STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000194	A. BUILDING: _____ B. WING: _____	07/02/2018

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KEDREN COMMUNITY MENTAL HEALTH CENTER	**4211 Avalon Blvd Los Angeles, CA 90011**

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E000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity Reported Incident: CA00559826 Representing the California Department of Public Health: Health Facilities Evaluator Nurse (HFEN): 2921/35792 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. CDPH substantiated violations of the regulations during the investigation of Entity Reported Incident CA00559826	E000		
E292	T22 DIV5 CH1 ART3-70215(a)(2) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. This Statute is not met as evidenced by: T22 DIV5 CH1 ART3-70215(a) (2) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning,	E292		02/20/2019

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

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	supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. These regulations were not met as evidenced by: Based on interviews and record review, the facility failed to: 1. Accurately assess Patient 2's risk of danger to self or others. Patient 2 was placed in a shared room with a patient who was highly assaultive. This failure resulted in Patient 2 not being placed on constant observation so staff assistance was not immediately available when Patient 2 strangled his roommate Patient 1. 2. Observe the wherabouts of Patients 1, 2 and 3 every 20 minutes. This had the potential for a change in behavior to be undetected by the staff. 3. Document what occured during cardiopulmonary resuscitation (CPR) when Patient 1 was found unresponsive. This resulted in an incomplete medical record for the patient. Findings: On 11/21/17, an unannounced visit was conducted at the facility to investigate the facility's self-reported incident, related to a patient's death on 11/2/17, received by the California Department of Health on 11/7/17. On 11/21/17, Patient 1, 2 and 3's medical			

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	records were reviewed. Patient 1 was admitted to the AIP1 on 10/28/17 with a diagnosis of psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). Patient 2 was admitted to the Adult In-Patient Unit 1 (AIP1) on 11/2/17 with diagnosis of psychosis. Patient 3 was admitted on 11/2/17 with a diagnosis of unspecified mood disorder (a persistent instability of mood involving numerous periods of depression and mild elation). A review of the "Initial Screening for Self-Harm Potential" document used by the facility to determine level of observation needed for Patient 2 dated 11/2/17 at 5 PM entered by RN 1 indicated the following question: Was there a potentially lethal suicide attempt in the past 72 hours in which the corresponding answer was marked 'Yes". Based on this assessment, Patient 2 was observed every 20 minutes. However, Patient 2 was admitted within the past 24 hours due to a suicide attempt (attempting to cut off penis) and would have met the criteria for constant observation (patient will be in arms reach from assigned staff member). On 6/4/18 at 1:08 PM, an interview was conducted with the Psychiatrist. The psychiatrist stated Patient 2 should have been placed on one to one supervison because he was admitted for wanting to cut off his penis. On 6/4/18 at 1:35 PM, an interview was conducted with the Chief Nursing Officer (CNO). She stated that RN 1 had placed the patient on 20-minute observation however Patient 2 should have been placed on constant			

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	observation 2. The video surveillance of the hallway in front of Room 248 (shared room of Patients 1, 2 and 3) on 11/2/17 from 9 PM to 9:15 PM was viewed with Chief Nursing Officer (CNO) and with the hospital's video consultant. The video reflected that no in-person observation was made at 9 PM in Room 248 however, staff documented on the Head Count document (form used to document the wherabouts of individual patients) that an in-person observation was made at 9 PM. From 8:45 PM to 9:14 PM, there was no staff observed going inside the shared room of Patients 1, 2 and 3. On 5/23/18, at 12:12 PM, an interview was conducted with the CNO. She confirmed the shared room of Patients 1, 2 and 3 were observed with no staff supervision from 8:45 PM to 9:14 PM on 11/2/17. Review of the hospital's head count form dated 11/2/17, showed Mental Health Worker 1 (MHW 1) documented the following: at 9 PM, Patient 1 was in the dayroom and Patients 2 and 3 were in their shared room. On 5/23/18, at 1:05 PM, an interview was conducted with MHW 1. MHW 1 stated he started doing rounds about 8:50 PM. He stated Patient 1 was in the dayroom at 8:55 PM and Patient 3 was not asleep. MHW 1 documented on the rounding form that an in-person observation was made at 9 PM however the video reflected that no in-person observations were made at 9 PM. Documentation on the head count document was not consistent with observations during video review. The Policy titled, "Rounds for Patient Observation" revised 9/2015 indicated the			

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	patient will be assessed regarding their ability to maintain personal safety (suicide, homicide, assault) every 20 minutes with an attachment titled, "24 Hour Special Precautions List". However the "24 Hour Special Precautions List" (which included a column to assess for suicide, homicide, and assault) was not used to document the patient observations. The "Head Count" Form was used and only documented the location of the patient. Therefore, the patient was not assessed for suicide, homicide, assault or other unsafe behaviors every 20 minutes. 3. On 5/23/18 at 1 PM, an interview was conducted with Mental Health Worker 1 (MHW 1). He stated that a staff member called for help in the hallway at 9:30 PM on 11/2/17. Patient 1 was in Room 248 on the bed. RN 3 performed the first set of chest compressions on Patient 2. RN 1 used the Ambu bag (used to deliver air to the patient's lung through a mask). MHW 3 stated he alternated with RN 3 and RN 1 to do chest compressions until the paramedics arrived. When asked were there any notes to document CPR, MHW 1 stated he did not document CPR because he thought the charge nurse had documented. On 5/23/18 at 1:56 PM, an interview with the CNO was conducted. She stated that the facility should have a CPR policy however she was unable to provide a CPR policy. On 5/23/18, at 4:10 PM, an interview was conducted with the CRN. She stated that she heard a fight in the hallway at 9:25 PM on 11/2/17. The CRN ran out of the nursing station and toward Patient 2 and Patient 3 fighting. Both patients were separated. As the CRN was walking back to the nursing station she was called to Room 248 by another staff member. Upon entering Room 248, the CRN found Patient 1 laying on the floor with a			

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	bloody nose, bruise face and bruises around both eyes. The CRN stated Patient 1 was unresponsive. She further stated she checked the carotid pulse, there was no pulse. CRN checked the femoral pulse and there was a faint pulse. She started CPR with assistance from RN 1, RN 2, RN 3 and MHW 1 until paramedics arrived. The CRN stated that she did not document when CPR was initiated, ventilation was started or when the paramedics arrived. She further stated that RN2, the nurse assigned to the patient, should have documented the incident. On 5/23/18, at 4:20 PM, an interview was conducted with the RN 2. She stated she saw Patient 3 hitting Patient 2 at 9:30 PM on 11/2/17. Both patients were separated. She asked Patient 3 the reason he was fighting. Patient 3 responded that Patient 2 is trying to kill him like he did to Patient 1. RN 2 further stated that Patient 2 would not allow Patient 3 to leave the room so Patient 3 hit him. As Patient 3 told this story to RN 2, she found Patient 1 on the floor in Room 248 unresponsive. RN 2 stated RN 1 and the CRN performed chest compressions. RN 2 stated that she did not document when CPR was initiated, ventilation was started or when the paramedics arrived. She stated her last entry was at 8 PM when she offered snacks to Patient 3. RN 2 further indicated that she would need to do a late entry to include CPR. On 5/23/18, a copy of the report (Case no. 2017-08040) from the Department of Medical Examiner-Coroner was received from the facility. The document revealed the following: Cause of Death: "Asphyxia, due to or as a consequence of neck compression". The Coroner's Report also stated that according to the Detective on 11/2/17 at 9:30 PM, one of the roommates was awaken by			

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	some noises in the room. In the low light, the roomate was able to see the other roommate strangling Patient 1. The roommate left the room and alerted the staff. The suspect left the room and washed his hands. The Police Department Officers responded to the scene. The Fire Department responded to the scene and initiated resuscitative measures. Patient 1 failed to respond to treatment and death was pronounced on 11/2/17 at 11:09 PM. Officers arrested the suspect. Therefore, the facility failed to implement one to one supervision and provide a safe environment for patients identified as danger to self or others. The above violations presented an imminent danger to the patient and were a direct cause of the death of the patient.			

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