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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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 following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00479941 - Substantiated Representing the Department of Public Health: Surveyor ID # 2623, HFE-N 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. Health and Safety Code Section 1280.3(a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a		**E 000 Initial Comments** Preparation and execution of this plan of correction does not constitute an admission of or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal/state law.	

accepted plan of correction
Bhuvan Ahuja 3/27/18

Event ID:NX9811 [illegible] 1:35:33PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 3/23/18

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 7

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. Informed Adverse Event Notification Health and Safety Code Section 1279.1 (c). "The facility shall inform the patient or the party 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. Health and Safety Code Section 1279.1(a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Health and Safety Code Section1279.1 (b) For purposes of this section, "adverse event" includes any of the following:		**Health and Safety Code Section 1279.1 (c)(a)(b)(f)(3)** The hospital under the direction of the Chief Executive Officer (CEO) directs and oversees the reporting of adverse events. The CEO in conjunction with the Regulatory Coordinator ensures adverse events that are ongoing, urgent or emergent are reported within 24 hours. This includes attempted suicides. The CEO has provided direction to all levels of leadership on how to appropriately report any adverse events that occur. In addition, the CEO meets at least bi-monthly with the Regulatory Coordinator to review reported events and ensure timeliness in reporting.	

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	1279.1 (3) Patient protection events, including the following: (C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility. California Code of Regulations Title 22. Division 5. Chapter 2. Article 7, 70213(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. 70215(a) (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 record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (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.		**Title 22 California Code of Regulations Division 5 Chapter 2, Article 7, Section 70213 (a) & 70215 (a)(1)** The Chief Nursing Officer (CNO) provides oversight of written policy and procedures pertaining to patient care and ensures compliance with Title 22 Codes and Regulations. Nursing leadership is responsible for ensuring patient assessments are completed per shift, and documented in the patients record in compliance with the Business and Professions Code. Nurse(s) will create a care plan upon admission and update as patient condition changes. Nursing care plans will provide a comprehensive patient overview.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	(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. 70415 (e) There shall be sufficient other licensed nurses and skilled personnel as required to support the services offered. The facility failed to ensure Nurse 1 documented an initial assessment of Patient 1 in the medical record that could be seen by the emergency department nurses. This is the assessment to be provided to the nurse assuming care of Patient 1 when the patient transferred from an unlicensed part of the psychiatric unit of the hospital to the emergency department (ED). The facility failed to ensure there were sufficient skilled personnel in order to keep Patient 1 safe in the ED. The facility failed to ensure the registered nurses developed a plan and intervention to keep the patient safe. These failures resulted in the lack of communication of Patient 1's suicide wish to ED staff, and therefore adequate protection was not provided by skilled staff to keep Patient 1 safe. These failures resulted in Patient 1 eloping from the ED and being hit by a car in a suicide attempt. This suicide attempt resulted in major trauma to Patient 1 as she required emergency life sustaining measures and surgery that left her with pain and a serious disability that required an extended hospitalization and long term care.		**Title 22 California Code of Regulations Division 5 Chapter 2, Article 7, Section 70415 (e) Staffing** The Hospital's CNO and Associate Hospital Chief Nursing Officer (ACNO), are responsible for the oversight and staffing of nursing and safety attendants as necessary to provide appropriate patient care. **Immediate Actions Taken:** Upon receipt of this Statement of Deficiencies, the CEO, Chief Medical Officer (CMO), CNO, ACNO, Inpatient Psychiatric Unit Medical Director, Inpatient Psychiatric Unit Operations Manager, and the Regulatory Coordinator met to review the findings. Leadership was presented with the completion dates for each finding listed in this Statement of Deficiencies.	2/26/18

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	Finding:		**Finding #1:** The CEO met with the CMO, CNO, ACNO, Inpatient Psychiatric Unit Medical Director, IPU Operations Manager, the ED Nurse Manager and the Regulatory Coordinator to review Hospital Policy 100.071 (Patient Elopement). The policy was found to be complete and comprehensive and no changes were required at this time.	3/11/16
Finding #1	On 3/11/16 at 3:50 p.m., interviews and record reviews were conducted with the medical director and administrator to investigate their report that Patient 1 eloped from the ED, lay down in the street, and was hit by a car. The medical director indicated that there was a witness to Patient 1's purposeful suicide attempt. Further interview revealed that Patient 1 was then readmitted to the ED for major trauma, had emergency surgery and was admitted to the intensive care unit. The medical director also indicated it was a hit and run accident.			
Finding #1b	Based upon an interview and concurrent record review with Nurse 1 on 3/29/16 at 8:40 a.m., it was revealed that Patient 1 was brought into an unlicensed part of the psychiatric unit of the hospital by a police officer on 3/9/16 after she had been a victim of abuse and had expressed a wish to die.		1b. Hospital Leadership, including, but not limited to, the CEO, CHO, CMO and the Health Care Agency Director, held further discussions regarding the transport of ED psychiatric patients to the Assessment and Referral Unit (A&R). The CEO discussed the option of closing the A&R Unit, placing 13 inpatient psychiatric beds in suspension and creating a Out Patient Psychiatric Observation Service (OPOS). OPOS would provide care for psychiatric patients pending disposition (e.g., admission to the IPU). The CEO discussed this option with the state licensing agency and formally requested a program flex	
Finding #2	Further interview and concurrent record review of Nurse 1's documentation revealed that he was not able to complete a medical screening examination (MSE) as required by policy, or assess Patient 1 for suicide risk because the patient was holding her head, screaming, moaning, and writhing on the floor in pain. Nurse 1 said that Patient 1 needed to go to the ED for a medical assessment and that he gave a full report to the charge nurse (nurse 2). Nurse 1 said he felt it was safe to have a security guard walk Patient 1 to the ED admitting window.			
Finding #3	Interview and concurrent record review with Nurse 3 on 3/29/16 at 8:10 a.m., revealed that he was the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
Finding #3 Continued	first to evaluate Patient 1 when she came to the ED triage desk complaining of a severe headache. Nurse 3 said that he did not receive a verbal or written assessment of Patient 1 and did not have any information of her suicidal thoughts. Nurse 3 also said that he did not screen Patient 1 for suicide risk because that is not done in triage. Nurse 3 said he escorted Patient 1 into the ED because she was yelling loudly in pain in the lobby Interview with Nurse 2 on 3/29/16 at 8:20 a.m., revealed that she did not get report of Patient 1's suicidal thoughts and felt she was coming to the ED for medical clearance due to pain. Nurse 2 indicated that there was no written documentation of Nurse 1's assessment. Nurse 2 also said that if she had known about the patient's suicide wish she would have had security staff sit with Patient 1 in the ED to protect her. Nurse 2 explained that in the ED the presence of police and security staff act as calming measures for suicidal patients.		for the OPOS. The A&R Unit was closed concurrent with the opening of the OPOS. Psychiatric patients who do not meet immediate criteria for admission to the Inpatient Psychiatric Unit, but continue to be a danger to self or others and whose psychiatric condition remains unsafe for disposition will be assessed and treated in the OPOS. The OPOS is located in a separate wing of the Inpatient Psychiatric Unit. A psychiatrist is available on site 16 hours per day and maintains clinical oversight of the patients assigned to the OPOS. The OPOS is staffed at a 1:4 nurse to patient ratio, with additional staffing support as deemed necessary by the Nurse Manager. There will be an additional nurse (out of ratio) to serve as a resource person and who assist with, among other things, escorting the psychiatric patient(s) to and from the ED.	1/16/17
Finding #4	Further interview with Nurse 2 revealed that during the time Patient 1 was in the ED she was in pain and was distressed. Nurse 2 said that Patient 1 was placed in the hallway area where a police officer and security guard could monitor her safety and were a deterrent for patient elopement, but that they were called out of the ED and were not available to deter Patient 1 when she eloped from the ED. Review of Patient 1's medical record on 4/12/16 at 3:00 p.m., revealed that Patient 1 left the ED at 10:52, and returned by ambulance at 11:14 after		A specially trained elite security guard is stationed in the ED, 24 hours, 7 days a week to provide support with patient who are at risk for elopement.	1/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	being hit by a motor vehicle. Review of the ED physician note revealed that on admit Patient 1 had a large scalp laceration, large bruises of her chest and abdomen, an unstable pelvis, deformities of her left upper arm and shoulder, right shoulder, wrist, foot and ankle, and left hip and knee. The physician also documented Patient 1 required blood transfusions for shock, and a breathing tube to keep her oxygenated. Interview with Patient 1 on 4/15/16 at 11:00 a.m., revealed that her biggest problem is pain and she has to wait in pain for her scheduled pain medication which is very difficult. She indicated that she has many problems due to the accident and is not improving very quickly. Patient 1 also indicated that she cannot get up or turn and will need long term care. Patient 1 was observed lying in bed, propped with special devices to hold her extremities in place, and was on suicide precautions. Review on 4/15/16 of the trauma progress note dated 4/14/16 revealed that due to the motor vehicle accident Patient 1 sustained injuries including, a liver laceration, left arm fracture, right shoulder and ankle dislocations, sacral fractures, multiple, bilateral pelvic fractures, arterial blood clots, six rib fractures, venous blood clots, fevers, chronic pain, pancreatitis, left hip dislocation, multiple abrasions and wounds. Record review and interview with administrative staff on 6/16/16 at 12:00 p.m., revealed that Patient 1 was transferred to a skilled nursing facility on 5/13/16. The discharge report revealed that Patient 1		**Complaince and Monitoring:** The CNO provides oversight of written policies and procedures pertaining to patient care and ensures compliance with Title 22 regulations. In addition, the CNO ensures compliance with policy guidelines set forth by the hospital's accrediting agency. The CNO and her designee performed weekly audits on the transport of psychiatric patients to and from the ED , OPOS and IPU. The goal of 100% compliance with safe transport of psychiatric patients was met. Data was tracked, trended and analyzed. Data was reported monthly to the Performance Improvement Committee, the Medical Executive Committee, and every other month to the governing body. The governing body (known as the Oversight Committee) has full responsibility for determining, implementing, and monitoring the facility's total operations and compliance with hospital's policies and procedures. The data of patient transports was provided to the licensing agency as part of the Program Flex.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	cannot weight bear, requires physical and occupation therapy, can be up in a chair daily, and requires pain medication. Review on 1/30/18 of facility policy titled "SUICIDE ASSESSMENT AND PRECAUTIONS" last revised 8/15 revealed that patients being treated for a complaint of an emotional or behavioral disorder will receive a suicide risk assessment. Record review revealed the suicide risk assessment was not done during triage or when Patient 1 was admitted to the emergency department, and therefore a plan was not developed to keep Patient 1 safe. The facility failed to ensure nursing staff documented and communicated that Patient 1 had suicidal thoughts and failed to provide staff to keep her safe. The facility failed to conduct an initial assessment of Patient 1. These failures resulted in a lack of monitoring of Patient 1 which allowed her to elope from the ED and attempt suicide by lying down in a busy street in front of traffic. Patient 1 was struck by a motor vehicle (hit and run), had multiple fractures, emergency surgery, admission to the intensive care unit, and endured pain and suffering during a prolonged hospital stay. Patient 1 then required skilled nursing care after discharge from the hospital 64 days later. The facility failed to communicate Patient 1's suicide risk and failed to provide a safe environment for Patient 1.		**Finding #2:** Psychiatric patients will receive a Medical Screening Exam in the ED prior to transfer to the psychiatric units. The ED physician orders the patient transfer once the patient is cleared, part of transfer orders includes mode of transport (e.g. gurney, wheelchair), any restraint requirements and additional staff (e.g. additional security guards, police) are necessary to ensure safe patient transfer. The hospital created policy 100.203 (Patient Transport/Escort to and from the Inpatient Psychiatric Unit (IPU), the Emergency Department (ED), and Inpatient Acute Care Units). Hospital Policy 100.203 was created to ensure a comprehensive and clear process for transport of patients. The policy requires that the patient be accompanied by a licensed staff member and an elite security guard. Local police or an additional security guard may be utilized, if deemed necessary, to ensure safe patient transport. The process for police assistance with transports was clarified to require that police be notified for assistance when hospital	

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		clinical staff (e.g., nurses, physicians) determine that there is an imminent threat of danger to the patient or others (e.g. uncontrollable psychotic state) such that police assistance is required. In those situations, the patient will remain in the ED until police assistance is available. Prior to transfer, communication occurs between the sending and receiving departments utilizing the Situation Background Assessment Recommendation (SBAR) form.	3/2016-1/25/17
			The CEO and City of Ventura Police Commander agreed to amend the current police contract to provide 24 hours, 7 days a week service in the Emergency Department. These changes shall occur when Ventura Police Department's staffing has increased. Under the current contract, the Ventura Police Department staffs one police officer on site 12 hours per day, 7 days per week.	1/7/16
			The CEO and Associate Hospital Administrator (AHA) of Support Services held discussions with the contracted security provider regarding	

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		the safe handling of patients in the hospital. An addendum was added to the security contract to increase the number of trained elite security guards in the ED, OPOS and IPU. One additional security guard was added for transport to and from the hospital, OPOS and IPU. Elite security guards have an additional 80 hours of training, including 12 hours of annual update training. The training classes for elite guards include: Safely Managing and Detaining High Risk Patients, Crisis Prevention Training (8 hours), Management of Aggressive Behavior Training (8 hours) and Patient Watch Training and Restraints. In addition, the contract amendment details, the ability of elite security guard(s) to detain a psychiatric patient when necessary. The CEO reviewed and approved the contract amendment. Nurse managers and the IPU Operations Manager were notified regarding the security contract changes. The CMO discussed the new transport policy and safe transport of psychiatric patients	12/13/16-12/21/16

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		with the chief physicians who are responsible for education of the physician staff under their supervision. Hospital Policy R-1 (Restraint use for Patients being Transported) was developed, reviewed and approved. Physicians, nursing staff, security guards and safety attendants were provided education on how restraints are ordered and steps to take when transporting a patient in restraints. **Compliance & Monitoring** The Associate Hospital Administrator (AHA) of Support Services will provided a bi-annual report to the CEO with the number of elite guards available for transports. The AHA for Support Services will also immediately notify the CEO of any staffing or contractual issue(s) that may impact patient care. Competency assessment(s) are documented for all elite security guards who have completed the training and work with high risk patients.	12/12/16 1/2017

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		**Finding #3:** Prior to patient transfer, communication shall occur between sending and receiving departments by utilizing the Situation Background Assessment Recommendation (SBAR) form, see Hospital Policy 100.203 (Patient Transport/Escort to and from the Inpatient Psychiatric Unit, the Emergency Department and Inpatient Acute Care Unit). The CNO reviewed policies: Z.01 (Adult Inpatient Psychiatric Clinical Practice), MST.48 (Nursing Care Plan), 100.023 (Suicide Precautions), and ER.38 (Patient Triage) to ensure the policies were clear and comprehensive. Hospital Policy MST.48 (Nursing Care Plan) requires the nurse to create, maintain, and complete care plans in the Electronic Health Record. Hospital Policy ER.38 (Patient Triage) requires the nurse to perform a suicide risk assessment during the triage assessment in the ED. Furthermore, the policy states the nurse is to contact security for assistance in monitoring psychiatric patients who are at risk	3/31/16-7/20/16 4/1/16

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		for elopement or there is an imminent threat of danger to the patient or others (e.g. uncontrollable psychotic state). The elite security guards were provided direction, and their contract reflects, that when they are on a patient watch they are not allowed to leave the patient unattended at anytime. The elite security guard is to be in line of sight, of patient, at all times and will report any changes in behavior to the patient's nurse immediately for intervention. **Compliance and Monitoring:** Education was provided to all nursing staff on the use of SBAR. Education is provided to nurses upon hire and annually regarding Care Plan creation, documentation and the policy guidelines for Care Plans. The Quality Improvement Department reviewed 30 nursing	4/1/16 12/21/16

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		care plans bi-monthly for three months and then re-evaluated to ensure the goal of 95% compliance was met with Nursing Care Plans reflecting the patient's condition. Corrective action was taken as necessary, including staff re-education. Data was tracked, trended, analyzed and reported monthly to the Quality Improvement Department. Data on compliance is reported monthly to Performance Improvement Committee and the Medical Executive Committee, and every other month to the Oversight Committee. Data on compliance is used to enhance performance improvement measures. **Finding #4:** The Hospital's CEO and Police Commander discussed obtaining additional police officers to provide on site coverage (currently there is one police officer on site 12 hours per day, 7 days per week).	

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		The CEO and Associate Hospital Administrator (AHA) of Support Services met with the contracted security provider and amended the contract to delineate the responsibilities of elite security guards responsibilities in the monitoring of psychiatric patients in the hospital. The contract was also amended to increase the number of elite security guards in the ED, OPOS and IPU. One additional security guard is stationed in the ED at all times, in order to assist nursing and perform patient watches. Elite security guards complete 80 hours of training including 12 hours of annual update training. The training classes will include: Safely Managing and Detaining High Risk Patients, Crisis Prevention Training (8 hours), Management of Aggressive Behavior Training (8 hours) and Patient Watch Training and Restraints. In addition, the contract amendment details, the ability for elite security guards(s) to detain a psychiatric patient when necessary. The CEO and Board of Supervisors reviewed and approved the contract amendments.	

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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

(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
	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).		documented for elite security guards who have completed training and work with high risk patients, which includes, but is not limited to, remaining in the line of sight of the patient at all times. **Person(s) Responsible:** Nurse Managers Associate Hospital Administrator of Support Services Assistant Chief Nursing Officer Chief Nursing Officer Chief Executive Officer	