POC - acceptable 3/1/16 SR

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

HEALTH FACILITIES INSPECTION DIVISION
ADMINISTRATION
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RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054055	(X2) MULTIPLE CONSTRUCTION B. WING	04/24/2012

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: CA00307558 - 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. W & I 5325.1(c) Persons with mental illness have the same legal rights and responsibilities guaranteed all other persons by the Federal Constitution and laws and the Constitution and laws of the State of California, unless specifically limited by federal or state law or regulations. No otherwise qualified person by reason of having been involuntarily detained for evaluation or treatment under provisions of this part or having been admitted as a voluntary patient to any health facility, as defined in Section 1250 of the Health and Safety Code, in which psychiatric evaluation or treatment is offered shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program		College Hospital Cerritos (CHC) respectfully submits its Plan of Correction (POC) in response to the Statement of Deficiencies (2567) received on 2/9/2016. 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 Health and Safety Code Section 1280.3; Welfare and Institutions Code 5325.1(c); Title 22 DIV 5 CH 2 ART3-71213; Title 22 DIV5 CH2 ART 6-71501; and Title 22 DIV5 CH2 ART6-71507. Based upon the surveyor's findings, the facility failed to follow its policy and procedure(s) for observation and monitoring and failed to ensure a patient was protected from self-harm. 1. A policy and procedure titled "Hand-held Shower Head with hose" was developed outlining the procedures on how to ensure the ADA compliant metal shower hose was secured when not in use. Per the policy, the hand-held shower hose is to be stored in the House Supervisor's Office and staff	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE President/CEO (X6) DATE 2/23/2016

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 11

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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	or activity, which receives public funds. It is the intent of the legislature that persons with mental illness shall have rights including, but not limited to, the following: (c) A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program. Title 22 DIV 5 CH2 ART3-71213. Psychiatric Nursing Service Requirement (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. (c) There shall be a written organized staff education program which shall include orientation and in-service education and training. Title 22 DIV5 CH2 ART6-71501. Governing Body (a) The governing body shall: (3) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the mental health needs of the community.		must sign it in/out on a log. The patient is to be on a 1 to 1 while using the shower hose. The hose is to immediately be cleaned and returned to the House Supervisor's office after each use. The policy and procedure was developed by the Associate Administrator of Clinical Services/Chief Nursing Officer and was approved by the Medical Executive Committee and by the Board of Directors. 2. All Nursing staff were educated by the Associate Administrator of Clinical Services/Chief Nursing Officer regarding use of the Hand-held Shower Head with Hose and the new policy and procedure. 3. An in-service was held for all nursing staff regarding the new Hand-held Shower head with hose policy and Procedure. The in-service also demonstrated how to attach and detach the hose. The in-service was provided by the Director of Psychiatric Services. 4. New Equipment Safety and Orientation was added as a standing agenda item to the EOC Safety meeting in an effort to ensure that all disciplines are aware of new equipment in patient care areas.	4/27/2012 & 5/7/2012 4/16/2012 4/22/2012 & 4/24/2012 Ongoing

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	Title 22 DIV5 CH2 ART6-71507. Patient Rights (a) All patients shall have rights which include, but are not limited to the following: (9) All other rights as provided by law or regulation. Based on observation, interview, and review of records, the facility failed to follow its policy and procedure(s) for observation and monitoring of a patient and failed to ensure a patient was protected from self-harm. Patient A was a minor, age 17, brought to the facility for voicing suicide intent. Shortly after Patient A's arrival to the facility, the nurse who was monitoring Patient A responded to a "Code Gray" (a patient acting out), and left Patient A unattended in a bathroom equipped with a shower head attached with a flexible metal hose that is intended for use by persons with disabilities. In the nurse's absence, another employee found Patient A in the bathroom with the shower hose wrapped around her neck. Cardio-pulmonary resuscitation measures were instituted, and paramedics were called. The patient was transferred to a General Acute Care Hospital, where continued efforts were unsuccessful and Patient A expired. Findings: On April 20, 2012, at 1:20 p.m., an unannounced		5. All nursing staff (RNs, LVNs/LPTs and MHWs) were educated 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. The educational in-service was provided by the Director of Psychiatric Services/Nurse Educator. 6. The Patient Care Assignment Sheet was revised to include a space to assign staff to conduct rounds in the event of a code on the unit. The importance of conducting rounds during emergency situations was discussed during the Nursing In-Services. 7. 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. 8. Monitoring of the Hand-held Shower Head with Hose sign in/out log was conducted by the Director of Quality Improvement/Risk Management to ensure the hose procedure was followed.	5/30/2012 & 6/9/2012 5/30/2012 & 6/9/2012

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	investigation was conducted in response to an entity-reported patient suicide. On April 20, 2012 at 1:30 p.m., during an interview with a nursing administrator (Registered Nurse 2), she stated Patient A was found in the bathroom in the patient's room by a mental health worker (MHW 6). She explained the bathroom was equipped with a shower head that had a flexible metal hose attached in order to be compliant with ADA (Americans with Disabilities Act) requirements. Upon inspection of the shower hose, a quick-release connector inside the end of the device was noted. The bathroom wall where the unit was connected was also examined. The wall attachment was designed to accommodate a quick connect/release attachment. The Building Engineer, Employee 4, demonstrated how the shower hose was connected and disconnected. A document titled "SP-7WC Quick Connect Hand Held Spray," was provided at 2 p.m. A review of the document revealed the attachment "allows for care of persons in wheelchairs using hand-held spray without presenting a point of ligature" (to tie or bind). A warning on the manufacturer's installation sheet declared, "The hand-held spray attachment is only intended for use under the supervision of facility staff. When not in use, the hose and spray head must be removed ...and stored in a secure location." According to Employee 4 (Building Engineer) on April 24, 2012 at 9:10 a.m., that information (to			

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	remove the shower head) was not communicated to the staff. "No one thought of it at the time," he stated. Asked who would have been responsible for educating the staff about removing the showerhead hose, Employee 4 responded on April 24, 2012 at 2 p.m., "The nursing (department) should teach their staff." Registered Nurse (RN) 1 replied, "Engineering should have gotten equipment information and given to the supervisors." RN 2 explained they did not have a policy and procedure that established responsibilities for sharing information pertaining to the new equipment. "It just never occurred to anyone," she added. A review of Patient A's clinical record in "Section II, Nursing Admission Assessment" form (page 7) disclosed Patient A's physical status was assessed. Under, "Review of Systems," (section 27), no muscular-skeletal or neurological issues were identified. On page 12, it noted the patient had no assistive devices, no gait disturbance, or impaired mobility. The physical assessment concluded Patient A was in "Good physical health," with no physical or occupational problems (page 13). Employee 6 (Director of Quality Improvement/Risk Management) acknowledged Patient A was not handicapped and did not require the use of a specially-equipped shower head. RN 2 interjected, "The shower head should have been removed before			

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	any patients were admitted to the room." Further review of Patient A's admission record revealed the patient was brought to the facility after announcing to her family member and a stranger she was going to kill herself by jumping from a cliff. An emergency psychiatric team evaluated the patient and determined, with the patient's admission of not taking medications, a history of previous suicide attempts, and current suicidal threats, there was imminent danger to the patient's own safety. Patient A was placed on a 5585 (a 72-hour legal hold under Welfare and Institutions Code 5585 et seq for psychiatric evaluation for minors who appear to be a danger to themselves or others), and transported to the psychiatric hospital. According to the "Integrated Admission Assessment," Patient A was admitted to the facility on April 10, 2012 at 7 p.m., and was immediately placed on observations every 15 minutes, in accordance with the facility's policy titled, "Observation and Monitoring" (policy 9083, dated 12/87 and revised 4/11). The admission assessment documents included a "Risk Assessment" questionnaire (page 11), which contained questions that addressed the patient's current suicidal thoughts and past suicidal attempts. Each answer carried a weighted score which was used, in part, to determine the degree of suicide risk. The patient's admission of a history of previous suicide attempts, along with other factors, established Patient A as "High Risk for suicide."			

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	A review of the "RN Admission Summary and Note" (page 15, section 49, Mental Status Upon Admission section), the admitting nurse (RN 4) wrote, on April 10, 2012, at 8:10 p.m., "[The patient] admits still feels suicidal. Stated, 'I just don't want to be here anymore.'" On page 16 of the same form, under "RN Narrative Summary & Treatment Priorities," RN 4 continued: "On 5585 DTS (danger to self)...has history of suicide attempts and multiple hospitalizations in the past. Most recently in February 2012. Non-compliant with medications [for] 3 weeks." On April 10, 2012 at 8:10 p.m., RN 4 placed Patient A on suicide precautions, and changed the observations schedule from every 15 minutes to every 5 minutes, and placed Patient A on suicide precautions. A physician's order for the same was obtained at 8:30 p.m. (MD Admission Orders and Certification form), and a "Close Observation Q 5 Minutes" form was started at that time. The Observation and Monitoring Policy (Number 9083), identified the facility's policy 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 of risk. Staff members are educated about their responsibility for patient care and oversight...regardless of the frequency of documented observations." Observations documented in 5-minute increments			

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	on the Q 5-minute Observation form, placed Patient A in the dayroom of the assigned unit from 8:30 p.m. to 8:45 p.m. The form then showed at 8:30 p.m., Patient A was awake in the bedroom from 8:45 p.m. to 9 p.m. Though not reflected on the form or in other documents, administrative staff members stated Patient A was in the bathroom when the incident occurred. During an interview regarding the facility's procedure for monitoring patients, MHW 6 stated on April 24, 2012 at 11:30 a.m., "We give them their privacy, and stand just outside the [bathroom] door and leave it open a crack. We can't just stand there and watch them when they go to the bathroom (sic)." A review of 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." Administrator 1 divulged during the interview on April 24, 2012, at 1:10 p.m., they were not aware of the directive that a patient must be visually observed every 30-seconds when the patient is in a bathroom, a shower, or getting dressed. During an interview, on April 24, 2012, at 2:45 p.m., RN 1 stated, "The nurse on duty (RN 4) was observing the patient outside [the door] when she			

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	got called away at 9:05 p.m. to get medicine during a 'code gray' (an emergency situation with a patient who is acting out)." She continued, "The MHW took over for the nurse within minutes. Everyone was right there, in the hallway and right next to the patient's room [where the code gray occurred]. According to the Observation Policy (#9083), under "Policy" on page 1, "Staff assigned to Q (every) 5 minute checks must hand off responsibility for maintaining observation of the assigned patient for any break." A review of the observation flow sheet did not show any staff changes in the observation of Patient A. A review of the nurse's documentation on the Multidisciplinary Progress Note (MPN) form, dated April 10, 2012, at 10 p.m., provided an accounting of the events that occurred with Patient A. The following is a synopsis of those documented events: While RN 4 was attending to the responsibilities of the code gray, a mental health worker discovered Patient A in the bathroom with "metal shower cord around her neck." A "code blue" (life threatening emergency) was called at 9:10 p.m., CPR (cardiopulmonary resuscitation) was started at 9:12 p.m., and continued until paramedics arrived at 9:22 p.m. Paramedics intubated Patient A (inserted a long breathing tube into the trachea, or wind pipe, through the mouth to permit air to pass freely to			

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	and from the lungs in order to allow air into the lungs) and continued resuscitative efforts. At 9:38 p.m., the patient left with the paramedics "while CPR was still in progress." A review of the Emergency Department Nurse's Note from the general acute care hospital dated April 10, 2012, indicated Patient A arrived at 9:51 p.m. with the chief complaint of cardiac arrest (loss of consciousness with no heartbeat). Patient A was unconscious, had endotracheal tube (placement of a flexible tube into the trachea (windpipe) to maintain an open airway, and was on a ventilator (machine that support breathing). Patient A was admitted to the critical care unit at 11:48 p.m. The Physician Documentation, from the general acute care hospital, dated April 10, 2012 indicated at 10:01 p.m., Patient A presented to the emergency room in cardiac arrest. Prior to the arrest, the patient attempted suicide and was found hanging at the acute psychiatric hospital. Patient A hanged herself on a shower cord which she wrapped twice around her neck. Patient A was admitted to the critical care unit with preliminary diagnoses of asphyxiation strangulation (condition of being deprived of oxygen by constriction of the neck using cord like object), cardiopulmonary arrest, metabolic acidosis (condition in which the kidneys are not removing enough acid from the the body) and severe depression. The Code Blue dated April 11, 2012, dictated at 10:58 a.m., indicated Patient A went into cardiac arrest and resuscitative measures were			

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	unsuccessful. Patient A was pronounced dead at 10:24 a.m. The assessment and plan indicated the diagnoses were ventricular fibrillation cardiac arrest with recent history of hanging, attempted suicide. The History and Physical dated April 11, 2012 dictated at 11 a.m. indicated Patient A was intubated, unresponsive and no response to pain. The admitting diagnoses included status post cardiopulmonary arrest with self-inflicted asphyxiation, ventilator dependent respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), and cerebral edema (brain swelling). According to the Death Certificate, the immediate cause of death for Patient A was "hanging" with the shower hose. The facility's failure to follow its policy and procedure for observation and monitoring of Patient A. The facility also failed to ensure Patient A was protected from self-harm by its failure to remove a shower hose spray attachment and to train staff on proper its use and removal. The facility's noncompliance with these requirements, jointly, separately or in any combination, 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.			