

*PDL - acceptable*  
*8/26/15 EC/KM*

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CA930000072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KAISER FOUNDATION HOSPITAL - LOS ANGELES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4867 SUNSET BLVD LOS ANGELES, CA 90027</b>
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E 000	Initial Comments  The following reflects the findings of the Department of Public Health during a complaint investigation.  Complaint Intake Number CA00415401  Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.  Representing the Department of Public Health: 28851, Pharm. D., Pharmaceutical Consultant 32022, Pharm. D., Pharmaceutical Consultant	E 000		
E1530	T22 DIV5 CH1 ART6-70577(a) Psychiatric Unit General Requirements  (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.  This Statute is not met as evidenced by: Based on interviews and records review, the facility failed: 1. To ensure Patient (PT) 1 receive the least restrictive restrain possible. PT 1 received walking restraint (wrists and ankles restraint that allow limited movement of the limbs, a type of physical restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others) and 4-point locked restraint	E1530	<p>RECEIVED AUG 24 AM 8:17 HEALTH FACILITIES ADMINISTRATION</p> <ol style="list-style-type: none"> <li>Policy Application and Management of Restraints were reviewed and Revised on 04/2015 (Attachment # 1)</li> <li>All staff training provided on the revised restraint policy including           <ul style="list-style-type: none"> <li>Requirements</li> <li>Patient rights</li> <li>Responsibilities</li> </ul> </li> <li>All Staff training provided includes application and removal of restraints, Monitoring and care of patients. (Attachment#2, 3 and 4).</li> <li>All Staff training provided with competency exam and return Demonstration (Attachment # 3, 4).</li> <li>All RNs training provided include seclusion and restraint RN competency training and exam. (Attachment# 7 and 8)</li> </ol>	04/2015  08/2014 Annually  08/2014 Annually  08/2014 Annually  12/2014 Annually

Licensing and Certification Division  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*M. Hospital Clinical Director*  
 TITLE  
*Beibin*  
 (X6) DATE  
**8/18/2015**

California Department of Public Health

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E1530	<p>Continued From page 1</p> <p>(bed restraint, a type of physical restraint that would lock patient's wrists and ankles to a bed) simultaneously. As a result PT 1 had overlapping uses of walking and bed restraints on 6/30/2014.</p> <p>2. To ensure the reasons for the use of restraints on PT 1 were based on current event and descriptions of the actual behavior.</p> <p>3. To ensure the computerized order entry interface did not allow standing order information for restraint orders.</p> <p>Findings:</p> <p>1. On 11/26/2014, a review of the clinical records revealed PT 1 was a 29 year-old male. He was admitted involuntarily for danger to others. His diagnosis included but not limited to schizoaffective disorder and substances dependence. PT 1 also had multiple psychiatric hospitalizations prior to this admission.</p> <p>A review of the clinical record, "Order Review" for PT 1, dated 6/30/14, revealed restraint orders for six walking restraints and 4-point locked (Velcro bed) restraints. PT 1 received one of the walking restraint orders at 12:33 p.m., and a 4-point locked restraint at 2:50 p.m.</p> <p>A review of the progress notes by MD 2, dated 6/30/14, at 2:52 p.m., indicated that PT 1 was placed in 4-point restraints because he threatened to harm others.</p> <p>A review of the "Multi-discipline Progress Notes", dated 6/30/14 at 3:15 p.m., indicated a "Face to Face" assessment conducted 3:15 p.m. and that "...The patient's immediate situation is: patient continues with walking restraints".</p>	E1530	<p>6. All qualified RN training provided includes competency for one hour face to face evaluation with competency exam. (Attachment# 9, 10 and 11)</p> <p>7. Training confirmation sheet (Attachment# 12)</p> <p>8. Nursing Assistant Manager will Conduct concurrent review of every episodes of restraint and seclusion to ensure compliance. (Attachment#5)</p> <p>9. The concurrent review of every episodes of restraint and seclusion use started Sept, October and November 2014 and ongoing. (Attachment# 6)</p> <p>10. Mental Health Center (MHC) will maintain 90% or greater compliance of the audit MHC will continue monitoring and will report to Quality on a quarterly basis. Responsible Person: MHC Nursing Director</p>	<p>12/0214 Annually</p> <p>08/2014 On going</p> <p>08/2014 On going</p> <p>11/2014</p> <p>09/2014 On going</p>
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E1530	<p>Continued From page 2</p> <p>During an interview, on 12/16/14, at 2:37 p.m., Staff Educator (SE) recalled the incident that led up to the 4-point restraint on 6/30/2014. SE indicated that PT 1 went into the bathroom and slammed his head against the wall. Staff escorted PT 1 to seclusion room. SE then instructed staff to put on the bed restraints.</p> <p>During record review with MD 2 on 12/16/2014 at 2:50 p.m., MD 2 confirmed that PT 1's bed restraint order overlapped with the walking restraint order.</p> <p>During an interview on 12/16/2014 at 2:50 p.m., ADMIN 2 confirmed that PT 1 had walking restraints on while in a bed with bed restraint for about 30-45 minutes. ADMIN 2 further stated there was a mistake that the Staff Educator told the staff to keep the walking restraints on while executing the bed restraint.</p> <p>During an interview, on 12/16/14, at 3:30 p.m., STAFF 1 recalled the incident on 6/30/2014 and stated that PT 1 was verbally abusive and physically abusive. STAFF 1 also stated PT 1 was already on walking restraints when nurses put on the bed restraints in the seclusion room. STAFF 1 further stated it was around 3 p.m., a nurse on the evening shift saw PT 1 on 8-point restraints (combining the four points, wrists and ankles, from walking restraints and the four points from bed restraints), got upset, and called the supervisors. STAFF 1 thought the 8- point restraint (both walking and bed restraints together) were on PT 1 for approximately one hour.</p> <p>A review of the "Multi-discipline Progress Notes", dated on 6/30/14 at 4:30 p.m., indicated "Patient was observed in 4 point Velcro bed restraints at</p>	E1530		
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*[Signature]* 8/18/2015

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E1530	<p>Continued From page 3</p> <p>the start of the shift ... "</p> <p>A review of the "Multi-discipline Progress Notes", dated on 6/30/14 at 5:30 p.m., indicated "Patient removed from 4 point Velcro bed restraints ... "</p> <p>During another interview on 12/16/2014 at 4:05 p.m., ADMIN 2 added that the facility investigation identified that staff recognized it was incorrect to use both bed and walking restraints on PT 1. However, they did not bring it up or question the instruction from the staff educator.</p> <p>A review of the facility policy and procedure number 3008, titled "Application &amp; Management of Restraints &amp; Seclusion", dated 7/13, indicated, "...Restraints shall be discontinued at the earliest possible time ... A physician's order for behavioral restraints/seclusion must ...reflect the least restrictive manner possible."</p> <p>2. A review of the clinical records revealed PT 1 had five walking restraint orders on 6/27/2014 at 3:45 a.m., 5:45 a.m., 10 a.m., 3 p.m., and at 7:15 p.m.</p> <p>A review of the "Patients' Rights subject to denial for good cause" patient notification form dated 6/27/2014 at 3:13 a.m., revealed the explanation for behavioral restraints was due to a "history of violent aggressive behavior." Another such form timed at 5:55 a.m., revealed the same explanation and "along with previous attacks on staff".</p> <p>A review of the order comments dated 6/27/2014 at 3:45 a.m., 5:45 a.m., and 7:15 p.m., revealed "continue walking wrists and ankles restraints due to unpredictable violent behavior."</p>	E1530		
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E1530	<p>Continued From page 4</p> <p>A review of progress note dated on 6/27/2014 at 4:51 a.m. revealed "the patient's behavior is very unpredictable due to symptoms of his illness. During the night shift minimal opportunity was available to observe these symptoms but these were observed on the previous shift."</p> <p>A review of the clinical records revealed PT 1 had six walking restraint orders on 6/30/2014 at 12:46 a.m., 4:18 a.m., 9:28 a.m., 12:33 p.m., 6:33 p.m., and at 10:31 p.m.</p> <p>A review of progress note dated on 6/30/2014 at 12:34 a.m. revealed "patient is asleep ...walking restraints renewed for another 4 hours due to patient established pattern of unpredictable aggressive and self-injurious behavior." Another note on 6/30/2014 at 4:06 a.m. revealed "patient is mostly asleep ...remains on restraints due to established pattern of unpredictable violent behavior ... " Another progress note on 6/30/2014 at 8:30 a.m. revealed "patient is very unpredictable with a history of intrusive, violent and aggressive behavior. Most recent episode of violence is on 6/23/2014 and 6/25/2014 ... Due to patient recent physical aggression and history of violence and physically injuring a staff on every admission ...needs to continue walking restraints." Similar verbiages also appeared on later progress notes at 12:30 p.m.</p> <p>A review of the clinical record, "Order History", dated 7/1/14 to 7/31/14, indicated that 28 out of 65 restraint orders commented on the use of a walking restraint based on PT 1's history or in anticipation of aggressive behavior. There was no documentation of what the patient did that initiated the use of physical restraints or the continuation of restraint orders.</p>	E1530		
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E1530	<p>Continued From page 5</p> <p>On 7/1/14 at 1:55 a.m. and 5:41 a.m., 7/2/14 at 7:09 p.m. and 10:46 p.m., 7/3/14 at 2:44 a.m., 6:53 a.m., 11:12 a.m., 2:47 p.m., and 3:53 p.m., and 7/26/14 at 5:04 p.m. and 9:08 p.m., the restraint order comments indicated, " Apply legal physical restraint orders, continuous ...due to patient's recently established pattern of unpredictable aggressive and self-injurious behavior."</p> <p>On 7/27/14 at 1:04 a.m., 5:27 p.m., and 9:21 p.m., 7/28/14 at 5:27 p.m. and 9:12 p.m., 7/29/14 at 12:57 a.m. and 4:50 a.m., 7/30/14 at 12:53 a.m., 4:55 a.m., 5:27 p.m., and 9:07 p.m., and 7/31/15 at 1:01 a.m., 4:49 a.m., 5:00 p.m., and 9:00 p.m., the restraint order comments indicated, " ...[order for walking restraints] ...due to patient's (re)established pattern of aggressive and unpredictable behavior."</p> <p>On 7/27/14 at 8:58 a.m. the order comments indicated, " ...patient remains unpredictable, highly aggressive and assaultive towards staff without provocation ... "</p> <p>On 7/27/14 at 1:05 p.m., the restraint order comments indicated, " ...patient is labile, highly aggressive, and unpredictable. Patient has recent history of assaultive behavior. "</p> <p>A review of the facility policy and procedure number 3008, titled "Application &amp; Management of Restraints &amp; Seclusion", dated 7/13, indicated, "The use of a restraint shall not be based on an individual's history or in anticipation of dangerous behavior ...restraints shall be discontinued at the earliest possible time, or when the initiating behavior is no longer present or less restrictive alternatives are effective. "</p>	E1530		
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E1530	<p>Continued From page 6</p> <p>3. A review of the facility policy and procedure number 3008, titled "Application &amp; Management of Restraints &amp; Seclusion", dated 7/13, indicated "standing orders for restraint or seclusion are strictly prohibited."</p> <p>A review of the PT 1's computerized restraint orders executed on 7/2/2014 revealed four walking restraints orders that were scheduled to start at 7:15 p.m. Two of those orders, placed on 7:01 p.m. and 7:09 p.m. respectively, indicated "standing order information" with continuous interval. Furthermore, on the same date of service, there were six other walking restraints orders (scheduled to start at 2:15 a.m., 5:45 a.m., 10:30 a.m., 2:15 p.m., and 11 p.m.) and one bed restraint order (scheduled to start at 5:45 p.m.) that contained the same "standing order information".</p> <p>On 12/16/2014, during an interview, MD 2 stated that each restraint episode should have a restraint order.</p> <p>At 4:15 p.m., during an interview, ADMIN 2 agreed that the computerized order interface was outdated and confusing.</p>	E1530		
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E1560	<p>T22 DIV5 CH1 ART6-70577(j)(5) Psychiatric Unit General Requirements</p> <p>(5) Record of type of restraint including time of application and removal shall be in the patient's medical record.</p> <p>This Statute is not met as evidenced by: Based on records review and interview, the</p>	E1560	<p>1. Application and Management of Restraints were reviewed and revised on 04/2015. (Attachment#1)</p>	04/2015
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E1560	<p>Continued From page 7</p> <p>facility failed to ensure its staff documented the time of restraint removal in Patient (PT) 1's medical record for thirty-five counts out of at least one hundred and eight episodes of documented restraints.</p> <p>Findings:</p> <p>On 12/16/2014 at 1:30 p.m., the surveyor reviewed the clinical records of PT 1 with MD 2. During a concurrent interview, MD 2 confirmed that PT 1 had a new telephone order on 6/30/2014 at 12:45 p.m. for a walking restraint (wrists and ankles restraint, a type of behavioral restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or others). MD 2 stated that when she visited PT 1 at around 2:50 p.m. on 6/30/2014, PT 1 had walking restraints on. However, MD 2 could not confirm when the walking restraints were removed.</p> <p>A review of the clinical records revealed a form titled "Patient's Rights Subject to Denial for Good Cause". The form indicated "documentation shall take place immediately whenever a right has been denied or a restriction imposed". The form also indicated the date and time a restraint imposed and removed. However, the record for the walking restraint order episode imposed on 6/30/2014 at 12:45 p.m. was not located.</p> <p>A further review of 108 counts of the above mentioned records presented by the facility, dated from 6/23/2014 to 8/18/2014, indicated 35 counts out of 108 records did not have a walking restraint removed time recorded.</p> <p>A review of the facility policy and procedure</p>	E1560	<ol style="list-style-type: none"> <li>2. All staff training provided on the revised restraint policy including <ul style="list-style-type: none"> <li>- Requirements</li> <li>- Patient rights</li> <li>- Responsibilities</li> </ul> </li> <li>3. All Staff training provided includes application and removal of restraints, Monitoring and care of patients. (Attachment#2, 3 and4).</li> <li>4. All Staff training provided with competency exam and return demonstration (Attachment # 3, 4).</li> <li>5. All RNs training provided includes seclusion and restraint RN competency training and exam. (Attachment# 7 and 8)</li> <li>6. All qualified RN training provided includes competency for one hour face to face evaluation with competency exam. (Attachment# 9, 10 and 11)</li> <li>7. Training confirmation sheet (Attachment# 12)</li> </ol>	<p>08/2014 Annually</p> <p>08/2014 Annually</p> <p>08/2014 Annually</p> <p>12/2014 Annually</p> <p>12/2014 Annually</p> <p>08/2014 On going</p>
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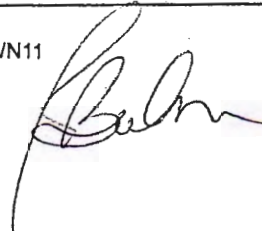


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E1560	Continued From page 8  number 3008, titled "application & management of restraints & seclusion", dated 7/13, indicated a physician's order for behavioral restraints/seclusion must be time-specific, with a maximum time limit of 4 hours for adult patients. The policy also indicated at the discontinuation of restraints and seclusion, the RN (registered nurse) shall document the removal of the restraint in the medical record.	E1560	8. Nursing Assistant Manager will conduct concurrent review of every episodes of restraint and seclusion to ensure compliance. (Attachment# 5)	08/2014 On going
E2145	T22 DIV5 CH1 ART7-70737(a) Reporting  (a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require.  This Statute is not met as evidenced by: Based on records review and interview, the facility failed to report a psychiatric patient elopement (a patient leaves the facility without staff or physician knowledge). Patient (PT) 3 suffered cuts on his extremities during his elopement. Law enforcement retrieved and	E2145	9. The concurrent review of every episodes of restraint and seclusion use started Sept, October and November 2014 and ongoing. (Attachment# 6)  10. All MHC Psychiatrist provided and Educated with new revised Policy: Restraint And Management of Restraint CMS interpretative guidelines A061-A024 including appropriate S&R orders. 08/13/2015. (Attachment #5)  11. Notify electronic medical record staff to correct the verbiage in MD order for Restraints. MD order set were corrected. (Attachment#14)  12. Mental Health Center (MHC) will maintain 90% or greater compliance of the audit  13. MHC will continue monitoring and will report to Quality on a quarterly basis. Responsible Person: MHC Nursing Director	11/2014  08/2015  07/2014  09/2014 On going  09/2014 On going



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E2145	<p>Continued From page 9</p> <p>returned PT 3 within four hours of the elopement. This incident was not reported to the Department.</p> <p>Findings:</p> <p>On 11/26/2014, a review of the clinical records revealed PT 3 was a 25 years old male. He was admitted involuntarily for agitation and psychosis. His admitting diagnosis included but not limited to schizoaffective disorder, substances dependence, and schizophrenia. PT 3 also had multiple psychiatric hospitalizations prior to this admission.</p> <p>A review of the facility document revealed that PT 3 was absent without leave (AWOL) while staff performed behavioral rounds (a process for nursing staff to account for the whereabouts and safety of each patient on the inpatient psychiatric units at the facility) on all patients in the unit on 6/19/2014 at approximately 3:41 p.m. PT 3 apparently broke off the toilet bowl cover in the bathroom. PT 3 then used the fixture to strike the wall and created a hole underneath a window in his room. PT 3 was able to leave his room through the hole, go outdoors, and leave facility premises unnoticed. The facility notified law enforcement who later returned PT 3 to the facility's care almost four hours after the AWOL.</p> <p>During an interview on 11/26/14 at 1:40 p.m., Admin 1 confirmed that the elopement had not been reported to the Department or the Department of Mental Health. The incident was only reported to the facility's Risk management per facility's policy.</p>	E2145	<p>1. Policy Elopement/Absent Without leave Revised 8/2015 (Attachment # 15)</p> <p>Risk Director and AREL Director Shall notify regulatory agency as appropriate</p> <p>Risk Manager and Quality Manager notified of Policy Elopement/ Absent without leave Revision. 8/13/2015</p>	08/2015
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*[Handwritten Signature]*  
8/18/2015