CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Poaccepted 3/22/16 HP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050378	A. BUILDING _____ B. WING _____	10/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacifica Hospital of the Valley	9449 San Fernando Rd, Sun Valley, CA 91352-1421 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: CA00365892 - Substantiated Representing the Department of Public Health: Surveyor ID# 22458, 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. Title 22 DIVS CH1 ARTS - 70215 Planning and Implementing Patient Care. (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 Title 22 DIVS CH1 ARTS – 70701 Governing Body. (a) The governing bode shall:		RECEIVED 2016 MAR 22 PM 2:54 HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION 1. The admission risk assessment in the electronic medical record was revised on 8/15/13 (see attachment 1, admission risk assessment) to provide more accurate tools to identify patients at risk due to behavioral, cognitive and emotional changes upon admission at each shift. Revision included the addition of a one to one (1:1), close observation intervention when significant changes in the patient's ability to navigate or respond to simple directions are observed by the licensed nurse, with immediate physician notification. The Elopement/AWOL policy was reviewed and revised on 8/20/2013 and was revised on Nov 2014 (see attachment 2, policy) to include all other acute departments in the process of patients leaving their assigned units without a physician's order.	8/15/13 8/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ayman Morsy TITLE: CEO (X6) DATE: 3/21/2016

By signing this document. I am acknowledging receipt of the entire citation packet, Pages 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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	(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community Title 22 DIVS CH1 ARTS – 70837 (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. Based on interviews and record review, the facility failed to: (1) plan and deliver care to prevent Patient 1 from exiting the facility's fire exit door; (2) maintain the exit alarm for the facility's fire exit door of Neuro 3 unit leading to the roof top, in good repair at all times; (3) provide appropriate physical resources and personnel required to meet the needs of Patient 1 to prevent an accident or harm. On August 10, 2013, from 8:20 p.m. to 11:40 p.m., Patient 1 exhibited increasing agitation (pulled out his intravenous/IV access site three times), severe disorientation (did not know where he was), wandered out from his unit/room, and was picked up and sent back to his room. There was no documentation between 11:40 p.m. and 12:50 a.m. to indicate the facility had developed a plan to closely		The Director of Education conducted inservices regarding the risk assessment and the AWOAL policy to the medical surgical nursing staff on August 15, 2013, and another reinforcement education started on March 8, 2016 and will be completed on by April 1' 2016 (see attachment 3, inservice). The Risk Manager will be the person responsible for monitoring compliance of the admission risk assessment in the electronic medical record and will report findings to the Quality Council on a quarterly basis. In addition, the Chief Nursing Officer will be the person responsible to ensure compliance by conducting random audits of each acute care unit. Findings will be reported to the Safety Committee, Quality Council Committee, and Governing Board on a quarterly basis for compliance.	4/1/2016

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	observe Patient 1 for safety. On August 11, 2013, at 12:50 a.m., Patient 1 was found missing from the medical/surgical unit. At 5:45 a.m., the security guard found a patient lying by the hospital, inside a brick fence and a steel {metal) gate. The security guard immediately informed LVN 1. When LVN 1 went to the scene, LVN 1 observed Patient 1 on the ground not breathing. According to the police report, Patient 1"... entered the stairwell and gained access to the roof top through the unlocked door {door alarm was not functioning)... dropped from the roof top [3rd floor/30 feet tall] landing onto the patio concrete below causing his death." A review of the Coroner Report {medical examination) disclosed: Patient 1's place of death was at the hospital; the manner was an accident; and cause was multiple blunt traumatic injuries. Findings: On August 16, 2013 at 10:45 a.m., an unannounced visit was made to the facility to investigate an entity-reported incident involving the death of Patient 1. A review of Patient 1's Admission Document disclosed Patient 1 was admitted to the facility on August 10, 2013, at 12:25 a.m., with diagnoses that included alcohol withdrawal and altered level of consciousness. {Symptoms of alcohol withdrawal include anxiety or nervousness, slurred speech,		The policy "Alcohol Withdrawal/Withdrawal from Substances" was reviewed and revised on 10/2/13, and again on 2/16, to provide clinical guidelines in recognizing; treating and stabilizing the symptoms relating to alcohol withdrawal (see attachment 4, policy). Staff inservices on Alcohol Withdrawal/Withdrawal from Substances" began in October, of 2013 with re-education started on March 15, 2016 and will be completed by April 1, 2016 (see attachment 5, inservice) . The Chief Nursing Officer will be person responsible for monitoring compliance by conducting random rounds and will report any variations to the Department of Medicine Committee, Quality Council, and Governing Board on a quarterly basis.	10/2/2013 4/1/2016

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	tremors/shakiness, and not thinking clearly ... symptoms get worse in 48 - 72 hours, and may persist for weeks.) A review of the electronic Clinical -Interdisciplinary Notes admission nursing assessment, dated August 10, 2013, at 1:30 a.m., indicated Patient 1was awake and alert, but sometimes his answers did not make sense. The assessment further indicated the patient exhibited intermittent (off and on) bilateral arm tremors (involuntary shaking movement that is repeated over and over). The Fall Risk Assessment, dated August 10, 2013, indicated the patient was at high risk for falls (total risk score of 9, the score of 5 or more is a high risk) due to disorientation, incontinence, gender/male, taking anticonvulsants, and mobility. One of the facility's interventions for fall high risk included "exit alarms are in place and active". A review of the Physician Orders, dated August 10, 2013, included the following: Ativan 1 mg IVP every four hours PRN (as necessary) for alcohol withdrawal, agitation, and anxiety (anti-anxiety medication); Ambien 10 mg orally every night (hypnotic agent for sleep); Seroquel 25 mg orally every night (anti-psychotic medication); and Librium 25 mg orally every six hours (anti-anxiety medication). The Physician Orders also included "cardiac monitor." (Cardiac monitor refers to continuous monitoring of the heart activity, generally by electrocardiography, EKG, for assessment of		2. Roof top cameras were installed on November 2013 with night vision capability and continue to be operational to monitor activities on the roof top. (Attachment, picture of monitor) see attachment 6, pictures). Additional alarms were installed to all exist doors including all exists to the roof top providing a double alarm system on 8/16/2013 (see attachment 7, pictures) The policy and procedure on "Routine Procedures – Security" was revised in October of 2015 to emphasize roof top locations for daily rounds for security personnel (See attachment 8, policy). The "Hospital and Grounds Security"policy was reviewed and revised to include the need for all security personnel to report any malfunctioning of fire exit door alarms to the Director of Facilities Management immediately for repair (see attachment 9, policy).	11/2/2013 8/16/2013

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	the patients' cardiac rhythm.) A review of the hand-written Medication Form document, dated August 10, 2013, indicated Patient 1 received a dose of Ativan 2 mg IVP at 2 p.m., Librium 25 mg orally at 6 a.m., 12 p.m., and 6 p.m.; Seroquel 25 mg at 9 p.m., and Ambien 10 mg orally at 10:30 p.m. An entry in the Clinical-Interdisciplinary Notes, dated August 10, 2013, and timed at 6:30 p.m., indicated the patient was medicated once with Ativan 2 mg IVP "for restlessness with some relief'. The primary physician history and physical (H&P), dated August 10, 2013 and timed at 8:50 p.m., indicated the following entry: "Patient with tremors, confusion, anxiety, and the onset is uncertain. The symptoms are severe, shaking, constant, v ariable duration ...history unobtainable due to treatment urgency or poor historian." (On October 8, 2013 at 12:35 p.m., during a telephone interview, the risk manager indicated she interviewed the primary physician on August 11, 2013, the actual assessment time was 6 p.m., but the history and physical was electronically transmitted at 8:50 p.m.) A review of Patient 1's Nursing Note, dated August 10 - 11, 2013, disclosed: at 20:20, ... disoriented, ambulatory, noted bleeding to the right arm due to heploc [IV access] pulled out		In August of 2013, Education to security personnel was completed on 8/21/2013 and Re-education for Security personnel on routine procedures began on March 14, 2016 with an expected completion date of April 1, 2016 (see attachment 10, inservice). The Detex monitoring system continued to be operational and security rounds are conducted every hour. The Detex system provides a detailed print-out of hourly security rounds for each exit (see example of Detex monitoring system print out, 11). Education and inservices on the "Hospital and Grounds Security" policy started on march 9, 2016 and will be completed by April 1, 2016 (See attachment 12, inservice). The Director of Security is the responsible person for monitoring compliance and reports variances to the Safety Committee, Quality Council and Governing Board quarterly.	4/1/2016 4/1/2016

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	...severe disoriented does not know where he was, and insistedto go down to buy something...at 21:00 IV access inserted on the right forearm...will monitor patient...at 22:30 patient pulled out IV access again..telemonitor [cardiac monitor] was disconnected ...at 23:00 patient wandered down the hallway by the Neuro 3 area and pulled out his IV again... RN [registered nurse] picked up the patient and back to his room..no further reinsertion of IV due to patient's disorientation... safety provided.. at 23:40 patient was given Ativan 2 mg IVP for agitation... patient continued to wander and was told to stay in the room... at 00:50 [August 11] ...patient was checked in the room and was not found...a nurse ...sitting in room 320 saw Patient 1 passed by toward Peds [pediatric] unit...security was notified and search was initiated..from 3rd floor to the basement, patient was not found.[There was no documentation between 23:40 and 00:50 to indicatePatient 1was being monitored for safety.] At 5:50 Patient 1was found lying on the pavement. At 7:10 1 the police came... A review of LVN 1's written statement for the facility's investigation, dated August 111 2013, from 7 p.m. to 11 p.m., indicated Patient 1 pulled out his IV line, a total of three times. He was unsteady and disoriented, constantly wandered the hallway, and was incontinent of urine. The statement also revealed the patient had received Ativan 2 mg IVP at 11:40 p.m. The statement indicated at around 5:45 a.m. a		3.The "One on One Observation" policy was reviewed and revised on 8/20/13 to ensure one on one acuity staffing for patients requiring elopement, fall precautions or any medical or behavioral concern, including alcohol withdrawal, is implemented as soon as possible upon admission to maintain safety needs of the patient. Several per-diem C.N.As were hired since 2013 to provide one to one observations as needed throughout the hospital. In addition, extra security guards were hired to ensure patient safety (see attachment 13, employees list) All CNAs were trained and evaluated for competency of maintaining staff and patient safety while on a 1:1 during orientation and yearly during the annual skills fair (attachment 14, inservice). The Director of Security is the responsible person for monitoring compliance and reports variances to the Safety Committee, Quality Council and Governing Board quarterly.	8/20/2013 11/26/13

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	guard that a patient/person was found lying by the hospital inside a brick fence and steel (metal) gate. LVN 1went to see that person and found Patient 1 on the ground, not breathing, the chest and abdomen area were not moving and the eyes were open. A review of the police report dated August 11, 2013, indicated, the police officer met with the fire department paramedic and found the decedent (Patient 1) to have no visible signs of life and was pronounced deceased at 0612 (6:12 am) hours. The fire department paramedic noted "trauma to head and bleeding from his head". The police investigation revealed the decedent/Patient 1 walked away from his hospital room, removed his heart monitor.., entered the stairwell and gained access to the roof top through the unlocked door (door alarm was not functioning). The decedent (Patient 1) walked along the roof and touched several ledges, on the east side of the building, the decedent climbed over the partition wall and sat down on the ledge. The decedent dropped from the roof top [3rd floor/30 feet tall] landing onto the patio concrete below causing his death. A review of the Coroner report (medical examination) disclosed: Patient 1's place of death was at the hospital; the manner was an accident; and cause was multiple blunt traumatic injuries.		After a thorough root cause analysis, a comprehensive plan of action was submitted to The Joint Commission on August 21, 2013 (see attachment 15, report: Organization Plan of Action Risk Reduction Strategy) and the Sentinel Event Measure of Success was accepted on March 27, 2014 with no further follow up action required. All invested parties pursuant to the above titled incident have forever discharged any future claims resulting from this incident which occurred on August 11, 2013. A release of all claims was filed and closed on November 6, 2013 (see attachment 16, release of all claims).	8/21/2013 8/11/2013

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	interview, the risk manager stated the camera videotapes for the Neuro 3 unit and Pediatric unit revealed Patient 1 was on both units the evening of August 10, 2013. At the time of the interview, a review of the Security Scanning form (computerized system that tracks location of the security guards during their facility rounds) with the administrator and risk manager, indicated the security personnel had accessed the roof top exit doors at approximately 12:25 a.m., and again at 2:20 a.m., looking for Patient 1. At 3:30 p.m. on August 16, 2013, during an interview, the security director stated he was not sure if the fire exit door alarms were functioning that night (August 10), and the Maintenance/Engineering staff made daily rounds of the roof. He further indicated there were no records to indicate the alarm system was checked on a regular basis. At 4:05 p.m. on August 16, 2013, during an interview, the 3-11 p.m. shift security officer stated he had worked the evening of August 10, 2013, and the roof access/exit door alarms for Neuro 3 were not functioning. When asked for how long the door alarm was not functioning, the security officer stated it had been for at least two weeks. When asked whether he had reported the non-functioning alarms, the security officer replied, "I think anyone who went up on the roof would have noticed", then stated both security and engineering staff were on the roof on a daily			

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	basis. At 4:10 p.m. on August 16, 2013, the Security Director stated when he checked the roof access/exit door alarms on August 11, 2013; they were all functioning except for the Neuro 3 unit exit door. On October 8, 2013 at 7:40 a.m., during a telephone interview, LVN 1 stated on August 10, 2013, during endorsement rounds with the day shift nurse at 7 p.m., he observed Patient 1 shivering and shaking, and he was told by the day shift nurse that the patient "has been like that". As the interview continued, LVN 1 stated Patient 1 was given Ativan 2 mg IVP at 11:40 p.m., after the patient had pulled out his IV line for the third time. LVN 1 stated that the charge nurse had gone to check on Patient 1, 30 minutes to one hour after he received the Ativan, but Patient 1 was not in his room. On October 21, 2013 at 7:40 a.m., during a telephone interview, RN 4 stated, she had asked LVN 1 to monitor Patient 1, as she was busy assisting another patient. When asked to describe Patient 1's gait (manner of walking), RN 4 indicated Patient 1 was a little unsteady, unable to stand up straight, and a little shaky. A review of the facility's policy titled, "Hospital & Grounds Security" revised May 2011, indicated Security Department personnel were responsible for the protection of life and property within the hospital environment, as			

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	well as for the detection of hazards and the prevention of accidents and injuries to patients. The functions of security included: the prevention of unauthorized entry of persons into restricted and closed areas; the detection and reporting of all potentially hazardous or unsafe conditions; and conducting regular inspections, tours, or patrols of the hospital and campus to ensure they were properly secured. A review of the facility's policy dated May 2011, titled, "One on One Obseivation", stipulated a one on one acuity staffing, for patients **requiring suicide precautions, elopement** precaut ions, close obser v at ion, fall precautions, or any medical or behavioral concern. The purpose of this policy is to maintain patent safety or to further assess patient impulsivity affecting the safety needs of the patient, staff or others. A review of the facility's policy and procedures dated February 2013, titled, "Assessment/Reassessment of Patients" stipulated all patients admitted to the facility will be provided with a comprehensive initial assessment and periodic reassessments to identify patient needs, status changes and responses to treatments or therapeutic interventions, assessment/reassessment data is used to develop and update patient plans of care. The facility's failure to: (1) plan and deliver			

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	care to prevent Patient 1 from exiting the facility's fire exit door; (2) maintain the exit alarm for the facility's fire exit door of Neuro 3 unit leading to the roof top, in good repair at all times; and (3) provide appropriate physical resources and personnel required to meet the needs of Patient 1, is a deficiency 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 Health and Safety Code Section 1280.1. 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).			