State of California-Health and Human Services Agency
California Department of Public Health

TOMAS J. ARAGON, M.D., Dr.P.H.
*Director and State Public Health Officer*

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APR D 4 2022

GAVIN NEWSOM
*Governor*

**REQUEST FOR PLAN OF CORRECTION FOR DEFICIENCIES**

March 24, 2022 **CERTIFIED MAIL**

Administrator
Sempervirens
720 Wood St.
Eureka, CA 95501

Dear Administrator:

On 03/11/2022, an exit conference was conducted regarding deficiencies found during an abbreviated survey for complaints CA00766920 and CA00765522, as well as, Facility Reported Incidents CA00758260, CA00763802 AND CA00756552 to this hospital to determine compliance with federal certification requirements as a provider of health care services.

This survey found the following deficiencies:

[ ] State deficiencies - noncompliance with state licensing regulations.

[X] Standard-level deficiencies - noncompliance with one or more of the standards that make up each condition of participation for hospitals.

[X] Condition-level deficiencies - any deficiency that substantially limits the provider's or supplier's capacity to furnish adequate care or which adversely affects the health or safety of patients.

CONDITION OF PARTICIPATION NOT MET IN 483.13 PATIENT RIGHTS with Immediate Jeopardy (IJ) identified at 3:51 PM on 12/09/2022 for 482.13(c)(2) and Immediate Jeopardy (IJ) removed at 3:35 PM on 12/21/2022.

The enclosed form, entitled "Statement of Deficiencies and Plan of Correction" documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR) and/or Title 22, California Code of Regulations (CCR).

A plan of correction (POC) must be submitted on the enclosed "Statement of Deficiencies and Plan of Correction" form. CDPH will not accept the POC on attachments. The POC must be developed for all deficiencies and returned to the California Department of Public Health (CDPH) within **ten (10) Calendar days** of receipt of the "Statement of Deficiencies and Plan of Correction". A rebuttal of a deficiency is not a plan of correction. The hospital administrator or appropriate individual must sign and date the POC before returning it to CDPH.

**Plan of Correction (POC)**

The plan of correction for each deficiency listed must contain the following:

A. The corrective action to be taken for each individual affected by the deficient practice, including any system changes that must be made;

B. The position of the person who will monitor the corrective action and the frequency of monitoring; and

C. Dates each corrective action will be completed.

CDPH will notify the hospital of the approval or rejection of the submitted POC. If CDPH does not approve the POC, CDPH may request additional information or a more specific plan. If necessary, CDPH will hold an informal conference with the facility to obtain a satisfactory plan of correction.

By providing a POC, a licensee or designee does not necessarily admit guilt for any alleged violations, nor does this interfere with the right to contest or appeal any alleged violations. If you disagree with any deficiency, you may submit a written request for an informal conference with the district administrator/district manager of this office.

**Allegation of Compliance**

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit.

If you have any questions concerning the instructions contained in this letter, please contact Clara Wu Health Facilities Evaluator Manager I, at 707-576-6775.

Sincerely,

Clarawu

for Dana Forney, HFEM II
District Manager

Enclosure CMS 2567

(OF/rd)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 054124 | A. BUILDING ______<br>B. WING ______ | C<br>03/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SEMPERVIRENS | 720WOODST<br>EUREKA, CA 95501 |

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| A 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during a Facility-Reported Incident (FRI) and Complaints investigation.<br><br>FRI Intake: CA00766920 and CA00765522<br>Complaint Intakes: CA00763802, CA00758260 and CA00756552<br><br>Representing the California Department of Public Health were Health Facilities Evaluator Nurses #12405, #37160, and #40849.<br><br>An IMMEDIATE JEOPARDY (IJ) was identified on 12/09/21 at 3:51 p.m. under Patient Rights: §482.13(c)(2) The patient has the right to receive care in a safe setting, A 144. At 4:56 p.m., Director D, Administrator I, Administrator E and Assistant Director of Nursing (ADON), who were in the conference room, and the Director of Nursing (DON) joined via telephone, were informed that the Immediate Jeopardy was identified<br><br>The IMMEDIATE JEOPARDY was removed on 12/21/21at 3:35 p.m. Administrator I and **ADON** were present in the conference room when the IJ was removed.<br><br>There were 10 sampled patients.<br><br>Three deficient findings were identified for FRI Intake: CA00758260.<br><br>No deficient findings for Complaint Intakes: CA00763802,CA00765522,CA00766920,and CA00756552. | AOOO | | |

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

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. (See instructions.) Except for nursing homes, the findings stated 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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| A 115 | PATIENT RIGHTS<br>CFR(s): 482.13<br><br>A hospital must protect and promote each patient's rights.<br><br>This CONDITION is not met as evidenced by:<br>Based on observations, staff interviews, clinical record review, facility document review, and other documents review, the facility failed to keep suicidal patients safe and free from access to ligature risks (A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.) when:<br><br>1. One of 9 patients (Patient 1) created a ligature from bed sheets and then utilized the bathroom door in his room to hang himself, which resulted in his death (Refer to A 144); and<br>2. One of 9 patients (Patient 2), who was danger to himself, was placed in the environment with ligature risks. The facility identified ligature risk items throughout the facility on 5/23/19. The facility did not address all the risk items including Patient 2's room. This failure had a potential for a patient to commit suicide using ligature points in his/her environment. (Refer to A 144).<br><br>The cumulative effect of this systemic problem resulted in the facility denying patients their right to receive care in a safe setting. | A 115 | | |
| A 144 | PATIENT RIGHTS: CARE IN SAFE SETTING<br>CFR(s): 482.13(c)(2)<br><br>The patient has the right to receive care in a safe setting. | A 144 | | |

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| A 144 | Continued From page 2<br>This STANDARD is not met as evidenced by:<br>Based on observations, staff interviews, clinical record review, facility document review, and other documents review, the facility failed to keep suicidal patients safe and free from access to ligature risks (A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.) when:<br><br>1. One of 9 patients (Patient 1) created a ligature from bed sheets and then utilized the bathroom door in his room to hang himself, which resulted in his death.<br><br>2. One of 9 patients (Patient 2), who was danger to himself, was placed in the environment with ligature risks. The facility identified ligature risk items throughout the facility on 5/23/19. The facility did not address all the risk items including Patient 2's room. This failure had a potential for a patient to commit suicide using ligature points in his/her environment.<br><br>An IMMEDIATE JEOPARDY (IJ-a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more condition level requirements has already caused, is causing, or is likely to cause, at any time, serious injury or harm, or death, to individuals) was identified on 12/09/21 at 3:51 p.m. under Patient Rights: §482.13(c)(2) The patient has the right to receive care in a safe setting. At 4:56 p.m., this surveyor informed the Director D, Administrator I, Administrator E and ADON, who were in the conference room, and | A 144 | | |

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| A 144 | Continued From page 3<br>the DON joined via telephone, about the Immediate Jeopardy.<br><br>On 12/20/21 at 1:41 p.m., the IJ removal plan was accepted, which indicated removing ligature risks inside the patient rooms and shower room and training the staff to ensure they have verbal response and virtual confirmation of patient's condition every 15 minutes while patient is in areas with ligature risks that requires construction.<br><br>During a unit tour on 12/21/21 at 1:40 p.m., Administrator I and the ADON showed how the facility implemented their Plan of Actions. At 3:35 p.m., the IMMEDIATE JEOPARDY was removed.<br><br>Findings:<br><br>1) Review of the facility document titled "Mental Health [Facility address] Safety Meeting 05/23/19" indicated the facility completed a walkthrough and identified ligature risk in the unit which included door hinges. The document did not indicate that sheets and pillowcases were identified as ligature risks.<br><br>Review of Patient 1's 5150 hold document (California law code for the temporary, involuntary 72-hour psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness), dated 10/18/21, at 9:50 a.m., completed by the county's behavioral health social worker, indicated Patient 1 was danger to self (reason of mental illness the person has threatened or attempted suicide or serious bodily harm).<br><br>Review of the County Jail Services, the Progress | A144 | | |

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| A 144 | Continued From page 4<br>Note dated 10/18/21 at 4:06 p.m., Patient 1 attempted to choke himself with his shirt, and he would be transferred from jail to the facility.<br><br>Review of the facility's clinical record, the "Initial Order Sheet" dated 10/18/21, at4:30 p.m., indicated Patient 1's legal status was 5150, and Suicide Precaution level was 2.<br><br>Review of the facility's policy and procedure titled "Suicide/Self Harm" revised dated 7/12/21, indicated Suicide Level 2 Precaution was for patients who have suicidal ideation and required every 15 minutes visual checks for potential self-harm behaviors and interventions to reduce potential.<br><br>Review of Patient 1's clinical record, the Inpatient Admitting Nursing Assessment indicated the facility admitted Patient 1 to the facility on 10/18/21 at 5:51 p.m. and put him in Room C. The reason for his admission was Patient 1 attempted to hang himself in the jail and suffering delusional beliefs. This document indicated Patient 1 stated, "You won't see me here tomorrow. I will be dead at the jail, I know it sounds like I am a lunatic."<br><br>Review of Patient 1's clinical record, the Inpatient Assessment dated 10/18/21 at 6 p.m., indicated Psychiatrist F diagnosed Patient 1 with Unspecified psychosis (when people lose some contact with reality) and Unspecified schizophrenia ( A disorder that affects a person's ability to think, feel, and behave clearly) spectrum and other psychotic disorder, and methamphetamine (also known as meth, crystal meth, crystal, tina, or crank, is a stimulant that produce feelings of euphoria and increased | A 144 | | |

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| A 144 | Continued From page 5<br>energy) use disorder.<br><br>Review of Patient 1's clinical record, the Inpatient Mental Status Exam dated 10/18/21 at 8:33 p.m., indicated Patient 1 had impaired judgement (ability to make considered decisions or come to sensible conclusions), impaired insights (capacity to gain an accurate and deep intuitive understanding of a person or thing) and Patient 1 was not suicidal (thinking of injuring oneself with the intent to die) nor violent.<br><br>Review of Patient 1's clinical record, the Safety Agreement dated 10/18/21, not timed, in which a patient would agree not to harm him/herself or any person while in the facility, indicated a note from the staff stating Patient 1 was too paranoid and agitated to participate in the agreement. The agreement did not have Patient 1's signature.<br><br>Review of Patient 1's clinical record, the Nursing Progress Note dated 10/19/21 at 7 a.m. to 1p.m., indicated Patient 1 reported having anxiety at 11:43 a.m., Nurse G gave Patient 1 Vistaril (anti-allergy medication with approved used for treating anxiety) 50 milligram (mg) and Zydis (treat psychotic conditions such as schizophrenia) 5 mg. Patient 1 denied suicidal ideation and "expressed paranoid delusions about being 'evaluated' for 'organ harvesting." At 12:40 p.m., Patient 1 was found hanging in his bathroom. Facility staff called Code Blue (hospital emergency code used to describe the critical status of a patient if he/she goes into cardiac arrest, has respiratory issues, or experiences any other medical emergency), initiated CPR (Cardiopulmonary Resuscitation - is an emergency lifesaving procedure performed when the heart stops beating), and called 911. | A 144 | | |

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| A 144 | Continued From page 6 | A 144 | | |

Review of the Emergency Medical Services (EMS) report dated 10/19/21, indicated at 12:51 p.m., the EMS personnel arrived at the facility and provided resuscitation for Patient 1 who was unresponsive. At 1:12 p.m., the EMS personnel discontinued the resuscitation.

Review of Sheriff's Office Report, conducted on 10/19/21, indicated Sergeant K investigated Patient 1's incident on 10/19/21 around 1 p.m. The report indicated, "On October 19th staff continued to check on him [Patient 1] every 15 minutes. When staff checked on [Patient 1's last name] at 1200 hours they found him in the small bathroom attached to his room. Staff spoke with [Patient 1's last name] through the bathroom door which was closed. The staff said they had not seen, and had not look for, a knotted sheet at the top of the door." The report indicated Patient 1 had some ligature indentation/mark of his neck. Sergeant K collected the noose; Sergeant K found a top sheet and found one of its edge had been torn away which matched the blue stitching of the sheet that made up the noose. The report indicated, "Through investigation and without evidence to the contrary [Sergeant K] indicated [Patient 1's last name] manner of death as Suicide."

Review of the Office of the Sheriff-Coroner Report dated 10/21/21 at 10 a.m., indicated Patient 1 "died as a result of asphyxia (a condition arising when the body is deprived of oxygen, causing unconsciousness or death; suffocation) due to ligature hanging" on 10/19/21 at 1:12 p.m.

During an interview on 10/28/2021 at 9:00 a.m.,

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| A 144 | Continued From page 7<br>the Director of Nursing (DON) stated that Patient 1 was placed on Suicide Precaution Level 2 precautions (SPL2) and placed in a room closest to the nursing station. The DON stated a patient on SPL2 precautions is checked every 15 minutes by a mental health worker with a visual check. The DON stated that even if the patient is in the bathroom, staff must open the door to the bathroom and visualize the patient.<br><br>During an interview on 10/28/2021 at 10 a.m., Senior Mental Health Worker (SMHW) B stated that Patient 1's room was a standard room with regular bedding. SMHW B stated that she was in the dining room when she heard MHWA asked for help during the incident on 10/19/21.<br><br>During the same interview on 10/28/2021 at 1O a.m., when doing every 15-minute check, SMHW B stated that when a patient is in the bathroom, she knocks on the door and states to the patient •1 need to hear a yes or no or I am coming in." SMHW B stated that the staff must physically look at the patient during every 15-minute check. SMHWB stated that she trained the mental health workers to always get a visual check during every 15-minute check because safety is the most important issue rather than privacy.<br><br>During a tour of the facility unit with concurrent interview on 10/28/2021 at 10:30 a.m., the DON stated that Patient 1's room, Room C, had a camera that allowed visualization of the room at the nursing station, but the camera did not record. The door to the bathroom had been removed but was in place when Patient 1 was in the room. The bathroom door could not be locked from the inside. | A 144 | | |

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| A 144 | Continued From page 8<br>During an interview on 10/28/2021 at 11 a.m., Supervising Psychiatric Nurse (SPN) C stated she was not assigned to Patient 1 on 10/19/2021, but at approximately 12 noon she heard MHWA asked Patient 1 "Are you in the bathroom?" SPN C stated she did not hear Patient 1's response. SPN C then heard MHW A stated **"OK,** I will put your tray down here." SPN C stated that if a staff person gets a response from a patient, it is acceptable to leave a meal tray in the patient's room for that patient. SPN C stated that the staff person must get a full verbal response from the patient; A full sentence is considered a full response. SPN C stated that at approximately 12:15 p.m., MHW A asked her if she had seen Patient 1. SPN C then walked to Patient 1's room. Patient 1's bathroom had a door. The door to the bathroom was closed. SPN C stated that she did not see Patient 1 in the room but saw a pillowcase knotted over the top of the bathroom door. SPN C stated " When I saw the pillow case hanging from the door to the bathroom, I knew what I would find." SPN C stated that when she opened the door to Patient 1's bathroom, Patient 1 fell to the ground. SPN C stated that the pillowcase was loosely around Patient 1's neck, and she did not have to cut it off. SPN C stated that Patient 1 was unresponsive and his lips were blue, but she did not see any marks on his neck. Marks on a patient's neck would indicate strangulation. SPN C stated she called for help and told the first staff person who responded to call 911 and told the second staff person who responded to call a code blue which is an emergency call for assistance from staff. SPN C stated that she started CPR with the staff that responded first. SPN C stated that EMS arrived approximately 10 minutes later and took over CPR. EMS performed CPR for approximately 10 | A 144 | | |

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| A 144 | Continued From page 9 | A 144 | | |

minutes but was not able to revive Patient 1. SPN C stated that EMS called time of death at 1:00 p.m. on 10/19/2021. SPN C stated that she did not write any notes on the incident.

During a review of facility policies on 10/29/2021, the policy titled "Suicide/Self Harm effective" date 6/1/2009 indicated that patients on SPL 2 who will not agree for safety on the unit will have all bed linens removed and be supplied with a safety blanket and mattress only. A safety blanket is a tear resistant blanket that prevents a patient from forming a noose to commit suicide.

During an interview on 12/08/21, at 12:19 p.m., Administrator I stated the facility conducted their own ligature risk assessment on 5/23/19, and the previous hospital administrator led the assessment.

During an interview on 12/09/21 at 10 a.m., Assistant Director of Nursing (ADON) stated MHW A was not available for interview.

During an interview on 12/09/21 at 10:25 a.m., Director D stated Patient 1's mechanism of his suicide risk might have been reduced if the ligature risks, identified on 10/23/19, were addressed.

During an interview on 12/09/21 at 1:40 p.m., ADON stated the facility have no policy and procedure related for a ligature-free environment.

During an interview on 12/09/21 at 1:47 p.m., Nurse H verified she conducted Patient 1's admission assessment. Nurse H stated Patient 1 was in a panic and afraid of terrifying events in his head, had no insight on why he was in jail and

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| A 144 | Continued From page 10<br>admitted h used Meth (addictive drug). Nurse H stated there was a conversation about Patient 1 having a safety blanket; she did not know who decided to have no safety blanket for Patient 1.<br><br>During an email correspondence on 12/15/2021 at 11:49 a.m., the DON indicated that the bedding on Patient 1's bed on 10/19/2021 consisted of a bottom and top sheet, a pillow case, and a blanket. The email from the DON indicated that there was no order for a Safety Blanket for Patient 1.<br><br>During an interview on 12/16/21, at 1:01 p.m., the DON stated the Level 2 precaution meant monitoring patients with visual checks every 15 minutes to make sure patients were safe and doing visual check in the environment.<br>The DON stated safety blanket use would be a prescribed order for patients who were at risk for self-harm; there would be no bedsheet, no pillowcase, only the mattress and the safety blanket.<br><br>When asked if the Patient 1's incident was avoidable, the DON stated, "Absolutely. If we removed the door." The DON stated the process of removing the doors was stucked when orders for new doors were not ADA compliant (refers to the Americans with Disabilities Act Standards designs must be accessible to people with disabilities), and it was stucked there.<br><br>During an interview on 12/16/21, at 2p.m., Psychiatrist F stated Patient 1 was on precaution Level 2 based on Patient 1 denying thoughts of harming himself at the facility. Psychiatrist F stated Patient 1 expressed feeling paranoid about having his organs harvested while in jail. | A 144 | | |

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|---|---|---|---|
| | 054124 | A. BUILDING ______ B. WING ______ | C 03/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SEMPERVIRENS | 720WOODST EUREKA, CA 95501 |

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| A 144 | Continued From page 11<br>Psychiatrist F stated Patient 1 received medications to control his anxiety at night and in the morning before the incident. Psychiatrist F stated there was no documentation about nursing request for a Safety blanket for Patient 1.<br><br>2. Review of the facility document titled "Mental Health [Facility address] Safety Meeting 05/23/19" indicated the facility completed a walkthrough and identified ligature risk in the unit and ligature points inside patient rooms' that included toilet doors hinges, exposed pipes in the toilet, door handle, curtains, and pipes under the sinks.<br><br>During a unit tour observation on 12/08/21, at 9:05 a.m., Patient 2, who had a 5150 hold by being danger to self as indicated in the census, was in Room A<br><br>During an interview on 12/08/21, at 12:19 p.m., Administrator I stated there was "some" work order related to 5/23/19 ligature assessment but work fell off.<br><br>During an interview and safety meeting minutes review on 12/08/21, at 12:19 p.m., the ADON stated there was no ligature risk assessment conducted by a consultant. The ADON provided a copy of the Safety meeting minutes, dated 5/23/19, indicating identified ligature points in the unit and action plans of items that needed to be replaced.<br><br>Review of Patient 2's clinical record, the Activities of Daily Living dated 12/08/21, indicated Patient 2 was on 5150 hold, danger to self, and under Suicide Precaution level 2 monitoring. Patient 2 was receiving every 15-minute monitoring. | A 144 | | |

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| A 144 | Continued From page 12<br>Review of Patient 2's clinical record, the Inpatient record, dated 12/09/21, at 1:07 p.m., indicated Patient 1's primary diagnosis was Delusional disorder, persecutory type (when an individual believes a person or group wants to hurt them. He/She firmly believes this is true, despite the lack of proof.).<br><br>During the unit tour observation, interview, and Safety meeting minutes review on 12/08/21, at 3:42 p.m., with the ADON, Patient 2 was in Room A. The ADON verified there were ligature points identified on Safety meeting minutes on 5/23/19 that were still present in the unit. The ADON verified the following locations had ligatures points:<br>1. Outdoor port- door hinges and door stop<br>2. Patio- 3 sprinklers, glass doors handle<br>3. Dining room- cabinet not secured to the wall, door hinges, faucet<br>4. Rooms A, 8, and C- ceiling vents, exposed pipes at toilet, door hinges<br>5. Hallways- Nurse call system, patient phone cord, safety mirrors hardware<br>6. Day room- hinges, curtains, door handle<br>7. Patient Room 1- door handle, curtain, pipe under sink, hinges<br>8. Patient Room 6- television cabinet hinges, curtain, pipe under sink, hinges<br>9. All other 8 Patient Rooms- curtain, pipe under sink, hinges<br>1O. Shower Rooms- Bench, faucet, towel rack.<br><br>After observations, interviews and record review, the facility was not able to provide evidence they were providing patients a safe environment free from ligature risks. On 09/21 at 3:51 p.m., in the facility, the Immediate Jeopardy was identified. At 4:56 p.m., Director D, Administrator I, | A 144 | | |

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| A 144 | Continued From page 13<br>Administrator E and ADON, who were in the conference room, and the DON joined via telephone, were informed that the Immediate Jeopardy was identified.<br><br>On 12/20/21 at 1:41 p.m., the IJ removal plan was accepted, which indicated removing ligature risks inside the patient rooms and shower room and training the staff to ensure they have verbal response and virtual confirmation of patient's condition every 15 minutes while patient is in areas with ligature risks that requires construction.<br><br>During a unit tour on 12/21/21 at 1:40 p.m., Administrator I and the ADON showed how the facility implemented their Plan of Actions. At 3:35 p.m., the Immediate Jeopardy was removed. | A 144 | | |
| A 273 | DATA COLLECTION & ANALYSIS<br>CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3)<br><br>(a) Program Scope<br>(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ...<br>(2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations.<br><br>(b)Program Data<br>(1) The program must incorporate quality indicator data including patient care data, and other relevant data such as data submitted to or received from Medicare quality reporting and quality performance programs, including but not limited to data related to hospital readmissions | A273 | | |

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| S_EMPERVIRENS | 720WOODST EUREKA, CA 95501 |

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| A 273 | Continued From page 14 | A273 | | |

and hospital-acquired conditions.
(2) The hospital must use the data collected to--
(i) Monitor the effectiveness and safety of services and quality of care; and ....

(3) The frequency and detail of data collection must be specified by the hospital's governing body.
This STANDARD is not met as evidenced by:
Based on interviews and facility record review, the facility failed to track the progress for removing the ligature risks at the facility. This failure resulted to lack of follow up and actions to remove the ligature risks resulting to one patient committing suicide using the ligature points (Reference to A 144 and A 701).

Findings:

During an interview on 12/09/21 at 10:05 a.m., Director D stated he was aware about the ligature risk identified on 5/23/19 Safety meeting minutes and the previous hospital administrator was working on it and making sure the doors were ADA compliance (refers to the Americans with Disabilities Act Standards designs must be accessible to people with disabilities). Director D stated the previous hospital director left on around October/November 2020 and the medical director left around 2018/2019. Director D stated with the key staff leaving and the pandemic, priorities were shifted, and it took another year to find another hospital director.

During a concurrent interview and record review on 12/09/21 at 10:55 a.m., Administrator E stated the facility's Continuous Quality Management (CQI) facilitated Quality Improvement meeting notes monthly including the ligature risks

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| A 273 | Continued From page 15<br>identified in 2019. Administrator E stated she remembered the issue but did not track them because she saw actions were being taken and felt tracking was no longer needed. Administrator E stated there was no set end goal for a ligature-free doors. Administrator E reviewed and verified the ligature risks were not included in CQI meeting agenda from May 2021 to November 2021. Administrator E stated the Hospital Administrator was responsible for following through with the Ligature risk. | A273 | | |
| A 701 | MAINTENANCE OF PHYSICAL PLANT<br>CFR(s): 482.41(a)<br><br>The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.<br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure a safe environment for ten of ten patient rooms and one of two shower rooms. This failure contributed to the suicidal death of one patient (Patient 1) and created potential for self-harm by suicidal patients on the unit. (Reference to A 144).<br><br>Findings:<br><br>Review of the facility document titled "Mental Health [Facility address] Safety Meeting 05/23/19" indicated the facility completed a walkthrough and identified ligature risk in the unit and ligature points inside patient rooms' that included toilet doors hinges, exposed pipes in the toilet, door handle, curtains, and pipes under the sinks.<br><br>During an interview on 12/08/21, at 12:19 p.m., | A 701 | | |

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| A 701 | Continued From page 16<br>Administrator I stated there was "some" work order related to 5/23/19 ligature assessment but fell off.<br><br>During a concurrent interview and safety meeting minutes record review on 12/08/21, at 12:24 p.m., the ADON stated there was no ligature risk assessment conducted by a consultant. The ADON provided a copy of the Safety meeting minutes, dated 5/23/19, indicating identified ligature points in the unit and action plans indicating items that needed to be replaced.<br><br>During the unit tour observation, interview, and Safety meeting minutes review on 12/08/21, at 3:42 p.m., with the ADON, there were ligature points identified on Safety meeting minutes that were still present in the unit. The ADON verified the following locations had ligature risks:<br>1. Outdoor port- door hinges and door stop<br>2. Patio- 3 sprinklers, glass doors handle<br>3. Dining room- cabinet not secured to the wall, door hinges, faucet<br>4. Rooms A, B, and C- ceiling vents, exposed pipes at toilet, door hinges<br>5. Hallways- Nurse call system, patient phone cord, safety mirrors hardware<br>6. Day room- hinges, curtains, door handle<br>7. Patient Room 1- door handle, curtain, pipe under sink, hinges<br>8. Patient Room 6- television cabinet hinges, curtain, pipe under sink, hinges<br>9. All other Patient Rooms- curtain, pipe under sink, hinges<br>1O. Shower Rooms- Bench, faucet, towel rack.<br><br>During an interview on 2/09/21 at 10:05 a.m., Director D stated he was aware about the ligature risk identified on 5/23/19 Safety meeting minutes | A 701 | | |

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| **SEMPERVIRENS** | **720WOODST**<br>**EUREKA, CA 95501** |

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| A 701 | Continued From page 17<br>and the previous hospital administrator was working on it and making sure the doors were ADA compliance.<br><br>During an interview on 12/09/21 at 1:40 p.m., ADON stated the facility have no policy and procedure related for a ligature-free environment.<br><br>During an interview on 12/09/21 at 2:59 p.m., Manager J stated her role was to oversee building maintenance of the facility. Manager J stated there was a request to change bathroom doors in October 2019, and it was determined the supposed replacement doors where not ADA complaint back in January 2021, so the project did not move forward. Manager J stated there was no request made to address the patient bathrooms. Manager J stated she did not remember any request made to address the toilet fixtures, ceiling, and faucet at this time. | A 701 | | |