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
	050057	A. BUILDING _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaweah Delta Medical Center	400 W Mineral King Ave, Visalia, CA 93291-6237 TULARE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: 576420 No complaints found - Substantiated Representing the Department of Public Health: Surveyor ID# 39602, 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(9): 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. Health & Safety Code 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. (b) For purposes of this section, "adverse event" includes any of the following: (6) Criminal events including the following: (D) The death or significant injury of a patient or staff		Please note: The following constitutes Kaweah Delta Medical Center's credible evidence of correction of the alleged deficiencies cited by the California Department of Public Health in the Statement of Deficiencies for CMS-2567 dated July 3, 2018. Preparation and/or execution of this credible evidence submission does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the Statement of Deficiencies. The Statement of Deficiencies Form-2567 was received in this office on July 13, 2018. Corrective action and associated monitoring plans begin below on page 1. Health & Safety Code 1279.1 **Corrective Actions:** 1. Focused education of Policy: "AP87: Sentinel Event and Adverse Event Response and Reporting" to discuss identification of sentinel and adverse events as well as the timeliness of reporting such events 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, as defined in Health & Safety Code 1279.1. This education will be conducted at a team meeting designed to capture 100% of the Risk Management staff. The education will include an agenda sheet, sign-in sheet, and a copy of the policy. The Risk Management staffs who are unable to attend the team meeting will receive this education prior to returning to their next shift within the Risk Management department. The	July 17, 2018

Event ID: 3JEQ11 7/10/2018 12:56:05PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Amy K. Hurst CEO 7/20/18

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 16

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.

2897 POC accepted 7/25/18

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	member resulting from a physical assault that occurs within or on the grounds of a facility. Health & safety Code 1280.3(9) 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. HEALTH AND SAFETY CODE - DIVISION 1.5. USE OF SECLUSION AND BEHAVIORAL RESTRAINTS IN FACILITIES (1180- 1180.6) 1180.4. (a) A facility described in subdivision (a) of Section 1180 .2 or subdivision (a) of Section 1180.3 shall conduct an initial assessment of each person prior to a placement decision or upon admission to the facility, or as soon thereafter as possible. This assessment shall include input from the person and from someone whom he or she desires to be present such as a family member, significant other, or authorized representative designated by the person, and if the desired third party can be present at the time of admission. This assessment shall also include, based on the information available at the time of initial assessment, all of the following: (1) A person's advance directive regarding de-escalation or the use of seclusion or behavioral restraints.		responsible persons of this education are the Director of Risk Management and the Chief Medical Officer. **Monitoring Plan:** 1. The Director of Risk Management will conduct an audit of 100% of self-reported events for timeliness of notification to the CDPH per Health & Safety Code 1279.1. Goal: 100% compliance for three (3) months. If a fallout is identified, individualized training with the associated licensed nurse and/or physician will be provided prior to their return to patient care. The results of these audits will be reviewed and monitored through the organization's quality improvement processes and reporting made to the Quality Council. Health & safety Code – Division 1.5 (1180 – 1180.6) 1180.4 **Corrective Actions:** 1. Revised Policy: "MH 32.01 Persons at Risk for Violence: Safety, Screening, and Recovery Support" and a revised process of electronic documentation is being utilized (and licensed nursing staff have been trained) as of June 29, 2018 consisting of a forced function of the nursing violence risk assessment (Broset Violence Checklist/BVC) upon admission which disallows the nurse to move forward in further documentation until completion of the nursing violence risk assessment. The revised process also implements an electronic prompt to licensed nursing staff of a checklist of	July 18, 2018 through October 18, 2018 July 20, 2018

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	(2) Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with a known or suspected history of aggressiveness, or persons who are currently aggressive. (3) Techniques, methods, or tools that would help the person control his or her behavior. (4) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion. (5) Any trauma history, including any history of sexual or physical abuse that the affected person feels is relevant. Based on observation interview and record review, the hospital failed to follow its policy and procedure to accurately assess two of three patients (2 and 3) and provide sufficient staffing as indicated by the assessment to ensure an environment that was free from harm. This failure resulted in an assault on Patient 1 by Patient 2 causing Patient 1 to sustain an orbital (bone around the eye) fracture, maxillary sinus wall (bone under the eye, in the upper cheek area) fracture, and vision loss in his left eye which was still present on discharge from the facility. Findings: Patient 1 was a 70 year-old male admitted from the Emergency Department (ED) to the hospital on 2/9/18 at 9:05 PM with the diagnostic impression of "brief psychotic disorder" (characterized by a sudden onset of psychotic symptoms, which may include delusions, hallucinations, disorganized speech or behavior), as well as a history of schizophrenia. On admission, Patient 1's weight was less than 125 pounds and height was 69 inches		patient safety interventions for selection of patients identified at risk for violence. Education of Policy: "AP161: Workplace Violence Prevention Program" to discuss nursing assessment of potential for violence and Policy: "MH 32.01 Persons Risk for Violence: Safety, Screening, and Recovery Support" as well as training of the revised process and revised electronic documentation will be conducted at a team meeting designed to capture 100% of licensed nursing staff at the Mental Health Hospital. This education will include an agenda sheet, sign-in sheet, a reference sheet, and a computer-based module with a post test. The licensed nursing staff who are unable to attend the team meeting will receive this education prior to returning to their next shift at the Mental Health Hospital. The education and training will be provided by the Director, Managers and Clinical Educator of the Mental Health Hospital. The responsible persons for this education are the Director of Mental Health Services and the Chief Operating Officer. 2. Focused education on "CUS" communication tool (Concerned – Uncomfortable – Safety) to discuss that a safety culture is recognized at the Mental Health Hospital and licensed nursing staff are encouraged to bring forth any patient safety concern to the attention of colleagues and/or leaders within the department. This education will be conducted at a team meeting designed to capture 100% of licensed nursing staff at the Mental Health Hospital. This education will include an agenda sheet, sign in sheet, and a	June 1, 2018

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	tall (5'9"). Patient 2 was a 41 year-old male admitted from the ED to the hospital on 2/26/18, at 8:41 PM, with the diagnostic impression of psychosis and danger to self and others. On admission, Patient 2's weight was greater than 185 pounds and height was 74 inches tall (6'2"). Patient 2 was admitted into the same room as Patient 1. During a concurrent review of the clinical record for Patient 2, and interview with the Director of Mental Health Services (DMHS), Nurse Manager 1 (NM 1), NM 2, and the Director of Risk Management (DRM), on 3/6/18, at 11 AM, the following Emergency Room Nursing Documentation indicated Patient 2 initially presented to the ED on 2/26/18 at 11:40 AM, requesting a mental health evaluation. The notes section indicated at 12:14 PM "CODE GRAY (internal alert system indicating a violent person) CALLED." At 12:17 PM, the notes indicated, "Restrain patient (Patient 2)... Violent/Destructive Behavior: Locking restraints applied to 4 point (both arms and legs); immediate threat of safety to patient and others present. . . Patient is severely agitated and/or combative." The Emergency Room Physician Documentation, dictated by the Emergency Department Doctor 1 (EDD 1) at 12:33 PM indicated, "Upon my initial evaluation of the patient I obtained the above history. I then notify [sic] the patient that I would begin a physical exam. I listen [sic] to his heart and lungs. Evaluated for posterior neck tenderness Performing an HEENT (head, eyes, ears, nose, and throat) exam - and without warning - the patient struck me with a		reference sheet. The licensed nursing staff who are unable to attend the team meeting will receive this education prior to returning to their next shift at the Mental Health Hospital. The education will be provided by the Director, Managers and Clinical Educator of the Mental Health Hospital. The responsible persons for this education are the Director of Mental Health Services and the Chief Operating Officer. **Monitoring Plan:** 1. The Director and Nurse Manager of the Mental Health Hospital will conduct an audit of 100% of patient records to ensure BVC risk assessments are conducted upon admission, reassessments are conducted at least every shift and more frequently based on patients' BVC risk assessment score, and interventions are documented and implemented according to patients' BVC risk assessment score. Goal: 100% compliance for three (3) consecutive months. If a fallout is identified, individualized training with the associated licensed nurse will be provided prior to their return to patient care. The results of these audits will be reviewed and monitored through the organization's quality improvement processes and ultimately reporting to Quality Council.	

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closed fist on the right side of my head. Patient was then obtained by security - placed in restraints - and the remainder of the care was turned over to [EDD 2]." At 4:36 PM, EDD 2 dictated, "Patient with unclear psychiatric past medical history self presents for unclear reasons. He has physically assaulted another resident physician and is clearly combative and internally distracted. The patient poses clear threat to himself and to others and anticipate psychiatry to admit for further care." At 5:03 PM, the Psychiatric Resident Physician (PRP) dictated, "... Patient is a 41 yo (year-old) male with past history of psychiatric treatment for psychosis while in prison who is presenting for "not thinking right."... He admits to auditory and visual hallucinations (seeing things that are not physically there) but is unable to elaborate on what these are specifically. Today while being examined by an ER (Emergency Room) provider he physically hit the staff in the face. He says he did this because of the "guy breathing on his face and his phone in his pocket." He has long pauses when talking and appears to [be] responding to internal stimuli (talking to himself). He has difficulty articulating his thoughts and is thought blocking (thought condition usually caused by a mental health condition such as schizophrenia. During thought blocking, a person stops speaking suddenly and without explanation in the middle of a sentence). He admits he hit the provider and says that he also is aggressive at home. . . He cannot provide a safety or crisis plan. . ." At 5:06 PM, EDD 3 dictated, "After return of studies and re-examination my impression is that [Patient 2] should be admitted to the hospital for further evaluation and care. . .

2. The Director and Nurse Manager of the Mental Health Hospital will conduct a voluntary and anonymous Safety Attitude Questionnaire survey of 90% of clinical staff, Psychiatric Assessment Team staff, and social work staff at the Mental Health Hospital to evaluate safety culture within the work and patient environments.

   Goal: Based on May 2018 Safety Attitude Questionnaire results, there will be an increase in the percentage of staff at the Mental Health Hospital who state they will speak up when a concern arises related to patient safety.

   The results of this survey will be reviewed and monitored through the organization's quality improvement processes and ultimately reporting to Quality Council.

December 31, 2018

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	[Patient 2) is too high risk to go home, based on psychosis and an active threat to harming self and others... "The section titled "Medication Administration Record" indicated at 7:52 PM Patient 2 received Ativan (medication used to relieve anxiety), Haldol Decanoate (a medication used to treat psychosis), and Benadryl (antihistamine - when these three drugs are given together, they have a sedating effect) via intramuscular injection (a shot in one of the large muscles). The section titled "Disposition" on the Emergency Room Nursing Documentation indicated Patient 2 was transported from the ED to the hospital in an ambulance at 8:28 PM. The DMHS, NM 1, NM 2, and DRM confined Patient 2 remained in four-point restraints from 12:17 PM until he arrived at the hospital. During an interview with the DMHS, NM 1, NM 2, and the DRM on 3/6/18, at 9:40 AM, NM 1 stated on 2/27/18, at 9:11 PM, Patient 2 came out of the room he shared with Patient 1 and said, "Man down!" Patient 1 exited the room behind Patient 2, walked up to the nurses' station, and stated, "That guy [Patient 2) hit me." NM 1 stated the two patients were immediately separated. Patient 1 was noted to have a laceration over his left eye and was taken by ambulance to the ED. NM 1 stated Patient 1 was diagnosed with a fracture to his left orbital bone and returned to the hospital. She stated Patient 1 currently could not see more than two feet in front of him out of his left eye. She stated Patient 1 was previously able to see normally with his left eye. NM 1 stated Patient 1 had been seen by an oromaxillofacial surgeon (doctor who specializes in treating diseases, injuries, and			

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	defects of the head, neck, face, and jaws) since discharge from the ED, as well as an ophthalmologist (specialist in medical and surgical eye disease). NM 1 stated the ophthalmologist referred Patient 1 to an ophthalmologic surgeon, as the ophthalmologist stated the impact of the punch likely tore the fibers in the lens of his eye, resulting in the vision loss. NM 1 stated Patient 2 was asked why he punched Patient 1 and he stated, "I had a bad day." During a review of the clinical record for Patient1, the ED Physician Documentation indicated Patient 1 was discharged from the ED on 2/28/18, at 3:31 AM, with diagnoses of "left lateral orbital wall moderate comminuted (producing multiple bone splinters) fracture with minimally mildly displacement [sic], lateral maxillary sinus fracture s/p (status post - after) trauma, and left mydriasis (dilation of the pupil of the eye). . . " During a concurrent observation and interview with Patient 1, on 3/6/18, at 9:30 AM, Patient 1 was noted to have a large purple bruise around his left eye, extending under his eye to halfway down his cheek. Patient 1 stated the bruise came from an incident he had with Patient 2 on 2/27/18 at approximately 9 PM. He stated on that evening, he had been laying in his bed and sat up on the edge, intending to go to the bathroom. Patient 2 then came up beside him and punched the side of his face. Patient 1 stated he had had no interaction with Patient 2 prior to the incident and there was no provocation for the punch. He stated he was currently unable to see out of his left eye, but had			

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	normal vision in that eye prior to being punched. During a concurrent review of the clinical record for Patient 1, and interview with the DMHS, NM 1, NM 2, and ORM, on 3/6/18, at 11 AM, the Psychiatric Admit Evaluation, dated 2/10/18, at 11:17 AM, indicated Patient 1 was a 70 year-old male admitted from ED to the hospital on 2/9/18. NM 2 stated when Patient 1 was first admitted, he was in the acute phase of his illness (time period when behaviors are most apparent), but had never been violent or aggressive. She stated by 2/27/18, he had been receiving medications and treatment for a couple weeks and he was stable. During an interview with EDD 1, on 4/4/18, at 4 PM, he stated he recalled evaluating Patient 2 in the ED. He stated after he had obtained as much of Patient 2's medical and psychiatric history as he could, he informed Patient 2 he was going to perform a physical examination. EDD 1 stated Patient 2 tolerated the examination until he went to check his eyes. He stated he was using his cell phone's flashlight to perform the examination. EDD1 stated Patient 2 tolerated one eye being examined, but when he went to examine the other eye, Patient 2 suddenly punched him on the right side of his face. EDD 1 stated security immediately entered the room to subdue the patient and he excused himself from the room and turned over the care of Patient 2 to EDD 2. EDD 1 stated he sustained bruising to the side of the face from the punch. He stated he considered the punch to be completely unprovoked and considered Patient 2 to be very unpredictable.			

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	During a concurrent review of the clinical record for Patient 2 and interview with Registered Nurse 1 (RN 1), on 3/8/18, at 3:15 PM, he stated he was the nurse who admitted Patient 2 to the hospital after he was transported by ambulance from the ED. The document titled Admission Data Base, dated 2/26/18, at 9:30 PM, indicated it was completed by RN 1. The section "Reason for Admit/Diagnosis" indicated, "Patient endorsing hallucinations, stated he is 'not thinking right,' punch staff member in emergency room." The section "Psychosocial Nursing Note" indicated "Patient admitted on 2/26/18 at 2041 (8:41 PM) from [Emergency Department]. Patient arrived to (the facility) sedated, unable to wake up, unable to participate in assessment. Patient was taken straight to his room, skin check performed; staff was able to change him into hospital scrubs. . ." RN 1 stated Patient 2 was completely sedated when he arrived at the hospital, and he was taken straight to the room that was assigned to him by the charge nurse prior to his arrival. RN 1 stated he was concerned about the safety of the staff and other patients due to the "assault in the ED," but Patient 2 slept all night, so he was unable to complete the assessment or assess for violence risk in the hospital. During an interview with RN 2, on 317/18, at 3:40 PM, she stated she was the charge nurse on 2/26/18 when Patient 2 was admitted to the hospital. RN 2 stated she was contacted prior to Patient 2's admission to receive information and she assigned him to a room at that time. RN 2 stated she was informed Patient 2 punched an ED doctor			

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	unprovoked, and that his behavior was such that he would be arriving to the hospital highly sedated. She stated he was considered to be at high risk for violence based on the assault on the doctor in the ED. RN 2 stated many factors go into the decision of which room to assign a newly admitted patient to, including violence and unit room availability. She stated she did not recall what factors she evaluated to determine room placement for Patient 2 with Patient 1. During an interview with RN 3, and concurrent review of the clinical record for Patient 2, on 3/8/18, at 10 AM, RN 3 stated she received in report on the morning of 2/27/18 that Patient 2 was at high risk for violence because he punched a doctor in the ED. RN 3 stated when she went to Patient 2's room to perform his assessment he was awake and pacing. The document titled "Body Systems and Categories", completed by RN 3, on 2/27/18, at 7:30 AM, indicated, "Client [Patient 2] was pacing and appears agitated." She stated she performed the assessment on Patient 2 that morning from the doorway because she was "guarded" and "feared for her safety" due to Patient 2's history of violence. RN 3 stated when the Psychiatric Medical Director Doctor (PMDD) came to perform Patient 2's initial assessment on 2/27/18, at approximately 10 AM, "he [PMDDJ kept his distance." She stated she recalled PMDD performed his assessment of Patient 2 from the doorway. The "Condition Update", completed by RN 3 on 2/27/18, at 5:58 PM, indicated "Client does get agitated later in the afternoon and states, 'I feel like I don't need to be here.'"			

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	During a concurrent interview with the DMHS, NM 1, NM 2, and the ORM and review of the clinical record for Patient 2, on 3/6/18, at 1 PM, the DMHS stated after a patient is admitted to the hospital, a multidisciplinary team comes together to plan the patient's care. The DMHS stated the team is comprised of facility staff, such as herself, the nurse managers, as well as the PMDD. The DMHS stated they use the information gathered from Admission Data Base to plan the care. She stated if the Admission Data Base is incomplete, they plan care based on other information available and the patient's current presentation. The Adult Acute Program Interdisciplinary Treatment Plan Integrated Summary, dated 2/27/18, at 9:33 AM, indicated under the section "Summary Statement", "Patient (2) in ED for MH (mental health) evaluation. Patient stating that he is "not thinking right." He was having hallucinations, and became physical while in the ED, striking a physician in the face." The DMHS stated as a result of the treatment planning meeting, two treatment plans were developed: Altered Thought/Perception and Discharge/Transition. The DMHS confirmed there was no treatment plan developed regarding Patient 2's violent behavior. During a concurrent interview with RN 3 and review of the clinical record for Patient 2, on 3/17/18, at 3:30 PM, he stated he was Patient 2's nurse on the evening of 2/27/18. He stated he received in report Patient 2 was at risk for violence and that he had assaulted a physician in the ED. He stated during that evening, Patient 2 was pacing in the hallway outside his room, "responding to internal stimuli"			

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	050057	A BUILDING _____ B 'NING _____	07/03/2018

NAME OF PROVIDEROR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaweah Delta Medical Center	**400 W Mineral King Ave, Visalia, CA 93291-6237 TULARE COUNTY**

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
	and stated he did not want to be in the hospital. During a concurrent interview with the PMDD and review of Patient 2's clinical record, on 4/4/18, at 10:15 AM, the Psychiatric Admit Evaluation, dated 2/27/18, at 9:57 AM, indicated, "Assault and Violence History: Pt [Patient 2) hit a staff in the face at the ED. Violence Risk to Others (over the past 6 months); high risk... Judgment: poor. .. Homicidal and/or Violent Ideation: agitation, delusions and hallucinations demonstrate patient is danger to others outside of hospital. . ." The PMDD stated he "kept his distance" from Patient 2 while performing the Psychiatric Admit Evaluation due to Patient 2's risk for violence. The PMDD stated Patient 2 had been in prison for a long time and had a "defensive prison mentality" and didn't like people getting near him. He stated he believed that was why Patient 2 punched EDD 1, because he felt him to be in his personal space, and his "prison mentality" made him reactively punch him. The PMDD stated Patient 2 was schizophrenic (schizophrenia - chronic and severe mental disorder that affects how a person thinks, feels, and behaves) and therefore quiet and more unpredictable than patients with other mental illnesses. During an interview with the DMHS, NM 1, and NM 2, on 4/4/18, at 10:30 AM, the DMHS stated she was unaware any nurses were concerned for their safety while caring for Patient 2, but if they were so concerned that they did not enter the room to perform assessments, they should have gone to the Charge Nurse so appropriate action could be taken.			

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	During a concurrent interview with NM 1 and review of the clinical record for Patient 2, on 4/18/18, at 4:10 PM, NM 1 stated a Behavioral Risk Assessment should be performed on every patient who has a risk for violence on admission and at least once a shift. NM 1 confirmed there was no Behavioral Risk Assessment completed for Patient 2 upon admission, nor during the day shift on 2/27/18. The Behavioral Risk Assessment was first completed for Patient 2 was on 2/27/18 at 6:41 PM, at which time he was assessed to be at moderate risk for violence. During a concurrent interview with the DMHS, NM 1, and NM 2, on 4/20/18, at 10 AM, the Behavioral Risk Assessment for Patient 2 dated 2/27/18, at 6:41 PM, was compared with the instructions for completing the Behavioral Risk Assessment tool, located within the hospital's policy titled" Behavioral Observation & Monitoring of Psychiatric Patients". The tool indicated, "This tool is used if a client: a. Has a history of violence... Directions: Assess each key factor. Circle one (of three) descriptors for each factor that best describes the client. c. Add the points for each circled item to obtain the total score." It was noted the assessment of Patient 2 at that time assigned him a risk score of 7. The "Scoring Key" located at bottom of the tool indicated a score of 3 - 8 was indicative of the patient being at moderate risk for violence, requiring safety checks of the patient every 15 minutes. The tool indicated, under the section "History of Aggression in Family of Origin", the patient being a victim or perpetrator of physical or sexual abuse would trigger a score of '2' for that section. Patient			

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	2's assessed score for "History of Aggression in Family of Origin" was 0, indicating "Witness or victim of verbal aggression -OR- No history of aggression in family." The DMHS stated since Patient 2 admitted in the ED to being aggressive at home, the score of O was incorrect, and should have been 2. A score of 2 in this category would have made Patient 2's total behavioral risk assessment score of 9. The "Scoring Key" indicated "High-risk precautions= 9 or more (1:1) (1 staff member assigned to monitor 1 patient, used for patients who need closer monitoring]." The DMHS confirmed the finding. During a concurrent interview with the DMHS, NM 1, and NM 2, on 4/4/18, at 1:20 PM, the clinical record indicated Patient 3 was admitted to the hospital on 2/19/18. The document titled "Mental Health Behavior Risk Patients" indicated on 2/27/18, at 7:38 AM and 7:16 PM, Patient 3 was assessed with a history of violence with injury to others while in the hospital and/or multiple assaults with injury outside the hospital. The behavioral risk assessment score was assessed to be 9, high risk for violence for each assessment. The hospital was unable to provide documentation of Patient 3 being placed on 1:1 precautions upon being assessed as "high risk". The hospital document titled "Standards of Care: Mental Health Nursing", undated, indicated ... II. Needs Assessment ... 4. Treatment Plan... The RN is responsible for interventions... Review and revise treatment plan at required intervals and PRN (as necessary). . . III. Safety Assessment ... 3. Risk Assessment and Screening. The RN is			

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	responsible for assessment and surveillance of... Violence risk (history, aggressive/impulsive) - each shift; reference policy Behavioral Observation & Monitoring of Psychiatric Patients... " The hospital policy and procedure titled "Behavioral Observation & Monitoring of Psychiatric Patients"; undated, indicated "... A) To support a safe and therapeutic environment, psychiatric inpatients will be assessed for imminent self-harm and imminent harm to others. All psychiatric inpatients will be assessed using ... the Behavioral Risk Assessment Tool (Attachment B) . . . upon admission, each shift, and as clinically indicated due to changes in patient condition. . . For situations when patient is on 1:1 for aggressive or intrusive behavior, staff will remain over an arm's length but within constant visual contact in the same physical room as the patient. .. " The hospital document titled "Acute Psych Registered Nurse job description", last modified 3/9/18, indicated, "The purpose of this position is to protect and promote health, prevent illness and injury, and alleviate suffering through nursing diagnosis and treatment..." The hospital failed to implement their policy and procedure to ensure a behavioral risk assessment was completed accurately, timely and adequate staffing was provided as determined by the assessment to ensure a safe environment. This failure created an immediate jeopardy situation, which resulted in serious injury to a patient.			

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	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(9).			