PRINTED: 08/23/2016
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000041	A. BUILDING: _____ B. WING _____	C 08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA VISTA DEL MAR HOSPITAL	801 SENECA ST VENTURA, CA 93001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	Initial Comments The following reflects the findings of the California Department of Public Health, Licensing and Certification, during an onsite investigation of an Entity Reported Adverse Event. Entity Reported Adverse Event No: CA00461741 - substantiated. Representing the Department: Surveyor 2623, HFEN The inspection was limited to the specific Entity Reported Adverse Event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1279.1(a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Health and Safety Code Section1279.1 (b) For purposes of this section, "adverse event" includes any of the following: Health and Safety Code Section 1279.1(b)(3)(C): A patient suicide or attempted suicide resulting in serious disability while being cared for in a heath facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.	B 000	8/29/16 Accepted Kathleen RECEIVED 2016 AUG 29 PM 1:52 LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/29/16

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B 000	Continued From page 1 Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. 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.	B 000	CA complaint # CA 00461741 CORRECTIVE ACTION FOR PATIENT: Not applicable in this case. The patient expired.	
B 752	T22 DIV5 CH2 ART6-71641(a) General Safety and Maintenance (a) The hospital shall be clean, sanitary, and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors. This Statute is not met as evidenced by: Based on record review, interview and observation the facility failed to provide patients a safe environment free from devices that could be used to hang a ligature. This failure resulted in the death of Patient 1 after she hung herself from a shower fixture (knob). Findings Review of Patient 1's record and concurrent interview with administrative staff on 10/14/15 at 10 a.m., revealed Patient 1 was a 17 year-old high school student that was admitted	B 752	CORRECTIVE ACTION FOR OTHER PATIENTS: All shower knobs and sink faucets were replaced with ligature proof devices on all units. This work was done on the adolescent unit first-the location of the event-then on all the other adult units. Adolescent unit done by 11/23/15 Bld A Adults done by 11/30/15 Bld G Adults done by 12/20/15.	

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B 752	Continued From page 2 involuntarily on 10/9/15 after a suicide attempt. Further record review revealed that a registered nurse received a verbal order on admission to keep Patient 1 within sight of staff while she was awake as she was assessed to be at high risk to commit suicide. The order was discontinued on 10/10/15. Record review revealed that a registered nurse (RN) and physician both documented on 10/11/15 that Patient 1 had poor impulse control and was at risk for suicide, but Patient 1 was not placed back on line of sight. Record review and concurrent interview with administrative staff on 10/14/15 at 10 a.m., revealed Patient 1 was found by a mental health worker (MHW, unlicensed staff) on 10/11/15 at 1:50 p.m., hanging by a noose made of bed linen from the shower knob. Record review revealed that a MHW documented the patient was in her bed at 1:45 p.m. Interview with RN 1 on 10/14/15 at 11:10 a.m., revealed that when RN 1 arrived in Patient 1's room on 10/11/15, Patient 1 was hanging by her neck from the shower knob. RN 1 stated he supported Patient 1's weight while another RN cut the noose. RN 1 described Patient 1 as having a gray face, no pulse, no respiration, and no reaction to stimuli. RN 1 said he immediately started chest compressions. RN 1 indicated that when another nurse attempted to push air into Patient 1's mouth, Patient 1 began to vomit. RN1 said staff continued with cardiopulmonary resuscitation until the ambulance arrived. Interview with RN 2 at 10/14/15 on 12 p.m., confirmed RN 1's interview, and RN 2 revealed Patient 1 was transferred to Hospital 1 via	B 752	IMMEDIATE CORRECTIVE MEASURES: Adolescent patient bathrooms were closed to patients except for one to be used with staff supervision until all of the fixtures could be replaced. All old fixtures were removed on 10/14/15 on the adolescent unit. MONITORING: The DON is responsible for reporting all incidents of self harm to the Morning Meeting held each Monday-Friday at 9:15am. Any significant instances will be investigated completely by the DON. Any corrective actions taken are documented on the investigation form and reported to the PI Committee monthly, and the Medical Executive Committee and Governing Board quarterly.	

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B 752	Continued From page 3 ambulance. Review of records from the facility on 10/14/15 revealed Patient 1 was in cardiac arrest upon EMS (emergency medical service) staff arrival on 10/11/15 at 2:54 p.m., and was taken to the nearest emergency department (Hospital 1) where Patient 1 was stabilized and then helicoptered to Hospital 2 for a higher level of care and pediatric admission. Patient 1 arrived at Hospital 2 at 6:16 p.m., according to the transport records. Review of the coroner's autopsy report dated 11/5/15 revealed that Patient 1 was pronounced dead at Hospital 2 on 10/11/15 at 10:22 p.m. Further review of the autopsy report revealed the cause of death was " hanging " . On 10/14/15 at 10:30 a.m., the administrator explained that changes had been made since the suicide, and staff were to keep patients out of their rooms during the day and be hypervigilant. In addition, the administrator indicated the shower and sink fixtures had been identified as unsafe because they could be used as ligature devices in a suicide attempt. A review of an inspection from another agency done in January of 2015 revealed the unsafe fixtures had been noted and brought to the attention of the facility at that time. The administrator shared that the devices were scheduled to be changed this year, but the work had not been started. During a tour of the facility with the administrator on 10/14/15 at 11 a.m., Patient 2 was observed in his room unsupervised, Patients 3 and 4 were observed in their room unsupervised, with the door closed. Interview with a MHW in the hallway, at that time, revealed that patients are allowed privacy in their rooms and are checked every 15 minutes. Record review directly after the tour with	B 752	DATES WHEN CORRECTIVE ACTION COMPLETED Shower knobs and sink faucets were replaced as noted below. Adolescent unit done by 11/23/15 Bld A Adults done by 11/30/15 Bld G Adults done by 12/20/15.	

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B 752	Continued From page 4 case managers revealed that Patients 2, 3 and 4 were admitted with suicidal ideation. These patients were observed in rooms unsupervised with bed linens, and shower knobs and sink fixtures that could hold a ligature. Interview with a social worker and a group leader revealed that patients are allowed privacy and nothing different is being done after Patient 1's suicide. Based on the tour, it was determined that staff were not aware of the administrator's plan to keep patients safe. The administrator was advised during the tour, that all patients are at risk as they are allowed unsupervised access to ligature devices in their rooms. Immediate Jeopardy was identified at 10/14/15 at 1:10 p.m. and the administrator was notified. It was observed that maintenance staff immediately began to remove the unsafe fixtures and the administrator and direct care staff instituted a plan to keep the patients safe by increasing staffing and patient observation. The immediacy was removed on 10/14/15 at 4:20 p.m. The facility's failure to provide a safe environment free from devices used to hang a ligature is a deficient practice 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 Saftey Code Section 1280.1 (c)	B 752		