

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>060159</b>	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  <b>02/06/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>VENTURA COUNTY MEDICAL CENTER INPATIENT D/P APH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 Hillmont Ave, Ventura, CA 93003-1647 VENTURA COUNTY</b>		
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	<p>The following reflects the findings of the California Department of Public Health-Licensing and Certification during an onsite investigation of an entity reported incident.</p> <p>Representing the Department: HFEN 2623</p> <p>Complaint #CA00386548 is Substantiated</p> <p>The inspection was limited to the investigation of the complaint and does not reflect the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1279 1(a):</p>		<p>Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies.</p> <p>The following constitutes Ventura County Medical Center Inpatient D/P APH's plan of correction.</p>	

*7/29/15 Accepted & Checked*

2015 JUL 27 PM 5:06  
VENTURA COUNTY MEDICAL CENTER  
VENTURA DISTRICT OFFICE  
DEPT OF PUBLIC HEALTH

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE **CEO** (X6) DATE **7/27/15**

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 11

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>(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> <p>Health and Safety Code Section 1279.1(b)(3)(C):</p> <p>(b) For purposes of this section, "adverse event," includes any of the following:</p> <p>(3) Patient protection events, including the following:</p> <p>(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.</p> <p>Health and Safety Code Sections 1280.1 (a), (c) and (d):</p> <p>(a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, 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</p>			

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	<p>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 the patient.</p> <p>(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</p> <p>California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, Section 70577, Psychiatric</p>			<p>2015 JUL 27 PM 2:40</p> <p>VENTURA DISTRICT OFFICE</p> <p>DEPT OF PUBLIC HEALTH</p>

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	<p>Unit General Requirements</p> <p>(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. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>(b) The responsibility and the accountability of the psychiatric service to the medical staff and administration shall be defined.</p> <p>Based on interview and record review, the facility failed to remove objects of harm from Patient 1 when ■ was admitted to a locked psychiatric unit which resulted in Patient 1's suicide and death. The facility did not have a policy or procedure to identify objects of harm, nor a policy or procedure to identify specific interventions that responsible nursing or medical staff should take to conduct a search and remove objects of harm. Additionally, responsible nursing staff failed to follow facility policy and procedure regarding the search of Patient 1 for objects of harm. These failures resulted in Patient 1 having access to a cord that ■ used to commit suicide in the facility.</p> <p>Findings: On 2/6/14, a review of facility policy entitled, "PRECAUTION POLICY" last reviewed 5/6/11, revealed the following: "All patients admitted without a face to face evaluation by a psychiatrist will be placed on close precautions</p>		<p><b>Title 22, Div. 5, Chapter 1, Article 6, Section 70577 Psychiatric Unit General Requirements</b></p> <p>Actions Taken: 1. Hospital Leadership reviewed and revised the "Precaution Policy" and the "Admission, Psychiatric Unit Procedures-Nursing" to clarify the process for identifying objects of harm and to identify</p>	<p>2/13/14 to 3/3/14</p> <p>2015 JUL 27 PM 2:41 VENTURA DISTRICT OFFICE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH</p>	

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	<p>until seen by a psychiatrist." Under the subheading of the Precaution Policy, entitled, "PROCEDURE NOTES," the following procedure is set forth: "3) Remove objects patient may use to harm self," and the policy also identifies that patients are observed every 15 minutes and reassessed every two hours. A further review of Patient 1's "CLOSE PRECAUTION PATIENT ADVISEMENT TREATMENT PLAN," dated [REDACTED]/14 at 8:00 p.m., revealed Patient 1 signed giving consent for the following: "My belongings will be searched and any dangerous items or articles of clothing will be removed and locked up to help keep me safe. I will be checked every 15 minutes by staff I may be asked to sign in every 15 minutes. I will be assessed by RN's every 2 hours for my continued ability to keep myself and/or others safe on the Unit."</p> <p>Record review revealed Patient 1 was evaluated by a registered nurse on [REDACTED]/14 at 8:00 p.m. for admission to the psychiatric unit, but not by a psychiatrist. Review of Patient 1's record on 2/6/14 revealed [REDACTED] was admitted to the facility emergency department on [REDACTED]/14, after a suicide attempt. The record also revealed Patient 1 had a prior admission to the facility for treatment of depression on [REDACTED] 2013, after [REDACTED] told [REDACTED] physician [REDACTED] had tried to kill [REDACTED] self on multiple occasions. After Patient 1 was medically cleared in the emergency department on [REDACTED]/14, [REDACTED] was escorted by security staff to the inpatient psychiatric unit for evaluation.</p> <p>Interview with the intake assessment psychiatric nurse (Nurse 1) on 3/21/14 at 11:15 a.m., revealed Patient 1 said [REDACTED] would kill [REDACTED] self if Nurse 1 did</p>		<p>specific interventions that responsible nursing staff are to perform when conducting a search and removal of objects of harm from a patient.</p> <p>Any patient admitted to the unit receives a contraband check. This check includes the patient taking off all of their clothes in one of the quiet rooms, including undergarments and socks and putting on a paper gown. Two same gender staff, one of whom is licensed, will assist the patient. Once the patient has put on the paper gown, belongings are separated and searched for contraband. Once the check has been completed, the patient may have their searched clothes returned or offered pajamas. Should a patient decline to turn over their belongings or change into the paper gown for the check, he/she will be immediately placed on 1:1 observation in the admission hallway. The 1:1 observation will continue until the patient cooperates with the contraband check. A log was created entitled "contraband refusal log" for documentation of any patient refusing contraband checks.</p>	7-27-15

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	<p>not admit [REDACTED] on [REDACTED]/14. Nurse 1 documented in the record on [REDACTED]/14 that Patient 1 had constant suicidal ideation, poor coping skills, and was appropriate for admission to the locked unit. Nurse 1 explained she did not have Patient 1 change into a gown in order to search [REDACTED] clothing. Nurse 1 stated she allowed Patient 1 to keep [REDACTED] clothes on, and had [REDACTED] "flip out" [REDACTED] pockets so she could check for "objects of harm." Nurse 1 advised that objects of harm might be shoe laces or a belt, for example, but that "objects of harm" is not specifically defined in policy. Nurse 1 explained Patient 1 was wearing "parachute" shorts with multiple pockets. Nurse 1 said Patient 1 had no jewelry, had slip on shoes without laces, and that she felt Patient 1's socks for "objects of harm." Nurse 1 did not recall removing any objects of harm from Patient 1.</p> <p>An Interview with the nurse manager on 3/21/14 at approximately 11:30 a.m. revealed she did not know what the industry standards were on how to conduct a search for objects of harm. The nurse manager confirmed that facility policy did not contain specifics on how to search, what clothes to remove, what "objects of harm" were, or what to do if a patient refused to be searched or to take off clothes. The nurse manager said that Patient 1 must have snuck in the cord [REDACTED] used to commit suicide.</p> <p>During an Interview on 3/25/14 at 1:50 p.m., the psychiatric inpatient admitting nurse (Nurse 2) recalled Patient 1 refused to remove [REDACTED] clothes upon admission of [REDACTED]/14 at 8:00 p.m. Nurse 2 stated she did not search Patient 1 or [REDACTED] clothing for objects of harm on admission to the locked</p>		<p>This log will be reviewed daily against those patients on 1:1 continuous observation to determine if any continuous observation was required due to the contraband refusal. Any failures to include contraband refusal on the log will require immediate assessment of the patient to ensure all staff are aware of contraband check refusal and the need for heightened awareness of the patient's potential for hiding a dangerous object. The registered nurse will complete the log upon assessment if the patient refuses contraband check with the charge nurse assessing the log against all 1:1 patient daily. Contraband log created 7-27-15, staff education to be completed by 7-31-15 via charge nurse email, direct one-on-one, huddles, and staff meeting. Nursing staff were educated on the revised policy, with special emphasis on strict adherence to contraband checks or 1:1 observation is necessary.</p>	7-27-15 to 7-31-15

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	<p>psychiatric unit because [redacted] refused. Nurse 2 did not recall getting a report from Nurse 1. During an interview with the nurse manager on 2/6/15 at 9:30 a.m., she indicated that Nurse 1 assessed the patient outside of the locked unit which is not part of the facility, to see if [redacted] was appropriate for admission. The manager said that Nurse 2 did the actual admission assessment to the psychiatric unit. Nurse 2 was interviewed about following the facility policy for searching a patient and removing objects of harm and said the patient did not have a belt or string, but refused the search. Nurse 2 escorted Patient 1 into the locked unit, and did not follow the policy to look for objects of harm or search the patient's clothing. Record review revealed that Nurse 2 did not document the patient's refusal to be searched. Further record review revealed Patient 1 was not evaluated by a psychiatrist prior to admission.</p> <p>Continued record review, facility policy review, and concurrent interview with NURSE 2 revealed Patient 1 was placed on "CLOSE PRECAUTION," on [redacted] 14 at 8 p.m., because the patient had thoughts of self-harm. The policy lists "Levels of Interventions" for the following: "General Precautions, Close Precautions, Strict Precautions and Nursing 1:1." Nursing staff were required to check on Patient 1 every 15 minutes and document [redacted] location, according to the facility policy entitled, "CLOSE PRECAUTION," last reviewed 5/6/11.</p> <p>Review of Patient 1's "CLOSE PRECAUTION ASSESSMENT RECORD PROGRESS NOTE" and an interview with Nurse 2 on 3/25/14 revealed that two hour assessments were completed for Patient 1, by Nurse 2, at 10 p m on [redacted] /14 and at 6 a m.</p>		<p>2. IPU Leadership reviewed the "Precaution Policy" and the "Psychiatric Unit Admission Policy, Unit Procedures upon receipt of the survey report. The process for checking for contraband did not require any revisions. Nursing staff were re-educated on the policies.</p> <p>3. IPU Leadership identified that a policy describing types of contraband, entitled the "Dangerous Articles" Policy, was in effect at the time of the survey. The policy was reviewed and did not require any revisions at the time. As detailed in the policy, staff will identify, remove, inventory, and secure dangerous articles and only return them to the patient upon discharge. The policy further defines the types of dangerous articles, which includes razors, knives, guns, sling shots, sharps (e.g., scissors, pins, safety pins, paper clips and all objects with sharp edges or points); medications, lotions, shampoos, cleaning chemicals and liquids which may be ingested and be toxic; matches, lighters and all flammable liquids; drug paraphernalia and all illegal substances; alcoholic beverages; needles, crochet hooks knitting needles and other craft items; knives, forks, spoons, soft drink aluminum cans, plastic serving cups and glass containers of all kind; manicure items (e.g., nail files, nail clippers, hair barrettes, combs and brushes with sharp handles); mirrors and all glass objects; all jewelry and watches; metallic toothpaste tubes, hard</p>	<p>7-23-15 to 7-31-15</p> <p>5-2015</p>

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	<p>on [REDACTED] 14. Nurse 2 indicated she had documented the patient did not have thoughts of self-harm at the 10 a.m. and 6 a.m. assessments. Nurse 2 also indicated that although she documented an assessment was done at 12 a.m. and 4 a.m., she did not actually assess Patient 1 because staff told her [REDACTED] was asleep.</p> <p>A further review of the facility policy entitled, "PRECAUTION POLICY," last revised September 2009, and reviewed May 2011, revealed staff are required to do the following: "remove objects patient may use to harm self," prior to admission to the psychiatric unit. However, review of the "Precaution Policy" revealed the policy does not specifically identify how responsible nursing staff may determine what might be considered an object of harm for patients admitted into the psychiatric unit, nor does the policy identify how to conduct the search for these items.</p> <p>The Medical Director and Nurse Manager were interviewed on 2/6/14 at 9:15 a.m., regarding searching patients for objects of harm. According to the Medical Director and Nurse Manager, the facility practice was to have the patient remove their clothes and change into a gown while staff checked the clothing and removed objects of harm. They identified objects of harm could be cords or shoe laces that could be used for hanging. If physician orders reflected the patient could wear their clothing, the clothes were returned to the patient after they were searched. Facility policy did not contain instructions on how to complete a search, what precautions to take if patients refused to remove their clothes for a search, and what might constitute objects of harm that should be removed</p>		<p>plastic items that can be reduced to sharps; plastic bags, saran wrap, foil and anything that can cut off air supply; keys, electrical appliances, and any other item that is determined by staff to be harmful.</p> <p>4. IPU Leadership reviewed the Dangerous Articles Policy upon receipt of the survey report and revised it to be entitled the "Contraband and Dangerous Articles" Policy. Clinical staff were re-educated on the renamed policy via small group education and written instructions on the log and flowsheet.</p> <p>5. IPU Leadership reviewed the Psychiatric Unit Patient Belonging Inventory flowsheet which documents the patient's belongings and storage of particular items, such as those identified as contraband. Clinical staff were re-educated on the flowsheet via small group education and written instructions.</p> <p>6. Hospital Leadership implemented additional measures to ensure ongoing patient safety in the IPU, including a process for every 15 minutes checks for each patient. Documentation of the safety checks on the "Patient Observation Record" include the time of the check, the patient's status (e.g., calm, agitated or sleeping), whether there are signs of injury and notification of the registered nurse. Clinical staff were educated on the process and documentation requirements.</p>	<p>7-23-15 to 7-31-15</p> <p>7-23-15 to 7-31-15</p> <p>7-23-15 to 7-31-15</p>

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	<p>from patients.</p> <p>The staffing assignment sheet for the inpatient psychiatric unit was reviewed on 2/6/14 and revealed that Nurse 2 was assigned the care of Patient 1 after admission on [REDACTED]/14 at 8:00 p.m. Review of the job description for Nurse 2 on 2/6/14 revealed that she was responsible for safety and risk management of Patient 1, and was required to be "Proactive in identifying, preventing, and addressing current or potential risks to patient or staff safety on the unit." Further review of Nurse 2's job description revealed she "Initiates and carries out RN responsibilities related to policies and procedures for medical clearance, contraband, AWOL, precautions and managing patient violence."</p> <p>Interviews on 3/21/14 with Nurse 1 and on 3/25/15 with Nurse 2 and the nurse manager, record review and policy review revealed the following: a) Nurse 1 had the patient "flip out" [REDACTED] pockets, but this was done prior to Patient 1 being admitted to the locked unit, and the patient was not in the locked psychiatric unit at that time; b) Nurse 2 was ultimately responsible for the safety of Patient 1 after admission to the locked unit; and (c) Nurse 2 did not search Patient 1, or check for objects of harm on Patient 1's person, according to her job assignment and facility policy</p> <p>During an interview and concurrent record review on 2/6/14 at 10:15 a.m., the day shift nurse (Nurse 3) revealed he assessed Patient 1 on [REDACTED] 14 at 8 a.m. to be without suicidal ideation or plan. Nurse 3 indicated he saw Patient 1 after breakfast and they discussed showering. The fifteen minute checks were documented at 8:15 a.m. and 8:30 a.m. At</p>		<p>7. Nurses were re-educated on performing and documenting patient assessments in the IPU.</p> <p>8. IPU Leadership performed a four month audit from February 2014 to May 2014 on admissions to the IPU to monitor compliance with assessing patients for contraband and placing patients on 1:1 if they refused to be searched for contraband. 100% compliance was achieved.</p> <p>Compliance and Monitoring:</p> <p>On a weekly basis the IPU Clinical Nurse Manager or qualified designee shall review 5 records of patients admitted during the week which represents approximately 15 % of total admissions (for three months and then re-evaluate) to monitor compliance with assessing patients for contraband or placing patients on 1:1 if they refuse to be searched on admission. The 5 records can be reviewed throughout the week or in volume, retrospectively.</p>	<p>7-23-15 to 7-31-15</p> <p>2-2014 to 5-2014</p> <p>7-23-15 to 10-31-15</p>

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(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>8:45 a.m., staff was alerted by Patient 1's roommate that Patient 1 was on the floor in ■ bathroom. Nurse 3 went to the room and found Patient 1 slumped between the toilet and the wall. Nurse 3 described that there was a cord tied "like a noose" around Patient 1's neck as Patient 1 was slumped face down near the toilet paper dispenser. Nurse 3 said that another staff had to cut the cord from around Patient 1's neck to begin emergency care. The patient was then transported to the emergency department where ■ was treated and declared dead on ■/14 at 9:19 a.m.</p> <p>Review of Patient 1's autopsy report dated ■/14 revealed Patient 1's cause of death on ■/14 was asphyxia (obstruction of air flow) due to hanging, and was suicide. Further review revealed a cord ("brown woven cord ligature") accompanied the patient and was found with an intact hangman's noose. Review of the County Death Investigation dated ■/14 revealed Patient 1's father indicated Patient 1 had access, at ■ home, to this same type of cord where Patient 1 used it to make bracelets.</p> <p>The medical examiner (ME) who conducted Patient 1's autopsy was interviewed on 3/17/14 at 12:46 p.m. According to the ME, the cord was made of woven strands of nylon inside a very strong cover, is referred to as paracord and is capable of holding up to 500 pounds. The ME also indicated the cord has multiple uses including making bracelets. An interview with the psychiatric unit Medical Director on 2/6/14, at 9:15 a.m., indicated that the cord Patient 1 used to hang ■self would not have been available at the facility and that Patient 1 must have had the cord with ■ upon admission to the</p>		<p>Corrective action is taken, if necessary, including staff re-education. Data will be tracked, trended, analyzed, and reported monthly to the Performance Improvement Department, and quarterly to the Performance Improvement Coordinated Council, Medical Executive Committee and Governing Board.</p> <p>Persons Responsible:</p> <p>Chief Nurse Executive Chief of Hospital Operations</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:  <b>050159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>VENTURA COUNTY MEDICAL CENTER INPATIENT D/P APH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 Hillmont Ave, Ventura, CA 93003-1647 VENTURA COUNTY</b>		
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	<p>psychiatric unit.</p> <p>The facility failed to develop, maintain and implement a policy that included instructions to nursing staff regarding how to conduct a search of patients for objects of harm, instructions on precautions or interventions to be undertaken when patients refuse to comply with facility practice regarding the conduct of a search, and specific identification of what objects of harm are that should be removed from patients. Additionally, the facility failed to implement appropriate interventions regarding the planning and delivery of care to Patient 1 upon [REDACTED] admission, when Nurse 2 failed to conduct any search of Patient 1 for objects of harm that was required pursuant to facility policy and procedure. These failures are deficiencies that have caused, or are 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(c).</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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