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A BEE EXCLUSIVE - Patient mistreatment at Sierra Vista

# Troubled hospital expanding

*Lapses in care cited in at least three deaths since 2000*

***By Todd Milbourn, Bee Staff Writer***

The $8 million structure rising behind a south Sacramento psychiatric hospital offers concrete proof of the facility's determination to become the region's largest destination for people in mental health crisis.

Yet Sierra Vista Hospital has one of California's worst patient mistreatment records, with 111 violations since 2004, ranging from understaffing to lax drug controls and failures to protect patients from violence, according to hundreds of pages of government inspections and court records reviewed by The Bee.

Such lapses are blamed for at least three patient deaths since 2000, most recently Steven Grant Burton, a Camino man who collapsed in his room Feb. 17 after the hospital failed to provide the respirator he needed while sleeping, according to a federal report obtained last week by The Bee.

Burton's widow, Vickie, said she's baffled regulators would even consider allowing construction of a new wing -- adding 48 beds to the current 72 -- in light of Sierra Vista's history.

"How many more families will have to go through this?" she asked during a tearful interview at the office of her attorney, who is planning a wrongful death lawsuit.

The fate of Sierra Vista Hospital's expansion rests with multiple government agencies -- each with different oversight responsibilities.

The Sacramento City Planning Commission reviews compliance with environmental and planning requirements. Last year, it endorsed the addition to the Bruceville Road facility.

But the hospital cannot treat patients in the new wing without approval from the state Department of Public Health, which has yet to receive an application. The health department will take into consideration "recent compliance history," said

Kathleen Billingsley, deputy director of the department's Center for Healthcare Quality.

That history includes two $25,000 state fines in the past four months for jeopardizing the lives of patients -- including Burton. Of California's 147 licensed acute psychiatric hospitals, Sierra Vista is the only one to have received that penalty, the harshest for negligent care under a new 2007 law.

Hospitals such as Sierra Vista serve those deemed an immediate threat to themselves or others, many of them suffering from schizophrenia or suicidal tendencies. Advocates are dismayed at the prospect of admitting additional vulnerable patients to an already troubled facility.

"This is a public health emergency," said Laurel Mildred, executive director of the California Network of Mental Health Clients. "And to have them getting even bigger, it just goes to show how patchwork the oversight is."

A Sierra Vista spokesman declined to comment, and a spokesman for the hospital's parent company, Psychiatric Solutions Inc., would not discuss specific cases.

Corporate President Joey Jacobs did assure investors during a 2006 conference call that Sierra Vista remained top-notch.

"We have an absolutely strong team at that facility, and they are delivering great care there," Jacobs said, according to a transcript. He added that the regulatory scrutiny has "not impacted our growth strategy on the beds there whatsoever."

**Long history of complaints**

Since 1986, Sierra Vista has occupied a one-story brick building off Highway 99, across the street from the Kaiser Permanente complex. Psychiatric Solutions bought the hospital in 2005.

Based in Tennessee, Psychiatric Solutions is one of the country's largest psychiatric hospital chains, ranked 49th on Fortune Magazine's list of 100 fastest-growing companies last year. It owns 101 facilities nationwide and six in California, including Heritage Oaks Hospital on Auburn Boulevard.

(Heritage Oaks has been cited twice since 2004, compared with Sierra Vista's 111 violations. Sutter Center for Psychiatry on Folsom Boulevard -- Sacramento's only other acute psychiatric facility -- had seven violations, according to a state data run.)

Despite its troubles with the state, plus a pair of threats from Medicare to cut off its funding, Sierra Vista has consistently received passing marks from the Joint Commission on the Accreditation of Healthcare Organizations. The commission,

an industry-funded agency, conducts inspections every three years on behalf of the federal government.

Those inspections are unannounced, but Leslie Morrison of Protection & Advocacy Inc. -- a statewide patient rights group -- said most hospitals know when they'll occur and can "throw together a quick fix."

Sierra Vista's poor record with state inspectors, whose visits are complaint-driven, dates at least to 1991. That year, inspectors found so many staffing, record-keeping and quality-of-care problems that they recommended shutting the place down. The hospital remained open by promising to fix the problems.

Over the next 17 years those problems repeatedly resurfaced, records show, with few consequences for Sierra Vista.

**Violence and abuse reported**

Among state inspectors' chief concerns has been the hospital's failure to protect patients from abuse, such as the 2001 case of a male patient attacking a female patient with multiple sclerosis four times before facing repercussions.

Inspectors found the hospital failed to protect Teresa Garcia, who, during a group therapy session in 2005, was stabbed in the neck with the sign-in pen by another patient. According to Garcia's pending lawsuit, the assailant was a two-time felon who had made prior threats at Sierra Vista and told psychologists he liked to carry knives "just in case." Her suit claims he should not have been allowed in a group setting.

A state inspection in September 2006 found that the hospital's own medical health technician had provoked a 17-year-old into fighting and then slammed the teenager's head into a wall, causing a cut that required four staples. The report also revealed a nurse had slapped a 13-year-old patient suffering from depression after he refused to go to bed.

Both employees had been fired before inspectors arrived.

The 2006 report documents how a nurse ridiculed a patient who repeatedly complained of abuse by writing in the patient's medical chart, "If self-pity were money, we'd have a little billionaire here."

During her two stays at Sierra Vista in 2007, Kathy Lund said she complained about orderlies rifling through her belongings and a patient barging into her room and making inappropriate sexual advances.

But instead of taking steps to protect Lund, who suffered from bipolar disorder, hospital officials called her to a meeting and asked: "Are you aware that you've put in five complaints against the staff?"

"It was like they were using that against me -- like I'm not well enough to get out of there because I'm making these complaints," said Lund, 59, a retired Alameda County worker.

**Patients' drugs mishandled**

State inspections show Sierra Vista Hospital repeatedly failed to closely monitor patients' drugs. A 2006 report found the hospital put patients at risk for potentially life-threatening side effects from an anti-psychotic drug, Clozopine, by failing to keep track of patients' blood work.

Hospital workers also gave patients expired drugs and left powerful psychotropic medications unaccounted for, the state reported.

In response, hospital officials pledged that the pharmacist would double-check every prescription that was administered.

Just six months later, however, records show a 29-year-old female patient received such a massive overdose of Zyprexa that 12 hours later she still could not speak and could hardly open her eyes.

State inspectors called the overdose a "system breakdown" and cited the hospital's failure to institute promised drug controls. The mistake resulted in a $25,000 fine, the first-ever against an acute psychiatric hospital under the 2007 law.

"There were no checks or balances to ensure that the medications were given according to physician orders," inspectors wrote. A hospital worker said the tougher oversight never materialized, because "staff do not have time, as they are so busy."

Even after Sierra Vista paid the fine and received a public rebuke, the hospital continued to mishandle the drug. A February investigation, following Burton's death, uncovered a patient who was prescribed 30 milligrams of Zyprexa "nightly at bedtime" -- 50 percent more than what the manufacturer says is a safe dose.

**Short staff, spotty training**

Many of Sierra Vista's troubles stem from inadequate staff and training, records show.

Inspectors in fall 2006 cited a lack of documented training in crisis prevention and basic life support for 12 of 13 employees whose files were reviewed. The report says staffing fell below appropriate ratios during 84 percent of the shifts studied.

Lack of training factored into the death of Ramona Knapp, an Elk Grove woman with bipolar disorder. Knapp, 51, died in 2005 after two staff members tried to restrain her by pinning her face against the hospital carpet. The Sacramento County Coroner's Office ruled the death a homicide, although no criminal charges were filed.

Records show the state attorney general's office declined to press charges because the staff members who restrained Knapp were "never specifically trained" in those methods, so they couldn't be held responsible.

Sacramento attorney Robert Buccola, who is representing Knapp's family in a wrongful death suit, said frequent turnover, spotty training and a workplace culture that stresses cost cutting have turned Sierra Vista into a dangerous environment.

"The written policies and practices at Sierra Vista are, in many ways, very sound. But they don't put them to practice," Buccola said. "They feel they can cut the corners ... save tens of thousands of dollars."

Esmie Branner, a former director of social services at the hospital, echoed that view in a 2005 wrongful termination suit. Branner, who worked at the hospital before Psychiatric Solutions took over, alleged she was routinely asked to release patients who were "costing the hospital money," even those she felt were not ready, to make room for patients with better insurance.

Sierra Vista settled the lawsuit with Branner, and the terms forbid her to speak about the facility. Two other former Sierra Vista employees said they signed similar waivers when they quit but confirmed that controlling costs took precedence.

Georgia Jenkins lives every day not knowing whether more staff or better training could have saved the life of her daughter, Jennifer, who died at Sierra Vista in 2000 at age 16.

By all accounts a bright and vivacious junior at Elk Grove High School, Jennifer arrived at Sierra Vista after saying she heard voices inside her head. She told a nurse that the voices wanted to kill her and that she was afraid she might harm herself.

But records show hospital staff ignored "critical changes" in Jennifer's condition and failed to keep close watch. When the staff wasn't looking, she tied a sheet around her neck and hanged herself from a doorknob.

"Eight years later and I'm still living my worst nightmare," said Georgia Jenkins, who later won a six-figure settlement in a wrongful death lawsuit against the hospital.

**Man died without respirator**

Details about the hospital's actions have been slow to emerge in the death of Steven Burton.

Burton, 55, was El Dorado County's assistant commissioner for agriculture, known by friends as "Dr. Barbecue" for his grilling skills. A drinking problem led his wife to check him into Room 101 at 5:20 p.m. on Feb. 16.

By the next morning, Burton was dead.

The state blamed Sierra Vista for Burton's death and issued its second $25,000 fine in May, but provided few details in a heavily redacted report. The coroner's investigation remains incomplete, although the family's Sacramento attorney, Daniel Wilcoxen, said coroner's officials told him they found high levels of two drugs in Burton's body when he died.

An unredacted version of the state report obtained through the Centers for Medicare & Medicaid Services states that Burton died of cardiorespiratory arrest after hospital officials failed to provide him with a respirator.

In an interview, Vickie Burton said she told hospital admissions that her husband had slept with the machine every night for nearly 15 years, and left the hospital confident one would be provided.

"I put my hands on his face, said 'I love you and I'll see you tomorrow,' " she recalled. "I left him with so much hope."

But the report shows that Sierra Vista admitted Burton even though it did not have the respirator and could not get one elsewhere "because it was a weekend." A Sierra Vista doctor told the investigators that the hospital routinely admitted patients with medical conditions it couldn't treat and "maybe we shouldn't be doing that."

At 4:25 a.m., hospital staff found Burton facedown on the floor, short of breath and "shaking like a leaf."

Although times have been scribbled out and rewritten in the chart, the on-call doctor apparently was paged at 5:30, 6, and 6:35. There is no record of those calls being returned.

At 7:21, an ambulance called by the staff arrived and Burton was transferred to Kaiser Permanente, but it was already too late.

Burton was pronounced dead on arrival at Kaiser, at 7:36 a.m.

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GRAPHIC: Carl Costas / ccostas@sacbee.com

Georgia Jenkins holds a picture of her daughter Jennifer, who died at Sierra Vista Hospital at age 16 after hanging herself from a doorknob. She told nurses that voices wanted to kill her, but records show the staff ignored "critical changes" and failed to keep close watch.

Family photo Steven Grant Burton collapsed in his room at Sierra Vista and died. The hospital failed to provide a respirator, records show.

Nathaniel Levine / nlevine@sacbee.com Sacramento's Psychiatric Hospitals Sierra Vista Hospital is one of three psychiatric hospitals in Sacramento that serve patients in crisis. Along with Heritage Oaks, it is owned by one of the nation's largest psychiatric hospital chains, Psychiatric Solutions Inc.