

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER DEL ROSA VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 N DEL ROSA AVE., SAN BERNARDINO, CA 92404 SAN BERNARDINO COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 24-2167-0006458-S Complaint(s): CA00191568</p> <p>REGULATION VIOLATION: 72311(a)(2) Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (2) Implementing of each patient's care plan according to the indicated methods. Each patient's care shall be based on this plan.</p> <p>An unannounced visit was made to the facility on 6/12/09 at 8:40 AM to investigate an entity self reported incident regarding a patient suicide.</p> <p>Based on interview and record review the facility failed to implement the care plan for Patient 1 by failing to:</p> <p>1. Implement the plan of care to monitor Patient 1 for suicide watch at all times from 6/1/09 through 6/11/09.</p> <p>Review of Patient 1's medical record indicated that Patient 1 was a 52 year old male who was admitted to the facility from the acute hospital</p>			

Event ID: MV8T11

8/11/2009

4:13:08PM

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	<p>Continued From page 1</p> <p>on 5/22/09 with diagnoses which included fracture of the left tibia and fibula from a suicide attempt on 4/21/09 in which he threw himself in front of a car, depressive disorder, schizophrenia and suicidal ideation.</p> <p>Review of acute hospital documentation located in facility record indicated a psychiatric consultation dated 5/8/09 and which indicated that Patient 1 had been admitted to the acute hospital on a 5250 hold after an "auto versus pedestrian" in a suicide attempt. Documentation indicated that Patient 1 remained unpredictable with intermittent thoughts of suicide and was at risk of harming himself therefore Patient 1 required placement in a skilled nursing facility upon discharge from the acute hospital.</p> <p>Review of facility physician orders dated 5/22/09 indicated an order for Clozapine 100 mg (milligrams) every morning and Clozapine 200 mg every evening for behaviors of responding to inner stimuli manifested by history of self harm, suicidal ideations, delusions and hallucinations.</p> <p>Review of care plan problem #11 dated 6/1/09 for depressive disorder, schizophrenia and suicidal ideation indicated that Patient 1 was to be on "suicide watch at all times." The care plan was written in black ink however documentation regarding the intervention for "suicide watch at all times" was written in red ink.</p>			
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	<p>Continued From page 2</p> <p>During an interview with the licensed nurse (LVN 1) on 6/19/09 at 2:40 PM she stated that she had admitted Patient 1 to the facility on 5/22/09 however she was not aware of any prior attempts by Patient 1 at self harm and did not consider Patient 1's prior attempt to jump in front of a car was presented as a suicide attempt. She confirmed that the acute hospital documentation which was present in Patient 1's facility record had been sent with Patient 1 when he was transferred to the facility however she did not have time during the admission process to review it since she was busy.</p> <p>LVN 1 reviewed the psychiatrist consultation dated 5/8/09 and the physician's history and physical dated 4/21/09 and stated that "I missed it. I didn't see it." She confirmed that both physician consultations indicated that Patient 1 had attempted suicide by jumping in front of a car and that physician admission orders indicated that Patient 1 had suicidal ideations.</p> <p>During further interview with LVN 1 on 6/19/09 at 2:40 PM she stated that she was unaware of the care plan which indicated that Patient 1 was to be on "suicide watch at all times."</p> <p>Review of nurses notes dated 6/11/09 at 3:30 (AM or PM not noted) indicated documentation by the licensed nurse regarding an observation of Patient 1 at the beginning of her shift to be "bouncing" in his wheelchair. Documentation</p>				

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	<p>Continued From page 3</p> <p>then indicated that at 11:20 PM (on 6/10/09) the licensed nurse heard a loud crash and that Patient 1 was found on the floor next to his overturned wheelchair. Patient 1 was assisted to bed and a "call out" to the physician was made. There was no documentation to indicate that the physician had returned the licensed nurses telephone call.</p> <p>Further review of documentation dated 6/11/09 at 3:30 indicated that Patient 1 was "up and down" several times and that he wanted to smoke. Documentation indicated that Patient 1 was told by the licensed nurse he should be sleeping and he returned to bed.</p> <p>Review of nurses notes dated 6/11/09 indicated that at 12:30 (AM or PM not noted) Patient 1 was in his wheelchair self propelling out the laundry room door to go smoke. There was no documentation that Patient 1 was accompanied by facility staff nor if Patient 1 was monitored when he went outside alone to smoke.</p> <p>Nurses notes dated 6/11/09 indicated that at 12:50 (AM or PM not noted) that the outgoing nurse from station two had received a call from someone in the parking lot that "someone was on the fence." Documentation revealed that Patient 1 was found hanging from a belt around his neck to the uppermost crossbar of the perimeter fence.</p> <p>Patient 1 was cut down and CPR (cardiopulmonary resuscitation) was initiated.</p>			

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	<p>Continued From page 4</p> <p>There was no documentation regarding a licensed nurse assessment of Patient 1's physical condition nor if his vital signs (pulse, respirations, blood pressure) were taken.</p> <p>During an interview with the licensed nurse (LVN 2) on 6/24/09 at 6:23 AM she stated that she saw Patient 1 self propelling out of the laundry room door on 6/11/09 at approximately 12:30 AM. She stated that Patient 1 went outside by himself and that no other staff member accompanied him.</p> <p>During interview LVN 2 stated that she did not go outside to check on Patient 1 because she got busy with a patient in another room. LVN 2 stated that she was unaware of Patient 1's prior history of suicide attempt and also stated that she was unaware of Patient 1's care plan intervention for "suicide watch at all times."</p> <p>During an interview with the certified nurses assistant (CNA 1) on 6/24/09 at 7:30 AM she stated that she was assigned to Patient 1's care on 6/11/09 for the night shift. She stated that she observed Patient 1 going out the laundry room door to the outside back parking lot. She stated that Patient 1 was not accompanied by facility staff.</p> <p>CNA 1 further stated during interview that she was unaware of Patient 1's care plan intervention for "suicide watch at all times." She stated that the licensed nurses are responsible for communicating information</p>				

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	<p>Continued From page 5</p> <p>related to patient care plans to the CNA so that they would know what to do. CNA 1 stated that CNA's are expected to follow the interventions listed on the care plan which would include any special instructions for monitoring.</p> <p>During interview with LVN 5 on 6/15/09 at 4:17 PM and with CNA 2 and CNA 3 on 6/19/09 at 3:40 PM and 3:52 PM they confirmed that they were unaware of Patient 1's care plan intervention dated 6/1/09 which indicated that Patient 1 was to be on "suicide watch at all times."</p> <p>Additionally during interview with LN 4 and the SSD on 6/24/09 at 9:14 AM and 8:40 AM they confirmed that they were unaware of Patient 1's care plan intervention dated 6/1/09 which indicated that Patient 1 was to be on "suicide watch at all times."</p> <p>During an interview with the licensed nurse (LVN 3) on 6/24/09 at 8:56 AM she stated that she was aware of Patient 1's history of suicide attempt when she reviewed his medical information at the time of his admission to the facility. She stated that she was also aware that Patient 1 had a long history of psychiatric issues prior to his admission.</p> <p>During interview LVN 3, stated that she developed the care plan dated 6/1/09 for Patient 1's depression, schizophrenia and suicidal ideations and that the approach for "suicide watch at all times" was due to his</p>			

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	<p>Continued From page 7</p> <p>acute hospital at 1:21 AM.</p> <p>Review of emergency room triage assessment dated 6/11/09 indicated that Patient 1 was admitted to the emergency room with absence of all vital signs and that his skin was pale, cyanotic and cool to touch. Documentation further indicated that his pupils were fixed and dilated. The record showed that despite ACLS (advanced cardiac life support) measures Patient 1's heart rhythm remained in asystole and Patient 1 was pronounced as expired at 1:33 AM.</p> <p>Review of the death certificate listed the cause of death as "hanging."</p> <p>The facility failed to:</p> <p>2. Implement the plan of care to monitor Patient 1 for suicide watch at all times from 6/1/09 through 6/11/09.</p> <p>The facility's failure to implement the care plan intervention for "suicide watch at all times" resulted in Patient 1 going outside of the facility on 6/11/09 at 12:30 AM unaccompanied by facility staff where he hung himself with his belt on the perimeter fence and the patient expired on 6/11/09.</p> <p>These violations presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and</p>			

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