| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 04/30/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PACIFIC GROVE HOSPITAL** | **5900 Brockton Ave<br>Riverside, CA 92506** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| B000 | Initial Comments<br><br>The following reflects the findings of the California department of Public Health during the investigation of one complaint.<br><br>Complaint number CA00583902.<br><br>Representing the California department of Public Health: Surveyor 22384, HFEN.<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>A deficiency was issued for complaint number: CA00583902. | B000 | | |
| B341 | T22 DIV5 CH2 ART3-71243(d) Dietetic Service General Requirements<br><br>(d) A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning modified diets. Copies of the diet manual shall be available at each nursing station and in the dietetic service area.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure the daily menus included modified diets for the staff to be able to reference, and the current dietary manual was updated. This failure may potentially impact the patient's nutritional needs and overall medical stability.<br><br>Findings:<br><br>An observation of the facility's kitchen was conducted with the facility's Registered | B341 | | 05/22/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | CA250000048 | A. BUILDING:<br>B. WING: | 04/30/2018 |

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|---|---|---|---|---|
| | Dietician (RD) on April 30, 2018, at 3 p.m. A review of the weekly patient menu for the week of April 30 through May 6, 2018, was conducted. The weekly patient menu for the staffs use included regular diets but did not reflect modified patient diets due to specific physicians orders which reflected the patient's medical needs.<br><br>A review of the diet sheet from both the secured and voluntary patient units was conducted. There was a total of 43 patients with diet orders. Out of those 43 patients, 14 had modified diets, the remainder were on regular diets.<br><br>An interview was conducted with the RD on April 30, 2018, at 3:30 p.m. The RD stated patients with modified diets do not have a weekly menu which reflect their specific dietary needs, such as controlled carbohydrate or low sodium diets documented so staff can refer to them as needed.<br><br>The RD further stated the modified diets are not reflected on the weekly menu, only regular diets are documented, so new staff may not know what foods are and are not included on the various modified diets.<br><br>The RD further stated the facility's dietary manual needed to be updated with respect to the modified diets as no changes were made to the manual last year. | | | |

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|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 01/09/2018 |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint number: CA00567236<br><br>Representing the California Department of Public Health:<br>2369/28294, HFEN<br><br>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate a violation of the regulations and a deficiency was issued for complaint number CA00567236.<br><br>Abbreviations used in this document:<br><br>DQM - Director Quality Management<br>MHW - Mental Health Worker | B000 | | |
| B6360 | T22 DIV5 CH2 ART6-71555(b) Patients' Monies and Valuables<br><br>(b) Each licensee shall maintain adequate safeguards and accurate records of patients' monies and valuables entrusted to his care.<br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the facility's process/policy and procedure was followed for the inventory and return of the patient's personal property for one patient (Patient 2). This had the potential to result in the loss of Patient 2's personal property/possessions.<br><br>Findings: | B6360 | | 01/26/2018 |

Licensing and Certification Division

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 01/09/2018 |

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| **PACIFIC GROVE HOSPITAL** | **5900 Brockton Ave<br>Riverside, CA 92506** |

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| | On January 2, 2018, a complaint was received in regards to the inability of the facility to find Patient 2's belongings which included a wallet, insurance card, identification card, credit/debt card, and some loose change. Patient 2 was able to describe the process which occurred upon being admitted to the facility which included two individuals signing an inventory of his belongings, belongings were placed in an envelope, and were taken to be locked up.<br><br>During an interview with the Director Quality Management (DQM), on January 8, 2018, at 9 a.m., the DQM stated he was aware of Patient 2's/Patient 2's family's allegation of the loss of Patient 2's wallet, insurance card, identification card, credit/debt card, and some loose change. The DQM stated staff had looked for Patient 2's personal property but had only been able to locate his clothing. The DQM stated there was no "Patient Valuables" envelope in the facility safe for Patient 2.<br><br>On January 8, 2018, the record for Patient 2 was reviewed. Patient 2 was admitted to the facility on December 11, 2017, with diagnoses including major depressive disorder, single episode, without psychotic features; hypertension; chronic obstructive pulmonary disease; and asthma.<br><br>The "Initial Psychiatric Evaluation" dated December 12, 2017, indicated Patient 2 was fully oriented to person, place, time and situation. In addition, "recent and remote memories are grossly intact."<br><br>The facility form listing Patient 2's personal property was signed by Patient 2 on December 11, 2017, at 2:45 p.m., and included the following items: belt; one jacket; two tee shirts; one socks/hose; one underwear; one undershirt; and one shorts. | | | |

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|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 01/09/2018 |

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| | There was no documented indication Patient 2 had a wallet, insurance card, identification card, credit/debt card and some loose change.<br><br>There was no documented indication an envelope was placed in the safe.<br><br>There was no documented indication of a staff signature/staff responsible for listing the property.<br><br>During an interview with Mental Health Worker (MHW) 1, on January 8, 2018, at 10:36 a.m., MHW 1 stated the patient's personal property was inventoried with the patient and listed on the personal property form. MHW 1 stated the patient's personal items, such as a wallet, cash, insurance cards, jewelry, or cell phone, that were to be locked in the safe, were inventoried on the "Patient Valuables" envelope and were not listed on the personal property form. MHW 1 stated a copy of the "Patient Valuables" envelope was not maintained in the patient's medical record. MHW 1 stated the "Patient Valuables" envelope was placed in the facility safe when time permitted. MHW 1 stated he was unable to remember if Patient 2 had arrived at the facility with a wallet and items in the wallet.<br><br>During a subsequent interview with the DQM, on January 8, 2018, at 11 a.m., the DQM stated all of the patient's personal property should be listed on the personal property form to include items placed in the "Patient Valuables" envelope. The DQM stated Patient 2's clothing items were returned to the patient's family member, he was unsure of the date this occurred, and the individuals signature for the return of the items was not obtained/documented. The DQM stated there should have been documentation/signatures when the patient's personal property was | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 01/09/2018 |

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| | returned to the patient/patient's family.<br><br>There was no documented indication on Patient 2's personal property list that his personal property had been released back to him as stated by the DQM.<br><br>The facility policy and procedure titled "Patient Belongings and Contraband" last reviewed by the facility September 2015, revealed "... It (patient's property) will then be logged onto the Patient Property/Clothing List. ... All of the patient's property considered to be valuable ... will be logged onto and placed into a patient valuables envelope and stored in the safe. ... The following are examples of items to be stored in the safe: Cash ... Credit cards, Wallet, ... Insurance card(s)." | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 01/16/2018 |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint number: CA00565998<br><br>Representing the California Department of Public Health:<br>2369/28294, HFEN<br><br>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate a violation of the regulations and a deficiency was issued.<br><br>Abbreviations used in this document:<br><br>CNO - Chief Nursing Officer<br>DQM - Director Quality Management<br>ER - Emergency Room<br>Lab - Laboratory<br>MAR - Medication Administration Record<br>Sat - saturation<br>% - percent | B000 | | |
| B4880 | T22 DIV5 CH2 ART6-71517(a) Admission, Transfer and Discharge Policies<br><br>(a) Each hospital shall have written admission, transfer and discharge policies which encompass the types of diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, policies concerning advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, | B4880 | | 01/26/2018 |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 01/16/2018 |

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| | insurance agreements and other financial considerations, discharge of patients and other related functions.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the facility's policy and procedure was followed when a patient (Patient 2) was transferred to a higher level of care. This resulted in no documented indication Patient 2 consented to the transfer, the Physician certified the transfer, the patient's condition at the time of transfer, and Facility B being unaware of Patient 2's continued care needs.<br><br>Findings:<br><br>On January 8, 2018, the record for Patient 2 was reviewed. Patient 2 was admitted to Facility A on December 11, 2017, with diagnoses including major depressive disorder, single episode, not associated with psychiatric disorder; chronic obstructive pulmonary disease; and high blood pressure.<br><br>The "Physician's Order Sheet" dated December 13, 2017, at 6 p.m., indicated "Sent to ER (Emergency Room) due to hypoxemia (abnormally low level of oxygen in the blood) O2 Sat(uration) 89%, using accessory muscles to breath."<br><br>The "Interdisciplinary Progress Notes" dated December 13, 2017, at 6 p.m., indicated a physician's order was obtained to send Patient 2 to the ER and the ambulance service was called.<br><br>There was no documented indication what time Patient 2 was transferred to Facility B, vital signs at the time of transfer, and the patient's condition at the time of transfer. | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 01/16/2018 |

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| | There was no documented indication the "Memorandum of Transfer" form was completed when Patient 2 was transferred from Facility A to a General Acute Care Facility (Facility B) on December 13, 2017.<br><br>There was no documented indication the "Physician Certification for Transfer" was obtained prior to Patient 2 being transferred to Facility B.<br><br>There was no documented indication Patient 2's consent for the transfer was obtained prior to Patient 2 being transferred to Facility B.<br><br>There was no documented indication Patient 2 was asked if he wanted his emergency contact person to be notified of his transfer.<br><br>During an interview with the the Chief Nursing Officer (CNO), on January 8, 2018, at 10:15 a.m., she reviewed the record and was unable to find documentation of the "Memorandum of Transfer," the "Physician Certification for Transfer," the patient's consent for transfer, the patient's condition at the time of transfer, when the patient was transferred to a higher level of care, report being given to Facility B, and was the patient asked if he wanted his emergency contact person notified of his transfer, for Patient 2, when he was transferred to Facility B on December 13, 2017. The CNO stated the "Memorandum of Transfer" and the "Physician Certification for Transfer" should have been completed. In addition, the CNO stated the patient's consent should have been obtained and the patient's condition at the time of transfer should have been documented. Then CNO stated report should have been called to Facility B and the necessary documents to continue Patient 2's care should have been sent with the patient when he was transferred to Facility B. | | | |

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|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 01/16/2018 |

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| | The facility policy and procedure titled "Emergency Care and Transfer" last reviewed by the facility in 2014, revealed "... When the medical emergency is determined to not be life threatening, but requires treatment at an acute medical facility, the following steps will be taken: ... Obtain patient's consent and signature on the Consent/Request of Transfer Form. ... The Transport Request and Physician Certification Statement shall be completed and faxed to (name of ambulance company). Complete the Memorandum of Transfer Form. When known, contact the receiving medical facility, providing them with all pertinent information. Obtain and document an accepting physician on the Memorandum of Transfer Form. Provide copies of the face sheet, MARs, Lab(oratory) results, History and Physical, Initial Psychiatric Evaluation and the original Memorandum of Transfer to the medical transport team. ... Ask the patient if they would like their emergency contact notified of their transfer. If they would, notify the emergency contact. Document the incident in the patient's medical record. Place a copy of the Memorandum of Transfer in the medical record. ..." | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 05/11/2017 |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of one complaint.<br><br>Complaint number: CA00533232.<br><br>Representing the California Department of Public Health: Surveyor 22384, HFEN.<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>A deficiency was issued for complaint number: CA00533232. | B000 | | |
| B2190 | T22 DIV5 CH2 ART3-71213(a) Psychiatric Nursing Srv General Requirements<br><br>(a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the physician's order to place Patient A on one to one (1:1) supervision for the safety of other patients was implemented. This failure could potentially lead to injuries to other patients, staff and visitors. | B2190 | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 05/11/2017 |

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| | Findings:<br><br>A review of Patient A's record was conducted on May 10, 2017. Patient A was admitted to the facility on April 17, 2017, for treatment due to his history of suicidal ideation and auditory hallucinations. Patient A's history includes schizophrenia, paranoid type, (Per Wikipedia-schizophrenia is a mental disorder characterized by abnormal social behavior and failure to understand what is real).<br><br>A review of the Interdisciplinary Treatment Plan Update dated April 24, 2017, at 12:46 p.m., indicated, "(Patient A) has had several assaultive behaviors in the past 7 days. He had punched/had a physical altercation with 3 patients. He had to be given emergency meds (medications) on 4/20 for severe agitation..."<br><br>A review of a physician's order dated April 27, 2017, at 9:30 a.m., indicated, "Place patient (Patient A) on 1:1 monitoring for safety. Patient agitated and hit other patient."<br><br>A review of the "Daily Observation Graphics Sheet" which reflected when Patient A was maintained on 1:1 monitoring was conducted. On April 27, 2017, at 7 p.m. through April 28, 2017, at 7 p.m., the documentation did not reflect Patient A was on 1:1 monitoring. On April 29, 2017, at 5:25 a.m. through 2 p.m., and from 3 p.m. through 7 a.m. on April 30, 2017, the documentation did not reflect Patient A was on 1:1 monitoring.<br><br>The record indicated the physician discontinued the 1:1 monitoring for Patient A on April 30, 2017, at 9:30 a.m.<br><br>A review of the facility policy, "Precautions and Observations of Patients (Reviewed: 2/2016)," was conducted. The policy indicated, "It is the | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 05/11/2017 |

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| | policy of (the facility) to provide a safe and secure environment for patients during their hospitalization. Levels of observation can be initiated by nursing staff and are accompanied by a physician order when a patient may be considered to be at increased risk for harm to self, others or property...Observation - 1:1...A progress note entry by nursing staff should be documented in the medical record at least every hour, reflecting the patient's condition and/or changes in patient status."<br><br>An interview was conducted with the Interim Director of Risk Management on May 10, 2017, at 5 p.m., who stated when 1:1 monitoring is ordered for a patient it must be documented in the record every hour. | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 04/28/2017 |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint number: CA00530890<br><br>Representing the California Department of Public Health:<br>2369/28294, HFEN<br><br>The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate a violation of the regulations and a deficiency was issued.<br><br>Abbreviations used in this document:<br><br>DON - Director of Nursing<br>LVN - Licensed Vocational Nurse<br>MHW - Mental Health Worker<br>RN - Registered Nurse | B000 | | |
| B2250 | T22 DIV5 CH2 ART3-71213(f) Psychiatric Nursing Srv General Requirements<br><br>(f) There shall be a method for determining staffing requirements based on assessment of patient needs. This assessment shall take into consideration at least the following:<br><br>This Statute is not met as evidenced by: | B2250 | | 05/12/2017 |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X1) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CA250000048 | A. BUILDING:<br>B. WING: | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **PACIFIC GROVE HOSPITAL** | **5900 Brockton Ave<br>Riverside, CA 92506** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| | Based on interview and record review, the facility failed to ensure the facility's policy and procedure for staffing based on the acuity of the patients was followed. This resulted in inadequate number of staff to care for the patients.<br><br>Findings:<br><br>On April 19, 2017, the staffing for the "Voluntary Unit" and the "Secured Unit" were reviewed and indicated the following:<br><br>For the "Voluntary Unit:"<br>a. On March 22, 2017, 7 a.m. to 7:30 p.m. shift, there were 29 patients with 1 Registered Nurse (RN), 1 Licensed Vocational Nurse (LVN), and 2 Mental Health Workers (MHW) [4 staff for 29 patients; ratio 1:7.25], and the "Patient Classification Acuity Form" indicated 5.4 staff members were needed to care for the patients.<br>b. On March 22, 2017, 7 p.m. to 7:30 a.m. shift (March 23, 2017), there were 24 patients with 1 RN, 1 LVN, and 1 MHW [3 staff for 24 patients; ratio 1:8], and the "Patient Classification Acuity Form" indicated 5.2 staff members were needed to care for the patients.<br><br>For the "Secured Unit:"<br>a. On March 22, 2017, 7 p.m. to 7:30 a.m. (March 23, 2017) shift, there were 22 patients with 1 RN, 1 LVN, and 2 MHWs, and the "Patient Classification Acuity Form" indicated 4.56 staff members were needed to care for the patients.<br><br>During an interview with the Director of Nursing (DON), on April 27, 2017, at 1:30 p.m., they reviewed the staffing for the "Voluntary Unit" and the "Secured Unit." The DON verified there were shifts when the minimum staffing of 1:6 was not met, and the staffing should have been at a minimum of 1:6. The DON stated the Units should be staffed based on the acuity of the | | | |

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| | patients.<br><br>The facility policy and procedure titled "Patient Classification/Nursing Staffing Plan" reviewed May 2015, revealed "To ensure quality nursing care and a safe patient environment by establishing an acuity system to determine and appropriate staffing pattern based on the assessment of patient needs. ... Level 1 ... approximately 2 hours of nursing care per shift (1:6 staffing ratio). ... Level 2 ... approximately 2.4 hours of nursing care per shift (1:5 staffing ratio). ... Level 3 ... approximately 3 hours of nursing care per shift (1:4 staffing ratio). ... One to One ... approximately 12 hours of nursing care per shift (1:1 staffing ratio). ..." | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 08/30/2016 |

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| E000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint and an entity reported incident.<br><br>Complaint number: CA00498313.<br><br>Entity reported incident number: CA00498573.<br><br>Representing the California Department of Public Health::<br>2784/33801, HFEN<br><br>The inspection was limited to the specific complaint/entity reported incident investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate a violation of the regulations and a deficiency was issued. | E000 | | |
| E1900 | T22 DIV5 CH1 ART7-70701(a)(5) Governing Body<br><br>(a) The governing body shall:<br>(5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure patients were kept safe when a staff member assigned to keep one patient (Patient A) in "Line of Site," was also assigned to monitor patients in the | E1900 | | 09/16/2016 |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 08/30/2016 |

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| | Day Room. This failure resulted in Patient A being assaulted by another patient (Patient B) and subsequently the arrest of Patient B.<br><br>Findings:<br><br>Code of Federal Regulations (CFR) - State Operations Manual: Appendix A - 482.13(c)(2) - "The patient has the right to receive care in a safe setting."<br><br>Code of Federal Regulations (CFR) - State Operations Manual: Appendix A - 482.13(c)(3) - "The patient has the right to be free from all forms of abuse or harassment."<br><br>On August 9, 2016, at 2:55 p.m., an unannounced visit was made to the facility for the purpose of a complaint and an entity reported incident investigations.<br><br>On August 9, 2016, the medical record for Patient A was reviewed with the Director of Nursing (DON). Patient A was admitted to a locked unit at the facility on July 27, 2016, with diagnosis of bipolar disorder (mental illness characterized by severe mood swings of depression and elation). A physician order, dated August 2, 2016, at 1:15 a.m., indicated, "Line of Sight for inappropriate behavior."<br><br>Patient A's medical record indicated, Patient B came into contact with Patient A on three previous occasions. Patient A told the police, On August 4, 2016, about 10 p.m., Patient B rubbed up against Patient A like he was slow dancing with her. On August 5, 2016, between 8 and 9 a.m., Patient B again rubbed up against Patient A. These events happened while Patient A was ordered to be on "Line of Sight" observation.<br><br>On August 10, 2016, at 9:12 a.m., Mental Health Worker (MHW 1) was interviewed. | | | |

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| | MHW 1 stated, she was assigned to have Line of Site on Patient A for day shift on August 5, 2016. MHW 1 stated, she was standing in the hallway outside of Patient A's room with her back to the medication room. She stated, "I was also responsible for watching the Day Room." (The Day Room is a community room with a television, tables, chairs, and couches.)<br><br>MHW 1 stated she heard and saw "Two patients started arguing in the Day Room." She stated when both patients stood and moved towards each other, she rushed into the Day Room to separate the patients and calm the situation. She stated, "I was in there about 3 or 4 minutes." When she came out of the Day Room, Patient A met her in the hall and told her there was a male patient in her room. MHW 1 stated she went into Patient A's room and saw Patient B, fully clothed. Patient B, stated, "I'm leaving now." Patient A was pacing in the hall and very upset. Patient A told MHW 1 that Patient B closed her door, got on top of her in bed and tried to kiss her. MHW 1 informed the Charge Nurse (CN).<br><br>On August 10, 2016, the "Staff Assignment Sheet" for the locked unit was reviewed with the DON. The assignment for MHW 1, indicated she was assigned the Line of Site duty for Patient A and was also assigned, to"Rounds, Groups-Specify Times, Patient Meals On/Off Unit, Contraband Room, Vital Signs, Supply Snack Ordering, and Code Teams - Assign Roles."<br><br>During a concurrent interview the DON was interviewed regarding Line of Site. The DON stated, "The patient should be visualized at all times. This would be a problem, that the patient was not visualized when (Patient B) came into her room."<br><br>On August 9, 2016, a facility policy entitled, | | | |

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| | "Precautions and Observation of Patients" reviewed February 1016, was reviewed with the DON. The policy indicated, "...Line of Sight, Guidelines for implementation of this level of observation include, but are not limited to, the following:<br>The patient is restricted to a secure unit.<br>The patient should be within visual range of the assigned staff at all times..." | | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 07/26/2016 |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint number: CA00494533<br><br>Representing the California Department of Public Health:<br>2369/28294, HFEN<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate a violation of the regulations a deficiency was issued.<br><br>Abbreviations used in this document:<br><br>CEO - Chief Executive Officer<br>DON - Director of Nursing<br>LVN - Licensed Vocational Nurse<br>MHW - Mental Health Worker<br>RN - Registered Nurse | B000 | | |
| B231 | T22 DIV5 CH2 ART3-71213(g) Psychiatric Nursing Srv General Requirements<br><br>(g) There shall be documentation of the methodology used in making staffing determinations. Such documentation shall be part of the records of the nursing service and be available for review.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the facility's policy and procedure for patient classification, acuity and | B231 | | |

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| | CA250000048 | A. BUILDING:<br>B. WING: | 07/26/2016 |

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| | staffing plan was followed. This resulted in incomplete shift documentation of patients' acuity, inadequate number of staff to care for the patients, and a Registered Nurse was not on all units, at all times.<br><br>Findings:<br><br>On July 7, 2016, the staffing for the "Voluntary Unit" and the "Secured Unit" were reviewed and indicated the following:<br><br>For the "Voluntary Unit:"<br>a. On June 26, 2016, 7 a.m. to 7:30 p.m. shift, there were 21 patients with 1 Registered Nurse (RN), 1 Licensed Vocational Nurse (LVN), and 1 Mental Health Worker (MHW) [3 staff for 21 patients; ratio 1:7].<br>b. On June 28, 2016, 7 a.m. to 7:30 p.m. shift, there were 19 patients with 1 RN, 1 LVN, and 1 MHW [3 staff for 19 patients; ratio 1:6.33].<br><br>For the "Secured Unit:"<br>a. On June 26, 2016, 7 a.m. to 7:30 p.m. shift, there were 20 patients with 1 RN, 1 LVN, and 1 MHW [3 staff for 20 patients; ratio 1:6.66].<br>b. On July 6, 2016, 7 a.m. to 7:30 p.m. shift, there were 19 patients with an RN for 6 hours, 1 LVN, and 2 MHWs. There was an RN orienting to the unit for 12 hours.<br>c. On July 7, 2016, 7 p.m. to 7:30 a.m. (July 8, 2016) shift, there were 20 patients with 1 RN, 1 LVN, and 1 MHW. In addition, two of the 20 patients required a 1:1, which was covered by two additional MHWs.<br><br>The facility was unable to provide the "Patient Classification Acuity Form" when requested for June 26 through 30, 2016, and July 6 and 7, 2016.<br><br>During an interview with the Chief Executive Officer (CEO), on July 7, 2016, at 2:30 p.m., she stated the "Patient Classification Acuity | | | |

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| | Form" was only completed if the acuity of the patients' was different from a Level 1. The CEO stated the "Patient Classification Acuity Form" was not done daily with each shift and if completed they were only retained for a few month.<br><br>During an interview with the CEO and Director of Nursing (DON), on July 21, 2016, at 1:10 p.m., they reviewed the staffing for the "Voluntary Unit" and the "Secured Unit." The CEO and DON verified there were shifts when the minimum staffing of 1:6 was not met and the staffing should have been at a minimum of 1:6. The CEO and DON stated there was not always a RN on duty, on each unit, at all times.<br><br>The facility policy and procedure titled "Patient Classification/Nursing Staffing Plan" reviewed May 2015, revealed "... The Patient Classification Acuity form will be completed each shift by the unit charge nurse two hours prior to the oncoming shift utilizing the guidelines on that form. ... The Patient Classification Acuity forms and the daily staffing sheets will be retained by the director of nursing for a period of three years. ... A registered nurse must be on duty, on all units, at all times. ... Level 1 ... approximately 2 hours of nursing care per shift (1:6 staffing ratio). ... Level 2 ... approximately 2.4 hours of nursing care per shift (1:5 staffing ratio). ... Level 3 ... approximately 3 hours of nursing care per shift (1:4 staffing ratio). ... One to One ... approximately 12 hours of nursing care per shift (1:1 staffing ratio). ..."<br><br>The facility "Staffing Ratio," provided by a staff member, undated, revealed "... Voluntary unit: ... # [number] of patients 13 - 19 ... 3 staff (1 RN [Registered Nurse], 1 LVN [Licensed Vocational Nurse], 1 MHW [Mental Health Worker])[exceeds minimum staffing ratio of 1:6]. ... Locked unit: ... # [number] of patients | | | |

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| | 11 - 19 ... 3 staff (1 RN [Registered Nurse], 1 LVN [Licensed Vocational Nurse], 1 MHW [Mental Health Worker])[exceeds minimum staffing ratio of 1:6].<br><br>The facility "Staffing/Standards Acuity Guidelines" undated, revealed for the Secured Unit a staff to patient ratio of 1:4.5 for both shifts, for 11 to 15 patients: 4 staff, and for 16 to 20 patients: 5 staff. | | | |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of a complaint.<br><br>Complaint number: CA00477926.<br><br>Representing the California Department of Public Health:<br>Surveyor 22764/1977, HFEN.<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>The Department was able to substantiate the allegations. Deficiencies were issued for complaint number CA00477926. | B000 | | |
| B492 | T22 DIV5 CH2 ART6-71517(e) Admission, Transfer and Discharge Policies<br><br>(e) No inpatient shall be transferred or discharged for purposes of effecting a transfer, from a hospital to another health facility, unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or attempts over a 24-hour period have been made and a responsible person cannot be reached. A transfer or discharge shall not be carried out if in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure: | B492 | | |

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| | 1. Patient 1 ' s conservators (the persons legally responsible for the patient [her parents]) were involved in the discharge process, and notified of her pending and actual discharge; and,<br><br>2. Patient 1 was discharged to the level of care determined by the physician to be safe.<br><br>These failed practices resulted in Patient 1 walking away from an unsupervised admission and going missing for five days (found at a homeless shelter by the police), and the potential for harm or death.<br><br>Findings:<br><br>During an interview with the Director of Performance Improvement/Risk Management (QI/RM) on February 29, 2016, at 11:29 a.m., the director stated Patient 1 was admitted to the facility involuntarily from a Board and Care (B&C-that provides a place of residence, meals, and varying level of care including medication assistance) facility due to aggressive behavior. She stated the physician and the Social Worker (SW) both indicated Patient 1's parents had given up conservatorship due to, "inability to control her." The director stated the facility had orders to discharge Patient 1 to a B&C, so they discharged her.<br><br>During an interview with Patient 1's conservator/parent, on February 29, 2016, at 11:30 a.m., he stated he and his wife never relinquished the conservatorship for Patient 1. He stated the court order for conservatorship was getting ready to expire (dates assigned by | | | |

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| | a judge in court), and there was a possibility that a new conservator would be assigned. He stated he had a conversation with the facility social worker on February 16, 2016, regarding him and his wife being her conservators, and the pending hearing for a change in conservatorship. He also requested to be informed him if Patient 1 was to be discharged before the hearing date, and explained the dangers in sending her back to a B&C facility.<br><br>He stated he then e-mailed the social worker regarding the discussion they had. He stated the hearing to appoint a new conservator was scheduled for February 25, 2016, and the facility "knew about it." He stated Patient 1 never showed up for the hearing, and when he called the facility to check on her, he was told by facility staff that she was discharged to a B&C. According to the conservator, when he called the B&C that Patient 1 was discharged to, the staff stated it was a Room and Board (R&B- a facility that provides a room, meals and limited services to individuals who are self-sustainable) not a B&C facility.<br><br>He stated Patient 1 was taken and, "dropped off," (by the R&B facility) at a county building to meet her potential new conservator, she was left on a bench in front of the building, and she had had not been seen since (for 96 hours). The conservator stated the facility knew he and his wife were Patient 1's conservators when she was discharged, but they discharged her, "anyway," to the wrong level of care, without discussing it with them.<br><br>The clinical record for Patient 1 was reviewed on February 29, 2016. Patient 1, a 51 year old | | | |

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| | female, was admitted to the facility on February 12, 2016, on a 5150 (involuntary confinement due to mental disorder that makes a person a danger to themselves or others, or unable to care for themselves), after she was evicted from a B&C for aggressive and intrusive behavior toward the staff.<br><br>The initial physician's assessment, dated February 12, 2016, indicated the following:<br><br>a. Family and Social History:<br><br>Patient 1's parents had recently given up conservatorship as they were unable to care for her; and,<br><br>b. Assets and Liabilities:<br><br>Patient 1 had family to care for her (not consistent).<br><br>The Interdisciplinary Progress notes, written by the social worker, dated February 17, 2016 (five days after admission), at 2:30 p.m., indicated the public guardian visited Patient 1 that day to discuss the conservator hearing scheduled for February 25, 2016. At 3:05 p.m., the patient was, "approved for Board and Care facility," (the same type of facility she was evicted from, and the type of facility her conservator felt was not safe for her to go back to).<br><br>The Physician Daily Progress Note, dated February 23, 2016, indicated Patient 1 was having auditory hallucinations (hearing voices) | | | |

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| | with paranoia and was depressed, but she could be discharged the next day.<br><br>The Physician Discharge Order Sheet, dated February 24, 2016, indicated Patient 1 was to be discharged to a Board and Care facility. There was no evidence the conservators were involved in the discharge discussions or plans.<br><br>The Interdisciplinary Progress Notes, dated February 24, 2016, at 2 p.m., indicated Patient 1 was," discharged home via Board and Care." (the day before the change of conservator hearing was scheduled). There was no evidence the current conservators (her parents) were involved in her discharge planning, or the decision regarding when or where to discharge her.<br><br>The "Discharge Care Plan," wrongly indicated Patient 1 was discharged to a B&C facility on February 24, 2016, at 2 p.m. (The patient was actually discharged to a R&B). There was no evidence the conservators were aware of the discharge.<br><br>During an interview with the facility social worker (SW) on February 29, 2016, at 12:40 p.m., the SW stated he had facilitated Patient 1 ' s transfer to the R&B. He stated there was a, "big difference," in the level of care the two facility types (B&C and R&B) provided. The SW stated Patient 1 required assistance, and was supposed to go to a B&C, not a R&B.<br><br>The SW stated he did not know Patient 1 had a conservator until he spoke to him the day after she was discharged. He stated the e-mail sent | | | |

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| | to him by the conservator did not get sent to the correct e-mail address.<br><br>The SW stated the public guardian was at the facility to see Patient 1 on February 17, 2016, and told him that the parents had relinquished their conservatorship. He stated the public guardian wanted to interview the patient to see if she still needed a conservator. The SW stated the conservatorship hearing was scheduled for February 25, 2016.<br><br>The SW stated Patient 1 was cleared to go to a B&C, and that was where she went. He stated Patient 1 was not under a conservatorship when she was discharged, and it did not matter if it was expired for one day or was going to be redone in one day, the day she left she was OK to be discharged to the responsibility of herself. The SW stated Patient 1's history of, or upcoming conservatorship was, "not my problem," and he could not be held responsible for anything that happened to the patient after she left.<br><br>During an interview with the House Manager (HM) of the R&B facility to which Patient 1 was discharged to, on February 29, 2016, at 4:25 p.m., the HM stated he remembered Patient 1 being admitted to his facility. He stated the Director of Nursing (DON) from the discharging facility transported Patient 1 to his facility. He stated Patient 1 was dropped off at, and admitted to the R&B facility. He stated he, "thought it was odd for her to be sent to a R&B home, but that was where they brought her, and they must know what was best for her."<br><br>The HM stated the following day he received a | | | |

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| | call from his boss telling him to take Patient 1 to a county building, where she was going to meet with the public guardian. He stated he drove her to the county building, had her sit on the bench outside, and told her to wait there for the public guardian.<br><br>An e-mail document provided by the parent/conservator was reviewed on March 1, 2016. The document was addressed from the conservator to the SW at the facility, dated February 16, 2016. The document read, "Thank you for calling today. Here are the key points we discussed. Please call or email me with comments and questions." The document indicated " From (name of parent) Father/Conservator of (name of Patient 1). " The e-mail document further indicated the hearing date for the change in conservatorship hearing, requested notification of the conservators if Patient 1 was to be discharged prior to the hearing date, requested assistance in placing Patient 1 in an IMD (Institute for Mental Diseases - a higher level of care), and gave some examples of IMDs in the area.<br><br>The Order of Conservatorship dated November 16, 2015, was reviewed on March 1, 2016. According to the order, Patient 1's parents were appointed co-conservators for her on February 26, 2015, and the order was due to expire on February 26, 2016 (the day after she was discharged to the B&C). On the hearing date (February 26, 2016), Patient 1 did not attend (and could not be located according to her conservator).<br><br>The Patient ' s clinical record was further reviewed on March 2, 2016. | | | |

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| | The 5150 document, dated February 11, 2016, at 4:25 p.m., indicated Patient 1 had conservators (her parents), and their names and phone number were written on the document. The document indicated her conservator (father) requested that she be admitted to the facility in an effort to place her in a longer term facility (higher level of care than a B&C) on discharge.<br><br>The Intake Assessment, dated February 12, 2016, at 10:25 p.m., indicated Patient 1 was unable to care for herself and was, "under conservatorship."<br><br>During a concurrent interview with the DON and the Director of PI/RM on March 2, 2016, at 1:35 p.m., the DON stated he was asked by the SW to find, "the right place," for Patient 1. He stated he found the R&B that she was sent to. He stated he took her to the facility when she was discharged, and it was a R&B, not a B&C.<br><br>The DON explained the difference in the two facility types. He stated a B&C was a licensed facility that could assist with medications, meals, and transportation. He stated a R&B was not licensed, and did not assist with medications or transportation. He stated a R&B was like, "renting a room with meals provided."<br><br>The PI/RM Director stated if Patient 1 was conserved, the discharge would have been done differently. She stated her discharge plan would have had to be approved by her conservator. She stated the facility finds out if a patient has a conservator when: 1) the patient would tell them; and/or, 2) another | | | |

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| | (transferring) facility would tell them; and/or, 3) the conservator would tell them.<br><br>The Director stated there was no way to research whether a patient had a conservator other than reviewing the information on the intake assessment. She stated if the intake nurse had any information regarding a conservator, they were responsible for communicating it to the team.<br><br>During a concurrent interview with the DON and the Performance Improvement/Risk Management Director (PI/RM) on March 2, 2016, at 2:20 p.m., both stated the intake staff should have notified the patient care staff of the conservatorship. Both of them stated the information was, "clear," in the record, and the staff should have known. They both stated Patient 1 should not have been discharged without conservator involvement, and she should not have been discharged to a R&B facility.<br><br>The facility policy titled, "Discharge Planning," was reviewed on March 2, 2016. The policy indicated the team would work with the patient and their family to develop a discharge plan. The policy indicated, " family," referred to a person or persons who played a significant role in the patient's life, and may or may not be related to the patient legally.<br><br>The facility policy titled, "Admission of Patients Under Conservatorship," was reviewed on March 2, 2016. The policy indicated the following:<br><br>a. Upon initial request for admission, the intake | | | |

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| | staff shall verify whether the prospective patient is conserved;<br><br>b. If the patient is a conservatee, the intake staff shall document on the intake form the name, date, county, and powers granted to the conservator; and,<br><br>c. On admission, the office shall note whether or not the patient has a conservator and request a copy of the papers.<br><br>Although Patient 1 (a mentally ill patient who had been determined by the courts to be unable to care for herself) had conservators (her parents) who notified the facility of their responsibility for the patient and their wishes for her discharge, the facility failed to communicate internally about the conservatorship, failed to acknowledge the current conservatorship and pending hearing (discharging her the day before her hearing), failed to acknowledge a conversation and follow-up e-mail with the conservator regarding the plan for her discharge, failed to accurately determine the services offered by facilities they were discharging their patients to, failed to notify the conservator of her pending and actual discharge, and failed to discharge her to the level of care the physician ordered her to go to.<br><br>During a follow up interview with Patient 1 ' s parent on March 7, 2016, at 12:15 p.m., he stated the Police Department had located Patient 1 at a homeless shelter on February 29, 2016, and subsequently was transferred to a Crisis Stabilization unit. | | | |

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| | The facility failed to ensure Patient 1 ' s parents/conservators were involved in the patient ' s discharge process, and failed to ensure the patient was discharged to the level of care determined by the physician to be safe for her which resulted in the patient being missing for five days and placing the patient at risk for harm and possible death. | | | |

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| B000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health during the investigation of one complaint.<br><br>Complaint Number: CA00468910<br><br>Representing the California Department of Public Health:<br>Surveyor: 1729/18918, HFEN.<br><br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br><br>A deficiency was issued for complaint number CA00468910. | B000 | | |

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| B449 | T22 DIV5 CH2 ART6-71501(a)(4) Governing Body<br><br>(4) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the governing body failed for one patient (Patient A), to conform to all applicable federal laws and regulations, when facility staff failed to ensure Patient A or Patient A's family members were counseled regarding Patient A's post-hospital care. The facility failed to ensure Patient A was educated about the patient's hospital acquired pressure ulcer per facility policy and in accordance with CFR (Code of Federal Regulations) 482.43(c)(3) & (c)(5). This failure placed Patient A at risk for worsening of her existing pressure ulcer.<br><br>Findings:<br><br>According to CFR 482.43(c)(3) & (c)(5): The facility was required to provide education and or training to prepare the patient and family members for post hospital care, when needed.<br><br>On December 28, 2015, at 3 p.m., Family Member (FM) 1, was interviewed. FM 1 stated Patient A developed a pressure ulcer to her buttocks, while a patient at the facility, and he was not instructed about post hospitalization | B449 | | 01/13/2016 |

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| | care. FM 1 stated he was not provided with instructions or supplies to perform wound care and was only given prescriptions for oral medications, at the time of Patient A's discharge.<br><br>An unannounced visit was made to the facility on December 29, 2015, at 9 a.m., for the purpose of investigating the allegations of this complaint.<br><br>During an interview, with the Director of Nurses (DON) and Risk Manager (RM), on December 29, 2015, at 9:30 a.m., the DON stated Patient A presented to the facility, on November 25, 2015. Patient A was depressed and eventually refused to get up, attend group and eat. The DON stated Patient A developed a pressure ulcer while hospitalized. The DON stated the pressure ulcer was an old pressure ulcer that reopened during this hospitalization. The DON stated Patient A's physician was informed about the wound and treatment orders were received.<br><br>Patient A's record was reviewed with the DON. Patient A's initial physical assessment, completed on November 25, 2015, at 3:17 p.m., indicated Patient A's skin was intact. There was no documentation on the assessment that Patient A entered the facility with a pressure ulcer.<br><br>The following was noted in Patient A's record:<br><br>On November 30, 2015, a physician documented the patient was "wheelchair bound...extremely withdrawn..."<br><br>On December 5, 2015, at 8:20 p.m., a physician documented "staff reported small skin redness on buttocks. Patient has some discomfort in the area. Says ointment helped in the past." The physician documented Patient A | | | |

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| | had a "R (right) buttock wound likely pressure related." The physician ordered pressure reduction and Neosporin ointment.<br><br>On December 8, 2015, at 9:15 p.m., a Registered Nurse (RN) documented she was informed by the patient's attendant the patient had a wound to the right buttock that measured 4 centimeter (cm) by .75 cm with superficial depth and reddened area, "Stage II." According to the note, the physician was notified and orders to alternate Zinc Oxide with Neosporin twice daily, was received.<br><br>On December 9, 2015, at 2 p.m., a physician documented Patient A had a stage II pressure ulcer to her right buttock. The physician documented:<br><br>-Counseled<br>-Rotate patient every two hours<br>-Keep off pressure<br>-Continue alternate Neosporin with Zinc<br>-Monitor size and depth<br>-Keep wound clean<br>-Dressing change.<br><br>On December 10, 2015, the physician documented the patient's pressure ulcer was improving and "continue Zinc and Neosporin."<br><br>On December 11, 2015, the physician indicated "Cont (continue) wound care," and follow up with her primary care physician on Monday, if patient was discharged the next morning.<br><br>On December 11, 2015, at 8:30 p.m., the physician following Patient A's medical care, wrote orders for the patient to follow up with her primary care physician on Monday. The physician indicated "Outpatient Care Instructions," included avoid prolonged sitting over two hours, turn in bed every four hours, and use eggcrate mattress. | | | |

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| | Patient "Discharge Care Plan," dated December 12, 2015, was reviewed. The document indicated the patient was discharged home. Follow up appointments with a psychiatrist and therapist were documented on the form. There was no documentation on the discharge plan instructing the patient she should follow up with her primary care physician. There was no documentation on the discharge form instructing the patient or her family member how to care for the patient's pressure ulcer.<br><br>During an interview with the Master (of) Social Work (MSW), on December 29, 2015, at 10:15 a.m., the MSW indicated she was involved in Patient A's discharge but medical and nursing issues were beyond her scope of practice. The MSW stated she did not instruct the patient or her family member about wound care.<br><br>During an interview with the DON, on December 29, 2015, at 11:20 a.m., the DON stated the patient and her family should have received more education/information about wound care during her discharge on December 12, 2015.<br><br>The facility policy and procedure titled "Discharge Planning," with a last revised date of October 2015, was reviewed. The policy indicated : "...The patient and/or, when appropriate, his/her family or continued care provider, are provided with the specific knowledge and/or skills required to meet the patient's ongoing health care needs...Case Manager Reviews the care plan with the patient... | | | |