morse fall scale in determining at risk status. We are currently educating staff to the new policy which will be approved by the Board on 6/18/18. Each patient will be assessed for fall risk. Specific interventions are triggered by the risk score. All high risk patients (defined as greater than 50 points) will be identified as needing a bed alarm. The Charge RNs are partnering in rounding on every patient. The goal is for the Charge RNs and/or the Director to determine if staff are doing purposeful rounding as required. The interviewers are using AIDET and asking the patient and/or family if their nurses rounded hourly on the previous day Shift and every two hours on the previous night shift.	09.16.2016 06.18.2018

Event ID:GQK011 5/9/2018 10:47:45AM

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	5. Patient care equipment 6. Mobility 7. Cognition The subsequent nursing interventions that were described and documented in the plan of care consisted of using a bed alarm, and making hourly rounds. RN 1 was interviewed on 12/23/16 at 8 AM and confirmed working on 12/1/16 and caring for Patient B during the 12-hour night shift into 12/2/16. RN 1 described the assessment of Patient B completed on 12/1/16, which indicated he was ambulating without any difficulty and using the bathroom without any assistance. Therefore, RN 1 chose to disable the bed alarm, which would have indicated Patient B had gotten out of bed. RN 1 stated the last time she observed Patient B was between 1:30 and 2 AM on 12/2/16 when she helped to "put on oxygen." RN 1 stated she was notified by a coworker that Patient B was no longer sending a telemetry signal and went to investigate at around 3 AM. Telemetry is the use of radio waves, telephone lines, etc., to transmit the readings of measuring devices, such as heart rate and rhythm, so patients can be monitored and recorded remotely. RN 1 stated she had inherited the workload of RN 2 at approximately 2:30 AM, while RN 2 was on a break. RN 1 stated this increased the patient		Noting that the bed alarm was not used for this patient we will be auditing bed alarm usage during Nurse Leader rounding. Plan for monitoring: The Unit's Nurse Leader will review the bed alarm status for ten high risk patients each week. Data collection will continue until three consecutive months demonstrate 90% compliance or greater. Data will be submitted to the Quality Care Committee. Charge RNs will complete and submit rounding tools to the Department Director each day. The Director reviews the data daily and coaches Staff who have not done appropriate rounding. Data collection will continue until three consecutive months demonstrate 90% compliance or greater. Data will be submitted to the Quality of Care Committee. Who will monitor: Nurse Leader and Charge RN's	06.01.2018 05.30.2018

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	assignment to eight patients during RN 2's break period. RN 1 stated she went to the room of Patient B, and discovered his absence then notified a charge nurse - RN 3. Hospital security was notified on 12/2/16 at 3:07 AM, and the documentation in the security report provided a search be initiated by the nursing and security services. RN 3 was interviewed on 12/22/16 at 7:25 AM, and was questioned about sufficient nursing staff on 12/1-2/16. RN 3 stated the nursing staff would "relieve each other" during break periods. RN 4 was interviewed on 12/23/16 at 7:35 AM, and again confirmed the nursing practice of relieving each other for break periods stating that RN 2 "took my patients." RN 2 was interviewed on 12/23/16 at 8:28 AM, and stated he was on break 12/2/16 at "around 3 AM" and "I had asked RN 1 to watch my patients" (4 patients) during the break period. RN 2 stated that after receiving a phone call from the telemetry monitor person indicating Patient B was off the monitor, RN 2 contacted RN 1 and requested to "fix the monitor in that room." During the breaks periods the nursing staff exceeded the nurse to patient ratio of one to four at all times. The process of relieving each other on break time increased the nurse to patient ratio to		The licensed nurse-to-patient ratio on the telemetry unit will be at 1:4 at all times. Every attempt will be made at the beginning of each shift to provide the appropriate number of licensed staff to meet the 1:4 nurse-to-patient ratio on the telemetry unit. In the event we are not at the required ratio, the staffing coordinator/Director/ House Supervisor will make every effort to bring in additional licensed resources such as per diem RN's and RN's from agency sources as well as overtime with the goal of meeting the required ratio. In addition, the department Director may be called upon to provide break relief in emergency staffing situations. Monitoring of staffing levels is done concurrently by the on duty Staffing Coordinator. The Coordinator reviews and reports the licensed staffing levels required and Actual staffing levels to the Staffing Office & Medical-Surgical Directors daily. Specific data to be reviewed and reported is as follows:	

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	one to eight, which is double the RN workload. Patient B was found at the bottom of a hospital interior stairwell at "approximately 3:54 AM" and was without a pulse. Patient B was removed from the stairwell area, transported to the hospital's emergency department, and efforts to resuscitate Patient B failed resulting in the death of Patient B. The Chief Nursing Officer (CNO) and Telemetry Nursing Director were interviewed on 2/23/17 at 12:45 PM. The primary nursing assignment document titled OPTILINK was reviewed with both of the aforementioned individuals. The CNO indicated that there was an absence of a dedicated break nurse or reliever nurse that would ensure the nurse to patient ratio would be at 1:4 at all times. The applicable policy and procedure titled, "Telemetry, Scope of Service" revised 11/2016, was reviewed in conjunction with the aforementioned interviews. The staffing plan indicated the nurse to patient ratio was not to fall below 1 to 4. The medical examiner's report dated 12/15/16, indicated the death of Patient B was a result "blunt force trauma" to include fractures of multiple ribs, cervical and thoracic spinal fractures, bleeding into the lung, and contusion/laceration to the forehead. The report also documented the death was an "accident" resulting from a "Fall to floor near stairwell."		Any variance of licensed staff to the Department staffing matrix. Variance is described as any difference in actual vs required licensed staff. Any action steps taken to correct a negative Variance of licensed staff (required to actual) and the communication of such actions to the Telemetry Director/Administrative House Supervisor. Staffing and variances are reviewed unit by unit each morning at the Daily Safety Huddle. The Chief Nursing Officer (CNO) attends the huddle such that daily report of all negative variance is then available to her. Monitoring Auditing includes all negative variances and review of all action steps taken to mitigate the variances. Findings will be summarized weekly by the CNO and discussed with Telemetry Director weekly for a period of three months then quarterly thereafter. Results and actions plans will be reported monthly to the Quality of Care Committee. Responsible individual: Chief Nursing Officer Monitoring began on 1/1/17	01.01.2017

Event ID:GQK011 5/9/2018 10:47:45AM

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	050602	A. BUILDING B. WING	05/01/2017

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	The medical examiner also concluded some of the aforementioned injuries are consistent with resuscitation efforts during CPR. The facility's noncompliance with these requirements 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 1280.3. 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 Safety Code Section 1280.3(g).			