POC ok acceptable 5/15/17 RR

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
	052031	A. BUILDING ______ B. WING ______	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barlow Respiratory Hospital	2000 Stadium Way, Los Angeles, CA 90026-2606 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: CA00447980 - Substantiated Representing the Department of Public Health: Surveyor ID # 11683, 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(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. The following reflects the findings of the Department of Public Health during a Complaint Investigation. Intake Number: CA00447980 - Substantiated Inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Surveyor #11683, RN, HFEN Health and Safety Code Section 1280.3(g) For purposes of this section, "Immediate		Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. The following constitutes Barlow Respiratory Hospital's plan of correction. Additionally, Barlow Respiratory Hospital respectfully requests an informal conference with the District Manager of the California Department of Public Health, Los Angeles County District Office, to discuss the merits of the deficiency. RECEIVED 2016 DEC 14 PM 2:52 HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION	

Event ID:RLKY11 11/28/2016 4:25:22PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gladys D'Souza TITLE: CNO (X6) DATE: 12-13-2016

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 9

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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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 DIV 5 ART 70213(a)

(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

Title 22 DIV 5 ART 70707(a)(b)(2)(d)

(a) Hospitals and medical staffs shall adopt a written policy on patients' rights.

(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:
(2) Considerate and respectful care.

(d) All hospital personnel shall observe these patients' rights.

Based on record review and interview, the facility failed to ensure Patient 1, who was unable to move her extremities normally and unable to call for help was free from sexual abuse from a Respiratory Therapist (RT 1). On June 18, 2015, between 7 p.m. to 7 a.m. RT 1 touched Patient 1's vagina three times. This failure to ensure Patient 1 was

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	free from sexual abuse resulted in Patient 1 being fearful, emotional and tearful. Findings: On June 25, 2015 at 8:15 a.m., an unannounced visit was made at the facility to conduct an investigation regarding an alleged sexual assault of Patient 1 by a respiratory therapist (RT). A review of the Patient Registration Form indicated Patient 1 was admitted to the facility on May 24, 2015, with diagnosis of respiratory failure with ventilator (machine that supports breathing or does all the breathing) support. Patient 1 has a history of multiple sclerosis, which is a disease of the central nervous system. Most patients experience muscle weakness in their extremities and difficulty with coordination and balance, which may be severe enough to impair walking or even standing. Patient 1 also has a history of a stroke which caused Patient 1 to have right sided paralysis, but was able to walk. A review of the Social Worker's (SW) investigation report dated June 22, 2015, indicated Patient 1 reported that she was touched three (3x) times inappropriately on her vagina by an RT. Patient reported that she was not familiar with this RT but described the individual as a Caucasian male approximately 50 to 60 years old with gray hair. Patient also reported that she could identify the RT if she sees him again. Patient also reported that her vagina was stimulated upon touch but no		Title 22 DIV 5 ART 70213(a) and Title 22 DIV 5 ART 70707(a)(b)(2)(d) Actions Taken: 1. Upon receipt of the Statement of Deficiencies on November 29, 2016, the Chief Nursing Officer and Leadership Team (including the Clinical Director and the Nursing Educator) discussed the survey findings and the actions taken in response at the time of the allegation, which included: a) discussions with other patients who received care by the alleged abuser and no issues of abuse/neglect were identified; b) a review of the "Patient Protection Against Abuse/Neglect" Policy, which did not require any revisions; c) refresher education between June 2015 and August 2015 to nursing and respiratory staff on the abuse/neglect policy, including identification and reporting of abuse allegations and d) revision of the "Patient Protection Against Abuse/Neglect" Policy in December 2015 to add the California Hospital Association "A Quick Reference Guide to Assault and Abuse Reporting Requirements" as an addendum reference to the policy with the Clinical Unit Directors providing nursing staff with an inservice on the policy addendum between December 2015 and January 2016.	11/30/16

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	fingers inserted in her vagina. Patient also reported that the RT told her she was "pretty" before touching her. Patient appeared emotional and requested SW to talk to her DPOA (durable power of attorney) who initially reported the incident to the SW. A review of the Clinical Coordinator's investigation report dated June 22, 2015, indicated she visited Patient 1 in her room and asked her of the reported concerns that took place on Thursday night, June 15, 2015. Patient had a PMV [Passy Muir Valve- a device that helps a person speak] on and was able to verbally provide the following information in front of the SW. Patient was alert and orientated to time, place and person. Patient reported that RT came in and suctioned her and told her that she is beautiful. She was touched three times on the same night inappropriately on her vagina. He did not put his finger or hand inside the vagina. She described the individual as a Caucasian male with gray hair. A review of the Respiratory Therapy documentation dated June 18, 2015 indicated RT 1 was in Patient 1's room at the following times: At 7:10 p.m. RT 1 documented "Patient resting quietly with no signs of acute respiratory distress noted at this time. Rhonchi clears with suction." At 8:50 p.m., RT 1 documented "Patient resting quietly with no signs of acute respiratory distress noted at this time. Rhonchi clears briefly with suction." At 11:30 p.m., RT 1 documented "Patient resting quietly with no signs of acute respiratory distress		Compliance and Monitoring: The Chief Nursing Officer or qualified designee reviews all allegations of abuse/neglect to achieve the goal of 100% compliance with the policy, including identification of reporting of abuse/neglect. Corrective action is taken as necessary, including staff re-education. Data is tracked, trended, analyzed and reported quarterly to the Patient Safety and Quality Committees. Compliance is reported at least every six months to the Governing Board, and is used for performance improvement measures. Person Responsible: Chief Nursing Officer	

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	noted at this time. Rhonchi clears briefly with suction." At 1 a.m., RT 1 documented "No adverse reaction to tx [treatment] noted. Patient resting quietly with no signs of acute respiratory distress noted at this time. Ronchi clears after suction." At 2:10 a.m., RT 1 documented "Patient resting quietly with no signs of acute respiratory distress noted at this time. Rhonchi clears briefly with suction." During an interview with the Social Worker on June 25, 2015, at 9:45 a.m., she stated when she came to work on Monday, June 22, 2015, she was informed by the Clinical Director that Patient 1 had expressed concern regarding a facility staff and needed her to investigate. The SW visited Patient 1 four (4X) times, who, at each time was awake, alert and oriented and requested to have the PMV placed on in order to be able to talk. The patient stated that on June 18, 2015, Thursday night, during the 7 p.m. to 7 a.m. shift, a male RT that the patient described as 50 to 60 years old, Caucasian came to her room to fix her tracheostomy (a hole inserted into the neck to form an airway). He told her that she was very beautiful and then RT reached over with his left hand to touch her vagina and stimulated her. It happened three (3x) throughout the shift with the same RT. The patient became emotional and started crying. At a later time on the same day, the Clinical Coordinator and myself [SW], spoke with Patient 1 regarding her concern with the RT. Patient 1 narrated the incident that happened on the night of June 18, 2015, which was consistent with what she had told			

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me [SW] earlier that day.

On June 25, 2015, at 10 a.m., Patient 1 was observed in bed with cool mist 28% oxygen to tracheostomy and gastrostomy tube (surgically created opening through the abdominal wall into the stomach for purposes of providing nutrition, and for medication administration) feeding of Fibersource.

An interview with Patient 1 was conducted in the presence of the Social Worker and Registered Nurse (RN) on June 25, 2015 at 10 a.m. The patient stated she could not be exact with the date of the incident but she remembered it happened in the evening. Patient 1 stated the following: "He (RT) came into my room three (3x) times that night. He took the call light, the head and foot light was off and the curtain was drawn. He kept telling me to relax and that I am beautiful. He touched me (pointing at her crotch) and rub it but did not go inside my vagina and asked me if I like it. I told him to stop. He won't stop. He did the same thing three (3x) when he came to the room through the night. I was afraid he would hurt me. I tried to scratch him each time while he was rubbing my crotch and he held my left hand."

Patient 1 further stated she did not tell the nurses the following morning because she was afraid the RT would come back and hurt her. The patient did tell her DPOA of the incident. The patient described the RT as a Caucasian man, 60 years old, with gray hair, not wearing moustache/beard and no accent. The patient became emotional and started crying. With tears in her eyes, Patient 1 added she

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had not seen the RT before, "on that one night he did it to me three times. "If I see the guy I would recognize him but I don't want to see him. For three nights he comes back in my dreams and suffocate me with a pillow."

During review of RT 1's personnel file on January 28, 2016, at 1:30 p.m., with Chief Nursing Officer (CNO) and Vice President indicated the following:

a. RT 1 was hired on March 8, 2007 as a Respiratory Therapist.

b. There was a Notice of Disciplinary Action noted such as:

Excessive tardiness - Five (5) occurrences in the period of January 1 through April 1, 2013. Initial Written warning.

Excessive absentees or sick calls - Three (3) occurrences for 90 days from January 16, 2013, February 9, 2013 and February 14, 2013. Verbal or First Written.

Failure to provide care to patients assigned to you on February 2, 2011. There was no action taken on this.

c. The Abuse/Neglect for the year 2009, RT 1 signed that he was signing the form under duress because of the first sentence [When a person is receiving care at Barlow Respiratory Hospital has a condition, illness or injury that may have been caused by another person's action or inaction, it is considered abuse and/or neglect]. I do not agree that anything that happens to a patient here is abuse or neglect.

The facility policy and procedure titled, Patient Protection Against Abuse/ Neglect, dated

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	September 2013, and approved by the medical director on January 29, 2014, indicated the following: "At no time, under any circumstances will any action or, lack thereof, be tolerated that results in the physical or emotional abuse, neglect or exploitation of any patient under care by staff, students, volunteers, other patients, visitors or family members. Should it be determined that a staff member has directly or indirectly, intentionally or unintentionally caused or contributed to the abuse, neglect or exploitation of a patient, he/she/they will be subject to corrective action up to and including termination." The policy and procedure indicated: "1. Any untoward or unexpected patient outcome will be investigated. 2. In the event that it is determined that the cause of the unexpected outcome might be attributable to abuse, neglect or exploitation, a further investigation will be directed toward determining the circumstances. a The Chief Nursing Officer/ Chief Operating Officer along with Clinical Director(s) will thoroughly investigate the incident as well as notify the Risk Manager and the CEO. Appropriate review of documentation, as well as interviews, will be conducted. The incident will be reported to DHS, law enforcement, APS, or other organization as required by law. b. A Notification of Unusual Occurrence will be completed along with the additional information." During an interview on January 28, 2016 at 12 p.m., the Chief Nursing Officer (Admin 1) stated the patient reported the abuse to the night shift charge nurse (Registered Nurse 1) on June 19, 2015 (Friday) and the charge nurse (RN 1) reported to			

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	the nurse manager (RN 2) on June 21, 2015, three (3) days later. Admin 1 stated RN 1 reported it Sunday night at 9 p.m., which was too late. It should be immediately. On Monday, June 22, 2015, the investigation was started. During an interview on January 28, 2016 at 1:30 p.m., Admin 2 (Vice President of Human Resources) and Admin 1 (Chief Nursing Officer) were interviewed. Admin 1 stated RT 1 was placed on suspension on June 22, 2015 and never came back. RT 1 resigned on September 16, 2015. Admin 2 stated RT 1 did not want to be interviewed, he refused. Admin 2 stated the incident had been reported to the police. A review of the Personnel Change Form for RT 1 with effective date of September 17, 2015 indicated, "Voluntary Resignation no reason given." The facility's failure to protect Patient 1, who was unable to protect herself due to her medical condition, from sexual abuse by RT 1 is a deficiency that has caused or is likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and safety Code Section 1280.3 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)..			