

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2016
NAME OF PROVIDER OR SUPPLIER  Palmdale Regional Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 38600 Medical Center Dr, Palmdale, CA 93551-4483 LOS ANGELES COUNTY	
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00480191 CA00482818 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 2091, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>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.</p> <p>Penalty Number: 930013312</p> <p>Health and Safety Code 1279.1 (b)(3)(c) (b) For purposes of this section, "adverse event" includes any of the following: (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</p>	<p style="text-align: center;"><b>RECEIVED</b> JUN 21 2017</p> <p>BY: _____</p> <p>This plan of correction does not constitute an admission of liability and is specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusion are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited were correctly applied. Further, the submission of the plan does not constitute an admission and/or agreement that the cited deficiency caused or contributed to Patient A' injury. This plan of correction constitutes the Hospital's written allegation of compliance for deficiency.</p> <p>A) <b>Corrective action:</b></p> <p>1) It is the policy of the hospital to provide adequate supervision to minimize incidents of self-harm in patients known to exhibit suicidal ideation. Some of the ways that this has been achieved is by nurse supervision as well as re-direction by nursing and non-physician staff such as what was attempted in the case of Patient A.</p>	

Event ID: 3Y2E11 *APOC 7/24/17 Jhd, HFEN* 7/6/2017 4:04:03PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Roshan C. Stangor Director of Risk Management* TITLE: *Director of Risk Management* (X6) DATE: *7-18-17*

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 12

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.

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	<p>were the reason for admission to the health facility.</p> <p>Title 22 DIV5 CH1 70213(a) 70213(a) Nursing Service Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>Title 22 DIV5 CH1 70215(b) 70215(b) Planning and Implementing Patient Care (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.</p> <p>Based on observation, interview, and record review, the Hospital failed to ensure that its Policies and Procedures titled, "Suicidal Risk Patient - Safety Management" and "Sitter (Constant Observation)" were implemented for Patient A, including but not limited to, its failure to ensure Patient A, who was a risk for suicide, was given a sitter who would be a trained constant observer.</p> <p>This failure resulted in Patient A obtaining a pair of scissors and stabbing himself 69 times, causing critical injuries including a stroke, injury to the heart, liver, abdomen, and neck, and left</p>		<p>Also, a patient such as Patient A is placed in a facility provided gown and searched for any contraband or items that could harm the patient or others. The patient is not to be allowed to access their Personal clothing or belongings. These items should be secured outside of the patient room. For this reason the staff considers the possibilities the patient may use to harm themselves or others. The nurse call or staff assistance device is maintained to summon assistance when needed as was done with security being summoned to assist with Patient A when immediately he immediately and without warning began causing self-harm. A safety and security assessment of the Emergency Department environment was completed by the Director of Risk management to identify and remove items that could be used to cause harm.</p>	

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	<p>sided paralysis.</p> <p>Findings:</p> <p>The clinical record for Patient A was reviewed. Patient A was admitted to the ED (Emergency Department) on 3/9/16, arriving via ambulance at 10:44 AM, due to Patient A calling EMS (Emergency Medical Services) requesting an "evaluation before ideations (thoughts of suicide) get worse."</p> <p>During an observation on 4/22/16, at 10:25 AM, in the ED, the patient room location assigned to Patient A was observed. There was a short corridor with four patient rooms, two on each side of the corridor facing each other, numbered Hall E 9, 10, 11, and 12. The closest restroom to the Hall E rooms was located 8 to 10 feet from room 9.</p> <p>During a review of the clinical record for Patient A on 4/22/16, the Los Angeles County Emergency Medical Services Report Form, dated 3/9/16, indicated they received a dispatch call for Patient A at 10:23 AM. The report indicated "patient drank Windex (liquid glass cleaner) two days ago. Put a butter knife to neck last night. Patient wants eval (evaluation) before ideations (thoughts of suicide) get worse." EMS transferred care to ED staff at 10:44 AM.</p> <p>During a review of the clinical record for Patient A, the ED Physician Record, dated 3/9/16 at</p>		<p>a. A checklist was created and used to ensure rooms are safe and clear of items that could be used for self-harm.</p> <p>2) The following practice guideline and policy were reviewed: Sitter-Constant Observation and Suicidal Risk Patient-Safety Management. Staff was provided education regarding policy and expectations. Both the practice guideline and policy require use of the "Suicide one-to-one Observation Checklist" and "Safe Environment Checklist".</p> <p>3) Education was created outlining the use of sitters from evaluation of the need of a sitter, obtaining approval to use a sitter, guidelines for sitter, patient care provided by sitter and documentation by the sitter. Education was mandatory for all Emergency Department staff</p>	

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	<p>12:48 PM, the Emergency Department Medical Doctor (EDMD 1) documented "patient also notes he drank Windex a few days ago, and felt like harming himself." EDMD 1's physician orders included an order for a Mental Health Hold Request (a process requesting evaluation by a county PET [psychological evaluation team]).</p> <p>Review of Patient A's ED Physician Record dated 3/9/16, at 8:00 PM, indicated a second physician assumed care from EDMD 1, approximately nine hours since admission to the ED, and documented Patient A, "presents to the emergency department for depression and suicidal ideations."</p> <p>During an interview with EDMD 1 on 5/11/16, at 1:30 PM, he stated he personally assessed Patient A when he was in the ED on 3/9/16, and was aware the patient came to the ED via EMS for complaints of suicidal thoughts and behaviors. EDMD 1 stated a physician order for a "sitter" to observe and monitor a suicidal patient was not required, and was a "standard of practice" for patients with psychiatric issues or concerns. He further stated he ordered a Mental Health Hold Request to have the patient evaluated by a psychiatric team.</p> <p>Record Review of Patient A's Nursing Note, "late entry" dated 3/10/16, at 5:19 AM, RN 1 documented, "Pt (patient) seen in hallway, approached pt and asked where he was going, pt stated 'to the bathroom'. I directed the Pt to</p>		<p>and was completed by 5/6/2017.</p> <p>A competency was developed and only staff who have demonstrated competency may be utilized as a sitter. The competency includes knowledge when sitters are appropriate, guidelines, environmental safety measures, observations and behaviors to report, sitter behavior, documentation, patient/family education and special considerations.</p> <p>4) Emergency Department Nursing Staff completed mandatory re-education by the Director of Emergency Department/ or Designee, the education was related to the identification care and Management of patients determined to be at risk of suicide: Active nurses have completed the re-education by the date of compliance, Prn nurses were completed prior to their first scheduled shift. (5/6/2016).</p>	

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	<p>the bathroom, opened the door for him and closed it behind him."</p> <p>During an interview with RN 1 (Registered Nurse) on 5/12/16, at 5:20 PM, he stated he was the RN assigned to Patient A upon arrival to the ED on 3/9/16. RN 1 stated he received report from EMS that Patient A was admitting himself voluntarily because he had suicidal ideations and behaviors. During this interview, RN 1 stated there was no "sitter" assigned to observe and monitor Patient A on 3/9/16. Further, RN 1 stated he had three other patients, all in Hallway E, rooms 9, 10, 11, and 12, and he would "try to keep an eye on all four patients" by performing patient cares while facing the doorway and watching the other rooms. RN 1 stated he gave patient hand-off report to oncoming RN 2 at the end of his shift, which included reporting Patient A's admission for suicidal thoughts and behaviors.</p> <p>During an interview with RN 2 on 5/12/16, at 6:00 PM, he stated on 3/9/16, at the beginning of his night shift, he received hand-off patient report from RN 1, and was informed Patient A was waiting for a psychiatric evaluation for suicidal thoughts and behaviors. RN 2 stated he was assigned the four patient rooms in Hallway E, rooms 9, 10, 11, and 12.</p> <p>During this interview, RN 2 stated there was no "sitter" assigned to Patient A during his shift on 3/9/16. RN 2 stated he was assessing a new patient being admitted to the ED on 3/9/16 at</p>		<p>a. Suicide risk indicators and specific interventions for low, moderate and high risk.</p> <p>b. Identification of suicide risk factors</p> <p>c. Identification of protective factors, internal and external factors that would decrease risk of carrying out suicide</p> <p>d. Specific questions to ask to assess suicide risk</p> <p>e. Determine level of risk for suicide and choose appropriate intervention to address and reduce risk</p> <p>f. Documentation of suicide risk assessment, rationale, intervention and follow-up instructions</p> <p>g. Identification and removal of items that could be used for self-harm.</p>	

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	<p>approximately 8:30 PM, and noticed Patient A leaving his room. RN 2 directed Patient A to the nearest restroom located by room 9. Further, RN 2 stated he got busy taking care of the newly admitted patient and was unable to see Patient A any longer, and a few minutes later he heard screaming and commotion going on in the hallways. RN 2 stated he went to assist and realized that Patient A had stabbed himself.</p> <p>Review of Patient A's Nursing Note dated 3/10/16, at 9:33 AM, RN 3 documented, "Late entry: Found pt (patient) walking in hall...I approached the pt and asked him if he needed help...as I walked with the pt he began to walk towards the RME (Rapid Medical Exam) provider office very quickly...where he grabbed a pair of scissors from the counter...the pt began stabbing his abdomen, chest and neck with the scissors...(pt) continued to stab himself rapidly until he fell to the ground."</p> <p>During an interview with RN 3 on 6/6/16, at 8:30 AM, she stated while working in another part of the ED and not Patient A's care provider, on 3/9/16, at approximately 8:30 PM, she saw Patient A trying to exit the ED double doors leading to the lobby. She stated she redirected him by the arm, he was mumbling, and "made a beeline" into the Rapid Medical Exam treatment room, laid his hands on a back counter and grabbed a "large pair of paper scissors".</p> <p>RN 3 stated during the interview on 6/6/16, at 8:30 AM, Patient A "literally started stabbing</p>		<p>5) Patients determined to be at risk for suicide are now changed into a green gown, to facilitate quick identification.</p> <p>6) Posters are displayed in the Emergency Department reminding staff signs of suicide risk, and probing questions to determine risk level.</p> <p>7) Patient/family education is provided to patients who trigger any level of suicide risk in the electronic medical record. Patient and family education with regard to resources for patients at risk are posted in the Emergency Department.</p> <p><b>B) Corrective action :</b></p> <p>A tracer was created to monitor the safety measures initiated in the ED to decrease risk of self-harm. 10 patients per month were monitored, by the Risk Manager, until 3 months of sustained improvement of 100% was achieved. Sustained improvement was accomplished on 9/26/2016 and reported to the Patient Safety Committee.</p>	

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	<p>himself with scissors," and eventually fell to his knees, dropped the scissors, and ED trauma staff began life saving treatment. During this interview, RN 3 stated she "knew to keep space between harm and staff. Yelled code gray (to get assistance from security staff), and removed other patients from the area." She stated she thought Patient A was going to harm her, but tried to intervene by directing a laboratory technician to throw a blanket toward the patient to distract him. She stated Patient A momentarily stopped stabbing himself, then continued stabbing himself. She stated, "No more I could do. I did everything" to try to stop him from stabbing himself.</p> <p>During an interview with the IRM (Interim Risk Manager) on 4/22/16, at 10:00 AM, she stated Patient A went to the restroom, "snuck out of the bathroom," then walked down a couple of hallways and entered a treatment area where he accessed a pair of scissors. The IRM stated Patient A stabbed himself multiple times in the chest, abdomen, and carotid artery, and kept stabbing himself until he passed out. The IRM further stated Patient A was at risk for suicide while in the ED related to his history of suicidal thoughts and behaviors, and "that he brought himself to the ED for those reasons."</p> <p>During an interview with the IRM on 4/22/16, at 11:15 AM, she stated Patient A was at risk for suicide when he was in the ED because of his history of drinking windex and putting a butter knife to his throat, and also because he</p>		<p>The Emergency Department Director/ or designee will continue to make frequent rounds to ensure at risk patients are safe and policy is followed. Corrective actions will be monitored to ensure all corrections are achieved and sustained:</p> <p><b>By the Director of the Emergency Department and/ or/Designee</b></p> <p>C) All corrective actions were completed 9/26/2016.</p>	

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	<p>admitted himself to the ED for those reasons.</p> <p>During an interview with the IRM on 4/22/16, at 2:10 PM, she stated Patient A did not have a designated "sitter" while he was in the ED on 3/9/16. The IRM stated a "sitter" could have been assigned based on nursing judgment if the patient had suicidal ideations.</p> <p>On 4/18/17, at 10:30 AM, the IRM provided the scissors Patient 1 used to stab himself with, for observation and photograph. The scissors were observed to be ordinary desk scissors for cutting paper. The cutting blades were approximately three and one-half inches in length, both blades had sharp pointed tips.</p> <p>During an interview with the EDCN (Emergency Department Charge Nurse) on 4/22/16, at 10:30 AM, he stated Patient A was being treated in one of the four rooms, and further stated the four rooms in Hall E were designated to care for patients with psychiatric concerns or problems. He stated a "sitter" (facility staff assigned to monitor/observe patients) could be placed in that area.</p> <p>The EDCN further stated Patient A went into and exited the restroom by room 9, walked down a hallway, identified as the ambulance hallway, past a nursing station, took a turn down another hallway, and went into a treatment area with staff present in the room. The EDCN stated Patient A obtained a pair of scissors that were on a desk along the back</p>			

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	<p>wall of the treatment area, and stabbed himself.</p> <p>During an interview with the IRM, on 4/18/17, at 10:30 AM, she stated the EDCN was not present during the time Patient 1 stabbed himself, but was called in the next morning on 3/10/16 for incident debriefing.</p> <p>Record Review of Patient A's ED Physician Record, dated 3/10/16, at 2:25 AM, physician notes indicated, "multiple stab wounds to abdomen, adipose (fat) tissue exposed at mid abdomen. Pt was intubated (a tube placed orally to provide oxygen), multiple superficial and subcutaneous stab wounds" to the front of the neck.</p> <p>Record Review of Patient A's Peri-OP Operative Procedural Notes dated 3/10/16, at 2:00 AM, indicated Patient A had 10 stab wounds to his neck, 44 stab wounds to his chest, and 15 stab wounds to abdomen including the liver. Patient A's operation included an incision and opening of his sternum for repair of the right and left heart ventricles, and repair of the right carotid artery.</p> <p>Record Review of Patient A's Discharge Summary dated 4/23/16, at 9:26 PM, indicated Patient A had acute respiratory failure due to multiple stab wounds, left sided hemiparesis (paralysis) secondary to cerebral infarction (stroke).</p> <p>Record Review of Patient A's Discharge</p>			

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	<p>Summary Addendum, dated 4/26/16, at 3:04 PM, indicated Patient A was being transferred to another hospital for treatment of an infection by an infectious disease specialist. The documentation further indicated Patient A needed this transfer "to allow him the most likely chance of survival from his chronic debilitating problems he has unfortunately suffered."</p> <p>During an interview with the IRM on 5/31/16, at 10:15 AM, she stated Patient A did not have a "sitter" to monitor him. Further, she stated Patient A should have had a "sitter" assigned to monitor and supervise him while he was in the ED on 3/9/16, due to his self-report of suicidal thoughts and previous suicide attempt.</p> <p>The facility Policy and Procedure titled "Suicidal Risk Patient - Safety Management" dated 9/16/14, section "Sitter/Constant Observation: Follow Sitter/Constant Observation Practice Guideline," indicated under the section titled "Purpose," "The purpose of this practice guideline is to provide a safe environment for individuals who are considered at risk for suicide in a non-psychiatric setting."</p> <p>Under the section titled "Procedure," "The following procedure will be implemented in an attempt to lessen the potential for suicide when an individual expresses suicidal ideas, initiates an action with the intention of causing his/her own death or is assessed by the physician or registered nurse as presenting a suicidal risk."</p>			

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	<p>If a patient presents a suicidal risk, under section three of "Procedure," the facility would do the following: "Sitter/Constant Observation: Follow sitter/Constant Observation Practice Guideline: The sitter reports to the charge nurse/assigned RN on arrival to the unit. The charge nurse orients the sitter to the unit and duties utilizing the Patient Sitter handoff and Checklist form. No physician order is required to place a sitter with the patient."</p> <p>Further review of the facility Policy and Procedure titled "Suicidal Risk Patient - Safety Management" dated 9/16/14, under number four of "Procedure," "Documentation every 15 minutes minimum by RN or sitter for suicide risk patient." Further, under number six of "Procedure," "The suicide precautions and sitter may be discontinued only when the patient had been seen by the physician with documentation in the Medical Record by the physician that the patient was no longer suicidal ."</p> <p>The facility Policy and Procedure titled "Sitter (Constant Observation)" dated 9/16/14, indicates under Definitions, "Sitter - an employee who has completed special education in the care of patients requiring continuous supervision with a focus on patient safety." Under the section titled "Procedures," "Evaluation of Need for Sitter - Determine the need for a Sitter. Situations include, but are not limited to: Safety Potential to harm self or others. [These may include] Acutely</p>			

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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:  050204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2016
NAME OF PROVIDER OR SUPPLIER  Palmdale Regional Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 38600 Medical Center Dr, Palmdale, CA 93551-4483 LOS ANGELES COUNTY		
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	<p>suicidal...Experiencing behavioral disturbances, psychosis, or personality disorders..."... "Physician order is not required for a sitter."</p> <p>During further review of the facility Policy and Procedure titled "Sitter (Constant Observation)" dated 9/16/14, under the section titled "Documentation" - "for all sitter patients: Patient care documentation in Cerner is required." Under the section titled "Patient Care," the policy indicated Patient Care duties of the Sitter included observing the patient and maintaining a safe environment while having an unobstructed view of the patient at all times.</p> <p>The hospital's failure to ensure Patient A, who was admitted for suicidal ideation, was provided with a sitter, caused or was 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).</p> <p>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).</p>			

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