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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050704	A. BUILDING _____ B. WING _____	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Community Hospital	14850 Roscoe Blvd, Panorama City, CA 91402-4618 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: CA00387972, CA00474816 - Substantiated Representing the Department of Public Health: Surveyor ID # 19582, 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. Welfare and Institutions Code 5325.1 Persons with mental illness have the same legal rights and responsibilities guaranteed all other persons by the Federal Constitution and laws and the Constitution and laws of the State of California, unless specifically limited by federal or State law or regulations. No otherwise qualified person by reason of having been involuntarily detained for evaluation or treatment under provisions of this part of having been admitted as a voluntary patient to any health facility, as defined in Section 1250 of the Health and Safety Code, in which psychiatric evaluation or treatment is offered shall be excluded from participation.		**Welfare and Institutions Code 5325.1** **How the correction will be accomplished, both temporarily and permanently.** The policy and procedure on Patients' Rights was reviewed with Director of BHU, Director of Risk Management and Administrator. At the time of new admission patients are provided with an admitting package. The admitting package includes a handbook from California Department of Mental Health and MCH handouts. This process brings about awareness and educates the behavior health patients about legal rights, including right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect; and that Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program. Furthermore, the manual by California Department of Mental health is provided to all BHU patients and it covers the following topics: Patient rights, access to patient's rights advocate, What to do if you have a compliant, Rights while you are involuntary detained, Confidentiality, Medical Treatment, Capacity hearing for medications, Rights that cannot be denied and Rights that may be denies with Good Cause. Facility handouts cover the following topics: provides the patient with the information that this facility's first priority is patient's physical and emotional safety and they should speak-up anytime the patient has any concerns.	01/18/2017

Event ID:FDMQ11 1/4/2017 12:45:58PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director PE/RISK — (X8) DATE: 01/30/17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 15

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 60 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.

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	It is the intent of the legislature that persons with mental illness shall have rights including, but not limited to, the following: (c) A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program. Health and Safety Code 1180.4 b) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. (c) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 may not use either of the following: (1)A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back. (2) A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process.		The Manager of Behavioral Health Unit ("BHU") has provided education to both the nursing and mental health workers at the time of new admissions, to ensure the following steps has been taken to provide the patient with an admitting package. **The title or position of the person responsible for the correction.** The Director and Manager of BHU. **A Description of the monitoring process to prevent recurrence of the Deficiency.** The Director and Manager of BHU will conduct weekly retrospective medical record documentation audits on randomly selected BHU patients to ascertain which patients have not received the admitting package. The audit findings/results will be forwarded to the PI/Quality department for analysis and corrective action as indicated. Staff re-education will be done immediately if any deficiencies are identified during the medical record audit process. The PI workgroup subcommittee of the Quality Assurance Performance Improvement Committee will review both the data and the audits on a quarterly basis to ensure compliance. The Director of BHU and the Manager of BHU is ultimately responsible for this process for corrective action plan and ongoing compliance. **The date the immediate correction of the deficiency will be accomplished.** The Director of BHU and the Manager of BHU will initiate the process of weekly retrospective medical record audit to ascertain if patients have received the admitting package at the time of admission. The process will be initiated 02/01/2017.	01/18/2017

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	(d) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 may not use physical or mechanical restraint or containment on a person who has a known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition. (f) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as deescalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person. (g) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 may not place a person in a facedown position with the person's hands held or restrained behind the person's back. (i) A facility described in subdivision (a) of Section 1180.2 or subdivision (a) of Section 1180.3 shall keep under constant, face-to-face human observation a person who is in seclusion and in any type of behavioral restraint at the same time. Observation by means of video camera may be utilized only in facilities that are already permitted to use video monitoring under federal regulations specific to that facility. (j) A facility described in subdivision (a) of Section		**Health and Safety Code 1180.4 (b)** **How the correction will be accomplished, both temporarily and permanently.** The policy and procedure on Restraint and Seclusion was reviewed with Director of BHU, Director of Risk Management and Administrator (Chief Nursing officer). It is the policy of this facility to protect patients from harm's way by both decreasing the use of restraint/seclusion. The restraints are only used for the safety of the patient and if other means have failed. The use of restraint is used as a last resort after alternative interventions have either been considered or attempted. The decision to use restraint/seclusion is not driven by diagnosis, but by a comprehensive individual assessment. Restraints and seclusion are only used if needed to improve the patient's well-being and if less restrictive interventions have been determined to be ineffective in protecting the patient(s) from harm. In a clear case of emergency a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order is obtained thereafter. If a verbal order is obtained it is recorded in the patient's medical record and signed by the physician by his next visit. Either a Licensed Independent Practitioner (Physician or Nurse Practitioner, or Physician Assistant) or a Qualified RN may complete face-to-face assessment. If any of these is not the ordering physician they will communicate with the ordering physician their assessment findings and recommendations as early as possible. The Director of BHU re-educated the BHU staff regarding this policy and provided information to the medical staff.	01/18/17

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	1180.2 or subdivision (a) of Section 1180.3 shall afford to persons who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others, and shall use the least number of restraint points. Title 22 DIV5 CH1 ART6 - 70577 Psychiatric Unit General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. (j) Restraint of patients. (1) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury. (2) Patients shall be placed in restraint only on the written order of the physician. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician on his next visit. (3) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes. (4) Restraint shall be easily removable in the event		**The title or position of the person responsible for the correction** The Director and Manager of BHU **A description of the monitoring process to prevent recurrence of the deficiency.** The Director of BHU and Manager of BHU will conduct ongoing audits and data collection on the patients that were restrained. The data will be collected for the reason(s) for restraint use. The data will be aggregated and analyzed to ascertain patterns, trends, or cluster of restraint use are evident. From data analysis, the process will be evaluated for opportunities to reduce the use of restraint(s) and/or redesign the care process. This data will be submitted to PI Council meetings for further recommendations from the committee. **The date the immediate correction of the deficiency will be completed.** The Director of BHU and the Manager of BHU will continue with the existing process of reviewing documentation on restraints retrospectively from the medical records. It is an on-going process; the data is reported to PI Council Meeting. **Health and Safety Code 1180.4 (c),(d),(f) ,(g), (i) and (j)** **How the correction will be accomplished, both temporarily and permanently.** The Director of BHU, Manager of BHU, Administration (Chief Nursing Officer) and Director of Risk Management reviewed the Restraint and Seclusion policy and the following additions will be made to the facility's existing comprehensive restraint and seclusion policy. The BHU staff may not use either of the following:	01/18/17

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	of or other emergency. (5) Record of type of restraint including time of application and removal shall be in the patient's medical record. Title 22 DIV5 CH1 ART6-70577(j)(2) Psychiatric Unit General Requirements (2) Patients shall be placed in restraint only on the written order of the physician. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician on his next visit. Based on record reviews and interviews, the facility failed to implement its policies and procedure titled, "Patient Status/ Precaution Levels - BHU", " Restraint & Seclusion," and "Combative/Assault Patient Behavior." On February 9, 2014, Patient 1 exhibited assaultive and aggressive behavior (resisting, spitting and hitting others). CNA 1, who was providing one-to-one supervision, restrained Patient 1 by placing Patient 1 on her stomach in bed with her face down for about 10 minutes. This position caused Patient 1 to stop breathing, subsequently became ventilator dependent (not able to breath on her own) and in a persistent vegetative state (severe brain damage). Findings:		(1) A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back. (2) A pillow, blanket or other item covering the person's face as part of a physical or mechanical restraint or containment process (3) Facility may not use physical or mechanical restraint or containment on a person who has a known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition. (4) Facility shall avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as de-escalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any sign of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person. (5) A facility may not place a person in a facedown position with the person's hands held or restrained behind the person's back. (6) A facility shall keep under constant face-to-face human observation a person who is in seclusion and in any type of behavioral restraint at the same time. The Director of BHU and the Manager of BHU created BHU-specific insert for registry orientation packet, including policies: 1) Combative/Assault Patient Behavior 2) Observation Strategy, Behavioral Health 3) Patient Status/Precaution Levels-BHU 4) Safety in BHU 5) Patients' Rights.	01/18/17 02/18/2014

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	A review of a facility letter dated February 14, 2014, submitted to the Department, indicated on February 9, 2014, while conducting patient observations in the Behavioral Health Unit [BHU], CNA 1 became aware that Patient 1 was not breathing and immediately called for assistance. Rapid Response Team [RRT] was paged and then a Code Blue. The letter indicated the patient [Patient 1] was stabilized and transferred to the Intensive Care Unit [ICU] of the hospital. A review of Patient 1's medical record disclosed Patient 1 was admitted to the facility's BHU on February 3, 2014. The Admission Orders dated February 3, 2014, indicated Patient 1's legal status was "5150" (California Welfare and Institution Code section 5150 approved for 72 hour detention for psychiatric evaluation and treatment) with precaution level two - checks every 15 minutes. The "Nursing Notes" dated February 8, 2014 at 7:55 p.m., indicated the "patient [Patient 1] in hallway, wandering in and out of peers room and following male peers in hallway, attempting to touch, hug, kiss. Requiring almost constant redirection." The nursing notes further indicated the physician observed the patient's [Patient 1] behavior. Patient 1's physician order, dated February 8, 2014, indicated to place Patient 1 on 1:1 observation [precaution level 4] for her own safety. There was no physician order for the use of physical restraint. A review of Patient 1's "Daily Focus Assessment		Mandatory BHU Staff meeting was held and discussed the inserts, instructed the staff that they need to inform registry of process when patient escalates. The BHU staff educated that they are responsible to educate and giving limits to registry staff and that registry staff are informed that they should not be restraining patients; instead they need to call for help. A mandatory BHU Staff meeting was held to discuss that rounds must be done as ordered in timeframes, at scheduled times and with accurate documentation. Initiated house-wide MAB program for consistency, with BHU staff taking advanced course with practice in approved restraint techniques. BHU Staff was educated at Annual skills fair for the following verified skills: 1) Proper application 2) Circulation Checks 3) Criteria for admission/release 4) Proper monitoring requirements and time frames. 5) Understanding of face-to-face process and form(RN's) The Director of BHU, Manager of BHU, Administrator (Chief Nursing Officer) and Director of Risk Management reviewed policy for Patient Status/Precaution Levels and the following addition was made to the existing comprehensive policy. 1) Assigned staff will be same sex as patient whenever possible. 2) Bedroom door to remain open whenever possible. If not possible charge nurse to be made aware for approval.	02/18/2014 03/19/2014

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	Report" dated February 8, 2014 at 11:35 p.m., indicated the following: " Psychiatric focus, altered thought focus, danger to self, danger to others, imminent danger to self/others and self care deficit. Group Note: patient was wandering the unit, frequently following male peers and male staff, and attempting to touch, hug, kiss, etc. Was given IM [intramuscular injection] (Zyprexa 10 mg [anti-psychotic], Ativan 2 mg [antianxiety], and Benadryl 50 mg [antihistamine] for agitated, violent, out of control behavior - not effective). Requires almost constant redirection. Actions: provide 1:1 observation (Initiate CP[care plan]), provide reality orientation, offered medication, medication given, active listening 1:1 time, emotional support given, set boundaries. Response: no change at this time. Evaluation: continue to monitor for safety, needs constant redirection, continue with treatment care plan. " A review of Patient 1's "1:1 Observation Q [every] 15 Minutes" record dated February 9, 2014, from 8:30 p.m. to 11:30 p.m. indicated CNA 1 documented Patient 1 was sleeping . The "Nursing Notes" dated February 9, 2014 at 10:10 p.m., indicated Patient 1 was "witness[ed] to be lying on her stomach in bed talking then became silent, when checked by 1:1 staff [CNA1], [Patient 1] was found not to be breathing and code blue called." Another "Nursing Notes" dated February 9, 2014 at 10:10 p.m. indicated at 9:34 p.m., rapid response was called, at 9:36 p.m., no pulse, code blue called.		**The title or position of the person responsible for the correction.** The Director and Manager of BHU. **A description of the monitoring process to prevent recurrence of the deficiency.** The Director of BHU, The Manager of BHU, Administrator (Chief Nursing Officer), and Director of Risk Management will meet to review any new incident that may have affected the patient and the needs of the patient(s) affected by the deficient practice. The Director of BHU and the Manager of BHU will ensure that the following steps have been taken depending upon the needs of the patient. 1) Review medical record documentation 2) Disclosure to the patient or patient representative This will be reported monthly and/or quarterly to Patient Safety Meeting, and Performance Improvement Council Meeting. **The date the immediate correction of the deficiency will be accomplished.** The Director of BHU completed the registry orientation packet completed on first visit and yearly thereafter. Nursing office is responsible for ensuring completion, unit clinical staff responsible for actual orientation. This process was completed in the month of February 2014. Three programs widely utilized in psychiatry facilities were evaluated between November 2014 and August 2015. MABPRO program was chosen for BHU since it meets the needs of our organization. The utilization of this program was approved in the month in the month of August/September 2015.	01/18/2017 02/18/2014 11/2014 08/14/2014

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	A review of the "Code Blue Record" dated February 9, 2014 at 9:36 p.m., indicated Patient 1 was unresponsive at the time of code, no palpable pulse, no spontaneous respiration, and no blood pressure. The chest compression was started at 9:36 p.m. and intubated (placement of a tube into the trachea (windpipe) to maintain an open airway) at 9:40 p.m. The code was terminated at 9:50 p.m. and Patient 1 was transported to the Intensive Care Unit (ICU). A review of the "24 Hour Critical Care Record" dated February 9, 2014, indicated Patient 1 was admitted to the Intensive Care Unit (ICU) at 10:15 p.m. Patient 1 was on a mechanical ventilator. The "BHU Discharge Summary" dictated by MD 1 on February 10, 2014 for discharge date of February 9, 2014 indicated Patient 1 came in with a "severe manic phase." The note indicated, Patient 1 continued to act out and was put on "one-to-one supervision to stop acting out." Patient 1 was "hypersexual" and on February 9, 2014, Patient 1 was "still intrusive, provoking others, throwing objects, destroying properties and fighting with staff." The discharge summary indicated MD 1 spoke with the "cardiologist, who did not see any cardiac (heart) issues or cardiac problem, and the question was why she (Patient 1) coded." A review of Patient 1's "ICU Record" indicated Patient 1 was admitted to ICU due to status post cardiopulmonary arrest (failure of heart and lung). The history and physical dated February 9, 2014 indicated sudden onset of unresponsiveness. The		The policy for patient Status/Precaution Levels was revised in the month of March of 2014. On-going education is provided to BHU Staff annually at skills fair. **Title 22 DIV5 CH 1 ART6-70577** **How the correction will be accomplished, both temporarily and permanently.** The policy and procedure on Restraint and Seclusion was reviewed with Director of BHU, Director of Risk Management and Administrator (Chief Nursing officer).) It is the policy of this facility to protect patients from harm's way by both decreasing the use of restraint/seclusion. The restraints are only used for the safety of the patient and if other means have failed. The use of restraint is used as a last resort after alternative interventions have either been considered or attempted. The decision to use restraint/seclusion is not driven by diagnosis, but by a comprehensive individual assessment. Restraints and seclusion are only used if needed to improve the patient's well-being and if less restrictive interventions have been determined to be effective in protecting the patient(s) from harm. The patients in behavioral restraints and seclusion are continuous observed face to face every 15 minutes. The attending or covering physician providers order for the use of restraint/seclusion. In a clear case of emergency a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order is obtained thereafter. If a verbal order is obtained it is recorded in the patient's medical record and signed by the physician by his next visit. The physician conducts a face to face assessment of the patient even if the restraint has been removed or to evaluate the continued need for restraint.	01/18/2017

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	cardiology consult dated February 10, 2014 indicated no history of diabetes, no history of hypertension, no history of MI (myocardial infarction [heart attack]). The consult was for evaluation of anoxic encephalopathy (brain injury caused by lack of oxygen to the brain), no other medical problem. The diagnostic impression of the cardiogologist (heart specialist) was anoxic encephalopathy status post arrest. There were three electroencephalograms (EEG) recording electrical activity of her brain performed: (1) February 10, 2014 indicated anoxic damage; (2) February 27, 2014, indicated an abnormal EEG, because of near flat line, which could be constituted as brain death; and (3) March 25, 2014, indicated "encephalopathy in the patient's case anoxic type." On August 6, 2014, Patient 1 was discharged from the ICU to a subacute care facility, unresponsive, on ventilator with tracheostomy (surgically created opening into the trachea [air passage] for the purpose of breathing and removal of lung secretions). A review of Patient 1's Minimum Data Set (MDS is a Resident Assessment and Care Screening) from the subacute unit dated July 17, 2015, indicated Patient 1 was in a "persistent vegetative state/no discernible consciousness." Several attempts were made to personally interview CNA1, however all attempts were unsuccessful. Yet, on August 2, 2016, the Department received an e-mail from CNA 1, dated February 10, 2016.		The Director of BHU and/or Chief Nursing Officer will review this policy at the Medical Staff meeting(s), more specifically at the Department of Psychiatry. Then this policy will be reviewed at Medical Executive Committee and Board of Directors for their approval. **The title or position of the person responsible for the correction.** The Director of BHU and The Manager of BHU. **A description of the monitoring process to prevent recurrence of the deficiency.** The Director of BHU and Manager of BHU will continue ongoing audits and data collection on the following metrics: the number of restraints, number of seclusions, number of physical holds. All restraints and paperwork and documentation is audited for completeness and accuracy. The data will be aggregated and analyzed to ascertain patterns, trends, or cluster of restraint use are evident. From data analysis, the process will be evaluated for opportunities to reduce the use of restraint(s) and/or redesign the care process. This data will be submitted to PI Council meetings monthly for further recommendations from the committee. **The date the immediate correction of the deficiency will be accomplished.** The Director of BHU and the Manager of BHU will continue with the process of review documentation on restraints retrospectively from the medical records.	01/18/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The email was sent from CNA 1 to the agency that employed CNA 1. The email indicated that on February 9, 2014 at approximately 9:30 p.m., CNA 1 was assigned to Patient 1. At that time, Patient 1, went to group smoke break and was alert and vocal throughout said break. She was returned to her room around 9:35 p.m., where CNA 1 sat with her for 1 to 1. CNA 1 stated "at 9:40 a female staff member entered the room; I assume on rounds or checkup. The patient got up and ran to Bed B of the room and stripped her pants off. She was temporarily restrained as redressed then put back in her own bed, where she became combative and spat. She was placed face down with nearest wrist to myself placed just above her butt to prevent harm and spit. Female staff left room and I was left with patient who was still being vocal and energetic. I let go of patient and sat next to her bed while she continued to lay face down and talk to herself and scribble patterns on mattress with her hand. Around 9:55 the patient had gone quiet and I assumed asleep. At around 9:57 she was still quiet but was not moving, at which point I called out to her verbally and got no response. I shook her shoulder and saw she was non responsive. I then turned her over and saw she was pale and turning blue at which point I called for assistance. She had a small pool of clear fluid on the sheet where her face had been in contact with it and she had wet herself. At around 10 the rapid response unit was on scene and she was resuscitated and admitted to ICU at around 10:15 p.m., where she was to my knowledge in relatively stable condition." During an interview on August 27, 2015 at 10:15		**Title 22 Div5 CH1 ART6-70577(j)(2)** **How the correction will be accomplished, both temporarily and permanently.** The policy and procedure on Restraint and Seclusion was reviewed with Director of BHU, Director of Risk Management and Administrator (Chief Nursing officer). It is the policy of this facility that the attending or covering physician provides the order for the use of restraint/seclusion. In a clear case of emergency a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order is obtained thereafter. If a verbal order is obtained it is recorded in the patient's medical record and signed by the physician by his next visit. . Either a Licensed Independent Practitioner (Physician or Nurse Practitioner, or Physician Assistant) or a Qualified RN may complete face-to-face assessment. If any of these is not the ordering physician they will communicate with the ordering physician their assessment findings and recommendations as early as possible The BHU staff was re-educated regarding the policy and the information was provided to Department of Psychiatry that after giving verbal orders for restraints the orders should be signed as soon as possible or during his or her next visit. **The title or position of the person responsible for the correction.** The Director and Manager of BHU. **A description of the monitoring process to prevent recurrence of the deficiency.** The Director of BHU and Manager of BHU will conduct ongoing audits and data collection on the patients that were restrained. The Director of BHU and Manager of BHU will continue ongoing audits and data collection on the following metrics: the number of restraints, number of seclusions, number of physical holds completeness and accuracy	01/18/2017

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	050704	A. BUILDING _____ B. WING _____	08/02/2016

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	a.m., the director of performance improvement and risk management (Admin 2) stated she had a telephone interview with CNA 1. CNA 1 stated he started a 1:1 supervision with Patient 1 on February 9, 2014 at 8 p.m. At 9:30 p.m., he [CNA1] took her [Patient 1] outside for a smoke. From 9:30 to 9:45 p.m., Patient 1 was resistive, combative and removing her pants. CNA1 said he requested for help and a female nurse (RN1) came to help. CNA1 said Patient 1 continued to be resisting, hitting, and spitting. He turned her around, face down on her bed, put one arm behind her back and the other arm was free. The patient was "talking, continuously talking." He held her in this position for approximately 10 minutes. Patient 1 stopped talking. One minute after Patient 1 stopped talking, he [CNA1] touched her [Patient 1] shoulder and turned her over. Patient 1 was blue, a cigarette butt stuck to her lower lip. CNA1 called for help. When asked about placing patient's face down on the bed, Admin 2 stated, "He [CNA1] said it." When asked if placing patient's face down on the bed was acceptable, Admin 2 stated, placing a patient face down on the bed was not interventions that were being taught "and this was not acceptable." When Admin 2 was asked who came to help CNA 1, Admin 2 stated RN 1. On August 27, 2015, between 10:30 a.m. and 11 a.m., an interview was conducted with Admin 1 [Associate Director of Behavioral Unit] and Admin 2. Admin 2 stated she interviewed RN 1. RN 1 said she went to the room, and helped CNA1 to put Patient 1's pants on. Admin 1 stated on the second		All restraints and paperwork and documentation are audited for completeness and accuracy. The data will be aggregated and analyzed to ascertain patterns, trends, or cluster of restraint use are evident. From data analysis, the process will be evaluated for opportunities to reduce the use of restraint(s) and/or redesign the care process. This data will be submitted to PI Council meetings monthly for further recommendations from the committee. **The date the immediate correction of the deficiency will be accomplished.** The Director of BHU and the Manager of BHU will continue with on-going process of review documentation on restraints retrospectively from the medical records.	01/18/2017

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	interview that RN 1 stated that she found the one to one sitter situation unusual. The practice was to assign the same gender between the patient and the sitter. RN 1 stated the door was closed prior to the code blue. When Admin 1 was asked if closing the door was acceptable, Admin 1 stated, "Not a standard of practice." Admin 1 stated the room was in front of the nurses' station. Admin 1 stated RN 1 was suspended, put on leave of absence and resigned. When asked about the charge nurse [RN 2], Admin 1 stated he was on leave of absence and terminated. When asked about Patient 1's roommate [Patient 2], Admin 2 stated Patient 2 was interviewed and, Patient 2 was emotional and tearful. Patient 2 stated Patient 1 was face down on her bed, arm held behind her back by CNA 1. Patient 2 stated CNA 1 sat on Patient 1 and when CNA 1 got up, Patient 1 was not moving and looked dead. CNA1 called for help and people came to the room. Admin 2 stated Patient 2 was interviewed three times and she was consistent with her story. Admin 1 stated Patient 2 was "high functioning." When asked about one to one supervision, Admin 1 stated a staff was constantly with the patient, within arm's length, and documented every 15 minutes. When asked about CNA 1's documentation indicating the patient was asleep on every 15 minute entry from 9:30 p.m. to 11:30 p.m. on February 9, 2015, [the time of admission to the			

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	ICU at 10:15 p.m.], Admin 1 acknowledged and stated it was noted during the investigation. When asked about placing patient face down on the bed, Admin 1 stated, placing a patient face down on the bed was not one of the interventions that was being taught. During an interview on August 27, 2015 at 11:25 a.m., Patient 1's attending physician (MD 1) stated this was a "routine admission" and the question was why she [Patient 1] "coded." There were no cardiac problems. MD 1 stated, "He (CNA 1) sat on her (Patient 1). [causing] Lack of oxygen to the brain." CNA 1 received certification for nurse assistant with an expiration date of December 17, 2015. CNA 1 is male 6 feet 5 inches tall and weighs 350 pounds. CNA 1 was employed by a registry agency. CNA 1 had a Professional Assault Crisis Training (Pro-ACT) Restraint Certification dated June 26, 2013 from another facility. According to facility documents, RN 1 was hired on July 1, 2013 as a per diem nurse at the BHU. RN 1 had training for management of assaultive behavior. RN 1 resigned on April 4, 2014. Facility documents indicated RN 2 was hired on April 1, 2003. RN 2 had a training for management of assaulted behavior. RN 2 was terminated on April 14, 2014. The facility policy and procedure titled, "Patient Status/ Precaution Levels - BHU" dated last			

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	reviewed July 2011, indicated the purpose was, "To assure that all patients admitted to the Behavioral Health Unit are assessed and monitored to guarantee that their needs for safety and security are met." There were 4 levels of observation: Levels 1 - minimal danger of harm to self and others; Level 2 - moderate danger of harm to self and others; Level 3 - severe danger of harm to self and others; and Level 4 - imminent danger of harm to self and others. The nursing action for Level 4 included precautions with 1:1, requires physician order and within arm's length of staff at all times. There was no indication that a restraint can be used at any observation level. The facility policy and procedure titled, "Restraint & Seclusion" dated July 2012, indicated the use of restraint/seclusion is the last resort, after alternative interventions have either been considered or attempted. Restraint and seclusion in the BHU setting requires additional standards that address staffing, specific training, additional initial assessment components, documentation, and leadership notification criteria. Restraint and seclusion may only be used if needed to improve the patient's well- being and if less restrictive interventions have been determined to be ineffective in protecting the patient. The use of a restraint has the potential to produce serious consequences such as physical and psychological harm, and even death. The facility policy and procedure titled, "Combative /Assault Patient Behavior" reviewed February 2014 and December 2014, stipulated it was the policy of			

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	the hospital to maintain a safe environment for all patients and staff to utilize the least restrictive means of intervention in order to manage combative/assaultive patients. Patient 1 ' s right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect was violated when the facility failed to implement its policies and procedures titled, "Patient Status/Precaution Levels - BHU, Restraint & Seclusion and Combative/Assault Patient Behavior." 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).			