

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2017
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NAME OF PROVIDER OR SUPPLIER SANTA BARBARA COTTAGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Pueblo Street, Santa Barbara, CA 93105 SANTA BARBARA COUNTY
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00454294 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 2675, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>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.</p> <p>Health and Safety Code Section 1279.1 (c):</p> <p>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.</p> <p>Health and Safety Code Section 1279.1 (a):</p> <p>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</p>		<p>The following constitutes the facility's response to the findings of the California Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies. These findings and the resulting plan of correction were reviewed, developed implemented by the Santa Barbara Cottage Hospital Clinical Nurse Coordinator - Emergency Department Holding Unit (EDHU) and Service Director - Emergency Services at the direction of the V.P. Patient Care Services, Chief Nursing Officer.</p> <p>70213</p> <p>a) The patient identified to have been affected by the practice was deceased in 2015. However, any patient that comes to the emergency department that is the emergency department holding unit (EDHU) with a behavioral health diagnosis waiting for voluntary admission to the inpatient behavioral health unit and/or involuntary patients on a 5150 hold waiting for placement by the County of Santa Barbara are included in the system changes that have been implemented. Patients in the EDHU are provided with a therapeutic environment that is more</p>	

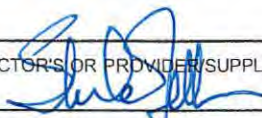
accepted plan of correction 9/29/17
 Santa Barbara Cottage Hospital

Event ID:D5Y111

9/5/2017

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

EVP/COO

(X6) DATE

9-18-17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 12

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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	<p>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.</p> <p>Health and Safety Code Section 1279.1 (b)(3)(C): For purposes of this section, "adverse event" includes any of the following:</p> <p>(3) Patient protection events.</p> <p>(C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to the 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.</p> <p>Title 22, California Code of Regulations, Sections: 70213 (a) Nursing Services Policies and Procedures.</p> <p>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>70215 (b) Planning and Implementing Patient Care.</p> <p>(b) The planning and delivery of patient care shall reflect all the elements of the nursing process: assessment, nursing diagnoses, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.</p>		<p>(cont.) conducive for behavioral health patient as compared to the general emergency area. Measures have been taken to provide a quiet, calm and safe environment to include:</p> <ul style="list-style-type: none"> • tamper-resistant and non-ligature fixtures, • doors that permit staff observation yet maintain provisions for privacy; in some cases i.e., closets doors have been removed • exterior windows are tamper proof and have a tamper resistant security glazing with laminate to prevent damage and potential injury • walls, ceiling and floor of patient rooms designed to withstand direct and forceful impact • special furniture for behavioral health patients . <p>Patients are provided with bathrooms in their room and access to a shower to tend to their personal grooming needs. Clean scrubs are provided while they are on the EDHU and clean clothing upon discharge or transfer if necessary.</p> <p>The Emergency Department (ED) policy titled "Emergency Department Holding Unit (EDHU)</p>		

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	<p>70217 (a) (8) Nursing Service Staff.</p> <p>(a)(8) In a hospital providing basic emergency medical services or comprehensive emergency medical services, the licensed nurse to patient ratio in an emergency department shall be 1:4 or fewer at all times that patients are receiving treatment. There shall be no fewer than two licensed nurses physically present in the emergency department when a patient is present...when licensed nursing staff are attending critical care patient in the emergency department, the licensed nurse to patient ratio shall be 1:2 or fewer critical care patients at all times.</p> <p>The facility failed to implement policies and procedures related to the delivery of care to patients in a safe environment. The facility failed to provide and implement care plan interventions for the safety of Patient A. The facility also failed to provide appropriate nurse to patient ratios for patients who came to the emergency department (ED), including Patient A, who sought help for suicidal ideations due to depression. As a result, Patient A sustained a traumatic brain injury (TBI) which resulted in a subarachnoid hemorrhage (bleeding in the space that surrounds the brain) and ultimately, Patient A died. According to Patient A's Certificate of Death, dated 8/17/15, the cause of Patient A's death was "Complications of Subdural Hematoma and a Witnessed Fall"(Subdural Hematoma- blood clot underneath the skull and the dura, sometimes associated with a skull fracture).</p>		<p>(cont.) Intake Process," which describes the patient population eligible for intake to the EDHU at Santa Barbara Cottage Hospital (SBCH) and the intake process. These adult patients are temporarily "held" pending admission or transfer to another facility or possible discharge to an outpatient treatment program. Patients that are moved to the SBCH EDHU is based on patient acuity determined by using the Emergency Severity Index (ESI) level system as described in policy titled "Staffing, Scheduling, Patient Acuity Guidelines for the Santa Barbara Cottage Hospital Emergency Department & Emergency department Holding Unit" and clinical judgement (i.e., ED physician, psychiatrist, and/or EDHU RN).</p> <p>b) The Service Director - Emergency Services ensures the collection of data on a monthly basis and reports quarterly on patient safety events for patients seen in the EDHU and reviews daily any patient safety concerns e.g., falls, elopement, medication events. If any sustained</p>	

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	<p>Findings:</p> <p>A review of Patient A's medical record was conducted on 8/19/15. According to the record, Patient A was a 93 year old male with a history of manic depression who presented to the ED on 8/7/15 with a complaint of suicidal ideations and depression for multiple months. According to Emergency Psychiatric Service (EPS) notes dated 8/7/15 at 3:04 p.m.: "Patient admits to suicidal ideation. Patient has plans for suicidal ideation"... "Pt (patient) was referred by his psychiatrist, (psychiatrist's name), who was concerned that pt. (patient) would become impulsive and follow through with SA (Suicide attempt).... Pt (patient) reports worsening depression, says he has lived quite long enough, has physical issues that will only get worse over time; was planning on deliberate fall to sustain a fatal TBI (traumatic brain injury)."</p> <p>In an interview at the facility with License Nurse 1 (LN 1) on 8/14/15 at 2:00 p.m., she explained upon Patient A's arrival to the ED on 8/7/15 at 9:40 a.m., she used the ED's triage screen, known as the "Psych Tool," to assess Patient A for suicide risk. LN 1 explained during her interview that the "Psych Tool" consists of approximately five questions that are asked to a patient to determine if the patient is suicidal. LN 1 agreed during the interview that Patient A, at the time and date of his arrival to the ED, was at risk for suicide, and as indicated by the "Psych Tool" screening she completed for Patient A. LN 1 further stated during her interview that she identified and documented Patient A's suicide plan, which was to "Fall onto his head and die like a</p>		<p>(cont.) variances are noted this data is reported via the internal quality improvement process</p> <p>c) Policies titled Emergency Department Holding Unit (EDHU) Intake Process" and "Staffing, Scheduling, Patient Acuity Guidelines for the Santa Barbara Cottage Hospital Emergency Department & Emergency department Holding Unit" revised and implemented in April 2017. The ED and EDHU staff were informally educated of the revisions to these policies in April 2017 by the Service Director - Emergency Services. Documentation of formal education on these policies will be provided by the by the Service Director - Emergency Services by October 6, 2017. On April 14, 2017, Santa Barbara Cottage Hospital submitted the aforementioned policies for review to the CDPH as part of the pilot program flexibility request for the</p>	

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	<p>relative did a month ago."</p> <p>In an interview with EPS on 8/27/15 at 12:02 p.m., emergency psychiatric services EPS [ED person who evaluates the psychiatric patients and refers patients to the psychiatrist] stated she performed a Suicide Safety Assessment on 8/7/15 at 3:04 p.m., for Patient A, indicating Patient A was at high risk for suicide. According to the EPS, the Suicide Safety Assessment consists of 8 questions; each question is assigned a number of points according to the answer. The number of points is tallied to determine the level of suicide risk. A total risk point score greater than 8 is considered a high risk for suicide. Patient A's total risk points score was 13. During the interview with EPS, the Suicide Safety Assessment was reviewed. The EPS agreed Patient A was at high risk for suicide and based on his suicide assessment, Patient A qualified for a "security guard" to monitor patient.</p> <p>A record review performed on 8/19/15 of ED MD 1 (Medical Doctor) included review of a progress note dated 8/7/15, at 11:59 a.m. The progress note revealed Patient A had chronic depression and at the time of evaluation he was feeling suicidal leading to a "feeling of not wanting to continue with his life".</p> <p>According to record review, Patient A was moved to the ED (BACK E) on 8/7/15 at 11:26 a.m., where LN 2 assumed his care. In an interview with LN 2 on 9/17/15 at 10:00 a.m., he acknowledged Patient A's suicide plan was to, "Fall onto head and die same as relative did."</p>		<p>(cont.) SBCH EDHU. The policies were reviewed and the program flex was granted by the Department on May 15, 2017.</p> <p>70215 a)The patient identified to have been affected by the practice was deceased in 2015. However, any patient admitted to the emergency department that is the emergency department holding unit (EDHU) is included in the system changes that have been implemented since 2015. Policies titled "Suicide Assessment" and "High Acuity and Suicide Risk" for the Emergency Department were drafted and implemented October 2015 and revised April 2016. These policies describe the assessment, reassessment, interventions, and safety plan for patients at risk for suicide. The policy titled "Rounding High Acuity Risk was implemented in February 2017; EDHU staff will increase monitoring/rounding on patients that are identified to have risks for harm so as to reduce potential risks to the patient.</p>	

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	<p>LN 2 further stated he performed a suicide assessment of Patient A utilizing the Suicide Risk Assessment Tool. The tool consists of questions and depending on the answer, the answer is rated as low risk, moderate risk or high risk. The ratings are tallied to determine the suicide risk level. Patient A was found to be at "High Risk" for Suicide. A security guard was placed outside Patient A's room.</p> <p>In an interview with security guard 1 (SG1) on 8/14/15 at 2:40 p.m., SG1 explained he was the security guard who was monitoring Patient A in the main ED. He was stationed outside Patient A's door approximately 4-5 feet away from the patient. He stated he was not aware of Patient A's suicide plan.</p> <p>Further review of MD 1's progress note dated 8/7/15 at 11:59 a.m., revealed MD 1 recommended Patient A to be admitted to the facility's 5 East wing (a voluntary Psychiatric Unit) to determine a treatment plan, but the "Voluntary unit could not manage the medical care and fall risk, but no other option for this pleasant minister with end of life depression."</p> <p>A review of the Event Log, dated 8/7/15, revealed Patient A was transferred from the ED (BACK E) to the Emergency Department Holding Unit (EDHU) room 4A at 1:19 p.m., to wait for an evaluation from the Crisis and Recovery Emergency Services (CARES-mobile crisis response and access to service for mental health) to determine further disposition.</p> <p>In an interview with the emergency department director (EDD) on 8/19/15 at 11:15 a.m., she</p>		<p>(cont.) On October 1, 2016, a new electronic medical record was implemented for SBCH including the EDHU. For the EDHU the suicide screen, suicide assessment, and care plan were a part of the new electronic medical record implementation. On admission to the ED and again on admission to the EDHU a patient with a behavioral health diagnosis is assessed for suicidal risks by nursing. Based on this assessment and nursing diagnosis, care planning is developed and the patient is evaluated based on goals.</p> <p>b) The Service Director - Emergency Services ensures the compliance with the suicide prevention measures by medical record review of all patients identified as a suicide risk on the EDHU on a monthly basis with a goal of 90% of sustained compliance for four-consecutive months. If any sustained variances are noted this data is reported via the internal quality improvement process.</p>	

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	<p>explained the EDHU was an extension of the ED but located as a separate unit on the 5th floor of the facility as opposed to the actual ED which is located on the first floor of the hospital. She further explained that ED LNs are expected to "assess and provide care depending on patient's need." She also added she does not want ED LNs to give any report to the security guards monitoring psychiatric patients. According to the EDD, "Security guards are not medical people," and "do not have to know what's wrong with the patient".</p> <p>A record review conducted on 8/25/15 of LN 3's (EDHU LN) documentation, dated 8/7/15 at 3:33 p.m., indicated Patient A expressed still being suicidal, "Wanting someone from the hospital to help him exterminate himself in a way that won't compromise their professional license or care." In a hand-off report from the previous LN (LN 2), Patient A had told LN 2 that he (Patient A), "knew of someone that fell, hit their head, and died from it, and hoped that might happen to him too."</p> <p>At approximately 7: 38 p.m., the CARES [Crisis and Recovery Emergency Services- a county mobile service for crisis response and access to mental health] evaluator arrived and went to Patient A's room to do an evaluation of the patient and he was placed on a 5150 hold (a hold that authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him or her a danger to him or herself, or a danger to others).</p> <p>In an interview on 8/27/15 at 4:43 p.m., with the CARES evaluator, she stated Patient A was placed</p>		<p>c) Policies titled "Suicide Assessment" and "High Acuity and Suicide Risk" for the Emergency Department was revised April 2016 and policy titled "Rounding High Acuity Risk was implemented in February 2017. The ED and EDHU staff were informally educated of the revisions to these policies in April 2017 by the Service Director - Emergency Services. Documentation of formal education on these policies will be provided by the by the Service Director - Emergency Services by October 6, 2017.</p> <p>All staff that were to have access to the new electronic medical record had to attend training before "go-live" date of October 1, 2016; for the ED/EDHU staff there were three training classes. These interactive courses were led by a vendor representative and/or specialist trained on the new electronic medical record and was completed in a classroom style. Attendance was verified and monitored by Management. New hire orientation is completed by a specialist trained</p>	

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	<p>on a 5150 hold because he was at "High Risk" for suicide. Patient A was notified of the 5150 hold, but that he could not be admitted to the voluntary psychiatric floor on 5 East, and needed to be transferred to another facility. According to the CARES evaluator, Patient A became very upset and said he wanted to go home. The CARES evaluator further stated that she explained to Patient A that at the time his only option was to be transferred to another facility. Patient A then stated to the CARES evaluator, "I put myself in an impossible situation." At that point, Patient A gave a, "Very personal good bye to his son." Subsequently, Patient A requested to be left alone for a few minutes. The CARES evaluator and Patient A's son stepped out of Patient A's room into the nursing station. According to the CARES evaluator, Patient A then deliberately fell on the floor, hit his head and sustained a TBI, as planned.</p> <p>In an interview on 8/14/15 at 3:09 p.m., with security guard 2 (SG 2), he stated the CARES female came out of Patient A's room, approached him and told him, "He (Patient A) said his good bye to the son. Keep a very close eye on him." At the time, SG 2 was monitoring Patient A via a video camera from behind the nurses' station (where he was sitting). Seconds after, he witnessed Patient A (via video), "Stand on the floor beside the bed, cross his arms in front of his body, and throw himself backwards onto the floor without extending his arms to break the fall."</p> <p>SG 2 further recalled that when he saw Patient A stand up, he did not think anything of it because he</p>		<p>(cont.) on the new electronic medical record. Again, attendance is verified by Management.</p> <p>On April 14, 2017, Santa Barbara Cottage Hospital submitted the aforementioned policies for review to the CDPH as part of the pilot program flexibility request for the SBCH EDHU. The policies were reviewed and the program flex was granted by the Department on May 15, 2017.</p> <p>70217 a) The patient identified to have been affected by the practice was deceased in 2015. However, any patient admitted to the emergency department that is the emergency department holding unit (EDHU) is included in the system changes that have been implemented since 2015. Staffing of the Emergency Department (ED) that is the Emergency Department Holding Unit (EDHU) is in accordance with the "Staffing, Scheduling, Patient Acuity Guidelines for the SBCH ED and EDHU" policy.</p>	

Event ID:D5YI11

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	<p>wasn't aware of the patient's suicide plan to fall on the floor and sustain a TBI. According to SG 2, no one had shared with him the patient's plan for suicide. SG 2 shared during the interview that it would be difficult to protect the patient without knowing the actual risk. He further explained that he was the only security guard in the EDHU on 8/7/15 and there were four patients in the unit that needed monitoring.</p> <p>In an interview with LN 3 (EDHU LN) on 8/14/15 at 12:05 p.m., she explained she did not perform a suicide risk assessment on Patient A because LN 1 had already performed one. She further explained that on 8/7/15 she was the only LN in the EDHU caring for four patients (including Patient A). She stated that SG 2 was the only security guard on the EDHU that night (8/7/15).</p> <p>During a tour and observation of the EDHU on 8/19/15 at 1:30 p.m., the security guard video camera station where SG 2 was sitting while monitoring Patient A on 8/7/15 was approximately 30 feet away from Patient A's room (4A). When Patient A was in the ED (BACK E), SG 1 explained he was outside Patient A's door approximately 4-5 feet away from the patient.</p> <p>According to review of Patient A's medical record, conducted on 8/25/15, following the fall Patient A was transferred from the EDHU area back to the first floor ED (FRONT 4) at 9:04 p.m. Patient A was then taken for a head CT scan (test that uses a special X-ray machine to take pictures of a patient's brain, skull, and blood vessels in the head). The</p>		<p>(cont.) . This policy describes the nurse to patient ratios for the SBCH ED and EDHU and provisions of care based on a patient acuity classification system. The staffing ratio for the SBCH ED and EDHU is 1:1, 1:2, 1:3, or 1:4. Patient acuity in the SBCH ED and EDHU is determined by using the Emergency Severity Index (ESI) level system.</p> <p>b) The Service Director - Emergency Services ensures the collection of data on a monthly basis and reports quarterly on the number of patients seen in the EDHU and the length of stay as well as staffing reports for staffing ratios in accordance with policy. If any sustained variances are noted this data is reported via the internal quality improvement process.</p> <p>c) Policy titled "Staffing, Scheduling, Patient Acuity Guidelines for the Santa Barbara Cottage Hospital Emergency Department & Emergency department Holding Unit" was revised in April 2017. The Service</p>	

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2017
NAME OF PROVIDER OR SUPPLIER SANTA BARBARA COTTAGE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Pueblo Street, Santa Barbara, CA 93105 SANTA BARBARA COUNTY		
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	<p>head CT scan report dated 8/7/15 revealed actively bleeding massive subdural hematoma (brain clot) and brain herniation (potentially deadly side effect of very high intracranial pressure that occurs when a part of the brain is squeezed across structures within the skull). Patient A's condition deteriorated that evening and he was pronounced dead on 8/7/15 at 11:07 p.m., by MD 2.</p> <p>A review of Patient A's Certificate of Death, dated 8/17/15, indicated the cause of Patient A's death on 8/7/15 was "Complications of Subdural Hematoma and a Witnessed Fall"(Subdural hematoma-A blood clot underneath the skull and the dura, sometimes associated with a skull fracture).</p> <p>A review conducted on 9/17/15 of the facility policy and procedure titled, "Psychiatric Services: Security Standby/Observation for High Risk Patients/Safety of Psychiatric Patients," (last revised 5/2015) indicated the goals of the policy was to:</p> <ol style="list-style-type: none"> 1. To manage "high-risk" patient in the Emergency Department in a manner that insures patient and staff safety at all times, including psychiatric and/or chemical dependency patients. 2. To establish clear protocols for determining when and how to utilize a secure setting and/or contact Security for standby/observation. 3. To assure that the high risk patient is placed in a location that is safe, monitored and clear of items that could cause harm to the patient or others. 		<p>(cont.) Director - Emergency Services provided training for staff on EDHU ratios and staffing via weekly memos sent by email to all ED and EDHU staff on January 17, 2017, January 27, 2017, February 3, 2017, and again April 7, 2017.</p> <p>On April 14, 2017, Santa Barbara Cottage Hospital submitted the aforementioned policies for review to the CDPH as part of the pilot program flexibility request for the SBCH EDHU. The revised policies were implemented on April 14, 2017 by the Service Director - Emergency Services. The policies were reviewed and the program flex was granted by the Department on May 15, 2017.</p>	

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	<p>Furthermore, the policy indicated, "All patients deemed "high-risk" due to any condition, including a psychiatric/chemical dependency condition, will be observed and/or placed in a secure setting. Under Procedure, the policy indicated the attending MD, Emergency Department RN or the Emergency Psychiatric Services (EPS) staff may request the patient be placed in a secure setting and/or contact Security for standby/observation. The criteria for "high-risk" patients included: (b) Suicidal patients and (f) Patients at risk for harm to self/others. The policy also set forth: "Patients will be placed in an ED room made safe for appropriate patient situation and needs." The policy was fully reviewed, however nowhere in the policy addressed or indicated the methods for high risk suicidal patient monitoring and communication between care providers and security guards in order to protect patients.</p> <p>Patient A was assessed by facility staff to be at "high risk" for suicide and Patient A had a suicide plan that was clearly documented by multiple staff at the facility, however, the facility failed to provide a safe environment and proper care to prevent Patient A from carrying out his suicide plan. The facility failed to ensure staff planned and delivered a safe plan of care for Patient A, reflecting the nursing process elements. Specifically, facility staff failed to acknowledge and effectively communicate Patient A's suicide plan to all care providers or any other staff responsible for Patient A's care interventions and/or monitoring, and failed to implement appropriate preventative safety measures and interventions to prevent Patient A from carrying out his suicide plan. Patient A was left alone in a room,</p>			

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	<p>which allowed him to carry out his suicide plan to "deliberately fall to sustain a Traumatic brain injury."</p> <p>The facility's failure to communicate and implement a plan of care to provide a safe environment for a patient who verbalized a detailed suicide plan while being cared for at the facility 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 the Health and Safety Code Section 1280.3</p> <p>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).</p>			<p style="text-align: center;">CA DEPT OF PUBLIC HEALTH 2017 SEP 20 AM 10:21 LICENSING & CERTIFICATION VENTURA DISTRICT OFFICE</p>	

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