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
	050159	A. BUILDING _____ B. WING _____	02/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00462955 - Substantiated Representing the Department of Public Health Surveyor ID # 2623, HFE-N 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. Health and Safety Code Section 1280.3(a): Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars		**E 000 Initial Comments** Preparation and execution of this plan of correction does not constitute an admission of or agreement with the facts alleged or conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal/state law.	

3/27/18 reviewed by D Berry
3/27/18 approved KA Chavez

Event ID:95VX11 2/20/2018 9:41:01AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 3/23/18

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.

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	($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. Health and Safety Code Section 1279.1 (c): "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. Health and Safety Code Section 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		**Health and Safety Code Section 1279.1 (c)(a)(b)(f)** The Chief Executive Officer (CEO) directs and oversees the reporting of adverse events. The CEO in conjunction with the Regulatory Coordinator ensures adverse events that are ongoing, urgent or emergent are reported within 24 hours to the California Department of Public Health (CDPH). This includes attempted suicides. The CEO has provided direction to all levels of leadership on how to appropriately report any adverse events that occur. In addition, the CEO meets at least bi-monthly with the Regulatory	

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	been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Health and Safety Code Section 1279.1 (b) (3) (c) (b) For purposes of this section, "adverse event" includes any of the following: (3) Patient protection events, including the following: (C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility. Title 22 California Code of Regulations Division 5 Chapter 3 Section 70213 Nursing Service Policies and Procedures. (a)Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Title 22 California Code of Regulations Division 5 Chapter 3 Section 70217 Nursing Service Staff. (m) Unlicensed personnel may be utilized as needed to assist with simple nursing		Coordinator to review reported events and ensure timeliness in reporting. Hospital Policy 107.023 (Adverse Events, Sentinel Events, Unusual Occurrences) details the hospital's appropriate response and action plan. **Title 22 California Code of Regulations Division 5 Chapter 3, Section 70213 Nursing Service Policy and Procedures.** The Chief Nursing Officer (CNO) provides oversight of written policy and procedures pertaining to patient care and ensures compliance with Title 22 regulations. **Title 22 California Code of Regulations Division 5 Chapter 3, Section 70217 Nursing Service Staff**	

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	procedures, subject to the requirements of competency validation. Hospital policies and procedures shall describe the responsibilities of unlicensed personnel and limit their duties to tasks that do not require licensure as a registered or vocational nurse. Title 22 California Code of Regulations Division 5 Chapter 7 Section 70701 Governing Body. (a) The governing body shall: (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. Based on record review and interview, the facility failed to ensure that Patient 1 who was psychotic and suicidal, was provided a safe transfer from the inpatient trauma surgery service to the inpatient psychiatric unit (IPU). This failure caused Patient 1 to sustain major traumatic injuries including a traumatic brain injury after he jumped from a 40- foot tall building. Findings: Finding #1 Record review on 10/24/16 at 4:00 p.m., revealed that Patient 1 was admitted by ambulance to the facility on 10/20/15 after two failed suicide attempts resulting in a fractured vertebra in his lower back. Patient 1 continued with suicidal ideations while in the hospital. The		Under hospital policies, the CNO and Associate Chief Nursing Officer (ACNO) may assign unlicensed personnel to assist with duties of registered or vocational nurses. In addition, the CNO or ACNO ensures proper training and education are provided before implementation of services. **Title 22 California Code of Regulations Division 5 Chapter 7 Section 70701 Governing Body** The governing body (known as the Oversight Committee) has full responsibility for determining, implementing, and monitoring the facility's total operations and compliance with hospital policies and procedures. The Oversight Committee meets at least quarterly, and as necessary to review overall operational and patient care issues, including but not limited to ensuring patient safety and safe patient transport between the Emergency Department (ED) and Inpatient Psychiatric Unit (IPU).	

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Finding #1 Continued	physician ordered Patient 1 to be on bedrest, to wear a back brace and have staff with him at all times as a suicide precaution. Review of physician notes dated 10/21/15 at 1:10 a.m., revealed that Patient 1 was found in his room with a cord wrapped around his neck attempting suicide by hanging. Review of nursing documentation dated 10/21/15 at 4:32 p.m., revealed that staff were able to remove the cord from his neck but had difficulty keeping Patient 1 on bedrest as ordered. Nursing documentation also revealed that Patient 1 had auditory hallucinations telling him to kill himself, and the nurse practitioner was notified. Review of a psychiatrists progress note dated 10/21/15 at 5:11 p.m. after the patient was found with a cord around his neck, revealed that Patient 1 was "imminently dangerous to himself", required psychiatric hospitalization, and was to be placed on a 5150 legal hold (danger to self). The psychiatrist documented that Patient 1 was to be a direct admission to the inpatient psychiatric unit (IPU). The psychiatrist ordered an antipsychotic medication to be given "now", before Patient 1 was transferred to the IPU with security. The psychiatrist documented that after the cord-wrapping incident staff should be ready to intervene immediately to keep Patient 1 safe because he was psychotic, highly impulsive, and highly suicidal.		**Immediate Actions Taken:** Upon receipt of this Statement of Deficiencies, the CEO, Chief Medical Officer (CMO), CNO, ACNO, Inpatient Psychiatric Unit Medical Director, Inpatient Psychiatric Unit Operations Manager, and the Regulatory Coordinator met to review the findings. Leadership was presented with the completion dates for each finding listed in this Statement of Deficiencies.	2/26/18
			Finding #1: The CEO met with the CMO, CNO, ACNO, IPU Operations Manager, ED Manager, and Regulatory Coordinator to discuss the events of 10/21/15 and reviewed the patient care provided on 10/21/15, including use of a safety attendant at bedside.	10/23/15
Finding #2	Interview on 10/26/15 at 3:15 p.m., with nursing assistant (NA) 1 revealed that on 10/21/15 she		Hospital Policy 100.204 (Safety Attendants) was created to define the conditions and procedures for the appropriate use of safety attendants in acute care, non-psychiatric areas of the hospital. Hospital Policy 100.023 (Suicide Risk Assessment and	

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Finding #2 Continued	was assigned to transfer Patient 1 to the inpatient psychiatric unit with two security staff. NA 1 explained that she wheeled Patient 1 out of one building and across an alley toward the psychiatric building accompanied by two security guards. Further interview revealed that when one security guard went ahead to open the door, Patient 1 jumped up out of the wheelchair and ran across the street. NA 1 explained that the staff were not allowed to hold or restrain Patient 1 to keep him in the wheelchair and they watched him run away as they notified police.		Precautions) was reviewed to ensure it provided clear direction on the care of psychiatric patients, including potential ligature points/environmental hazards. A competency standard for safety attendants was established and implemented, to ensure safety attendants are fully trained on their role and responsibilities. Among other things, the standard requires that safety attendants provide 1:1 or 1:2 observation of patient(s), ensure the environment is safe of hazards, and assist with movement of the patient. **Compliance & Monitoring** Education and training were provided to nursing staff and safety attendants on policies and procedures regarding the care of psychiatric patients, including psychiatric patients in a psychotic state. The training included identification of patients who are at risk for suicide, proper monitoring of suicidal patients, identification of ligature points, and reduction of potential environmental hazards. The	8/2016-11/01/16 8/2016-11/01/16
Finding #3	Review on 1/30/18 of facility policy titled "Restraint & Seclusion" last revised and approved 8/1/15 page 2, revealed that a registered nurse may restrain a patient in an emergency to protect the patient. A registered nurse was not present with NA1 at the time of Patient 1's transfer. Interview with administrative staff and review of facility policies on 1/8/18 revealed that there were no policies at the time of Patient 1's transfer on how to transfer psychotic or 5150 patients with appropriate staff and restraint options to keep them safe if they try to run. Record review on 10/24/16 revealed that the failed transfer of Patient 1 to IPU occurred on 10/21/15 at 5:44 p.m.			
Finding #4	Review of NA 1's "Annual Competency 2014 Validation Checklist" on 10/24/16 revealed that she had no evidence of training related to			

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Finding #4 Continued	managing or caring for a psychotic patient. Review on 10/25/16 of physician admission notes dated 10/22/15 at 11:04 p.m., revealed that during the transfer Patient 1 ran across the street to another building and jumped approximately 25-40 feet to the ground. Review of emergency responders records dated 10/21/15 at 6:42 p.m., revealed that Patient 1 had jumped head first off a building and was found lying prone on the cement with police in attendance. Further review revealed the emergency responders then took Patient 1 back to the facility emergency department as a tier 1 trauma by ambulance. Review of the physician discharge note dated 3/9/16 revealed that Patient 1 sustained the following new injuries resulting from the jump off the building on 10/21/15: skull fracture and epidural hematoma (spinal cord bleeding), compression fractures of three vertebra, open displaced L humerus (arm) fracture, numerous facial fractures, sacral fracture, R acetabular (hip socket) fracture, bilateral heel fractures, and a right-sided knee joint fracture. In addition, Patient 1 had a prolonged intensive care stay and multiple surgeries with injuries including: Traumatic left epidural hematoma with herniation syndrome (bleeding causing pressure) Pneumocephalus (air or gas within the brain		guidelines for patient observation were reviewed, including how to respond an urgent/emergent situation. **Finding # 2:** Hospital Policy 100.203 (Patient Transport/Escort to and from the Inpatient Psychiatric Unit, the Emergency Department and Inpatient Acute Care Units) was created to ensure a comprehensive and clear process for transport of patients. The policy requires that a patient be accompanied by a licensed staff member and an elite security guard. Local police or an additional security guard may be utilized, if deemed necessary, to ensure safe patient transport. The process for police assistance with transports was clarified to require that police be notified for assistance when hospital clinical staff (e.g., nurses, physicians) determine that there is an imminent threat of danger to the patient or others (e.g. uncontrollable psychotic state) such that police assistance is required. In those situations, the patient will remain in the ED until police assistance is available. Prior to	

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	cavity) Severe traumatic brain injury with cognitive impairments Left temporal epidural hematoma with midline shift (bleeding causing pressure) Expressive aphasia (difficulty speaking and making sense) Bilateral comminuted (reduced to minute particles or fragments) nasal bone fractures Third cranial nerve palsy (paralysis), right eye Vision impairment, left eye Nasal septal fractures Sphenoid (compound bone behind the eyes and below the front part of the brain) fractures Bilateral orbit (eye sockets) fractures Frontal bone (forehead area) fracture Multiple facial lacerations (cuts) Left parasagittal (a parallel line dividing the body) sacral (where the back bones connect to the pelvis and stabilizes the pelvis) fracture, closed Fractures through the right superior and inferior pubic rami (pelvic bones) Mild hemorrhage in the right obturator internus and abductor musculature (bleeding in thigh muscles) Right lateral meniscus (knee cartilage) tear Closed fracture of first metatarsal (foot) bone Closed fracture of right knee region Closed bilateral calcaneal (heel bone) fractures Thrombosis (blood clot) of distal right cephalic vein Left grade I open humerus (upper arm bone) fracture Traumatic cranial neuropathy (skull nerve		patient transfer, communication shall occur between sending and receiving departments by utilizing a Situation Background Assessment Recommendation (SBAR) form. The CEO and City of Ventura Police Commander agreed to amend the current police contract to provide 24 hours, 7 days a week service in the ED. These additional services will be provided when Ventura Police Department has sufficient staff. Under the current contract the Ventura Police Department stations one police officer on site 12 hours per day, 7 days per week. The CEO and Associate Hospital Administrator (AHA) of Support Services held discussions with the contracted security provider regarding the safe handling of patients in the hospital. The hospital revised its contract with the security provider. An addendum was added to the contract to increase the number of elite security guards in the ED and the IPU.	3/2016-1/25/17 1/7/2016 12/13/16-12/21/16

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	problem) Right sided hemiparesis (paralysis) with spasticity Abnormality of gait and mobility Impaired activities of daily living Impaired mobility Further review of the discharge summary of 3/9/16 revealed Patient 1 had the following procedures: 10/21/15 Emergent craniotomy for evacuation left EDH 10/21/15 Left humerus irrigation and debridement; simple closure of left humerus wound 10/22/15 Repair of 4 cm complex left supraorbital (above the eye) laceration 10/22/15 Left femoral arterial line 10/22/15 Right femoral eve 10/27/15 Bilateral orbital floor exploration, reconstruction of left orbital floor 10/29/15 Open reduction internal fixation left humerus; I&D left humerus; application of long arm splint (surgery to repair arm fractures) 11/01/15 Percutaneous tracheostomy (tube placed into the trachea for breathing) 11/3/15 PEG placement (tube placed for feeding) Review of a physician discharge summary dated 6/1/16 revealed that Patient 1 was hospitalized 10/21/15 through 3/9/16, was home for two weeks, admitted again on 3/16/16 and discharged on 6/1/16. During this second		One additional security guard was added for transport to and from the hospital and IPU. Elite security guards will have an additional 80 hours of training, including 12 hours of annual update training. The training classes include: Safely Managing and Detaining High Risk Patients, Crisis Prevention Training (8 hours), Management of Aggressive Behavior Training (8 hours) and Patient Watch Training and Restraints. In addition, the contract amendment defines the ability of elite security guard(s) to detain a psychiatric patient when necessary. The CEO and Ventura County Board of Supervisors reviewed and approved the contract amendments. Nurse managers and the Inpatient Psychiatric Unit Operations Manager were notified regarding the security contract change. The CMO discussed the new transport policy and safe transport of mental health patients with the chief physicians who are responsible for education of the physician staff under their supervision.	12/21/16

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	admission a tube was inserted into his stomach so that food and medications could be given because Patient 1 refused to eat. Further review revealed that Patient 1 who was independent prior to his suicide attempt was now dependent on his family for care and not capable to make informed decisions due to severe traumatic brain injury. . The facility failed to provide a safe transfer with competent personnel. 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).		**Compliance & Monitoring** The AHA of Support Services provides a bi-annual report to the CEO with the number of elite security guards available for transports. The AHA for Support Services will immediately notify the CEO of any staffing or contractual issue that may impact patient care. Competency assessment(s) are documented for all elite security guards who have completed the additional training and work with high risk patients. **Finding #3:** Hospital Policy 100.203 (Patient Transport/Escort to and from the Inpatient Psychiatric Unit, the Emergency Department and Inpatient Acute Care Unit) was created to ensure a comprehensive and clear process for transport of patients. The policy requires that a patient be accompanied by a licensed staff member and an elite security guard. Local police or additional security guards maybe be utilized, if deemed necessary, to ensure safe patient transport. The process for police	

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	admission a tube was Inserted into his stomach so that food and medications could be given because Patient 1 refused to eat. Further review revealed that Patient 1 who was independent prior to his suicide attempt was now dependent on his family for care and not capable to make informed decisions due to severe traumatic brain injury. . The facility failed to provide a safe transfer with competent personnel. 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).		patient(s) and effective communication. Monitoring of the use of the SBAR form and safe transport practices was initiated, with data tracked, trended, and analyzed and reported to the Performance Improvement Committee. The Performance Improvement Committee presented the data to the Medical Executive Committee on 5/10/16, and the Oversight Committee on 5/25/16. The Performance Improvement Department collected data for 24 months. **Finding #4:** Hospital Policy 100.204 (Safety Attendants) was created to define the conditions and procedures for the appropriate use of safety attendants in the acute care, non-psychiatric units of the hospital. Hospital Policy 100.023 (Suicide Risk Assessment and Precautions) was reviewed to ensure it provided clear direction on the care of psychiatric patients, including potential ligature points/ environmental hazards.	8/2016-11/1/16

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	admission a tube was inserted into his stomach so that food and medications could be given because Patient 1 refused to eat. Further review revealed that Patient 1 who was independent prior to his suicide attempt was now dependent on his family for care and not capable to make informed decisions due to severe traumatic brain injury. . The facility failed to provide a safe transfer with competent personnel. 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).		A competency standard for safety attendants was established and implemented, to ensure safety attendants are fully trained on their role and responsibilities. Among other things, the standard requires that safety attendants provide 1:1 or 1:2 observation of patient(s), ensure the environment is safe of hazards, and assists with movement of the patient. **Compliance & Monitoring** Education and training were provided to nursing staff and safety attendants on policies and procedures regarding the care of psychiatric patients. The training included identification of patients who are at risk for suicide, proper monitoring of suicidal patients, identification of ligature points, and reduction of potential environmental hazards. The guidelines for patient observation were reviewed, including how to respond an urgent/emergent situation(s). Nurse managers who oversee safety attendants shall provide annual	8/2016-11/1/16

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VENTURA COUNTY MEDICAL CENTER	300 Hillmont Ave, Ventura, CA 93003-3099 VENTURA 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
	admission a tube was inserted into his stomach so that food and medications could be given because Patient 1 refused to eat. Further review revealed that Patient 1 who was independent prior to his suicide attempt was now dependent on his family for care and not capable to make informed decisions due to severe traumatic brain injury. . The facility failed to provide a safe transfer with competent personnel. 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).		training and review of policies and procedures pertaining to the care of psychiatric patients in the non-psychiatric area of the hospital. This training shall include the safe handling of patients during transfer and care of psychiatric patients including psychiatric patients in a psychotic state. **Person(s) Responsible:** Nurse Managers Associate Hospital Administrator of Support Services Associate Chief Nursing Officer Chief Nursing Officer Chief Executive Officer	