The following reflects the findings of the California Department of Public Health during a Complaint investigation.

Complaint No: CA00123066

Representing the California Department of Public Health:

1280.1(a) HSC Section 1280

(a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Sections 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.

1280.1(c) HSC Section 1280

(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.

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.

Title 22 CCR-70217(a)(8) Nursing Service Staff
(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios. Licensed nurse means a registered nurse, licensed vocational nurse and, in psychiatric units only, a licensed psychiatric technician. Staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system.

No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.

Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time. "Assigned" means the licensed nurse has responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number of patients and the total number of licensed nurses on the unit during any one shift nor over any period of time. Only licensed nurses providing direct patient care shall be included in the ratios.

Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed
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nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit.

Licensed vocational nurses may constitute up to 50 percent of the licensed nurses assigned to patient care on any unit, except where registered nurses are required pursuant to the patient classification system or this section. Only registered nurses shall be assigned to Intensive Care Newborn Nursery Service Units, which specifically require one registered nurse to two or fewer infants. In the Emergency Department, only registered nurses shall be assigned to triage patients and only registered nurses shall be assigned to critical trauma patients.

Nothing in this section shall prohibit a licensed nurse from assisting with specific tasks within the scope of his or her practice for a patient assigned to another nurse. "Assist" means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited.
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(8) In a hospital providing basic emergency medical services or comprehensive emergency medical services, the licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times that patients are receiving treatment. There shall be no fewer than two licensed nurses physically present in the emergency department when a patient is present.

At least one of the licensed nurses shall be a registered nurse assigned to triage patients. The registered nurse assigned to triage patients shall be immediately available at all times to triage patients when they arrive in the emergency department. When there are no patients needing triage, the registered nurse may assist by performing other nursing tasks. The registered nurse assigned to triage patients shall not be counted in the licensed nurse-to-patient ratio.

Hospitals designated by the Local Emergency Medical Services (LEMS) Agency as a "base hospital", as defined in section 1797.58 of the Health and Safety Code, shall have either a licensed physician or a registered nurse on duty to respond to the base radio 24 hours each day. When the duty of base radio responder is assigned to a registered nurse, that registered nurse may assist by performing other nursing tasks when not responding to radio calls, but shall be immediately available to respond to requests for medical direction on the base radio. The registered nurse assigned as base radio responder shall not be counted in the licensed nurse-to-patient ratios.
When licensed nursing staff are attending critical care patients in the emergency department, the licensed nurse-to-patient ratio shall be 1:2 or fewer critical care patients at all times. A patient in the emergency department shall be considered a critical care patient when the patient meets the criteria for admission to a critical care service area within the hospital.

Only registered nurses shall be assigned to critical trauma patients in the emergency department, and a minimum registered nurse-to-critical trauma patient ratio of 1:1 shall be maintained at all times. A critical trauma patient is a patient who has injuries to an anatomic area that: (1) require life saving interventions, or (2) in conjunction with unstable vital signs, pose an immediate threat to life or limb.

The hospital failed to provide sufficient licensed nurses and skilled personnel to monitor and provide a safe and secure environment to avoid elopements. This resulted in an Immediate Jeopardy that was implemented on August 14, 2007 at 3:54 PM.

On July 24, 2007, at 1:15 PM, an onsite visit was made to the Kern Medical Center Emergency Department, Emergency Psychiatric Assessment Center (EPAC) by the Acting District Administrator and Health Facilities Evaluator Supervisor from the Bakersfield District Office. The clinical record for Patient A was reviewed. Documentation in the clinical record on March 29, 2007 at 8: 23 AM, revealed Patient A was brought to the EPAC by...
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local law enforcement with an involuntary hold (5150) in place after being deemed a danger to herself by law enforcement. The psychiatric nursing assessment done by Licensed Staff 1 on March 29, 2007, at 9 AM, read, "patient states she wants to die and plans to cut herself." Continued documentation on March 29, 2007, at 2 PM, by Licensed Staff 1 read, "Walking outside without security even though on jail hold." An entry in the clinical record dated March 29, 2007, at 3:30 PM, by Licensed Staff 1, read, "unable to locate patient. Went to bathroom and did not return."

On July 24, 2007, at 2:50 PM, during record review, Page 4 of the evaluation of Patient A by the EPAC psychiatrist could not be found in the clinical record. This was confirmed by the Health Information Staff. On July 24, 2007, at 3 PM, during an interview with the EPAC psychiatrist he revealed the following information; "Everything was done by me on Page 4 of my evaluation of Patient A. Patient A was to be transferred to jail custody and have a suicide watch in jail. The 5150 remains in effect until the patient is handed over to corrections because of the risk; in custody she would be under suicide watch. She was never handed over to custody staff. Hospital staff had overheard her making plans to elope. At the time Patient A left she was still a 5150 because she had not been handed to the custody of law enforcement. If a patient is on a 5150 they are not to go outside without supervision. I saw her outside and brought her back in."

On August 13, 2007, at 1 PM, review of the
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coroners report for Patient A, revealed death occurred on April 1, 2007 at 12:35 PM, as the result of acute cocaine intoxication. The death of Patient A occurred 48 hours after eloping from the EPAC at Kern Medical Center.

On August 11, 2007 at 3:49 PM, during interview with the EPAC Clinical Supervisor he was asked "what is the required staffing in the EPAC"? The Clinical Supervisor stated, "Ideally I try to staff 4 Licensed Nurses at all times with 4 CNAs to cover all EPAC zones."

Review of the EPAC Log from March 26, 2007 - April 3, 2007 revealed a census of 10 - 18 patients daily. On March 29, 2007, 14 patients were present in the EPAC with 1 elopement, which was Patient A.

Review of the staffing for March 29, 2007 - April 3, 2007, between 9 AM and 3:30 PM, revealed staffing in the Emergency Department was two (2) registered nurses and one (1) licensed vocational nurse, indicating the staffing ratios were below the regulatory requirement of 4:1 or less every day.

On August 13, 2007 at 1:40 PM, during observations of the hospital's EPAC, patients admitted to the unit were seen freely walking and standing in the hallway in front of the EPAC nursing station; sitting in chairs along the wall in front of the nursing station; or lying on gurneys, recliner chairs, or on the floor in four separate rooms (rooms 13, 16, 1520, and, 1522). The EPAC Nursing Station is at the southwest end of the hospital's
Emergency Department (ED). There are two main hallways that lead to the back of the ED that were observed to be busy with hospital's staff, other ED patients, and visitors. The west hallway leads to the main entrance for arriving and departing ambulances. These doors were observed to be a high traffic point of entry and exit. There was no hospital staff posted at the doorway.

On August 13, 2007 at 1:49 PM, during an interview with Charge Nurse 1, she admitted that there were 17 patients currently admitted to the EPAC unit. All patients were being held involuntarily (5150).

On August 13, 2007 at 2 PM, during an interview with Licensed Nurse 1, she confirmed that the current staffing assignment consisted of three Licensed Nurses and two Certified Nursing Assistants (CNA) that were providing direct care to the current 17 admitted patients. Licensed Nurse 1 continued stating, two nurses and one CNA were stationed at the EPAC Nursing Station in the ED and one nurse and one CNA were stationed in what was referred as the EPAC Extension Room (a room along the west hallway, just outside of the ED).

On August 13, 2007 at 3:15 PM, during review of the hospital's Day Shift EPAC Staffing Record and the hospital's Daily Unit Census Record confirmed that of the admitted 17 patients, seven patients were assigned to Charge Nurse 1 and four patients were assigned to Licensed Nurse 1. CNA 1 was assigned all patients in the EPAC area. Six of the patients were assigned to Licensed Nurse 2 and CNA 2 in the EPAC Extension Room.
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On August 13, 2007 at 3:49 PM, during an interview with the EPAC Clinical Supervisor, he was asked what is the required staffing level of the EPAC unit? The Clinical Supervisor stated, "Ideally, I try to staff four licensed nurses at all times with four CNA's to cover all EPAC Zones." When asked what was the staffing situation for today, the Clinical Supervisor stated, "Today I have three licensed nurses and two CNAs. I know I'm understaffed, I've had people call off today that were scheduled to work and everyone I've tried to call in to cover have refused to come in." When asked if understaffing was a frequent problem on the unit, the Clinical Supervisor stated, "It is a continuous problem because no matter what my staffing level is there are frequently too many patients being admitted to the EPAC. Because we are the only facility designated in the entire county to receive 5150's they all come here. So we frequently become saturated with 5150's." The Clinical Supervisor gave an example of the overcrowding that occurs, he stated, "There was a day in July when the EPAC admitted approximately 31 patients. When I tried to close the unit in order to prevent any more patients from saturated with 5150's." The Clinical Supervisor gave an example of the overcrowding that occurs, he stated, "There was a day in July when the EPAC admitted approximately 31 patients. When I tried to close the unit in order to prevent any more patients from being brought to the ED, I was told that the EPAC unit cannot be closed nor could incoming patients be diverted to other facilities because we were the only facility in the entire county to accept 5150's." The Clinical Supervisor then stated, "The problem
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with having that many patients is that the unit is not physically designed to safely hold that many people. It is impossible for the staff to keep an eye on everyone. When asked if there were concerns about patients elopements, the Clinical Supervisor admitted, "There are frequent elopements from the EPAC."

On August 13, 2007 at 1:40 PM, during interview with the EPAC Clinical Supervisor he stated, "Those at risk for elopement are placed in the back in the EPAC extension; it holds seven Patients. The front area for 5150's holds three patients maximum, the reality is more. We have had up to 31 patients in the EPAC holding areas."

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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.