

"AMENDED"

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER Adventist Health St. Helena	STREET ADDRESS, CITY, STATE, ZIP CODE 10 Woodland Rd, Saint Helena, CA 94574-9554 NAPA COUNTY
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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00317773 - Substantiated			
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FEB 27 2019

	Representing the Department of Public Health: Surveyor ID # 2214, HEEN			
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BY: _____

	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. Penalty Number: 110014686 E264 T22 DIV5 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. E1578 T22 DIV5 CH1 ART6-70579(d) Psychiatric Unit Staff (d) There shall be registered nurses with training and experience in psychiatric nursing on duty in the unit at all times.			
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MAR - 8 2019

BY: _____

Event ID: MTM711

2/20/2019

7:48:20AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Antonio J. Hernandez, R.D., R.S.N., C.S. Patient Care Exec (X6) DATE: 3/6/19

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.

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	<p>Based on observation, interview and record review, the hospital failed to develop and implement a policy and procedure to train all employees who have access to the locked Mental Health Unit (MHU), on how to ensure the exit doors were locked upon leaving the locked MHU. This failure allowed Patient 1 to exit the locked MHU and attempt a suicide which resulted in massive life threatening injuries.</p> <p>THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.1 IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN THE FACILITY FAILED TO HAVE A WRITTEN POLICY IN PLACE TO EDUCATE THE HOUSE SUPERVISOR IN SAFETY ISSUES REGARDING EXIT AND ENTRY INTO THE LOCKED MENTAL HEALTH UNIT (MHU) RESULTING IN PATIENT 1 ELOPING FROM THE UNIT AND AN ATTEMPT AT SUICIDE WITH LIFE THREATENING INJURIES.</p> <p>Findings:</p> <p>During an interview with Administrative Staff A on 07/13/12 at 11 a.m., she stated that Patient 1 was admitted to the MHU on 07/02/12 from the Emergency Room on a 72-hour hold (5150) a day after he had tried to hang himself at home. He was diagnosed with depression and acute suicidal ideation. Administrative Staff A also stated that on July 8, 2012, while on a 14-day hold (5250), Patient 1 managed to get out of the locked MHU, go outside and jump down to a concrete patio, which caused</p>			

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	<p>Patient 1 multiple traumatic injuries. Patient 1 was subsequently airlifted to a trauma center. Administrative Staff A stated that the facility's investigation revealed Administrative Staff E left the MHU through a door that had not locked and was left unsecured.</p> <p>Patient 1's Treatment Plan for Suicidal Ideation's, dated 07/02/12, was reviewed and indicated an intervention: "1 b. Initiate appropriate level of supervision" for safety checks every 15 minutes.</p> <p>A viewing of two taped security videos (Video 1 and Video 2), consisting of surveillance of the MHU and 3 East Lobby on 07/13/12 at 1:30 p.m., revealed the following observations: Video 1: The MHU corridor was observed. Patient 1 was observed behind Administrative Staff E as she walked through the MHU exit door, located at the end of the MHU corridor, and exited into the 3 East Lobby. Patient 1 was the only observed patient in the MHU corridor. As the MHU exit door began to close behind Administrative Staff E, Patient 1 was observed to reach the MHU exit door before it fully closed. Patient 1 was further observed looking through the exit door window and then observed walking through the MHU exit door and exiting into 3 East Lobby.</p> <p>Video 2: The 3 East Lobby was observed. The 3 East Lobby was located outside the MHU exit door where</p>			

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	<p>Patient 1 was observed on Video 1 walking and exiting into the 3 East Lobby. The MHU exit door points towards the elevators located in the 3 East Lobby. Patient 1 was observed walking and exiting through the MHU exit door and waiting for the elevator, then stepping into the elevator.</p> <p>During an interview with Licensed Staff C on 07/13/12 at 2:30 p.m., she stated that on 07/02/12, at approximately 1:15 p.m., a patient on the MHU came to the desk and stated that one of the patients had left. An immediate search was initiated to determine who had gone AWOL (Absent Without Leave). Licensed Staff C was assigned to search the second floor for any wandering patients. By the time Licensed Staff C returned to the MHU it had been determined that Patient 1 was the eloped patient. As Licensed Staff C left the MHU again to look for Patient 1, she went to the 3 East exit door and exited to the 3rd floor patio. On exiting to the patio, Licensed Staff C saw the MHU RN Supervisor attending Patient 1, who was lying on the patio covered in blood, trying to move, moaning and stating, "Just let me die."</p> <p>During an interview with Security Staff D on 07/13/12 at 3 p.m., he stated he had been working at the Hospital for two years, and on the first day of work, he was trained to the MHU security policy for all the locked doors. Security Staff D further stated he was, "Trained to look in the door window and convex mirrors to see if patients were near the door, and when leaving, to check to see that patients were not near the exit and to check and make sure the door was closed when leaving."</p>				

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	<p>During an interview with Administrative Staff E on 07/13/12 at 3:35 p.m., she stated that, at the time of the incident, she had not noticed Patient 1 fifteen to twenty feet behind her, and there were no other patients around the door. She further stated, as she keyed herself out of the locked MHU door, she received a phone call on her cell phone and thought she had heard the door clicking locked behind her. Administrative Staff E did not double check to make sure the door to the MHU was firmly locked, and she returned to her office. Administrative Staff E also stated she had worked at the Hospital for a long time, first as a medical surgical nurse, floating to the MHU, then as House Supervisor, and she had never been oriented to the MHU and never received specific training on making sure the MHU locked doors were secured when going in and out.</p> <p>Review of Patient 1's History and Physical Examination, dated 07/08/12, completed after Patient 1's trauma transfer to the receiving facility, indicated Patient 1 fell....."approximately 30 feet onto concrete.....with a multitude of orthopedic and neurologic injuries.....arrived with bilateral lower extremities (legs) splinted as well as the left upper extremity (arm) splinted.....a cervical (neck) collar.....complex lacerations and open fractures to the nasal complex."</p> <p>During an interview with Administrative Staff F, and concurrent review of the Hospital House Supervisors training book on 07/13/12 at 3:45 p.m., no policy was found regarding MHU door security. A review of a House Supervisor, "Orientation Checklist /</p>				

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	Competency," draft dated 04/07/12, regarding MHU safety measures, indicated an update on 07/09/12, by Administrative Staff F, which read: "31. Shows knowledge of Mental Health Unit safety measures and AWOL risk. NEW."				
	Further review of the of the Competency Checklist (dated 04/07/12) revealed the following: "POLICY. Administration Department employees (House Supervisor) are expected to complete general hospital and department-specific orientations... Competency Checklist to be completed by training House Supervisor."				
	The hospital's failure to develop and implement a policy and procedure to train all staff who had access to the locked Mental Health Unit (MHU), to adequately lock the unit exit door, resulted in Patient 1 exiting the locked MHU and attempting a suicide which resulted in massive life threatening injuries and is in violation of Sections 70759(d) and 71203(a) of Title 22 of the California Code of Regulations. This deficiency has caused or is likely to cause serious injury or death to the patient; therefore, constitutes an Immediate Jeopardy within the meaning of Health and Safety Code, Section 1280.1. 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(g).				

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ADVENTIST HEALTH ST. HELENA
10 WOODLAND ROAD
SAINT HELENA, CA 94574
PROVIDER IDENTIFICATION NUMBER: CA 110000058

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Date Survey Completed: July 12, 2012
Plan of Correction completion date: February 8, 2019

ID PREFIX TAG	CORRECTIVE ACTION	POSITION RESPONSIBLE	COMPLETION DATE
E 264 T22 DIV5 CH1 ART 3-70213 (a) E1578 T22 DIV5 CH1 ART6-70577(m) Psychiatric Unit Staff	1. Policy MHM 1.5; <i>Door Control</i> , was developed. The policy outlines restrictions to the Mental Health Unit door. Access to unit via main door is restricted to MHU staff only. Access to unit for other hospital personnel requiring entry into the unit is by use of door H 362 (e.g. waiting room entry). All other entry into the unit via the main door requires a mental health staff escort. Staff trained to "Own the Door" practice, this includes intentional observation and awareness when entering or exiting the unit to verify that no patients are within proximity of door to prevent a sudden elopement attempt.	Mental Health Unit Manager	August 1, 2012
	2. POC submitted to the August 9, 2012 Performance Improvement Committee for inclusion into the QAPI data for Governing Board review.	Mental Health Unit Manager	August 9, 2012
	3. Staff training and competency assessment was conducted for all Mental Health Unit staff, Nursing Supervisors and other staff who require access to the locked Mental Health Unit as part of their work-related responsibilities.	Mental Health Unit Manager	August 1, 2012

Report completed by Maria Pena, BSN RN
February 8, 2019

2/27/19 - POC was accepted on 2/14/19 with the deficiency 2567. Maria Pena was notified.