CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050236	A.BUILDING B.WING	01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adventist Health Simi Valley	2975 Sycamore Drive, Simi Valley, CA 93065-1201 VENTURA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00556765 - Substantiated Representing the Department of Public Health: Surveyor ID# 2623, HFE-N 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(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. Health & Safety Code Section 1280.3 (a) and (g): (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation.	January 14, 2019 Accepted POC Kathleen Cheevis	**Adventist Health Simi Valley is committed to providing quality care. Preparation and/or implementation of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by law.** The following actions and/or changes have been initiated in response to events cited for Patient 1, and applies to all current and future patients admitted to the facility regarding the planning, implementation, supervision, and evaluation of care for behavioral health patients in the Emergency Department (ED). The Emergency Department (ED) clinical educator created a written educational packet for staff training and review. The ED clinical educator provided 1:1 training of all charge nurse personnel who then provided 1:1 training of all ED personnel. Education included the following to ensure behavioral health patients are identified, risk is communicated among all members of the healthcare team including the sitter, all elements of the policy are followed, and documentation is completed. The processes and content of the following policies included: • Facility policy # 10694 *Suicidal*	11/30/2017

Event ID:63VD11 1/3/2019 9:49:3BAM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Director, Risk Management & Accreditation 01/11/19

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 10

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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	(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. Title 22, California Code of Regulations, Division 5, Chapter 1, Article 3, Section 70215, subdivision (a) (2). Planning and Implementing Patient Care: (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. Title 22 California Code of Regulations, Division 5, Chapter 1, Article 3, Section 70213, subdivision (a). Nursing Service Policies and Procedures. (a) Written policies and procedure for patient care shall be developed, maintained and implemented by the nursing service. Findings: The facility reported an unusual occurrence to the Department on 10/12/17 that Patient 1 ran out of the emergency department while on an involuntary hold		*Patient/Suicide Precautions & Care of the Behavioral Health Patient* with emphasis on screening, risk identification, communication of risk level and interventions for patient safety. • Facility policy # 13188 *Sitter Guidelines* with emphasis on nurse communication to the sitter of pertinent assessment information, risk level, communication of an environmental risk safety check, and interventions that include altering the environment for safety, maintaining visual contact, and accompanying patients for toileting and other procedures. • New Facility Policy #14361 *Intake Inventory by Security Official in the ED* on identifying behavioral health patients on intake (arrival) to the Emergency Department with roles for Security and Nursing personnel. Emphasis on the process for patient search and belongings segregation. All education was reinforced during the November 2017 Emergency Department staff meetings by the Emergency Services director, Clinical Educator, and Clinical documentation specialist. The Security manager provided 1:1 education of security personnel on behavioral health patient escorts to include tactical positioning and avoidance of using the patient restroom near ED ambulance doors. Training has also been incorporated into security official orientation for all new hires.	11/30/2017 10/19/2017

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	because he was a threat to public safety and an investigation was conducted at the facility on 10/16/17. Based on interview and record review the registered nurse (RN1) failed to provide supervision and special instructions to unlicensed staff (ULS1) involved in the care and safety of Patient 1. In addition, the facility failed to plan an effective and safe transfer for Patient 1. Consequently, patient 1, a psychiatric patient, admitted to the hospital involuntarily while under a Welfare and Institutions Code (WIG) Section 5150 order (a 24-hour involuntary hold due to a danger to self or others) ran out of the hospital's emergency department (ED). The facility failed to follow their policy to provide Patient 1 a safe environment and arrange for a safe transfer to a psychiatric facility. Patient 1, after running out of the emergency department of the facility, was shot by police and taken to a trauma emergency department for treatment. As a result of the facility's failures to properly supervise Patient 1 and failing to effectuate a safe transfer of Patient 1, Patient 1 sustained serious injury and harm. On October 16, 2017, a review of Patient 1's medical record and facility Policies and Procedures was conducted. The facility's policy and procedure entitled, "SUICIDAL PATIENT/SUICIDE PRECAUTIONS & CARE OF THE BEHAVIORAL HEALTH PATIENT," dated 3/20/17, set forth the following: "If a staff member determines that a patient may be a danger to either themselves or others (including gravely disabled), the following steps should be taken: Provide a safe environment to protect patient by removing or restricting access to potentially harmful items...Ensure the safety of		House-wide education was completed by the Risk Management director to educate all nursing staff on new facility policy # 14361 *Intake Inventory by Security Officials in the ED* on identifying behavioral health patients on intake (arrival) to the facility, safe processes for search and belongings segregation for ED and inpatients, sitter requirements for communication of patient status, sitter responsibilities, and environment risk safety checks and interventions for patient safety. Direct observations, video surveillance, closed record reviews, and event report reviews were conducted by the Risk Management director monthly for all Emergency Department patients who were screened for a possible involuntary psychiatric hold. Goal of compliance was 100% of all cases reviewed for three months would have a comprehensive safety screening completed including sites communication and documentation, no incidents with prohibited items, no patient injures, and no elopements. The goal was met and reported out to the Quality and Performance Improvement committee which reports up to Quality Council, Medical Executive Committee, and the Governing Board.	12/03/2017 02/28/2018

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	the patient...Assign a staff member or private duty sitter to remain with the patient for observation...Do not leave patient unattended in the bathroom; maintain visual contact...If a patient is not medically stable for transfer to a psychiatric facility or discharge home from the Emergency Department, the patient will be admitted to the appropriate acute unit based on the admissions criteria. When the patient is deemed medically clear, obtain a physician order for a Crisis Team Evaluation if the patient is deemed suicidal (a danger of harm to self), homicidal (a danger to others). is gravely disabled (unable to provide for his/her own basic needs), or is experiencing an urgent mental health issue." The policy also directs staff, "If a patient is placed on a 5150 hold" (a 24 hour involuntary hold as the patient is a danger to self or others), "or is seeking voluntary admission to a psychiatric facility, prepare the patient for transfer...and arrange transport by ambulance (EMT), Ventura County Crisis Team, the Simi Valley Police Department or other Law Enforcement agency." A review on 10/16/17 of the facility's policy and procedure entitled, "SITTER GUIDELINES," dated 12/21/16, set forth the following:"The sitter reports to the charge nurse upon arrival to the unit for assignment information. The primary nurse will give report to the sitter to include special instructions for patient care and safety, and review required documentation...Sitters in the ED will carry a 2-way radio to alert Security of a patient elopement...Sitter will maintain a visual of an eloping patient until relieved by security and/or law enforcement arrives...The sitter accompanies the patient for any		To ensure ongoing compliance, the Risk Management director conducts ongoing case reviews of all Emergency patients identified as possible involuntary psychiatric holds for compliance with safety screenings, hand-off communication, no patient harm or elopements, and documentation. Individual staff fallouts will be addressed by the Emergency Department director for 1:1 education and progressive disciplinary action as appropriate. Variances will be reported to the Patient Advisory Council which reports up to Quality Council, Medical Executive Committee, and the Governing Board. 2019 JAN 14 AM 11:10 LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE CA DEPT OF PUBLIC HEALTH	Monthly and ongoing

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	clinical tests or procedures off the unit and remains within 4-6 feet of the patient." Record review of the ED physician's final report dated 10/11/17 at 10:20 a.m. set forth that Patient 1 was brought in to the ED at 10:04 a.m. in handcuffs by police officers after police determined he had been hearing voices and was a danger to others. Further review of the ED physician documentation revealed Patient 1 was being held involuntarily on a 5150 order. Review of the 5150 order in the medical record revealed that police documented at 10/11/17 at 10:00 a.m. that Patient 1 was a danger to himself and others. In addition, the police officer documented that due to the mental state of Patient 1, he "was an extreme danger to the public." Telephone interview with the ED physician on 10/16/17 at 1:47 p.m. revealed that Patient 1 was so opposed to physical restraints that he was given the choice of an injection of Geodon (an antipsychotic medication) to calm him down rather than continue in restraints. The physician also indicated that after the Geodon was given Patient 1 was calm and cooperative. Further review of the ED physician final report dated 10/11/17 revealed that at 10:19 a.m. he ordered Geodon for acute agitation in schizophrenia once and as needed for agitation, and at the same time wrote an order for physical restraints. Review of nursing documentation dated 10/11/17 revealed that Geodon was given intramuscularly at 10:44 a.m. and no other doses were given. A review of Daily Med (United States National Library of Medicine) information on Geodon revealed the half-life is 2-5 hours (the time for the drug to lose half its strength).			

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	Further review of the ED physician's final note 10/11/17 at 10:20 a.m. revealed that after Patient 1 was reexamined the physician determined he should be transferred to a psychiatric hospital. Review of nursing notes dated 10/11/17 revealed that at 12:28 p.m., the transport ambulance was called to transfer Patient 1, and at 1:35 p.m. nursing documented that, the ambulance would arrive at 14:30 (2:30) p.m. Further review of ED nursing documentation revealed that the ambulance arrived at 3:36 p.m. at Patient 1's bedside for transport, 5 hours after Geodon was given. The ED physician also documented in his final note from 10/11/17, which was verified by him on 10/13/17 at 9:44 a.m., that when the transport team told Patient 1 he would have to be restrained for transfer Patient 1 suddenly ran from the ED. Interviews with RN1, on 10/16/17 at 2:14 p.m., and 10/24/17 at 4 p.m., revealed she was responsible for the care of Patient 1 while he was in the ED on 10/11/17 and was aware Patient 1 was uncooperative and very opposed to physical restraints on admission and was a flight risk. She also recalled Patient 1 felt there was no reason he should be in the hospital. RN1 indicated after the Geodon injection was given Patient 1 calmed down. RN1 also indicated she did not give report to the sitter on the special care or safety needs of Patient 1. RN1 stated that when ambulance personnel arrived at 3:36 p.m. and told Patient 1 he would have			

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	to be physically restrained for safety, Patient 1 refused to be restrained. During interview, RN1 stated she told the ambulance staff she would speak to Patient 1 about the restraints, hoping she could convince Patient 1 to be restrained during transport to the psychiatric hospital. She stated that before she could speak with Patient 1, he asked to go to the bathroom. RN1 stated she was surprised when she observed ULS1 escort Patient 1 to a bathroom located by the ED exit, instead of using the safer bathroom away from the exit doors. RN1 explained that Patient 1 should have been taken to the other bathroom because he was an elopement risk. Review of nursing documentation dated 10/11/17 revealed that a care plan was not developed, documented or communicated to ULS1 to provide safe care to Patient 1 in the ED, and for transfer. RN1 indicated during interview that she did not stop the sitter and instruct him to use the safer bathroom away from the exit door. RN1 stated she did not instruct the sitter to use the safer bathroom, further RN 1 shared she did not give report upon the sitter's assumption of duties. Review of the sitter direct observation record revealed that he came on at 3:00 p.m. and was with Patient 1 when he ran from the ED at 3:39 p.m. During an interview with the sitter (ULS1), on 10/16/17, at 4:00 p.m., he stated he had not received report from RN1 when he came on duty and was not ever aware Patient 1 would become upset by being restrained during transport during his time on duty with the patient from 3:00 p.m. until 3:39 p.m. ULS1 indicated that the prior sitter gave him		2019 JAN 14 AM 11:10 LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE CA DEPT OF PUBLIC HEALTH	

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	report and that revealed Patient 1 was calm and to keep an eye on him. ULS1 said that when the transport team arrived Patient 1 asked for a drink of water, which was provided and then asked to use the bathroom to wash his mouth out. ULS1 said that he escorted Patient 1 to the bathroom by the exit doors, but did not hold his arm or stand in a manner to prevent him from exiting. The sitter stated he was surprised when Patient 1 ran from the ED, and said he was not close enough to try to stop him. The sitter indicated he should have been an "arm's length" away from Patient 1 so he could have grabbed his arm to keep him from leaving the hospitals ER, but he was not. Review of facility policy and procedure titled "SITTER GUIDELINES" revised 12/21/2016, revealed sitters are to stay within 4-6 feet of the patient. UL1 also indicated that he did not use the safer bathroom because it may have been in use, and he did not expect the patient to run. The sitter said that he did not follow Patient 1 out of the ED to maintain visual contact with him as required by facility policy because it was more important to tell staff to call 911. An interview with the Director of Risk and Accreditation and concurrent review of Patient 1's emergency department record, 5150 order from 10/11/17, and the facility report to the Department dated 10/12/17 occurred on 10/16/17, at 12:00 p.m. Patient 1 ran away from the ED at 3:39 p.m., 911 was called immediately by the ED secretary. Patient 1 was then located by police in a medical office building 0.2 miles away from the hospital, destroying property and threatening others. During interview, the Director of Risk and Accreditation			

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	explained that police arrived at the office and shot Patient 1. Review on 10/16/17 of the admitting consulting physicians note dated 10/11/17 revealed that Patient 1 was admitted on 10/11/17 at 4:37 p.m., (about an hour after he ran from the previous hospitals ED). According to the admitting note, Patient 1 had injuries to include a right chest gunshot wound, right rib fracture with bullet fragment, liver laceration, right ankle contusion and superficial burns to the right chest wall and right arm. Review on 10/16/17 of Patient 1's discharge summary from the trauma hospital, dated 10/12/17, revealed that on admission Patient 1's blood was positive for amphetamines and THC, and he was discharged to jail. The discharge summary also indicated that after he eloped from the previous hospitals ED he was tazed, shot with rubber bullets and finally shot with a 40-caliber gun by the police. The facility failed to plan, implement, supervise and evaluate the nursing care for Patient 1. The facility further failed to provide a safe environment for Patient 1 and to communicate and develop a safe plan for transfer, and failed to implement its policies and procedures. These failures are regulatory violations that constitute an "immediate jeopardy" 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			

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	patient. 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(9).			

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