STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630016368	A. BUILDING: B. WING:	01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN JOSE BEHAVIORAL HEALTH	**455 Silicon Valley Boulevard San Jose, CA 95138**

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B000	Initial Comments The following reflects the findings of the California Department of Public Health during a complaint investigation conducted from 11/21/17, 11/22/17, 1/3/18 and 1/4/18. For Complaint CA 00561859 regarding Quality of Care/Treatment, state deficiency was identified (Title 22, 71215 (c)). Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 25438, Health Facilities Evaluator Nurse; 26295, Health Facilities Evaluator Manager I.	B000		
B2420	T22 DIV5 CH2 ART3-71215(c) Psychiatric Nursing Service Staff (c) Sufficient registered nursing personnel shall be provided to: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide sufficient registered nursing personnel when the nurse-patient ratios were not followed. This failure potentially impacts patient's care and safety. Findings: During an interview on 1/3/18 at 10 a.m., the director of nursing (DON) stated the licensed nurse-to-patient ratio is 1:6. Review of the hospital's staffing assignment	B2420		

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	and the census from 11/1/17 to 12/31/17, indicated the licensed nurse-to-patient ratio did not meet 1:6. The night shift assignment and the census, dated 11/5/17, were reviewed. In Unit A, the census was 22, two registered nurses (RNs) worked, and the nurse-to-patient ratio was 1:11. In Unit B, the census was 16, one RN worked, and the ratio was 1:16. In Units C and D, the census was 37, three RNs worked, and the ratio was 1:12.3. The night shift assignment and the census, dated 11/12/17, were reviewed. In Unit A, the census was 20, one RN worked, and the ratio was 1:20. In Unit B, the census was 16, two RNs worked, and the ratio was 1:8. In Unit C, the census was 22, one licensed vocational nurse (LVN) worked, and the ratio was 1:22. In Unit D, the census was 16, one RN worked, and the ratio was 1:16. During an interview with RN G on 1/3/18 at 9:01 p.m., she stated she called 911 for Resident 1 and another nurse initiated the Code Blue for Patient 1. She also confirmed she had 35 patients for the night shift and two mental health techs (MHT) on 11/19/17, night shift. She stated it has always been that way--one RN and two MHTs. Review of Patient 1's Code Blue (a hospital code used to indicate a patient requiring immediate resuscitation) Record dated 11/20/17, indicated at 4:25 a.m. Code Blue was activated in Unit C for the patient. Review of night shift assignment and the census, dated 11/19/17, indicated the census in Unit C was 35, One RN worked in Unit C and another RN worked in both Units C and D. The ratio was 1:17.5			

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	The night shift assignment and the census, dated 11/26/17, were reviewed. In Unit A, the census was 23, on RN worked, the ratio was 1:23. In Unit B, the census was 14, one RN worked, the ratio was 1:14. In Unit C, the census was 21, one RN worked, the ratio was 1:21. In Unit D, the census was 17, two RNs worked and one RN left at 3 a.m. The ratio after 3 a.m. was 1:17. During an interview on 1/4/18 at 1:40 p.m., the DON stated for the licensed nurse-to-patient ratio, the ratio 1:6 was the ideal ratio and the usual ratio was 1:8 or 1:9. She stated she was aware of the short staff and the management was also fully aware regarding the short staff issue. The hospital did not have a policy regarding the licensed nurse-to-patient ratio.			

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	CA630016368	A. BUILDING: B. WING:	12/29/2017

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B000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 11/29/17, 12/4/17, 12/8/17, 12/15/17, 12/18/17, and 12/29/17. For Entity Reported Incident CA00561697 Resident/Patient/Client Rights, a state deficiency was identified (see California Code of Regulations, Title 22, Section 71213(a)). Inspection was limited to the entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 37883, Health Facilities Evaluator Nurse	B000		
B2190	T22 DIV5 CH2 ART3-71213(a) Psychiatric Nursing Srv General Requirements (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. This Statute is not met as evidenced by: Based on interview and record review, the hospital failed to ensure a registered nurse (RN	B2190		

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	1) followed the appropriate procedure for restraining a patient (Patient 1). This failure had the potential to result in injury to the patient and her unborn child. Findings: On 11/16/17, the California Department of Public Health received an emailed report from the hospital regarding a witnessed "inappropriate CPI (Crisis Prevention Institute) hold utilized by a staff member when restraining a patient." A review of Patient 1's medical record "HISTORY AND PHYSICAL EXAMINATION" indicated she was admitted to the hospital on 11/10/17 on a 5150 (an involuntary psychiatric hold) for DTS (danger to self). The medical record further indicated Patient 1 was pregnant. During an interview with registered nurse 2 (RN 2) on 12/8/17 at 3:15 p.m., she stated on 11/13/17, she responded to a code gray (a psychiatric emergency) and when she arrived she saw RN 1 sitting on Patient 1 who was lying on her back on the floor. During an interview with physician 1 (MD 1) on 12/8/17 at 1:19 p.m., he stated he arrived at the code gray and observed Patient 1 on her back and RN 1 "straddling the abdomen." During an interview with the director of quality assurance (DQA) on 12/5/17 at 10:30 a.m., she stated RN 1 was trained on "CPI holds" on his first day of orientation. In a subsequent interview on 12/8/17 at 8:30 a.m., the DQA stated "We are taught to each take an arm and each take a leg. He instead sat on her and held her arms." During an interview with the director of nurses			

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	(DON) on 12/5/7 at 10:11 a.m., she stated "he should not have straddled the patient." A review of the hospital's 1/17 policy "CODE GRAY - PSYCHIATRIC EMERGENCY" indicated "All staff responding will utilize intervention methods of Nonviolent Crisis Intervention (Crisis Prevention Institute)." A review of the hospital's 3/29/16 policy "RESTRAINT" indicated "A restraint is any manual method that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, regardless of length of time" ... "Patients will be restrained in the supine position, unless contraindicated and in accordance with CPI." A review of the hospital's training booklet "CPI NON-VIOLENT CRISIS INTERVENTION" indicated "Physical intervention is not without risk, so it is important that organizations authorize and approve the specific physical interventions that can be used, and ensure that staff are well trained and competent."			