POC - acceptable
1/29/16

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054055	A. BUILDING ______ B. WING ______	07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE HOSPITAL	10802 College Pl, Cerritos, CA 90703-1505 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00313278 - Substantiated Representing the Department of Public Health: Surveyor ID # 17116, HFEN 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: 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. T22 DIV5 CH2 ART3-71213(a) Psychiatric Nursing Srv General Requirements (a) Written policies and procedures shall be developed and maintained by the director of nursing 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. Based on observation, interview, and review of records, the facility failed to follow policy and		College Hospital Cerritos (CHC) respectfully submits its Plan of Correction (POC) in response to the Statement of Deficiencies (2567) received on 1/11/2016. This POC constitutes the facility's response to the findings of the California Department of Public Health and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. This POC is submitted to meet requirements established by state and federal law. The POC is based on the surveyors' evaluation and assessment of noncompliance with T22 DIV5 CH2 ART3-71213(a) Psychiatric Nursing Services General Requirements. Based upon the surveyor's findings, the facility failed to follow its policy and procedure for observation and monitoring and ensuring that a patient was protected from self-harm. 1. All licensed nursing staff (RNs and LVNs/LPTs) were re-educated regarding Comprehensive Suicide Risk Assessments, Q Shift Suicide Risk Assessments and Suicide Risk and Protective Factors. The education in-service was by the Director of Psychiatric Services/ Nurse Educator. 2. All nursing staff (RNs, LVNs/LPTs and MHWs) were educated	5/27/2012 & 5/29/2012 5/30/2012 & 6/9/2012

Event ID:DV3411 1/11/2016 12:30:58PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE President/CEO (X6) DATE 1/28/2016

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 8*

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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	procedure(s) for observation and monitoring of a patient and ensuring that a patient was protected from self-harm. According to a facility's letter to the Department dated May 29, 2012, disclosed Patient B, was admitted to the facility on May 19, 2012 as a danger to self after an overdose attempt. The patient was placed on suicide precautions, with observations ordered for every 5 minutes. The letter also indicated while patient B was alone to take a shower in the bathroom, Patient B tied an article of clothing around his neck and secured it to the bathroom doorknob in an attempt to hang himself. When discovered by a mental health worker (MHW), Patient B had no pulse or respirations. A "code blue" (life-threatening medical emergency) was called and cardio-pulmonary resuscitation (CPR) measures were instituted. Paramedics arrived, intubated the patient and took over resuscitative efforts. Patient B was transferred to a General Acute Care Hospital for emergency medical treatment. Findings: On July 10, 2012, an unannounced visit to the facility was conducted to investigate an entity-reported incident regarding one patient's (Patient B) suicide attempt. The nursing administrator (Nurse 1) described the incident during an interview at 11:30 a.m. "Patient		regarding Suicide Precautions, Levels of Observation, and Environmental Safety Rounds. The in-service also included role playing to demonstrate various patient scenarios that staff may encounter while monitoring patients. The in-service also addressed dealing with difficult and intimidating patients. Staff were also educated during the in-service regarding guidelines for patient use of the shower and limiting the number of clothing article taken into the shower by patients. The educational in-service was provided by the Director of Psychiatric Services/ Nurse Educator. 3. A Reassessment for Suicide Risk/ Precaution Tool was developed by the Associate Administrator of Clinical Services/Chief Nursing Officer. This assessment is completed by the registered nurse every shift or at least every 8 hours for all patients that are on suicide precautions or heightened observations for self-injurious behaviors or for those patients whose clinical presentation has changed to warrant a reassessment for suicide risk. For all other patients, the reassessment is to be completed once every 24 hours.	

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	B was just taken off 1:1 (observed by one staff member at all times), and placed on Q5 observation (staff members observe and note the patient's location and activity every 5 minutes) the day before," she stated. On the day of the incident, the patient had been in the shower "quite awhile, and when the water went off (sic)," a mental health worker (MHW) went to check on him. When she did, Patient B "yelled and screamed" that he was getting dressed. Nurse 1 disclosed, "The MHW was intimidated by him," and she left to give him privacy. When the MHW returned to check on the patient again, Nurse 1 continued, "the door wouldn't move much, but the MHW could see Patient B hanging from the door inside." She called for help, and a nurse came and assisted opening the door. The patient was pulseless and not breathing. He was pulled out of the shower and resuscitative measures were initiated until paramedics arrived. Upon arrival, paramedics took over resuscitative efforts, intubated Patient B, and transported him to a medical facility. "He was breathing when he left," Nurse 1 stated. A review of Patient B's clinical record revealed the patient was admitted from a medical hospital on May 19, 2012, following a suicide attempt. He was given a psychiatric evaluation and placed on a 5150 (a legal hold to obtain a psychiatric treatment for a person who has been identified as a danger to himself), then transported to the psychiatric facility.		4. The Reassessment for Suicide Risk/Precaution Tool was approved by the Medical Executive Committee and by the Board of Directors.	7/27/2012 & 8/6/2012
			5. Education was provided to all nursing staff by the Associate Administrator of Clinical Services/ Chief Nursing Officer regarding Documenting Significant or Unusual Events. The education stressed the importance of documenting significant and/or unusual events in a timely manner.	8/1/2012
			6. An educational in-service was held for all licensed nursing staff by the Director of Psychiatric Services/ Nurse Educator. The in-service included education regarding the Reassessment for Suicide Risk/ Precaution Tool as well as Clinical Documentation Guidelines.	8/26/2012 & 8/30/2012
			7. Anti-ligature doorknobs were installed on all patient bathrooms and showers.	8/31/2012
			8. Monitoring of Patient Rounds was conducted to ensure that patient rounds were performed as ordered and rounds were current and accurate. The Associate Administrator of Clinical Services/ Chief Nursing Officer was responsible for the monitoring.	12/31/2012

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The facility's Pre-Admission Screen document ("Integrated Admission Assessment" form, page 1), contained a notation that Patient B tried to overdose on his anti-depressant pills. He also admitted he had "tried to hang himself" after his sister committed suicide four months earlier.

According to the "Integrated Admission Assessment" form, dated May 19, 2012, the admitting nurse assessed Patient B and determined the patient to be at risk for suicide. In accordance with the facility's policy titled, "Observation and Monitoring" (policy 9083, dated 12/87 and revised 4/11), Patient B was placed on suicide precautions, with observations every 15 minutes (Q15) to monitor his location and behavior.

The physician's "Psychiatric and Mental Status Examination" report, dated May 20, 2012, was reviewed. In the report, the physician disclosed Patient B was "admitted on an urgent basis...to provide twenty-four hour nursing supervision to prevent further decompensation."

Additional nursing notes and physician's progress notes written during the patient's stay were reviewed. On May 21, 2012, at 8 a.m., a nurse documented the patient "continues to verbalize suicide ideation (thoughts)." The physician's progress note, dated the same date, contained a mental status exam, and recorded: "...intent to kill himself. No specific plans, but [patient states], 'something that won't hurt.' " The physician concludes, "Patient still remains an acute danger

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to self."

Family meeting notes were documented by the social worker representative (SS 1). Dated May 22, 2012, at 12:30 p.m., Patient B was reported as stating, "I've tried to look for ways to kill myself even being here."

On May 22, 2012, at 1:15 p.m., nursing wrote on the Daily Nursing Flow Sheet, "...Patient admits, 'I tried to hang myself last night and I feel like doing it right now. I still want to.' " Patient B reportedly "agreed to contract for safety," but admitted he still wanted to hurt himself: "I don't know how to control it," the nurse quoted him saying.

The physician was notified, and an order was written to change Patient B's monitoring from observations Q15 minutes to continuous, one-on-one (1:1) observation.

Examination of the patient's file failed to produce any additional information regarding Patient B's suicidal gesture and attempted hanging.

From May 22, 2012 through May 24, 2012, while on 1:1 observation, nursing and physicians documented Patient B's continued suicidal thoughts, and his statements describing his impulsivity and unpredictability. On May 22, 2012, the physician documented in the Progress Note that Patient B stated, "I feel like if nobody was there, I would do it in the middle of the night."

On May 24, 2012, at 12 noon, a nurse documented

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on the Daily Nursing Flow Sheet (DNFS) that Patient B remained depressed, anxious, and irritable. In the same note, the nurse wrote, "Pt reports decreased suicidal thoughts, able to contract for safety."

At 11:30 a.m., on May 24, 2012, the physician discontinued (D/Cd) 1:1 observation, and placed Patient B on Q5 minute observations.

On May 25, 2012, at 2:15 p.m., nursing documented in Patient B's clinical record on the DNFS: "depressed mood. No interaction with peers. Withdrawn. Attempted to throw self on the floor at risk of self harm...Continues to be suicidal and isolative." Later that day, at 7:35 p.m., nursing documented Patient B was "laughing with other patients and staff, playing a game, happy and laughing visiting with wife."

According to the "Close Observation Q5 Minutes" form dated May 25, 2012, which contained documentation of patient observations every 5 minutes, Patient B entered the shower room at approximately 8:20 p.m. He was last observed in the shower at 9:10 p.m. Documentation of observation was unclear after that, but Nurse 1 explained during interviews that staff had discovered the patient and were dealing with the emergency "within minutes" after the last notation.

The physicians progress note, dictated May 26, 2012, at 11:36 a.m., was reviewed. It contained an accounting of the physician's experience of the event surrounding Patient B's suicide attempt.

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According to the note dated June 7, 2012, a nurse telephoned and disclosed to him that the patient was in the shower when the "person checking on him every five minutes knocked on the door," Patient B told that person to "give me a few minutes [more]." The physician added, "She [the nurse] stated that 'in her estimation, it was like seven, eight minutes, and then they were cleared to open the door...and noticed what he had done'."

The Observation and Monitoring Policy (Number 9083), under the heading, "Q 5 Minutes Observations" (page 3), stipulates, "When the patient showers, changes clothes, or uses the bathroom, the staff will visually check the patient at least every 30 seconds. Staff will attempt to maintain the patient's privacy as much as possible; however, the safety of the patient must be the main consideration."

During an interview with Nurse 1, she explained the policy had recently been revised, and the 30-second observation rule was no longer required. A copy of the approved, revised policy was not provided.

The existing policy titled, Observation and Monitoring Policy (Number 9083), was again reviewed. It identified the facility's policy was to "ensure patients receive care in a safe...environment. Staff members assigned to each patient will provide continuous monitoring...to provide for their safety and security." It further decreed: "The intensity of patient observation...will be commensurate with the assessed level and type

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of risk. Staff members are educated about their responsibility for patient care and oversight...regardless of the frequency of documented observations."

On July 2, 2012, at 2:20 p.m., the receiving General Acute Care Hospital that accepted and treated Patient B following the suicide attempt was contacted. During that telephone interview, an administrative officer disclosed Patient B was discharged, after 8 days of treatment, with "swallowing and speech issues, but no significant sequelae."

The facility's failure to follow its policy and procedure for observation and monitoring of Patient B and ensuring Patient B was protected from self harm is a deficiency that has caused, or likely to cause, serious injury or death to a patient and therefore constitutes an immediate jeopardy within the meaning of the 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).