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
	050276	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Contra Costa Regional Medical Center	2500 Alhambra Avenue, Martinez, CA 94553-3156 CONTRA COSTA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00528846 - Substantiated Representing the Department of Public Health: Surveyor ID # 2909, 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. AMENDED STATEMENT OF DEFICIENCY AND ADDED TITLE 22 REGULATION 70213(A) AND CORRECTED THE SURVEYOR ID NUMBER 70213(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Based on observation, interview and record review, for two (patients 13 and 14) of three sampled patients the hospital failed to implement its policies and procedures to ensure that Patient 13 and 14 were protected from all types of abuse. These failures resulted in physical and emotional harm when:		RECEIVED MAY 10 2018 Licensing & Certification East Bay District Office The concerns raised in the statement of deficiencies about the care and protection of Patients 12, 13 and 14 were abated during the Complaint Validation Survey on 4/3/17. Patient 12 was placed on 1:1 observation in a private room and a psychiatric nurse rounded twice a day to collaborate on the patient's plan of care and treatment. Hospitalized patients who may potentially exhibit aggressive behavior were also placed on 1:1 observation and their plans of care and treatment were modified to further ensure a safe and supportive environment for all patients. Additional training was provided to nursing staff assigned to monitor aggressive patients. The following actions were taken to ensure that aggressive patient behavior is identified and escalated according to hospital policy and that patient complaints are resolved promptly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Shelly Thakar TITLE CEO (X6) DATE 5/10/18

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.

POC Accepted 5/16/18

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	1. Patient 13 was emotionally abused by Patient 12's hostile behavior. 2. Patient 14 was physically abused when she was slapped across the face and kicked by Patient 12. This event constituted an Immediate Jeopardy (IJ) which placed the health and safety of Patients 13 and 14 at risk when the facility did not stop Patient 12 from emotionally and physically abusing Patients 13 and 14. These failures resulted in the abuse of Patient 13 and 14. Health and Safety Code (HSC) section 1280.3 authorizes the department to issue APs to hospitals for violations of state licensing laws, and establishes the maximum AP assessment amounts for deficiencies constituting State immediate jeopardy (IJ) and specified non-IJ deficiencies, for incidents occurring on or after April 1, 2014. Findings: 1. A review of the admission record of Patient 13 showed she was a 59 year old female admitted on 3/10/17 with medical diagnoses that included abdominal pain, history of CVA (Stroke, blood flow to a part of the brain is stopped) with right sided weakness, COPD (chronic obstructive pulmonary disorder, lung disease with poor airflow), and cognitive decline/dementia (brain disease that cause a decrease in the ability to think and remember). Patient 13's medical record showed she communicated her needs well.		(Continued) POLICY REVISION The hospital policy, "Escalation Policy", was clarified to emphasize responsibility of all staff members to ensure patient safety and to report matters through the chain of command when patient safety or comfort is threatened or patient complaints cannot be immediately resolved. Escalation Policy & Guideline, Hospital Policy No.624: reviewed and revised. Education on Escalation Policy provided to staff through presentation: "What you need to know policy and expectation review". 95% of staff received training. Tri-fold education pamphlets were also provided to each unit manager. The "Management of Patients with Adverse Behavior" policy was modified to provide clear guidance to clinical staff members for the management of aggressive patient behaviors. Management of Patients with Adverse Behavior, Policy No. 577: reviewed and revised. Education on Management of Patients with Adverse Behavior policy change provided to staff through presentation: "What you need to know policy and expectation review". 95% of staff received training. Tri-fold education pamphlets were also provided to each unit manager.	7/2017 12/2017 7/2017 12/2017

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	In an observation and concurrent interview on 3/ 30/17at 3:02 p.m., Patient 13 ambulated slowly with a walker. Patient 13, stated that Patient 12 was her roommate and that Patient 12 was "a terror, mean, and rude all the time, I fear for my well-being...She (Patient 12) makes me nervous, scared and feel unsafe. I want to move to a different room". Patient 13 added that she had told the staff about her concern several times and about her desire to move to a different room. Patient 13 stated she had not received a response from staff since her request a few weeks ago. Patient 13 stated "I don't care where I go, anywhere is fine but not in the same room with her". Patient 13 further stated, "I am scared to sleep at night because of her. There is no staff staying in our room all the time to watch her (Patient 12). The hospital needs to do something about this situation, she aggravates patients and staff, and I hope they can control her physical aggressiveness. I don't see the staff following her when she walks out of the room". Patient 13 stated that she saw Patient 12 physically attacked CNA (Certified Nursing Assistant) 2 this morning. Patient 13 added "She had no right to put her hand on the staff, now she did it". In an interview on 3/ 30/17at 2:18 p.m., RN 4 stated that there were problems with Patient 12's "labile" behavior and being "mean" and "racist". RN 4 stated Patient 12 had history of verbal and unpredictable physical aggression and added that this was a safety issue with regards to the management of Patient 12's behavior. RN 4 stated that Patient 12 was watched mostly by one CNA who also was		(Continued) SPEAK UP PROGRAM: In addition, a new program to facilitate the escalation of clinical concerns has been developed by the Medical Director of Quality and Safety. This program is designed to build a workplace culture that is supportive of patient safety and empowers staff members to be assertive, without fear, when they observe potential safety opportunities. The program was launched on July 20, 2017 at the leadership level and disseminated throughout all physician and non-physician staff members beginning August 21, 2017. Speak Up Campaign SBAR was delivered to PSPIC The effectiveness of the program was measured through the hospital's Culture of Safety staff survey conducted during the 4th quarter of 2017. The Performance Improvement Committee also monitors through surveillance of adverse reports.	12/2017

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	watching another patient (staff ratio 1:2). At times when Patient 12 verbalized suicidal ideation the ratio would change to 1:1. 2. A review of the admission record of Patient 14 showed she was admitted on 11/2/15 with medical diagnoses that included Huntington's disease (HD inherited disorder that results to death of brain cells), dementia, gait instability, and inability to care for self. Patient 14's medical record showed that she had the ability to make self be understood. In an observation and concurrent interview on 3/30/2017 at 12:30 p.m., Patient 14 curled up in bed. Patient 14 had continuous jerky movements of head, both arms and talked very slowly. There was an unopened lunch tray on the bedside table of Patient 14. She stated she did not have an appetite. Patient 14 stated that Patient 12 entered her room alone late at night about two weeks ago, went through her closet and took her belongings. Patient 14 stated that Patient 12 slapped her hard across the face and hit her knees when she tried to stop Patient 12 from taking her belongings. Patient 14 showed where she had been injured and stated that she had pain on her face and knees. Patient 14 stated that Patient 12 made her angry and scared and recalled that she had to defend herself as Patient 12 attacked. Patient 14 stated there was no staff in her room during her altercation with Patient 12. Patient 14 stated that she yelled for help then the staff came to her room and removed Patient 12. Patient 14 stated that her sleep had not been good since this incident and that she was afraid that		(Continued) PROTECTION OF PATIENTS: Attending physicians, resident physicians and registered nurses assigned to inpatient medical or surgical units received education as to the hospital's process for the care of patients with aggression. The care given to this population is monitored concurrently by social workers and nursing educators/ managers to ensure that assessments have been appropriate and that the interventions specified in the patient's plan of care and treatment correspond with the assessed needs of the patient. Such interventions may include, as appropriate to the patient's needs: --Relocation of the patient to a more suitable environment; --Continuous 1:1 supervision of patients who pose a threat to others; --Involvement of behavioral health specialists in the care of the patient; or --Provision of occupational therapy when indicated. Interventions included in Management of Patients with Adverse Behavior, Policy No. 577: reviewed and revised. Education on Management of Patients with Adverse Behavior policy change provided to staff through presentation: "What you need to know policy and expectation review". 95% of staff received training by . Tri-fold education pamphlets were also provided to each unit manager.	7/2017 12/2017

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	Patient 12 may come back to her room and attack her again. Patient 14 stated that she frequently saw Patient 12 outside Patient 14's room since the incident. Patient 14 stated that, "It makes me angry and afraid thinking about the incident, the hospital should do something and move her away from me". Patient 14 stated, "I'm very afraid of her (Patient 12)". A review of Patient 14's care plan, dated 3/6/17, did not show documentation for ongoing patient assessment, supervision and monitoring for Patient 14's safety nor any plan to address her fear or anger since the incident. A review of the admission record showed that Patient 12 was admitted on 9/20/2016 with medical diagnoses that included history of dementia with behavioral disturbance, paranoid delusions (misinterpretation of perceptions or experiences), and was admitted on a '5150' (involuntary psychiatric hold for the seventh time, with history of being aggressive toward the hospital staff). In an interview on 3/30/2017 at 1:35 p.m., RN (Registered Nurse) 3 stated that Patient 12's mood alternated between, "Nice and friendly to more aggressive", and was very labile. RN 3 further stated that Patient 12, "Curses a lot and had outburst of aggression that happened more last week". RN 3 stated that Patient 12 was placed on four point restraints (application of limb restraints on both arms and legs at once) after she had physically attacked and pulled the hair of CNA 2 this morning (3/30/17).		(Continued) BEHAVIORAL RESPONSE TEAM: The hospital reinforced the hospital-wide scope of its behavioral health response team (one or more psychiatric nurses) to respond to calls by any bedside caregiver at any hour of the day throughout the institution. Personnel on all units within the hospital have been notified of the team's availability. Monitoring sponsored by the executive leadership has verified that staff members know when and how to contact the team. Behavioral Response Team (BRT), Hospital Policy No. 354: Originally written 2007. Activated BRT to conduct rounds twice a shift and as needed. EDUCATION AND TRAINING: Nursing personnel assigned to the inpatient hospital service (excluding those assigned to the inpatient psychiatry unit) were educated as to the content of the revised policy ("Management of Patients with Adverse Behaviors") via the hospital's online learning management system. Nursing assistants assigned to provide close observation for potentially aggressive patients were previously required to complete training in the management of aggressive patients. This two-day CPI ("Crisis Prevention Institute") training program is and will continue to be required for all nursing assistants. Currently employed nursing assistants attended a 4-hour CPI refresher course.	4/2017 12/2017

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	In an interview on 3/30/17 at 1:50 p.m., CNA 2 stated that on 3/30/17 at 7:00 a.m., Patient 12 walked over to Patient 13's bed, who was asleep, and pulled Patient 13's blankets off. CNA 2 stated that she told Patient 12 that it was not ok to do that and covered up Patient 13 who was awakened and upset at Patient 12. Patient 12 then went back to her bed and sat on her bed. CNA 2 stated Patient 12 got up, walked over to Patient13 and pulled out her blankets again. CNA 2 told Patient 12 in a slow speech that it was not ok to pull Patient 13's blankets off. CNA 2 stated that Patient 12 got angry, became verbally hostile and called her "fat, black bitch... funny bitch" and that "everyone at the nurse's station heard". Patient 12, then took her pillowcase off her own pillow and threw the pillow at Patient 13. Patient 13 was upset and shook her head side to side. CNA 2 stated that at 7:50 a.m., when she was writing on the white board in the room of Patient 12 and 13 with her back to them, Patient 12 suddenly grabbed CNA 2's pony tail and wrapped CNA 2's hair around her (Patient 12's) hand a couple of times. CNA 2 stated her hair was pulled hard backward by Patient 12 and that she screamed loud. CNA 2 stated the staff came in the room and grabbed Patient 12's hand to let go of her pony tail and then they had to restrain Patient 12 back to her bed. CNA 2 added the hospital did not provide training to her and other staff on how to handle patients with behavioral aggression leaving the safety of Patient 13 and 14 unaddressed. She stated this was a big safety issue. CNA 2 stated		(Continued) All hospital staff members were educated as to the content of the revised policies via the hospital's online learning management system or through written materials. Education on Escalation and Management of Patients with Adverse Behavior is continued through mandatory annual Safety, Infection Control and Regulations Review (SICRR) e-learning. MONITORING Compliance with hospital expectations, as described above, will be monitored through the concurrent review of high-risk medical-surgical patients (e.g. patients with a history of aggression). The review will focus on patients referred to the Extended Stay Work Group (a Utilization Management sub-group). All care of all patients referred to the group, a maximum of 30 records per month, are reviewed by the Nursing Quality and Social Services departments for compliance with hospital expectations. Reported adverse events are also monitored for any indication of harm or potential harm to any patient. Results of the proactive and ongoing monitoring referenced above, and information from the review of any adverse events involving aggression are incorporated into monthly Performance Improvement committee meetings. RESPONSIBLE PERSON Chief Nursing Officer	

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	that Patient 12's roommate, Patient 13, told her last week that she would like to move to a different room because Patient 13 was afraid of Patient 12. CNA 2 stated that she notified her charge nurse (RN 4) of Patient 13's concern and request. In an interview on 3/30/17at 4:25 p.m., RN 5 stated that Patient 12's moods "went up and down very quickly" and escalated for no reason. RN 5 stated , "Patient 12 is very paranoid" and "there is a safety issue with regards to the management of Patient 12's behavior". In an interview on 3/30/17 at 5.35 p.m., MD (Physician) 4 stated that in the last two weeks Patient 12's behavior had decompensated (lost ability to maintain normal or appropriate defenses) a lot and that Patient 12's paranoid ideation had increased as well to the point of unpredictability. MD 4 stated that Patient 12 manifested combative behavior without bodily warning (hints) for physical aggression. Record review of the progress notes by MD 5 dated 3/5/17, indicated that, "per RN Patient 12 was restrained then fell asleep then was taken off restraints". Patient awoke and walked to Patient 14's room. Patient 12 kicked this patient in the right foot and smacked her on left side of the face. Patient 14 then kicked Patient 12 back". No care plan was provided. A review of Patient 12's progress notes by MD 4 dated 3/6/17 showed, Patient 12 was a 75 year old female admitted on 9/20/2016 with medical			

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	diagnoses which included history of dementia with behavioral disturbance and paranoid delusions (misinterpretation of perceptions or experiences). Further record review indicated MD 4 was planning on reviewing and possibly changing patient 12's medications and was planning on discharging Patient 12 to a locked dementia unit or a SNF (Skilled Nursing Facility) with wander guard (signaling device or departure alert system for wandering management). Record review of Patient 12's progress notes by MD 4 dated 3/31/17, showed that Patient 12, "Continues to be threatening, shows poor impulse control, wanders into other patients rooms, is verbally abusive to the roommate, and when redirected by sitter threatened to punch the RN". In an observation on 3/30/17, at 2:30 p.m., it was noted that Patient 12 was not moved and her room was in close proximity to Patient 14' room. Patient 12 and 13 still shared the same room. In an interview on 3/30/17 at 3:02 p.m., Patient 13 stated she was told no other room was available for her. Review of the hospitals Policy and Procedure titled, "Patient Rights and Responsibilities" revised 6/2010 indicated, "Procedure: D.4. Receive care in a safe setting, free from all forms of abuse and harassment". Review of the hospitals Policy and Procedures titled, "Adverse Event reporting" revised on 8/2013			

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	Indicated "Serious disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual". Review of the hospitals Policy and Procedure titled "Standards Escalation Process" dated 2/23/17 indicated, "Address patient safety concerns and report to front line staff, CN (charge nurse) and Physician of final resolution, direct communication of changed care plan to care team: ensure patient/family needs are met. Provide concise, discreet communication between DON (Director of Nursing), patient and family about status of patient safety issue". There were no measures in place to address the safety of Patient 13 and 14. The medications were not optimized to address Patient12's increased paranoid ideations and mood stabilization. Based on the investigation findings the hospital failed to implement its policies and procedures to ensure that Patient 13 and 14 were protected from all types of abuse. 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).			