

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 054114	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER San Diego County Psychiatric Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 3851 Rosecrans St, San Diego, CA 92110-3115 SAN DIEGO 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: CA00359931 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 22479, 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 1280.1(c): 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>1280.1 (a) Health and Safety Code Section 1280 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (25,000) per violation.</p> <p>(c) 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 a patient.</p>		<p>Deficiency:</p> <ol style="list-style-type: none"> 71545 (a) - Restraint was used prior to the use of alternative methods in order to protect the patient or others from injury. 71545 (b) - Restraint was applied without a physician order, including the reason and type to be used, nor was there authorization from a registered nurse as would be expected in an emergent situation. The hospital failed to ensure that staff members followed the hospital's policies and procedures regarding the use of manual restraints and the proper procedure for handling a patient emergency in which there is imminent danger to self or others. There was no evidence that restraint was necessary. <p>Plan of Correction:</p> <ol style="list-style-type: none"> Immediately after the adverse event the staff who were directly involved in the restraint were removed from patient care and reassigned to alternate County of San Diego work sites pending a thorough investigation. The investigation resulted in: <ol style="list-style-type: none"> Resignation of one employee. Suspension of one employee. Written disciplinary action for one employee. 	<p>6/26/13</p> <p>Following Immediate Reassignment</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maria Rivera* TITLE: *Assistant Administrator* (X6) DATE: *2-9-15*

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	(d) This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars (\$100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars (\$50,000) for the first administrative penalty, up to seventy-five thousand dollars (\$75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars (\$100,000) 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 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. 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.		<p>3. All re-education & training focused on:</p> <ul style="list-style-type: none"> a. Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury. b. Patients shall be placed in restraints only on the written order of the physician and to include the reason & type of restraint; or at the discretion of a registered nurse and a verbal order obtained thereafter. c. The hospital policy & procedure pertaining to the use of restraints. <p>4. Re-education & training on a one-to-one basis conducted with the suspended employee and the employee who received written disciplinary action.</p> <p>5. Re-education was conducted for all clinical staff pertaining to the policy and procedure for the use of restraints.</p> <p>6. All staff are required to attend de-escalation training on an annual basis.</p> <p>7. All nursing staff are required to attend de-escalation training at time of hire and subsequently on an annual basis.</p> <p>8. All nursing staff are required to attend training on the application of restraint at the time of hire and subsequently on an annual basis.</p> <p>9. The policy & procedure pertaining to the use of restraint is included in the annual skills fair.</p>	<p># 2 11/16/13</p> <p>Upon return to work at SDCPH - has not occurred</p> <p>2/17/15 Q3A JA CDPH 2/17/15</p> <p>7/12/13</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Annually</p>

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	<p>(b) For purposes of this section, "adverse event" includes any of the following:</p> <p>(5) Environmental events, including the following:</p> <p>(E) A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.</p> <p>(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of the individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.</p> <p>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.</p> <p>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.</p> <p>22 CCR 71507 All patients shall have rights which include, but are not limited to the following: (9) All other rights as provided by law or regulation.</p> <p>Welfare and Institution Code 5325.1</p> <p>Persons with mental illness have the same legal</p>		<p>10. Conduct Code Green drills (staff intervention drills for high risk of harmful behavior) on each shift.</p> <p>Monitoring Process:</p> <p>1. All episodes of restraint are monitored by the following methods:</p> <p>a. Immediately following a restraint intervention, a debriefing is conducted with the patient and the results are documented.</p> <p>b. Following a restraint intervention, a debriefing with staff is conducted and the results are documented.</p> <p>c. The Nursing Supervisor or ICN of the same shift that the restraint intervention occurred, reviews the process that occurred and any concerns or process problems that were revealed in the patient and staff debriefings. "Real time" coaching will occur if opportunities for improvement are discovered.</p> <p>d. All documentation pertaining to each episode of restraint is reviewed by the Staff Education/Training Coordinator inclusive of the debriefings to further discern opportunities for improvement. This information is then incorporated into future de-escalation trainings.</p>	Monthly

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	<p>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 or 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 in, be denied the benefits of, or be subjected to discrimination under any program or activity, which receives public funds.</p> <p>It is the intent of the legislature that persons with mental illness shall have rights including, but not limited to, the following:</p> <p>(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.</p> <p>Title 22 Regulations</p> <p>71213 (a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall</p>		<p>e. Results analyzed for all episodes of restraint are reported to the hospital's Quality Council (responsible for Quality & Safety oversight, for additional monitoring).</p> <p>2. Nursing orientation/training at the time of hire is monitored by the Coordinator of Staff Education/Training. All orientation/training activities are documented and maintained in staff education/training files.</p> <p>3. De-escalation training & the "application of restraints" training are conducted at time of hire and on an annual basis. Competencies are monitored through performance observation & documentation.</p> <p>4. Code Green drills are monitored through observation of performance. Results are documented.</p> <p>5. All training & education pertaining to restraint interventions are required. Monitoring occurs to ensure that all staff are current on all required training.</p> <p>6. Results of training, the ongoing monitoring, and observed proficiencies/ deficiencies are reviewed with the Director of Nursing.</p> <p>Person Responsible for Plan of Correction: Director of Nursing</p>	

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	<p>be approved by the administration and medical staff where such is appropriate.</p> <p>71545 (a) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.</p> <p>71545 (b) Patients shall be placed in restraints 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 signed by the physician on his next visit.</p> <p>The above regulation was NOT MET as evidenced by:</p> <p>Based on observation, interview, record and document review, the hospital failed to ensure that staff members followed the hospital's policies and procedures regarding use of manual restraints (any manual method, physical or mechanical, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely) and the proper procedure for handling a patient emergency in which there is imminent danger to self or to others. Staff members placed Patient 1 in a manual restraint without a physician's order or the authorization of a Registered Nurse (RN). The restraint was unnecessary, excessive, and not used in</p>				

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	<p>accordance with the hospital policy and procedure. Patient 1 sustained a fracture of the left humerus (upper arm bone) when staff members applied a manual restraint. Patient 1 was subsequently transferred to a general acute care hospital and underwent a surgical operation to repair his fractured arm.</p> <p>Findings:</p> <p>Patient 1 was brought to the hospital by the police on 6/24/13 on a 5150 for a grave disability (Welfare and Institution Code Section 5150, when any person, as a result of a mental disorder is a danger to others, or himself or herself, or gravely disabled). Patient 1 was admitted with diagnoses of psychotic disorder and chronic schizoaffective disorder, according to the Admission Face Sheet.</p> <p>An interview was conducted with the hospital's Assistant Administrator (AA) on 6/27/13 at 9:30 A.M. The AA stated that, around dinner time on 6/25/13, Patient 1 was very agitated and acting abusive. This occurred in the Day Room of Patient 1's nursing unit at about 5:45 P.M. Staff followed Patient 1 out of the day room. Two male staff members grabbed Patient 1's arms. "In the tussle that ensued, Patient 1 broke his left arm." Patient 1 was transferred, via ambulance, to an acute care hospital for the treatment of his left arm fracture. The AA further explained that, after he investigated the incident and interviewed all the staff members involved, it was his opinion that Patient 1 was "not an imminent risk. There was no reason for staff to apply 'hands' on this patient. It was a very poorly</p>				

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	<p>done intervention. If the staff had followed the hospital's de-escalation policy, this would not have happened."</p> <p>On 6/27/13 at 10:50 A.M., an interview was conducted with the hospital's Assistant Director of Nursing (ADON). Following a meeting with the staff members who were involved in the incident, the ADON determined the following: A staff member gave Patient 1 a verbal order to go to his room. Patient 1, then, started walking toward his room. At this point, the staff should have disengaged and not followed the patient because Patient 1 responded to the staff's verbal request. The ADON stated that she could see clearly that a few individuals did not follow hospital policy and procedure. The ADON acknowledged that this was a situation of "poor judgment" on the part of the staff. The ADON stated that a patient should only be restrained as a last resort and only after other interventions had been applied. The ADON explained that a "Code Green" should have been called if Patient 1 was deemed a danger to self or others.</p> <p>A review of the hospital policy and procedure, entitled "Code Green/Show of Support/Personal Alarms" and dated 4/26/12, indicated that "When there is a patient emergency in which there is imminent danger to self or to others and, the unit staffing resources require extra assistance to contain, physically restrain or seclude a patient supplemental assistance shall be secured through a CODE GREEN (ALL CALL) Telephone Paging System. A personal alarm system will be made</p>			

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	<p>available to all [name of hospital] employees who provide patient care. It is a requirement to be wearing a personal alarm when providing patient care."</p> <p>A review of the hospital policy and procedure, entitled "Restraint and Seclusion, dated 8/23/12, indicated that "Restraint is any method...that immobilizes or reduces the ability of a patient his or her arms, legs, body, or head freely..Physician Responsibilities for Violent or Self destructive behaviors: Order the use of restraint/seclusion..Nursing Staff Responsibilities: R.N. only: Provide leadership to other clinical staff during times of patient escalation and the implementation of seclusion/restraint..Nursing Staff: Implement less restrictive alternatives and de-escalation techniques whenever possible to avoid seclusion or restraint."</p> <p>On 6/28/13 at 2:15 P.M., an interview was conducted in the general acute care hospital with Patient 1. Patient 1 was observed with a fiberglass cast on his left arm. The cast extended from his left elbow to his left shoulder. Patient 1 was asked what happened to his left arm. Patient 1 explained that the incident "happened at [name of hospital]." Patient 1 stated that he was told to go to his room. When he got to the door of his room," two men grabbed him and twisted his left arm behind his back until it broke."</p> <p>A review of Patient 1's general acute care hospital medical record was conducted on 6/28/13 at 2:30 P.M. Patient 1 was admitted on 6/26/13 at 3:12</p>				

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	<p>A.M. with a diagnosis of fracture of the left humeral shaft, according to the Admission Face Sheet.</p> <p>Per a History and Physical dated 6/26/14, an X-ray film of Patient 1's left arm revealed a displace spiral fracture of the distal third shaft of the humerus (arm bone was twisted apart at an area closer to the elbow). During this admission, Patient 1 underwent an open reduction and internal fixation (a surgical operation that uses metal plates and screws for the purpose of repairing a fractured bone) of his left humeral fracture on 7/30/13.</p> <p>On 7/2/13 at 1:45 P.M., an interview was conducted with a Licensed Vocational Nurse (LVN) 1. LVN 1 stated that on 6/25/13 at about 3:00 P.M., he became involved with Patient 1 by re-directing Patient 1 from being intrusive and offensive to other patients. At approximately 5:15 P.M., LVN 1 heard staff members tell Patient 1 "to stop". LVN 1 was told by staff that Patient 1 tried to hit a staff member. The staff asked Patient 1 to go to his room. Patient 1 walked briskly to his room. About five staff members, including LVN 1, followed Patient 1. When Patient 1 reached the door of his room, he turned and started to lunge at staff with his left fist closed. LVN 1 stated he grabbed Patient 1's left arm and moved to his left side. Patient 1 started struggling, pushing and pulling. Patient 1 kept pulling away from LVN 1. Then LVN 1 heard a "snap". The staff let go of Patient 1 who went to his bed to lie down. The staff then noticed a deformity of Patient 1's left arm. LVN 1 explained that his actions in this case were not what he was taught regarding handling</p>				

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	<p>aggressive patients. LVN 1 stated that he had been taught to:</p> <ol style="list-style-type: none"> 1. Medicate 2. Redirect 3. Give Patient Quiet Time <p>LVN 1 explained that he was taught to let the patient go to his room by himself. LVN 1 acknowledged that he did not use his personal alarm and he did not activate a Code green.</p> <p>A second interview was conducted with LVN 1 on 7/3/13 at 3:35 P.M. LVN 1 stated that if a patient tries to hit you, he had been taught to:</p> <ol style="list-style-type: none"> 1 Try to deflect blow or move away from the patient 2 Try to deescalate the patient 3 Call patient by name 4. Talk in a calm manner 5 Call for support-Code Green <p>LVN 1 explained that the proper thing to do in a situation such as that which occurred with Patient 1 would have been to move back form the patient. LVN 1 stated that once he touched the patient he was applying a manual restraint. LVN 1 explained that he did not have the authority to make the decision to apply manual restraint to Patient 1. LVN 1 acknowledged that he did not follow the hospital's policy and procedure.</p> <p>On 7/2/13 at 2:30 P.M an interview was conducted with LVN 2. LVN 2 was assigned as the medication nurse on 6/25/13 from 3:00 P.M. until</p>				

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	<p>11:30 P.M. Per LVN 2's observations, Patient 1 was in "an angry mode upon approach, cursing, yelling, pacing a lot, and banging on the medication room window." Patient 1 asked for two Ativan (anti-anxiety medication). LVN 2 administered one Ativan, which didn't seem to be effective, so she informed RN 1. Per LVN 2, RN 1 called the physician in the Emergency Psychiatric Unit (EPU) and received an order for Zyprexa (antipsychotic medication) and Depakote (mood disorder medication). Those medications were administered to Patient 1 at 5:00 P.M. Per LVN 2, at 5:30 P.M., there was still no effect from the medications, and the patient's behavior started to escalate. She observed Patient 1 raise his hand in an attempt to strike MHA 2. MHA 2 stepped back from Patient 1, while LVN 2 ran towards the patient and told him to "stop, and go to your room." Per LVN 2, Patient 1 ran down the hall and five staff followed him. Patient 1 grabbed the door handle of his room with his right hand. Patient 1 was facing away from his room and lunged towards the staff. MHA 1 grabbed one arm and LVN 1 grabbed the other arm. LVN 2 heard a "snap." Patient 1 then lay prone (face down) on the bed and his left upper arm looked "deformed." LVN 2 ran to get help. Per LVN 2, in retrospect, everyone should have given Patient 1 "a lot more room, let him run around, and call a Code Green."</p> <p>An interview was conducted with Patient 1's primary care nurse (RN 1) on 7/2/13 at 3:15 P.M. RN 1 stated that she was assigned to care for Patient 1 on 6/25/13. RN 1 explained that Patient 1 kept going to the medication window asking for</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 054114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER San Diego County Psychiatric Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 3851 Rosecrans St, San Diego, CA 92110-3115 SAN DIEGO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>Ativan (a medication used to treat anxiety disorders). After Patient 1 received his Ativan he went up to RN 1 at the nurses' station and swung at her. RN 1 took a step back because that is what she has been taught. Patient 1 walked to the Day Room and was told to go to his room. Staff escorted Patient 1 to his room. As RN 1 approached Patient 1's room she heard a "snapping" noise. Patient 1 was holding the door handle. RN 1 stated that she went to the Charge Nurse because she was concerned that LVN 1 was holding Patient 1's left arm. RN 1 stated that holding a patient's arm is a form of manual restraint and that the use of manual restraints must be ordered by a physician or instituted by an RN. RN 1 further explained that the situation could have been handled better. She stated that the staff should have kept her informed of the increased frequency and intensity of Patient 1's behaviors. RN 1 stated that it is not appropriate for staff to ever grab a patient's arm. RN 1 explained that she was never taught to grab a patient's arm when they are assaulting you.</p> <p>On 7/2/13 at 4:05 P.M., an interview was conducted with a Mental Health Assistant (MHA 1) MHA 1 stated that after dinner, on 6/25/1, at 5:45 P.M., Patient 1 was yelling and screaming and calling names at staff. Patient 1 was "getting out of control and tried to hit staff." Patient 1 was told to go to his room and staff followed him. At the door to his room, Patient 1 tried to hit the staff members. LVN 1 grabbed Patient 1's left arm and MHA 1 grabbed Patient 1's right wrist. MHA 1 stated that this was not what he was taught to do if</p>				

Event ID:

1/13/2015

1:47:00PM

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	<p>a patient tried to hurt him. MHA 1 explained that he was taught to "walk away and ask for help"</p> <p>The hospital failed to ensure that staff members followed the hospital's policies and procedures regarding the use of a manual restraint and handling a patient emergency in which there is imminent danger to self or others. The patient sustained a fracture of the left humerus (upper arm bone) when the staff members applied the manual restraint. As a result, Patient 1 was transferred to a general acute care hospital and underwent a surgical operation to repair his fractured arm.</p> <p>On 10/23/13 at 4:20 P.M the Assistant Administrator was informed of the potential for an Administrative Penalty to be issued as a result of that violation.</p> <p>The facility's noncompliance with these requirements, jointly, separately or in any combination, has caused, or is likely to cause, serious injury or death to the patient, and therefore, constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.</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 1280.1(c)</p>				

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