P-O-C: accepted
S. C. 2/3/16

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 |
|---|---|---|---|
| | 050135 | A. BUILDING<br>B. WING | 06/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hospital at Hollywood | 6245 De Longpre Ave, Los Angeles, CA 90028-8253 LOS ANGELES 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: | | Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by state law. | |
| | Complaint Intake Number:<br>CA00358774 - Substantiated | | | |
| | Representing the Department of Public Health:<br>Surveyor ID # 17030, 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: 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. | | RECEIVED<br>2016 JAN 22 PM 1:52<br>HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION | |
| | T22 DIV CH1 ART3-70213(a) Nursing Service Policies and Procedures | | | |
| | (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. | | | |
| | T22 DIV5 CH1 ART6-70413(a) Basic Emergency Medical Service, Physician on<br>(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. | | | |

Event ID:XH6I11 1/8/2016 12:21:14PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 1/22/16

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s). 1 thru 6

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: 050135 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/27/2013 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Southern California Hospital at Hollywood | STREET ADDRESS, CITY, STATE, ZIP CODE: 6245 De Longpre Ave, Los Angeles, CA 90028-8253 LOS ANGELES 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 |
|---|---|---|---|---|
| | Procedures shall be approved by the administration and medical staff where such is appropriate.<br><br>Based on record review and interview, the facility failed to implement its policy and procedure for "Emergency Room and Emergency Department Overflow Staffing" by failing to ensure the staffing in the emergency room (ER) overflow area included two (2) licensed, (1) certified nursing assistant and one (1) security officer on June 10, 2013 at 4 p.m. As a result of this deficient practice, Patient A, who had dementia and aggressive behavior, eloped from the ER Overflow area on June 10, 2013 at about 4:30 p.m. On the next day, on June 11, 2013, Patient A was found dead lying in a prone position on the beach shoreline in Location A. The "Autopsy Report" dated August 8, 2013, indicated Patient A died as a result of drowning.<br><br>Findings:<br><br>On June 24, 2013, an unannounced visit was conducted at the facility (Southern California Hospital at Culver City) to investigate a facility reported incident regarding a patient who had eloped from the facility's emergency room.<br><br>Patient A's electronic medical record was reviewed. The Encounter Sheet indicated Patient A was admitted to the facility's Emergency Room by stretcher from a retirement center on June 8, 2013, at 10:39 a.m., for a psychiatric evaluation due to aggressive behavior.<br><br>The MD Notes dated June 8, 2013 at 11:20 a.m., | | Immediate Actions Taken:<br>1. Immediately following the incident of June 10, 2013, a keypad alarm device was installed to the entrance/exit door of the Emergency Room Overflow area. The entrance/exit door is manned by security personnel at all times and access to/ egress from the Emergency Room Over-flow area can only be granted by authorized personnel.<br><br>2. Immediately following the incident of June 10, 2013, the Director of Security provided an in-service to the security staff to remind them of their responsibility for ensuring that the security post in the Emergency Room Overflow area is manned at all times. They were further reminded that they are not break for restroom or meal/break periods, unless relief coverage is secured. | 06/11/2013<br><br>06/11/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 050135 | A. BUILDING ______ B. WING ______ | 08/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hospital at Hollywood | 6245 De Longpre Ave, Los Angeles, CA 90028-8253 LOS ANGELES 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 |
|---|---|---|---|---|
| | indicated Patient A was confused and had dementia with aggressive behaviors. The physician's assessment indicated Patient A had diagnoses of aggressive behaviors and dementia. The MD Notes dated June 8, 2013 at 2:46 p.m., indicated the disposition of the patient was to admit as inpatient. | | 3. Immediately following the incident of June 10,2013, the hospital appointed Security staff to ensure adequate coverage of the Emergency Room Overflow area to include coverage for restroom and meal/ break periods 24 hours per day. The coverage further extended to support the escort service of those patients who need to be transported from the Emergency Room Overflow area to the Inpatient Psychiatric Unit. | 06/11/2013 |
| | According to the ED Nursing clinical note, dated June 8, 2013 at 11:02 a.m., it was disclosed that the patient was alert and oriented to person, place, and time. Patient A was in the over flow area of the emergency room. At 11:07 a.m., the "patient continuously attempting to walk out of ER." A translator informed the patient that he needed to stay in the emergency room and in bed for safety. Patient A verbalized his understanding. | | 4. Immediately following the incident of June 10, 2013, the Director of Emergency Department provided an in-service to Emergency Room personnel to remind them of their responsibility to ensure that minimal staffing requirements for the Emergency Overflow area are adhered to at all times. They were further reminded that coverage must be attained before leaving for breaks of any kind. | 06/11/2013 |
| | The ED Nursing clinical note dated June 9, 2013 at 5:34 p.m., indicated the "patient awake, alert and walking around. Anxious to go home. Refused dinner. Uncooperative some time, frequent redirection, unable to follow simple direction. All safety measures met, will continue monitor for safety."<br><br>The ED Nursing clinical note, dated June 10, 2013 at 9:04 a.m., indicated Patient A was agitated, wandering on the unit and was not following directions at 12:55 p.m., 1:42 p.m. and 2:20 p.m. and that Patient A was pacing the unit and was redirected to sit down. There was no further documentation of the whereabouts of Patient A until | | 5. Immediately following the incident of June 10, 2013, the hospital's policy titled "Scope of Service-Emergency Department Urgent Care" was updated to clarify the California Title 22 staffing guidelines for the Emergency Department with a minimal staffing of 2 licensed personnel plus one security officer for a census <5 patients when the unit is opened for the holding of Behavioral Health or Chemical Dependency patients. The associated staffing matrix for the Emergency Room Overflow area was further revised to appoint 3 licensed personnel plus 1 security officer for a census of >5 patients when the unit is opened for the holding | 06/11/2013 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 050135 | A. BUILDING ______ B. WING ______ | 06/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hospital at Hollywood | 6245 De Longpre Ave, Los Angeles, CA 90028-8253 LOS ANGELES 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 |
|---|---|---|---|---|
| | June 10, 2013 at 4:32 p.m.<br><br>The ED Nursing clinical notes, documented by Employee 5 (licensed vocational nurse) and dated June 10, 2013 at 4:32 p.m., indicated Employee 5 called Employee 4 (registered nurse) and reported Patient A was missing. Employee 5 called the facility security officer and the local police department.<br><br>According to the "Investigative Report" in the "Autopsy Report," dated June 12, 2013, the decedent (Patient A) was found lying prone on the beach on the shoreline in Location A on June 11, 2013. The "Opinion" of the "Autopsy Report" signed by the Deputy Health Examiner and dated August 8, 2013, indicated Patient A died as a result of drowning.<br><br>An interview was conducted with Employee 8 (security officer) on June 24, 2013 at 9:40 a.m. Employee 8 stated he was stationed in the ER Overflow area on June 10, 2013. Employee 8 stated that around 4 p.m. on June 10, 2013, he accompanied Employee 4 (registered nurse) to escort two (2) patients to the Behavior Health Unit (BHU) P6. According to Employee 8, there was no security officer to relieve him prior to leaving his post when he escorted the two (2) patients to the BHU (P6).<br><br>During an interview on June 24, 2013 at 9:52 a.m., Employee 6 (certified nurse attendant) stated he was assigned to the ER Overflow area on June 10, | | continued from page 3<br>of Behavioral Health or Chemical Dependency patients. The Director of the Emergency Department also provided an in-service to Emergency Room personnel on the updated policy, with specific emphasis on the minimal staffing requirement and associated staffing matrix.<br><br>6. Immediately following the incident of June 10, 2013, the hospital implemented an ED Shift Assignment and Meal & Rest Period Record that references the shift assignment for the day and the times that meal/break periods are to be taken by the staff assigned to each shift in the Emergency Room Overflow area. The Emergency Room Overflow area staff were in-serviced on the ED Shift Assignment and Meal & Rest Period Record and the expectation for acknowledging the times those meal/break periods are to be taken. The Director of the Emergency Department or designee, is responsible for completing the Meal & Rest Period Record for each shift and staff members are responsible for initialing the record to acknowledge the times those meal/break periods are to be taken.<br><br>7. Immediately following the incident of June 10, 2013, the hospital's policy titled "Elopement" was revised to delineate the House Supervisor's responsibility if a patient elopes. This includes contacting law enforcement, the patient's attending physician, the Hospital Administrator or qualified designee, the Director of Quality, | 06/11/2013<br><br>06/11/2013 |

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 |
|---|---|---|---|
| | 050135 | A. BUILDING ______ B. WING ______ | 06/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hospital at Hollywood | 6245 De Longpre Ave, Los Angeles, CA 90028-6253 LOS ANGELES 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 |
|---|---|---|---|---|

**Summary Statement of Deficiencies:**

2013. Employee 6 stated he was on his break time on June 10, 2013 at 4 p.m., while Employee 8 and Employee 4 escorted the two (2) patients to the BHU (P6).

During a telephone interview on June 24, 2013 at 2:10 p.m., Employee 5 (licensed vocational nurse) stated he was the only staff member in the ER Overflow area while both Employee 4 and Employee 8 escorted the two (2) patients to the BHU/P6 around 4 p.m. on June 10, 2013. According to Employee 5, there were seven (7) patients in the ER Overflow area at that time.

During a telephone interview on June 27, 2013 at 8 a.m., Employee 4 stated she was not aware that Employee 6 was taking his break around 4 p.m. on June 10, 2013.

The ED Shift Assignment for the 7 a.m. to 7 p.m. shift dated June 10, 2013, indicated that one (1) registered nurse, one (1) licensed vocational nurse and one (1) certified nursing assistant were assigned to the ER Over flow area. There was no documentation when both Employee 4 and 8 left the ED Overflow area and escorted 2 patients to the BHU (Behavior Health Unit)/P6. There was no documentation Employee 6 had been assigned to take his break around 4 p.m. on June 10, 2013.

During an interview on June 24, 2013 at 10:28 a.m., Employee 3 (ER director) stated the ED Shift Assignment for the day shift of June 10, 2013 did

**Provider's Plan of Correction:**

continued from page 4

the patient's responsible party, the last known residence, and posting the incident on the RediNet System. The Chief Nursing Officer provided an in-service to the House Supervisors on the revised policy with specific emphasis on their role and responsibility for execution of the policy should an elopement incident occur.

8. Immediately following the incident of June 10, 2013, the hospital developed and implemented a "Code Green Policy" that outlines a protocol for immediate staff response should an elopement incident occur. Immediately following the incident of June 10, 2013, the Director of the Emergency Room in-serviced the Emergency Room Overflow staff on the "Code Green" policy. — 06/11/2013

Subsequent Actions:

1. Hospital Leadership discussed the Statement of Deficiencies and immediate jeopardy finding. — 01/11/2016
2. The Director of Emergency Department provided a refresher education to ED personnel regarding the Elopement and Code Green policies. — 01/23/2016
3. The Director of Security provided a refresher education to Security staff. A memo was also sent to the Contracted Security Company reiterating the Hospital's Elopement and Code Green policies and procedures. — 01/23/2016

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 050135 | A. BUILDING ____<br>B. WING ____ | 08/27/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hospital at Hollywood | 6245 De Longpre Ave, Los Angeles, CA 90028-8253 LOS ANGELES 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 |
|---|---|---|---|---|
| | not indicate Employee 6 had been assigned to take his break. According to Employee 3, Employee 4 should have maintained the minimum staffing of two (2) licensed nurses in the ED Overflow area.<br><br>According to the facility's policy and procedure on "Brotman Emergency Department (ED) Overflow Staffing Matrix" developed on April 2013, under "STAFFING," it stipulated the following:<br><br>"When the ED Overflow area is needed to care for patients with non-psychiatric complaints, staffing shall be a minimum of (2) Licensed ED trained Nurse."<br><br>"When the ED Overflow area is opened for holding of P6 (Behavior Health Unit) /T6 (Chemical Dependent Unit) patients, minimum staffing shall include (2) Licensed Nurses, (1) CNA and (1) Security Officer."<br><br>The facility's failure to implement its policy and procedure on "Emergency Department Overflow Staffing Matrix" by failing to ensure the minimum staffing in the ER Overflow area of two (2) licensed nurses, one (1) certified nursing assistant and one (1) security officer when the ER Overflow area was opened to care and hold patients to transfer to the BHU of the hospital, is a deficiency that has caused, or likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1. | | Compliance and Monitoring:<br>Notification of the Immediate Jeopardy deficiency resulted in a process evaluation which consists of the Director of Security and Director of Emergency Department, or designees, performing 7 random observations per week (capturing all shifts) (for 3 months and then re-evaluate), to monitor compliance with the entrance/exit door to the Emergency Room Overflow area being manned by sufficient security personnel at all times. In addition, the Director of Emergency Department and Director of Security or qualified designees shall review, at least weekly, the ED Shift Assignment and Security Assignments with the Meal and Break Record to ensure sufficient coverage during the shift. A benchmark of 100% compliance has been established. Corrective action is taken, including 1:1 staff re-education and may include further disciplinary action for noncompliance with hospital policy. Data is tracked, trended, analyzed and reported monthly to the Quality Council, Medical Executive Committee and Governing Board, and is used for performance improvement measures.<br><br>Persons Responsible:<br>Director of Emergency Department<br>Director of Security | 01/19/2016 |