PLAN OF CORRECTION

NAME OF FACILITY Sempervirens (SV) Psychiatric Health Facility	**NAME OF ORGANIZATION** Humboldt County Mental Health	**REVIEW DATE:** June 25, 2019
LICENSE NUMBER 10 16 0037	**LICENSE EXPIRATION DATE** 1/31/2022	BIENNIAL REVIEW
MHP Contact: Paul Bugnacki, DHHS Behavioral Health Deputy Director and Interim Hospital Administrator pbugnacki@co.humboldt.ca.us Phone: (707) 362-0610 720 Wood Street Eureka, CA 9550	**TELEPHONE NUMBER** (707) 268-2900	**COUNTY** Humboldt
POC REVISION DUE DATE: November 30, 2020 (approved extended due date) **Please see Revisions made in Section 77101:"Types of Restraints and Seclusion", in green font, pages 4-7.** **Please see Response to DHCS 12/3/20 communication from Juliet Chou in blue font, pages 8-10**	**POC REVISION TO BE SUBMITTED TO:** email address mhlc@dhcs.ca.gov	**Date Notification of revised POC received:** October 23, 2020 **Date POC Sent:** November 25, 2020 **Date Notification of non-approval of the revised POC:** December 3, 2020 **Date updated revised POC Sent:** February 24, 2021

Identified Deficiency	Specific Corrective Actions taken / Preventative Measures	Responsible Party / Position Title	Monitoring Process / Frequency of Monitoring / Responsible Individual(s)	Date of Implementation and / or Completion
ARTICLE 3 BASIC SERVICES				

77061. Staffing				
REPEAT DEFICIENCY 77061(h)(1): S PHF has a licensed capacity of sixteen (16), and the facility is required by regulations to provide a minimum of five (5) FTE licensed nursing (LN) staff, five (5) mental health workers {MHWs), and two (2) licensed mental health professionals (LMHPs) for coverage in a 24-hour period. The licensee is in violation of section 77061 (h)(1) because an interview with administrative staff and a review of staffing schedules and executed time cards for the months of April, May and June of 2019 indicated that the facility did not meet the minimum staffing requirements for LMHPs, as required in this section of the regulations. The licensee is required to provide two (2) LMHPs in a 24-hour period when the census is between eleven (11) and sixteen (16); however, the facility failed to meet the requisite number of LMHPs on duty within a 24-hour period in three (3) months reviewed as follows: 1. (1 out of 30 days = 3% out of compliance): April 6, 2019 2. (3 out of 31 days= 10% out of compliance): May 26, 27, 28, 2019 3. (7 out of 30 days= 23% out of compliance): June 1, 8, 15, 16, 22, 23, and 24, 2019	The MHP will improve the process for creating staffing calendars to assure that minimum staffing requirements are met on a daily basis. Process: 1. Create staffing calendar for the month 2. One week prior to beginning of each month, the SV PHF Analyst reviews staffing calendar to assure the minimum staffing requirements for LMHPs are met. This includes maintaining a daily Census and LMHP Staffing Log that indicates the SV census for each day, and the names of assigned LMHPs on duty within a 24 hour period. This log serves as a tool to monitor and assure the minimum staffing requirements are met on a daily basis (see attached template). 3. In the event of an unforeseen staffing shortage; clinicians assigned to the Mobile Response Team (MRT) serve as back-up. Shift supervisor or designee notifies Administrator on Call who will contact MRT program staff and assure coverage as needed. 4. If MRT staff are unavailable; Administrator on call will utilize the On-Call list of MH Clinicians (LMHPs) from other programs and assure coverage. With regards to failing the staffing ratio requirement in June 2019, the MHP would like to note that one SV clinical staff became licensed as LCSW on May 30, 2019. Therefore, during	SV MH Clinician SV Administrative Analyst Shift Supervisor or designee Hospital Administrator	The SV PHF Administrative Analyst will keep the Census and LMHP Staffing Log up to date. The Administrative Secretary will add a review of this tool to the agenda for the SV Management Team meeting. Review is to occur quarterly and will include identifying and resolving any issues surrounding staffing schedules and staffing requirements for LMHPs.	7/1/20 ; then ongoing October 2020 (first report for previous quarter)

	the month of June, the MPH was out of compliance for 4 out of 30 days (=13% out of compliance): June 16, 22, 23, and 24, 2019).			
ARTICLE 4 ADMINISTRATION				
77101. Types of Restraints and Seclusion				
DEFICIENCY 77101 (a): The licensee is in violation of section 77101 (a) because a review of one (1) patient health records and seclusion and restraint incidents and confirmed by an interview with the Administrator/Clinical Director indicated that the facility placed patients in "restraint chair" which is not an approved method of seclusion and restraint in a psychiatric health facility and had not been approved by the State Fire Marshal. The order dated December 8, 2018 indicated the use of "Restrain chair." **REQUIRED CORRECTIVE ACTION:** The intent of the regulation specified in this section and title 9, sections 860 through 865.5 is to provide clients with sufficient safeguards and protections and to ensure denial of client rights is not to be used as punishment, for the convenience of the staff, or as a substitute for less restrictive, alternate forms of treatment. Any denial of a patient's rights shall meet applicable statutory and regulatory requirements. For this reason, the facility administrator should work collaboratively with the local patient's rights advocate in formulating appropriate policy and in- service training to ensure that all nursing staff, physicians, and nurse practitioners are familiar with denial of rights regulations and	The MHP uses a safety chair, which is an approved type of mechanical restraint. The safety restraint chair may be used by Crisis Prevention Institute (CPI) certified staff to provide safe transport from other areas in the facility and containment of a patient exhibiting violent or uncontrollable behavior and to prevent self- injury or injury to others when other control techniques are not effective. Use of the safety chair require an order by a Physician and face to face evaluation by a Physician/NP/PA or trained RN within one hour, along with documentation and review required just as with all other restraint procedures. The conditions for its use are described in SV policy 0200.0806 Seclusion and Restraints (attached), including the process for denial of rights. Additionally, policy 0200.1204 Patients' Rights (attached) outlines SV patient's rights and processes around denial of rights.		Form 2028 Patient Denial of Rights Monthly Tally and the SV Denial of Rights S&R Log are used to record and monitor any denial of rights during incidents of S&R. This log is reviewed daily by the Assistant Director of Nursing and Supervising Nurse. Staff receive training on policy 0200.0806 Seclusion and Restraints as part of the onboarding packet upon hire, and is set in the Relias eLearning Management System to recur annually. Training completion is tracked in Relias. Staff Training completion is reported into SV CQI quarterly. Any issue of non-compliance will be addressed through the QI Tracking process as outlined in policy 0704.940. Form QI-55	Daily / ongoing

comply with them. The governing body shall adopt and implement written policies regarding patients' rights to ensure compliance with this section of the regulations.			"Quality Improvement Tracking" will be used to identify the issue, and to track corrective actions all the way through resolution.	
All physical restraints with locking devices used or available for use in the S PHF shall be approved by the State Fire Marshal.	On March 13, 2020, SV PHF passed a fire inspection which included inspection of the safety chair and approval of its use by the local fire authority (see attached annual fire inspection report). On April 28, 2020, the Integrated Clinical and Administrative Information Systems core work group (ICAIS CORE) reviewed and approved a modification to form 2037 (Physician Seclusion and /or Restraint Orders) in Avatar (the MHP's electronic Health Record) in order to better capture the use of the bed, chair, and other types of restraints. Specifically, a checkbox for Mechanical Restraint will be added and the number or restraint points will be documented on the form.	Fire Authority Quality Improvement Coordinator in collaboration with IS Programmer / Analyst	Annual Fire Inspections are coordinated with the County Risk Manager and fire marshal	3/13/20 / Annually 5/12/20 (modified in Avatar test environment; see attached screenshot) 6/1/20 (projected implementation date)
Revision 1: Regarding the plan of correction (POC) for Sempervirens PHF onsite review, please confirm and provide documentation indicating that Patients' Rights Advocate has reviewed and approved the Policy and Procedure (P&P) number 0200.0806 titled "*SECLUSION AND RESTRAINT*" (with Revision Date of 5/08/20) submitted as part of this POC.	The MHP continues to evaluate business practices with input from our Patients' Rights Advocate (PRA). We continue to engage the PRA on all junctures concerning Sempervirens. Please see attached evidence: • 10/3/19 email to PRA, requesting input in policy 0200.0806 Seclusion and Restraints	DON, Hospital Administrator, QIC	Policy & Procedures meeting attendance roster, work group meeting invitations, email communications as needed	Ongoing engagement

In addition, please confirm that Patients' Rights Advocate has provided input to Sempervirens PHF on the proper use of "restraint chair", and has provided guidance on staff training in the use of "restraint chair".	• 9/9/2019 P&P committee sign-in list, including PRA • 9/9/19 P&P committee meeting minutes showing SV policies on agenda • 11/13/20: email response from PRA providing input in policy 0200.0806 Seclusion and Restraints and training materials on safety chair instructions • Most recent example is a project on reviewing and updating the SV Work Plan and UR manuals. The PRA is invited to our upcoming second work group meeting.			
Furthermore, update POC (Section 77101 a) to remove Nurse Practitioner and Physician Assistant as NP and PA are not to provide orders for seclusion and restraint as per Title 9 Section 77103 (b).	This section has been removed from Policy 0200.0806 Seclusion and Restraints, with a revision date of 5/8/2020.			
Modify the P&P 0200.0806 "Seclusion and Restraint" as below:	Attached policy 0200.0806 Seclusion and Restraints has been revised on 11/23/20; changes are highlighted in the document. Training on the revised policy has been assigned to staff in Relias eLearning management system. Please see attached course enrollment detail.			
1. Specify that this County of Humboldt P&P applies to Sempervirens "psychiatric health facility".	1. This item was not changed. The term "Affects" in the header of the policy indicates the policy is specific to SV			

2. Specify the location where a restraint chair will be utilized (e.g. inside a room designated for seclusion or restraint).	2. Change made, see policy section 4.1.7.3			
3. Page 3 of 9 shows "2.3 *The Seclusion/Restraint Committee will perform an administrative review of selected S&R events*." Please edit to show that All S&R are to be reviewed. Refer to Health & Safety Code (HSC) 1180.	3. Change made. Practice was already in place.			
4. Page 5 of 9 shows "7.3 *Obtain verbal or written order from the Physician for the procedure prior to implementation or as soon as possible after an emergency implementation of seclusion/restraint and document* ….." Please modify the P&P to show Within one (1) hour. Relevant Section is 77103 (b).	4. Change made.			
5. Page 7 of 9 shows "11.1 *The hospital shall conduct regular training for all staff involved in the use of seclusion and restraints, alternatives, methods of deescalation, and review of systems including review of medications and labs*." Please edit to show "The Psychiatric Health Facility shall conduct ….."	5. Change made.			
6. Page 7 of 9 shows "11.3.8. *The use of first aid techniques and certification in the use of Cardiopulmonary Resuscitation including periodic recertification (Nursing Staff).*" Please edit to show that All PHF staff are to be trained in CPR.	6. Change made.			
7. Page 7 of 9 shows "11.3.9. *All staff that participate in the management of assaultive*	7. This is already stated in 11.2 "Staff will receive annual de-escalation /Crisis Prevention Institute (CPI)			

behavior will demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, providing care for the patient in S&R, and procedures for termination of restraints. Please change to All staff are required to attend MAB annually. Relevant section 77117 (b).	Training and only staff participating in MAB need the competency test. See Revision 1 Update below, pages 9-10			
8. Page 7 of 9 shows "11.4 *Documentation of this training will be maintained by the hospitals Administrative Analyst who will work with the Director of Nursing (DON) or the ADON to ensure compliance*." Please edit to "PHF".	8. Change made.			
9. Page 8 of 9 shows "13.2 *The Hospital Administrator, DON, or designee will report to CMS each death that occurs while a patient is in restraints or seclusion…*" Please edit to "And DHCS".	9. This is now 13.3 in the updated policy, change made.			
10. Page 8 of 9 shows "13.3 The Quality Improvement Coordinator will ensure a process to maintain a database, prepare and distribute reports regarding these occurrences at periodic intervals but not less than quarterly. This information is analyzed and reported on a quarterly basis to the Sempervirens Quality Improvement Committee, Hospital Administrator, Medical Director, Director of Nursing Services, and to the medical staff."	10. Revision of the policy led to some numbering changes. This is now 13.4. Section 13.2. is new language, stating that the Ward Clerk provides quarterly reports to DHCS. See attached report templates: • 1180 Seclusion and Behavioral Restraint (data collection quarterly report tool) • MH 308 (denial of rights county summary)			
Please add in "HSC 1180 reporting requirements". Refer to HSC 1180.3 (c) (1) through (5).	This has been added.			

Revision 1 – Update POC for 77101 a - POC is not ok to approve at this time as "Use of the safety chair require an order by a Physician/NP/PA …" is still inside the revised POC (see page 3 of 15). Furthermore, page 1 of the "Safety Restraint Chair Instructions" says "Use of the safety chair require an order by a Physician/NP/PA …" Pertaining to the requests sent to the facility via our Fri 10/23/2020 email: ○ The Fri 10/23/2020 email requested facility to provide documentation indicating that Patients' Rights Advocate (PRA) has reviewed and approved the Policy and Procedure (P&P) number 0200.0806. However, this PRA's approval of the 0200.0806 P&P does not appear in the Wed 11/25/2020 POC documents.	This sentence has been corrected above in POC for 77101 a and now reads: Use of the safety chair require an order by a Physician and face to face evaluation by a Physician/NP/PA or trained RN within one hour, along with documentation and review required just as with all other restraint. Safety Restraint Chair instructions have been updated accordingly and now read: "Use of the safety chair require an order by a Physician and face to face …" We have also added the brand name "Humane Restraint Emergency Restraint Chair" (which was a PRA recommendation). Please see Attachment 1, Safety Chair Instructions revised). In our previous response, we have demonstrated PRA involvement including her recommendations for P&P 0200.0806 Seclusion and Restraint, as well as Safety Chair instructions. The Director of Nursing (DON) has reviewed the recommendations and subsequently added two of the PRA's recommendations to the policy (see Attachment 4). Many of the PRA's			

○ Page 6 of 15 of the revised POC says "…only staff participating in the MAB need the competency test" instead of All Staff as requested in the Fri 10/23/2020 email.	recommendations were already part of our policy. We are re-sending the PRA recommendations, but this time with DON responses in the document. (Attachment 2). We have a formal approval process for policies in place. New or revised policies are brought to our weekly Policy and Procedures committee. This committee is comprised of Quality Improvement staff, Medical Records, BH Administration, and representatives from clinical programs. The PRA has a standing invite to attend the weekly meetings. Policies are approved by this committee. (See Attachment 3, P&P Meeting invite lists). The PRA has the opportunity to make recommendations for revisions and approve polices during these committee meetings. All direct care PHF staff (PHF personnel, including contracted and temporary staff, assigned to perform direct patient care responsibilities, including but not limited to, licensed nursing staff, physicians, and other licensed independent practitioners (LIPs), physician assistants (PA) and nurse practitioners (NPs), recovery assistants, social services staff, rehabilitative specialists, and dietary staff) receive training. Only staff trained and demonstrating competence may apply S&R. Please see Attachment 4, policy 0200.0806 with these revisions:			

	11.1 All direct care PHF staff shall receive training and demonstrate competence in Crisis Prevention and Intervention (CPI) techniques by a certified Crisis prevention Institute instructor, as part of orientation and subsequently on a periodic basis no less than annually. 11.3.9. Only staff that demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, providing care for the patient in S&R, and procedures for termination of restraints, will participate in the management of assaultive behavior.			
77103. Behavioral Restraint and Seclusion				
DEFICIENCY 77103 (c): The licensee is in violation of section 77103 (a) and Health and Safety Code (HSC) 1180.4 (b): A facility described in subdivision (a) of section 1180.2 or subdivision (a) of section 1180.3 may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. In patient health records that were reviewed, staff documentation, in some instances, to support the use of seclusion and restraint did not	Since the DHCS onsite review in June 2019, the following in-service trainings have been provided to SV staff: Trauma Informed Care (1/8/20; 1/15/20; 1/23/20; 1/29/20) Team Building (1/2/19 MH Clinical Skills Training (8/28/19; 11/6/19) MH Crisis Training (8/20/19; 8/27/19; 9/19/20) Crisis Intervention (8/27/19) MH Clinical Skills Countertransference (9/25/19; 10/2/19; 10/30/19)	Director of Nursing / Assistant Director of Nursing	The Utilization Review (UR) committee meets quarterly. It is part of our utilization review business practice to retrospectively review the use of specific S&R occurrences (e.g. multiple S&R orders during one stay, or S&Rs that were long in duration. This review of S&R orders is a standing agenda item at each UR Committee meeting. The group discusses	Ongoing

meet requirements in this section of the regulations. Documentation did not establish that seclusion and restraint was necessary due to an emergency, or that it was the most effective and least restrictive level of intervention for the patients. Staff documentation in one patient chart regarding orders for restraint and seclusion dated June 21, 2019 states that a patient was restrained for *"Pt started yelling in his room about "some girl that dialed the number...'; he walked to the medication room window and hit it with his fist as he yelled about the "girl"* Another order, for the same patient, dated June 22, 2019, documents the patient was secluded and restrained for *"pt yelling, cursing, threatening staff, pulling and banging phone"* These are inappropriate indications for restraining and secluding a patient. The facility shall ensure that prior to seclusion and restraint, a patient must represent imminent dangerousness; that is, unless restrained, patients will physically harm themselves or others. Patient refusal to follow staff direction or for the convenience of staff on the unit is not the same as imminent dangerousness from which the patient or others must be protected. **REQUIRED CORRECTIVE ACTION** The facility is to provide in-service training to its staff regarding the indications for and the documentation of seclusion and restraint. This type of training is often offered with the consultation of the local patient's rights advocate. The facility may want to consider utilizing that expertise.	These various trainings covered topics such as Inpatient Crisis Prevention Plan, Clinical Practice Guidelines, Counter Transference, Patient-Centered Trauma Informed Care and Restraint Application Competency. Furthermore, SV's Crisis Intervention team (CIT) program was enhanced through monthly team building and de-escalation training. The updated SV Inpatient Documentation Manual was published in September 2019 (see attached QI Bulletin 19-Q010 and SV Inpatient Documentation Manual). Between January 1, 2019 and April 27, 2020, seventy five SV staff completed the Seclusion and Restraints course in Relias. Goal of this training is to understand the principles of prevention of the use of Seclusion and Restraints, and to safely manage behavior in the event that alternative measures have been utilized and are not sufficient to protect the patient and others from injury. The training includes a review of the policy as well as instructions on S&R documentation. It is required for all nursing staff, psychiatrists and Mental Health Workers at Sempervirens as part of their annual training plans. See attached training completion report and training materials. On 5/15/20, the Assistant Director of Nursing was granted Administrator privileges in		alternative methods to help a client and to inform future practice. Additionally, QI staff (with no involvement in direct client care) write up a case study based on documentation review alone in preparation for the UR committee meetings. This case study is discussed with the team, which includes Hospital Administration and Psychiatric Prescribers, at the UR committees meetings. (see attached SV UR Minutes 2020-1-30 and Utilization Review Seclusion and Restraints case study sample) Training activities are assigned and tracked in Relias. Staff Training completion is reported into SV CQI quarterly. Any issue of non-compliance will be addressed through the QI Tracking process as outlined in policy 0704.940. Form QI-55 "Quality Improvement	Ongoing

	Relias in order to be able to verify that the annual competency tests for nurses are being completed. In addition to the existing trainings, the Assistant Director of Nursing collaborated with the Patient's Rights Advocate (PRA) and the Hearings Officer to co-host a Legal and Ethics Training, with CEU credits approved. This training was scheduled to be launched in June 2020, but had to be postponed due to the COVID-19 Public Health emergency. The Patient's Rights Advocate (PRA) is invited to attend Policy and Procedures (P&P) committee meetings wherever SV polices are discussed. The PRA has also proposed and submitted draft policies for review and approval by the P&P committee.	Assistant Director of Nursing / PRA / Hearings Officer	Tracking" will be used to identify the issue, and to track corrective actions all the way through resolution.	Implementation pending lifting of COVID-19 restrictions
77121. Employee Health Examinations and Health Records				
DEFICIENCY 77121 (a): The licensee is in violation of Section 77121(a) because a review of health records for twenty six (26) employees hired since June 6, 2017, revealed four (4) employees did not have initial health exams within six (6) months prior to	Currently, the job class "MH Clinician" does not require an initial health exam for employment in our system, which includes outpatient and inpatient services. Going forward and with immediate effect, all MH Clinicians hired to work			

employment or within one (1) week after employment with SV PHF.	on SV PHF must pass a health exam within six months prior to start date, or within one week after employment with SV PHF. The MHP will collaborate with Employee Services to develop a policy and procedure that reflects this change. In order to ensure timely health exams, staff who transfer from outpatient programs to SV PHF, who passed their initial health exam more than six months prior to employment with SV PHF, must pass a new health exam within one week after employment with SV PHF. The MHP will collaborate with Employee Services to develop a policy and procedure that reflects this change.	Quality Improvement Program Manager and Employee Services Analyst	The MHP is in the process of implementing MD Staff credentialing software. Once implemented, initial health exam dates will be entered into MD Staff by Employee Services. The software has reporting features which will allow us to monitor compliance with the initial health exam requirement. As an alternative, this information could also be captured in the Relias Requirements Tracking feature (QI Analyst or QI Training Clinician).	5/13/20; ongoing 7/1/20
DEFICIENCY 77121 (b): The licensee is in violation of section 77121(b) because a review of twenty six (26) new employee health exams indicated four (4) employees did not have an initial health exam that included a tuberculosis (TB) screening within six (6) months prior to employment with S PHF.	Per policy 0205.134 Employee Health, Immunization and Communicable Disease Screening, SV staff will be screened for tuberculosis on hire. Humboldt County's DHHS Public Health department conducts the PPD screenings upon hire, and annually for all eligible DHHS employees, which include Behavioral Health staff. This means TB screenings are conducted		Employee Services keeps a TB screening log and sends PPD notifications for annual due dates to staff and their supervisors (see attached PPD Annual Renewal Notice). Additionally, the Behavioral Health Annual Performance Review	Upon hire / annually

	separate from the initial health exams. During the hiring process, form DHHS-21 EOF 'Employment Opportunity Form' (attached) communicates to Employee Services that a potential new hire will be required to have PPD testing done. Employee Services then initiates the testing process. According to our Employee Services files, all 26 employees reviewed during the audit had documentation that PPD testing was completed. The evidence was provided to DHCS following the June 2019 audit.		checklist includes proof of TB screening. It requires employees to submit documentation of the completed screening to their supervisor at that time (see attached Required Employee Document Checklist).	
77129. Fire and Internal Disasters				
REPEAT DEFICIENCY 77129 (c): The licensee is in violation of section 77129 (c) because a review of the facility's Fire and Internal Disaster Drill records for calendar year 2018 revealed the licensee failed to conduct drills for the following quarters and shifts: Year: 2018 | Quarter: 4th | Drill: Fire | Shift: AM/PM	The MHP ensures that each shift conduct their own fire drill. The shift supervisor initiates the drill. In the absence of a supervisor the Assistant Director of Nursing conducts the drill. The SV Administrative Secretary schedules the quarterly fire drills for each shift and sends an outlook meeting for each drill to: the Hospital Administrator, the Director of Nursing, the Assistant Director of Nursing, the Shift Supervisor and the Hospital Administrator's Administrative Analyst. Sign-in sheets for each drill are logged and kept in the Hospital Administrator's electronic files, and in a binder. They are emailed to the Behavioral Health Director's Administrative Analyst and the	Shift Supervisor / Assistant Director of Nursing Admin Secretary	Fire and Internal Disaster Drill records are reported quarterly into the SV CQI (Continuous Quality Improvement committee) / Administrative Analyst. See attached sample SV CQI minutes and report and most recent Safety Committee minutes. Any issue of non-compliance will be addressed through the QI Tracking process as outlined in policy 0704.940. Form QI-55 "Quality Improvement Tracking" will be used to identify the issue, and to	Ongoing

	Hospital Administrator's Administrative Analyst. Reminder emails are being sent out to the Hospital Administrator, the Director of Nursing, the Assistant Director of Nursing, the Shift Supervisor and the Hospital Administrators Administrative Analyst.		track corrective actions all the way through resolution.	
77141. Health Record Content				
DEFICIENCY 77141 (a)(10)(D): The licensee is in violation of section 77141(a)(10) (D) because a review of order dated December 8, 2018 for restraint indicated the use of "Restrain chair" as type of restraint instead of indicating type of restraint as "mechanical restraint" or "physical restraint" as defined by Health and Safety Code (HSC) Section 1180.1. HSC Section 1180.1 defines mechanical restraint as *"the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body or restricts normal access to the person's body, and that is used as a behavioral restraint."* HSC Section 1180.1 defines physical restraint as *"the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint."* Physical restraint "is any staff-to-person physical contact in which the person unwillingly participates."	The MHP has updated form 2037 'Physician Seclusion and/or Restraint Orders' with additional checkboxes that clarify the type of restraint used. On 4/28/20, the Integrated Clinical and Administrative Information Systems core work group (ICAIS CORE) reviewed and approved the modification to form 2037. The modified form now captures the use of the bed, chair, and other types of restraints. Specifically, a checkbox for Mechanical Restraint has been added and the number of restraint points is also documented on the form. The Information Systems team will built the revisions into Avatar electronic Health Record.	Director of Nursing Information Systems Programmer / Analyst		5/12/20 (modified in Avatar test environment; see attached screenshot) 6/1/20 (projected implementation date)

ADDENDUM HEALTH AND SAFETY CODE SECTION 1180.4				
DEFICIENCY HEALTH AND SAFETY CODE SECTION 1180.4 (a) (1-5) and (j): The licensee is in violation of HSC section 1180.4 (a) (1) through (5) because the licensee was not able to provide documented evidence of advance directive as defined by 1180.4 (a) for an incident of seclusion and restraint on December 8, 2018.	The MHP has implemented policy 200.0579 Inpatient Crisis Plan (attached). Upon admission, or as soon thereafter as possible, the patient or someone the patient desires to be present (e.g. a family member, significant other, authorized representative) is asked to provide input into their advance directive regarding de-escalation or the use of seclusion or behavioral restraints. Patient input may include information about their triggers, warning signs and coping strategies that can assist the treatment team in the development of strategies and approaches to avoid the use of seclusion and restraint. The Patient attests to the fact that although these techniques have been identified, they may not be used if they will compromise their safety or the safety of others. This information is captured on Form 2107 Inpatient Crisis Prevention Plan (attached).	Director of Nursing	Policy 0200.0402 Discharge Audit (attached) lines out a continuous process to ensure review and completion of all required documentation and communicating pertinent information to the treatment team. Discharge Audits are performed on all patients by nursing staff each night shift. Night shift staff provide a patient report to the treatment team daily. The patient identified interventions are added to the patient's Master Treatment Plan 2056 (attached) after being discussed with the daily treatment team.	Daily / ongoing
The licensee is in violation of HSC section 1180.4 j) because the order for restraint dated December 8, 2018 did not indicate the number of points to be utilized during the restraint. Without this information, the reviewer was not able to validate that the least number of restraint points was used as required.	Director of Nursing will update Policy 0200.0806 Seclusion & Restraints to indicate that documentation of mechanical restraints must include the number of restraint points (e.g. 5-point restraint). The number of restraint points will be documented on form 2037 'Physician Seclusion and/or Restraint Orders' when using the Safety Chair.	Director of Nursing	Form QI-96 SV RN Documentation Monitoring has been updated to indicate the number of restraint points utilized during the restraint (section VIII S&R item E., attached) Results of the SV RN Documentation	5/8/20: 0200.0806 S&R Policy revision completed 5/18/20: revised 0200.0806 S&R policy scheduled to be reviewed

			Monitoring activities are reported into SV CQI quarterly. Any issue of non-compliance will be addressed through the QI Tracking process as outlined in policy 0704.940. Form QI-55 "Quality Improvement Tracking" will be used to identify the issue, and to track corrective actions all the way through resolution.	and approved at Policy and Procedures committee 6/1/20: updated policy will go into effect and will be posted on the DHHS Bulletin page
ADDENDUM HEALTH AND SAFETY CODE SECTION 1180.5				
DEFICIENCY HEALTH AND SAFETY CODE SECTION 1180.5 (b) (2) through (4): The licensee is in violation of HSC section 1180.5(b) (2-4) because the licensee was not able to provide documented evidence of staff debriefing for a seclusion and restraint incident dated December 8, 2018.	Director of Nursing will update Policy 0200.0806 Seclusion & Restraints to include a process for staff debriefing after incidents of seclusion and restraints. The Assistant Director of Nursing (ADON), Supervising RN or Staff RN will review the SV Denial of Rights/Seclusion and Restraint Log each day and initiate a staff debriefing with all involved staff as soon as possible following the procedure to determine patient management strategies to avoid future incidents. The review will be documented on the Sempervirens Staff Debriefing Tool (attached).	Director Of Nursing	The Staff Debriefing Tool is part of the audit tools used for S&Rs. It is reviewed daily by the Supervising RN, and four times per week by the Infection Control Preventionist.	5/8/20: 0200.0806 S&R Policy revision completed 5/18/20: revised 0200.0806 S&R policy scheduled to be reviewed and approved at Policy and Procedures committee 6/1/20: updated policy will go into effect and will be posted on the DHHS Bulletin page