

PDC - acceptable
11/4/17

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA930000157	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/26/2016
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE LITTLE CO OF MARY MED CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 W 7TH ST SAN PEDRO, CA 90732
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E 000	<p>Initial Comments</p> <p>The following reflects the findings of the Department of Public Health during an entity reported incident investigation.</p> <p>Entity Reported Incident #CA00495270.</p> <p>Representing the Department of Public Health: Evaluator ID #36926 Evaluator ID #36925</p> <p>The inspection was limited to the specific entity reported incident investigation and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code 1280.3 (g) for purposes of this section, "immediate Jeopardy" means a situation in which one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>22 CCR 70213 (a) and (b) Nursing Service Policies and Procedures.</p> <p>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>(1) Policies and procedures which involve the medical staff shall be reviewed and approved by the medical staff prior to implementation.</p> <p>(2) Policies and procedures of other departments which contain requirements for the nursing service shall be reviewed and approved by the nursing service prior to implementation.</p> <p>(3) The nursing service shall review and revise policies and procedures every three years, or more often if necessary.</p> <p>(4) The hospital administration and the governing body shall review and approve all policies and procedures that relate to the nursing service</p>	E 000	<p>2567 Statement of Deficiencies was received on 10/26/2017.</p> <p>This plan of correction constitutes our written allegation of compliance for the deficiencies cited, but does not constitute an agreement with or admission in whole or part that the findings were cited correctly.</p>	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE
Admin Director

(X6) DATE
11/5/2017

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E 000	Continued From page 1 every three years or more often, if necessary. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.	E 000		
E 693	T22 DIV5 CH1 ART6-70413(a) Basic Emergency Medical Service, Physician on (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. This Statute is not met as evidenced by: Based on observations, interviews and record reviews, the facility's staff failed to implement its policy and procedures on "Safety Attendant Guidelines" and "Patient Safety Attendant Guidelines for Sitter Coverage" which included the requirements to observe the patient within arm's length, to keep patient hands visible at all times, to never leave the patient alone, and to attempt at all times to remain within arm's length of the patient to ensure safety. These policies and procedures also required facility staff to observe and remove any objects that patients may use to harm themselves or others, including cords and rope, and to contact the nurse right away. On 7/10/16 at 8:15 p.m., Patient 1 was admitted to the Emergency Department (ED) from the	E 693	Tag E693 Corrective action(s) accomplished for the practice found to be deficient: 1. Additional focused education for 'Sitter Safety' was developed and assigned to applicable staff. 2. 'Sitter Guidelines' checklist reviewed and updated to include added reference for 'visual observation at all times, even when using restroom.' The ED Charge RN reviews these guidelines with sitter prior to sitter beginning shift. 3. ED Behavioral Health Checklist & Guidelines reviewed and updated to ensure standardized work in checking environment of care for safety. 4. Required nurse call light pull string in ED bathroom replaced with a psychiatric safe breakaway cord to reduce chance of being used as a ligature. 5. 'Sitter Safety' education assigned to staff as ongoing refresher education. 6. Projected target date for 'Sitter Safety' refresher education to be complete. (continued on next page)	8/30/2016 8/24/2016 6/8/2016 & 9/11/2017 10/31/2017 11/2/2017 11/25/2017

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E 693	<p>Continued From page 2</p> <p>facility's Chemical Dependency Unit (CDU) for attempted suicide. Patient 1 was admitted to the ED with a diagnosis of attempted suicide and was on a 5150 hold (a 72- hour involuntary hold for psychiatric evaluation of patients who may be a danger to themselves or others). Patient 1 was provided a 1:1 sitter (an employee designated to sit with a patient to provide continuous observation). On 7/11/16/ at 7:10 am, the sitter allowed Patient 1 to go to the ED restroom alone where he closed and locked the door. A registered nurse later found Patient 1 kneeling on the restroom floor with the call light cord around his neck. Patient 1 was assisted back to his room and was subsequently admitted to the General Acute Care Hospital (GACH) psychiatric unit. Not observing Patient 1 at all times, including when he was in the restroom, and failure to search for and remove any objects, such as cords, that the patient may use to harm themselves, placed Patient 1 at risk for harm and possible death.</p> <p>Findings:</p> <p>A review of the CDU discharge report, dated 7/10/16, indicated Patient 1 admitted to being depressed. He denied suicidal ideation. At approximately 1920 hours (7:20 p.m.), the patient was found in the shower with superficial scrape marks over his wrist. Patient 1 had a belt in his shower. "He stated he wished no longer to live. For this reason, he will be discharged to be evaluated at the acute hospital and placed on a 5150 hold due to being suicidal and a danger to himself in life." The report further indicated Patient 1 was discharged to the emergency room to be evaluated and placed on a 5150 hold.</p> <p>During a telephone interview on 7/19/16 at 1:09 p.m.; RN 3 stated she worked noon to midnight</p>	E 693	<p>Tag E693 continued:</p> <p>7. As part of QAPI, patient safety issues/ concerns are discussed daily during the weekday at the hospital Safety Huddle</p> <p>8. As part of QAPI focused around behavioral health, safety concerns are reviewed and addressed during the redesigned daily weekday Behavioral Health Safety Huddle.</p> <p>Person(s) Responsible: Chief Nursing Officer Department Nursing Leader</p>	<p>7/1/2016 & ongoing</p> <p>6/13/17 & ongoing</p>
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E 693	<p>Continued From page 3</p> <p>on 7/10/16. RN 3 stated Patient 1 came to the ED from the CDU for attempting to hang himself and ingest chemicals. RN 3 stated that Patient 1's neck was reddened but later the redness resolved. Patient 1 did not have difficulty breathing. Patient 1 had superficial scratches on the left wrist, medication was applied to the left wrist and was wrapped with pink coban (a self-adherent bandage wrap). The physician came to assess Patient 1 and ordered a sitter. RN 3 called poison control. RN 3 stated that Patient 1 was not talkative, was withdrawn, and had a moment of being emotionally distraught. RN 3 stated that Patient 1 needed continued observation. RN 3 was asked if Patient 1 used the restroom during her shift, RN 3 stated Patient 1 had to go to the restroom and was provided a urinal. Later that evening, the sitter asked if Patient 1 could use the restroom, RN 3 stated she said yes, he can go to the restroom. RN 3 was asked, did the sitter go with Patient 1 to the restroom, RN 3 stated, "As far as I know, the sitter was with him. They're not supposed to leave them alone." RN 3 stated she did not remember the name of the sitter. RN 3 stated she ended her shift at 1 a.m. and was replaced by RN 4.</p> <p>A review of the Brief Assessment dated 7/10/16 at 2018 (8:18 p.m.) completed by RN 3, in regards to skin color, indicated Patient 1 had redness of the neck area and a cut to his left hand from a shaver.</p> <p>A review of the Emergency Department (ED) admission record/notes dated 7/10/16 at 8:33 p.m., indicated the physician ordered a sitter at the bedside for Patient 1.</p> <p>The ED Quick Notes dated 7/10/16 at 2358 (11:56 p.m.), RN 3 documented Patient 1 was</p>	E 693		
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E 693	<p>Continued From page 4</p> <p>"crying and talking to the sitter about religious beliefs and visual hallucinations he had." The doctor was made aware and Ativan (a drug used to relieve anxiety associated with depression) was ordered.</p> <p>During a telephone interview on 7/21/16 at 2:36 p.m., RN 4 stated he was working on July 10, 2016 from 5 p.m. - 5 a.m. RN 4 stated he did not have an assignment at first because he was floating around the ED and was helping triage (the process of sorting people based on their need for immediate medical treatment) patients. RN 4 stated, "I triaged him [Patient 1] maybe around 7, 8, or 9 p.m., I'm not really sure. I took over care for Patient 1 around midnight. I believe it was RN 3 who gave me report on Patient 1." RN 4 stated there was a sitter in Patient 1's room. RN 4 stated he does not remember the name of the sitter and she does not work in the area, referring to the ED. He stated he believed he had seen her in the hospital. She was there with Patient 1, prior to him taking care of Patient 1. RN 4 stated he knew the sitter was aware of Patient 1's situation. RN 4 was asked did Patient 1 go to the restroom while he was taking care of Patient 1, RN 4 stated, "I don't recall the patient going to the restroom, I think he had a urinal." RN 4 was asked, did the sitter ask him if Patient 1 could go to the restroom? RN 4 stated, he doesn't remember being asked.</p> <p>During an interview on 7/18/16 at 2:50 p.m., Certified Nursing Assistant (CNA 1) stated she worked 7/10/16 from 11 p.m. to 7 a.m., as a sitter in the ED. CNA 1 stated she does not usually work in the ED, she works on the 4th floor Transitional Care Unit, but when the patient census is low, she floats to other units inside the hospital. CNA 1 stated the ED charge nurse (CN)</p>	E 693		
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E 693	<p>Continued From page 5</p> <p>gave her report on Patient 1 and informed her that Patient 1 was suicidal. CNA 1 stated, "She told me to watch Patient 1". Patient 1 had to go to the restroom several times that night. CNA 1 stated she asked RN 3 if Patient 1 could go to the restroom by himself and RN 3 told her yes. CNA 1 stated around 7:10 a.m., Patient 1 went to the restroom. CNA 1 stated the CN asked her if Patient 1 was the one pulling the call light in the restroom. According to CNA 1, she and another registered nurse (RN) went to the restroom and the door was locked. CNA 1 stated that she did not remember if Patient 1 unlocked the door or if she and the RN unlocked the door. CNA 1 was asked if she had a key to the restroom, CNA 1 stated, she did not have a key and did not know where the key was located. CNA 1 stated when the door was unlocked and opened, Patient 1 had the call light cord around his neck. CNA 1 was asked if Patient 1 had any injuries, CNA 1 stated, no. CNA 1 was asked what a 1:1 sitter means, CNA stated, "It's some kind of situation for high-risk patients; you have to watch them." CNA 1 was asked if she had been a 1:1 sitter before, CNA 1 stated, "Yes, but not with this kind of situation." CNA 1 stated she was not used to working with suicidal patients. CNA 1 stated she would usually go with the patient to the restroom, but she wanted to check with RN 3 to get more information. CNA 1 stated RN 3 told her it was all right for Patient 1 to go to the restroom alone. CNA-1 was asked if a sitter should accompany a suicidal patient to the restroom, CNA stated, yes.</p> <p>During a telephone interview on 7/19/16 at 10:37 a.m., RN 5 stated that he was just coming in to work at 7 a.m. on 7/10/16 and saw the restroom call light go off. RN 5 went to the restroom, the door was locked and no one was answering. RN 5 unlocked the door and found Patient 1 with his</p>	E 693		
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E 693	<p>Continued From page 6</p> <p>knees on the floor, his left arm on the hand rail, and the call light cord wrapped around his neck. RN 5 stated he got Patient 1 up, and then he (RN 5) and CNA 1 walked Patient 1 back to his room. RN 5 stated no marks or injuries were noted on Patient 1's neck. RN 5 was asked if he was given report on Patient 1, RN 5 stated "Not lengthy, I knew there was a sitter with him." RN 5 was asked was the sitter with Patient 1 in the restroom? RN 5 stated, "I'm thinking CNA 1 was in Patient 1's room when Patient 1 was in the restroom." RN 5 stated that he reported the incident to the Emergency Department Director (EDD).</p> <p>A review of the ED Notes by RN 5, dated 7/11/16 at 7:10 a.m., indicated the sitter allowed Patient 1 to go to the restroom, and while Patient 1 was in the restroom, the call light went off. The note indicated the restroom door was locked and a registered nurse (RN 5) entered the restroom and found Patient 1 with a cord around his neck. The cord was not tight. Patient 1 was assisted back to his room.</p> <p>During an observation on 7/14/16 at 5:25 p.m., the ED restroom was located outside Patient 1's room (close to the nurses' station), around the corner approximately 20 feet away from Patient 1's room. The bathroom was approximately 12' x 6' and had a call light cord attached to the wall, hanging down towards the floor. The door was equipped with a door knob that had a push-button privacy lock.</p> <p>During an interview on 7/14/16 at 5:15 p.m., EDD stated a patient who is transferred to the ED on a 5150 hold is placed in a room closest to the nurse's station for better visibility. A patient on a 5150 hold is provided with a 1:1 sitter. When a</p>	E 693		
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E 693	<p>Continued From page 7</p> <p>sitter is needed, the house supervisor provides the ED with a staff that has received basic patient care training. EDD stated there was no restroom in Patient 1's room; the restroom was located around the corner. EDD was asked was patient 1 allowed to go to the restroom by himself? EDD stated, "The patient should be accompanied by the staff into the restroom." EDD stated the door to the restroom can be locked; two keys are kept in the nurses' station and can be accessed by any staff to unlock the door.</p> <p>During an interview on 7/14/16 at 5:30 p.m., the nursing house supervisor (NHS) stated that when ED requests a sitter, she pulls one from one of the floors in the hospital. The sitter receives an orientation once they arrive in the unit. NHS was asked if sitters receive training for psychiatric patients, she stated they receive basic training and are given additional instructions. NHS was asked what the additional instructions are; NHS stated the facility has a list of guidelines. NHS handed the surveyor a copy of the facility's guidelines titled, "Patient Safety Attendant Guidelines for Sitter Coverage." The NHS was asked for a job description for sitters and the risk management director (RMD) who was also present during the interview, indicated she would fax the sitter job description to surveyor the next day.</p> <p>A review of CNA 1's employee file indicated that facility's instruction sheet titled "Patient Safety Attendant Guidelines for Sitter Coverage" was signed by CNA on 4/20/16.</p> <p>On 7/15/16, at 11:48 a.m. surveyor received fax from facility, indicating facility does not have a sitter specific job description.</p>	E 693		
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E 693	<p>Continued From page 8</p> <p>A review of the facility's policy and procedure titled, "Safety Attendant Guidelines", dated 7/2013, indicated the ratio of safety attendants to patients, whether 1:1 or 1:2, is determined by the unit manager/house supervisor, in consultation with the physician, charge nurse and patient's nurse. The policy further states if a Patient is determined to be suicidal, the assigned safety attendant must attempt at all times to remain within arm's length of the patient to ensure safety.</p> <p>According to the facility's "Patient Safety Attendant Guidelines for Sitter Coverage", undated, the patient must be observed at all times and never left alone. The guidelines indicated to keep the patient safe by visually observing the patient at all times (within arm's length), even when the patient is using the toilet or showering, and patient hands should be visible at all times. These policies and procedures also required facility staff to "Observe and remove any objects that patients may use to harm themselves or others, and contact the nurse right away. These items may include ...cords, rope."</p> <p>This deficiency 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 1280.3 subdivision (g).</p>	E 693		