

*P.O.C. accepted  
S.C. 2/25/16*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/06/2015
NAME OF PROVIDER OR SUPPLIER St. Mary Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Linden Ave, Long Beach, CA 90813-3321 LOS ANGELES 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: CA00363083 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 17030, 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: 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>T22 DIV5 CH1 ART3-70213. Nursing Service Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff.</p> <p>T22 DIV5 CH1 ART3-70413. Basic Emergency Medical Service, Physician on Duty, General</p>			

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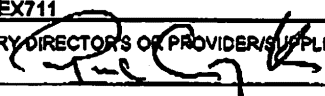
2/10/2016

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

TITLE

(X6) DATE



*COO*

*2-24-16*

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 8

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>Requirements.</p> <p>(a) Written policies and procedures shall be developed and maintained by the person responsible for the service 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.</p> <p>(k) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff</p> <p>Based on record review and interview, the facility failed to implement its policy and procedure on Suicide Risk Assessment and Precautions by failing to assess Patient A using the "Suicide /Self Harm Assessment Tool" which included assessing the patient's "elopement risk" and "suicide ideation" in order to place Patient A on suicide precautions. Although Patient A was identified with suicidal ideation, his "Suicide/Self Harm Assessment" did not indicate he was assessed for risk for elopement from the Emergency Room and did not reflect he had suicidal ideation. Patient A's physician was not notified that Patient A was assessed as moderate risk for suicide. Patient A eloped from the Emergency Room and committed suicide by jumping off the facility's parking garage after he left the Emergency Room. As result, Patient A died of multiple blunt trauma from the fall.</p> <p>Findings:</p> <p>On July 24, 2013, an unannounced visit was</p>		<p>Policy PC.050, Suicide Risk Assessment &amp; Precautions and Policy RI.003.1, Patient Elopement were revised by Emergency Dept. Management and Risk Mgmt to include re-assessment criteria and required communication among the ED team.</p>	07/29/13

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NAME OF PROVIDER OR SUPPLIER  St. Mary Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Linden Ave, Long Beach, CA 90813-3321 LOS ANGELES COUNTY		
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	<p>conducted at the facility to investigate a facility reported incident regarding Patient A's suicide.</p> <p>A review of the "Rapid Medical Screening" record of the Department of Emergency Medicine, dated July 20, 2013, at 1:51 p.m., indicated Patient A "walked-in" to the Emergency Room (ER) of the hospital to request medication for HIV (Human Immunodeficiency Virus) (a retrovirus that causes the acquired immunodeficiency syndrome, a progressive failure of the immune system allows life-threatening opportunistic infections and cancers to thrive). The Rapid Triage Patient Progress Record indicated Patient A eloped at 3:25 p.m. on July 20, 2013.</p> <p>During an interview with Employee 1 (chief operating officer) on July 24, 2013 at 9:15 a.m., Patient A walked out of the Emergency Room after MD 1 had talked to him in the Emergency Room. According to Employee 1, Patient A committed suicide by jumping off the facility's parking garage after he eloped from the Emergency Room at 3:25 p.m. on July 20, 2013.</p> <p>During a telephone interview with MD (Medical Doctor) 1 on August 1, 2013 at 10:07 a.m., she stated after she talked to Patient A, she went to the computer to check information on the patient's recent hospitalization around 3:05 p.m. on July 20, 2013. MD 1 stated while she was looking at the computer, she saw Patient A leaving the gurney in the hallway by the nursing station and walking away from the Emergency Room. MD 1 stated Patient A did not think he needed HIV medications</p>		<p>Inservice was completed by ED management for ED RN's regarding the revised policy and the importance of team communication for high risk patients.</p> <p>Follow-up monitoring to prevent recurrence: A sampling of emergency department records will be reviewed to monitor the compliance with <i>Policy PC.050, Suicide Risk Assessment &amp; Precautions</i>.</p> <p>Data will be tracked, trended, analyzed, and reported monthly to the Performance Improvement Department, and quarterly to the Patient Safety Committee, Quality Council, Medical Executive Committee, and Community Board.</p> <p>Responsible Parties: ED Nursing Director ED Medical Director</p>	08/21/13  Ongoing

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	<p>and Patient A told him that he was going home. According to MD 1, RN 2 did not notify her that Patient A had been assessed as moderate risk for suicide.</p> <p>During an interview with Registered Nurse (RN) 1 on July 24, 2013 at 9:30 a.m., Patient A was in Room 2 and was moved in a gurney to Hallway L by the nursing station. RN 1 stated Patient A was placed on "line of sight" observation in Hallway L at 3:05 p.m. on July 20, 2013. According to RN 1, she saw MD 1 talking with Patient A and that she was supposed to monitor Patient A.</p> <p>A review of the "Rapid Medical Screening" record documented by RN 2, at 3 p.m. dated July 20, 2013, indicated "Pt (Patient) told PA(Physician Assistant) positive SI (Suicidal Ideation), Form filled out, Pt with unorganized thts (thoughts), Says not suicidal then yes, charge RN (Registered Nurse) notified."</p> <p>The "Rapid Triage Patient Progress Record" dated July 20, 2013, 3:10 p.m., completed by RN 3, documented that Patient A talked to the voices telling him to kill himself.</p> <p>The "Suicide/Self-Harm Assessment Tool" dated July 20, 2013 at 3:15 p.m., completed by RN 2, indicated Patient A's suicide risk score was "7." The "Suicide/Self-Harm Assessment Tool" dated July 20, 2013, indicated for the score of "7," the patient should be monitored at least every 15 minutes and should notify the physician. For the score between 3 and 8, the patient will be placed</p>		<p>The <i>Suicide/Self-Harm Assessment Tool</i> was revised to include High and Low risk criteria to be used in scoring the 'Elopement risk' section. Additionally, the form was revised to include a repeat assessment must be done by an LIP or clearance by a psychiatrist before removal of precautions or discharge for any patient with Moderate or High Risk.</p>	07/29/13

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	<p>on moderate risk precautions. There was no documentation the physician was notified of Patient A's suicide risk score/status.</p> <p>The "Suicide/Self-Harm Assessment Tool" dated July 20, 2013, under the "11 Key Factors," indicated "elopement risk" and "suicidal ideation" were part of suicide assessment for Patient A. However, on this Assessment Tool, Patient A was scored "0" for "suicide ideation," and there was no documentation that Patient A was assessed for "elopement risk."</p> <p>During an interview with RN 2 on July 24, 2013 between 10:22 a.m. and 10:35 a.m., she stated she did not notify the physician about Patient A's suicide risk score. According to RN 2, she failed to assess the "elopement risk" for Patient A.</p> <p>According to the facility policy and procedure titled, "Suicide Risk Assessment &amp; Precautions" revised April 2012 (Policy#: PC.050), a suicide assessment is an assessment that included an evaluation of the patient's thoughts, feelings, and behaviors relating to hurting oneself and the ER staff are to utilize the "Suicide/Self-Harm Assessment Tool" for this purpose. The facility's Suicide/Self-Harm Assessment Tool indicated the suicide assessment score between 3 and 8 means placing the patient on moderate risk precautions. The suicide precautions for moderate risk means observation every 15 minutes.</p> <p>The policy also stipulated that patients considered</p>		<p>Inservice was completed by ED management regarding the revised tool.</p> <p>The ED medical staff reviewed and approved revised tool.</p> <p>Follow-up monitoring to prevent recurrence: A sampling of emergency department records will be reviewed to monitor the compliance with completing the <i>Suicide/Self-Harm Assessment tool</i>.</p> <p>Data will be tracked, trended, analyzed, and reported monthly to the Performance Improvement Department, and quarterly to the Patient Safety Committee, Quality Council, Medical Executive Committee, and Community Board</p> <p>Responsible Parties: ED Nursing Director ED Medical Director</p>	<p>8/21/13</p> <p>8/5/13</p> <p>Ongoing</p>

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	<p>at risk for suicide require continuous observation in an environment where special precautions for suicide risk are taken. An order for suicide precautions will be written by the physician. Patients at risk for suicide, who are on suicide precautions, are not allowed to leave the department for tests and procedures unless accompanied by the sitter/observer.</p> <p>Based on the "Suicide/Self-Harm Assessment Tool" dated July 20, 2013 at 3:15 p.m., the suicide risk score for Patient A was "7" (moderate risk precautions for suicide), and the patient should be monitored at least every 15 minutes, and ER staff should notify the physician.</p> <p>During a telephone interview with RN 2 on March 6, 2015 at 2:58 p.m., she stated the "elopement risk" for Patient A should have been either "2" (high risk) or "1" (moderate risk). RN 2 further stated the "suicide ideation" for Patient A should have been "4" (moderate risk). According to RN 2, the suicide risk score for Patient A would possibly be "10" (high risk precautions for suicide) which indicated the ER staff should monitor the patient by direct observation and notify the physician about the high suicide risk.</p> <p>The "Rapid Triage Patient Progress Record dated July 20, 2013, at 3:25 p.m., indicated Patient A eloped after MD 1 examined the patient. It also noted Patient A had disorganized thoughts and Patient A told MD 1 that he wanted to go home and sleep.</p>			

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	<p>The Emergency Department Report, dictated by MD 1 on July 20, 2013 at 4:28 p.m., indicated while MD 1 was looking at the electronic medical record and in visual sight of Patient A, 15 feet away, Patient A got up, started to walk out of the emergency department down the hallway. MD 1 told Patient A to wait, and Patient A stated he would go home and get some sleep. Fifteen minutes later, MD 1 was told by a passerby in the parking area that someone had been seen falling, possibly from the facility's parking structure. The police were called and MD 1 and another physician went out, saw the patient was already deceased and noticed that it was the same patient who had just eloped from the facility's emergency room. The physician's initial assessment of Patient A included history of hearing voices, possible psychiatric disorder (unspecified), and had recent treatment for pneumonia.</p> <p>According to the "Preliminary Examination Report - Field" in the "Autopsy Report," dated July 20, 2013, the decedent (Patient A) was found lying on supine (face up) position on concrete sidewalk in Location A at 3:35 p.m., on July 20, 2013. The "Medical Report" of the "Autopsy Report" signed by the Coroner's Investigator dated July 21, 2013, indicated a suicide and Patient A died as a result of multiple blunt trauma.</p> <p>The facility's failure to implement its policy and procedure on Suicide Risk Assessment and Precautions by failing to assess Patient A using the "Suicide /Self Harm Assessment tool" which included assessing the patient's "elopement risk"</p>				

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	<p>and "suicide ideation" in order to place Patient A on suicide precautions, is a deficiency that has caused, or 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 1280.1.</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>			

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