DEPARTMENT OF PUBLIC HEALTH POC - acceptable 8/25/16 FORM APPROVED:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050138	A. BUILDING:_____ B. WING_____	05/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaiser Foundation Hospital – Los Angeles	4867 Sunset Blvd, Los Angeles, CA 90027-5969 LOS ANGELES, CA

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	The following reflect the findings of the Department of Public Health during an inspection visits. Complaint Intake Number: CA00309142- Substantiated Representing the Department of Public Health: Surveyor ID# 19004 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 the purposed of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of the licensure has caused, or is likely to cause, serious injury or death to the patient. Title 22 Section 70213(a) Nursing Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing services. Title 22, Division 5, Chapter 1, Article 6, 70215 Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessment as defined in the Business and Professional Code, section 2725(b) (4) Such assessment shall be performed, and the findings documented in the patient's medical			

LABORATORY DIRECTORS OR PROVIDER / SUPPLIER REPRESENTATIVES SIGNATURES TITLE (X9) DATE

SUP/Am 8/24/2016

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

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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State-2567

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	record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (2) The planning, supervision, implementation and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. (3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient. (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient. (d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record. T22 DIVS CH1 ART6-70577(a) Psychiatric Unit General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the services in consultation with other appropriate health professionals			

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	and administrations. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Based on record review and interview, the facility failed to implement its policy and procedure titled, "Rounds" to ensure the safety of Patient A. On May 1, 2012 at 8:12 a.m., Patient A was discovered hanging from his closet door. Patient A was transported to a general acute care hospital (GACH) and admitted to the intensive care unit. Patient A died after life support was discontinued. There was no documentation to indicate the facility staff performed patient rounds and provided safety check on Patient A between 7:46 a.m. and 8:11 a.m. on May 1, 2012. Findings: On May 4, 2012 at 8:30 a.m., an unannounced visit was conducted at the facility to investigate an entity reported incident regarding a suicide involving Patient A that occurred on May 1, 2012 in the Mental Health Center. On May 4, 2012, a review of a facility's letter submitted to the Department date May 2, 2012, indicated the Mental Health Unit on May 1, 2012 at approximately 8:12 a.m. Patient A was discovered hanging from his closet door. The staff took immediate action to release and start CPR (Cardiopulmonary Resuscitation). Patient A was transported to a general acute care hospital (GACH) and admitted to the intensive care unit. The Mental Health Center was informed by the family that Patient A died after life support was discontinued.		1. Immediate measures were taken to ensure patient safety on 5/1/12 that included huddles with all staff and physicians conducted by the MHC Medical Director, Director of Nursing (DON), Administrator and Nurse Educator to debrief the event and emphasize the following key safety elements: a. Strict adherence to the existing 15 minute rounding policy b. 100% accounting for all patients' whereabouts every 15 minutes c. Oversight of the rounding process by the Charge Nurse and Nurse Supervisor d. Immediate escalation of patient safety concerns 2. The MHC Rounding Policy #2.006.2 was revised by the MHC DON and Nurse Educator to include: a. Change of shift patient safety rounds conducted on all patients by the oncoming Charge Nurse (CN) with the off-going CN. b. Assignment of an RN to perform rounds on all patients at least once every hour; c. Assignment of LVNs, LPTs and CNAs to perform rounds on all patients every 15 minutes. d. Use of a visible sign to denote the staff member who is responsible for rounding, e.g. a colored vest or clip board. e. Implementation of a "no distraction" rule for the staff member who is rounding,	5/1/12 affected patients vs ALL patients? #2

	On May 4, Patient A's medical record was reviewed. A review of the medical record indicated Patient A was voluntarily admitted to the facility on April 16, 2012 with major depressive disorder. The nursing care plan for Patient A dated April 16, 2012 included Suicide Risk. The documentation indicated the patient admitted to having suicidal ideation prior to current admission however, the patient denied any present suicidal ideation. The intervention included to monitor patient for safety every 15 minutes. The Unit Rounds dated April 30, 2012 to May 1, 2012 were reviewed. The documentation on unit rounds on the night shift of April 30, 2012 was every 15 minutes from 12 a.m. to 7:45 a.m. of May 1, 2012, The last unit rounds documentation indicated "W: at 7:45 a.m. meaning "Awake in Bed" for Patient A. There was no documentation the staff performed rounds May 1, 2012 at 8 a.m. The policy and procedures titled, "Rounds" dated approved by the Nursing Practice and Standards Committee 01/12 was reviewed and May 4, 2012. The policy stipulated the purpose was, "To establish a process for nursing staff to account for the whereabouts and safety of each patient admitted in the inpatient units at the KP Mental Health (KMHC)." Further review of the policy indicated the following under Policy section 1 and 2: "patient rounding shall occur for all		forbidding other staff members from disturbing rounds in progress and restricting the staff member who is rounding from attending to other issues until every patient's whereabouts is accounted for and documented. f. A process to account for the whereabouts of all patients during emergent situations, e.g. Code Blue or Code Red by: i. Gathering all uninvolved patients to a location away from the site of the emergency, such as the community room or dining room ii. Documenting on the Safety Rounds sheet the location of all patients during the emergency, e.g. code patient located in room x, remaining patients listed individually as located in community room. 3. Rounding Policy #2.006.2 was revised and approved by the MHC Medical Director on 6/4/12. 4. The MHC Nursing Supervisors, Quality Director and Nurse Educator monitored staff compliance with the ***existing*** rounding policy throughout the period immediately after the event through completion of staff training 5/2/12 to 6/17/12. 5. The MHC Nurse Educator trained the staff on the ***revised*** Rounding policy revisions and validated staff understanding from 6/18/12 to 7/30/12. 6. The MHC Nursing Supervisors, Quality Director and Nurse Educator monitored for staff compliance with the revised rounding process during staff training from 6/18/12 and extended through 7/30/12. Monitoring continued after training concluded beginning on 8/1/12 and ending on 11/30/12. Compliance with the rounding policy was maintained at 100% from August thru November 2012 with a total of 260 audits conducted.	6/4/12 6/17/12 7/30/12 11/30/12

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	inpatient units; rounds shall be done every 15 minutes around the clock, seven (7) days a week. The Policy further stipulated "completes rounds together and document findings on unit rounds sheet." A review of the Multi-Disciplinary Progress Notes for Patient A dated May 1, 2012 indicated the following: 1. "At 8:12 a.m., staff informed primary staff that there was a problem in room 306. Staff walked into patient's room and observed patient with eyes closed with bed sheet tied around his neck and bed sheet also trapped on closet door, pt [patient] with one knee touching the floor. Patient was lifted by 1 staff and I staff untied sheet from patient's neck and 2 staff lowered him to the floor, called for code blue after patient was not breathing and no pulse was present. Internist and nurse practitioner paged, 911 called. Started CPR continuously until fire paramedics arrived to patient's room." 2. At 8:13 a.m., the nurse practitioner documented the following: "Responded to code blue in unit 3. On arrival found patient, unresponsive on the floor 306. Patient's color was pale and cyanotic around the lips. He had no pulse and was not breathing. Started CPR at 8:12 am by nursing staff and called 911. Patient was found hanging in the room by CNA at 8:11 am. Last documentation on rounds board at 7:45 am noted patient lying in bed. AED [automated external defibrillator] was attached and no shock advised. Continued CPR until paramedics arrived at 8:30 am. Patient remained pulseless and not breathing, attempted to start IV [intravenous] by this			

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	writer and was unsuccessful at 1 attempt and 911 staff took over. Patient received Epinephrine and other ACLS [Advance Cardiac Life Support] drugs and was intubated upon transportation." On May 4, 2012, a review of a written statement by Certified Nursing Assistant (CNA) dated May 1, 2012, indicated the CNA was on Unit III and was doing vital signs at 7:45 a.m. As the CNA was finishing up the taking of vital signs on another patient, she started looking for Patient A, the last patient for whom vital signs would be taken. The CNA did not see the patient in the TV room and asked the registered nurse (RN 1). RN 1 said she saw the patient in his room. The CNA went to the patient's room, knocked on the bathroom door and there was no answer. The CNA looked in the room and to the right and saw Patient A with a sheet hanging from the closet tied around his neck. During the interview on May 4, 2012 at 12:50 p.m., the DON acknowledged that the CNA failed to document every 15 minutes visual rounds. The DON stated she was not sure if this CNA did visual check at 8 a.m. He was a new employee but A review of the Certificate of Death indicated the following: Date of Death 5/2/12, Immediate Cause (A) Hypoxic/ischemic Encephalopathy (B) Hanging, Manner of Death was Suicide, Injury Date 5/01/12. (Hypoxic/Ischemic Encephalopathy is a condition that occurs when the brain is deprived of adequate oxygen supply.) 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).			