CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation. Complaint Intake Number: CA00143523 Representing the Department of Public Health: [redacted] Pharm.D, Pharmaceutical Consultant [redacted], HFEN 1280.1(a) HSC Section 1280 If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation. 1280.1(c) HSC Section 1280 For purposes of this section, "immediate jeopardy" means a situation in which the licensee's			

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. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 1 noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY ALPHABETICAL LIST OF ABBREVIATIONS: a.m. - morning (ante meridiem) cc - cubic centimeter mg- milligram ml - milliliter mg/ml - milligram per milliliter IJ - immediate jeopardy p.m. - afternoon (post meridiem) STAT - immediately Based on review of facility and clinical records, and interviews with staff, the facility failed to establish policies and procedures to ensure that current and accurate records were maintained regarding the distribution and use of all federally scheduled			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2 (controlled drugs.) The facility failed to establish a system to accurately monitor the over-ride (drug removal before review by pharmacy) use of controlled drugs from an automated dispensing machine (MedSelect) for Patient 1 resulting in an undetected diversion of controlled drugs and administration of medications that were not prescribed by the physician. For Patient 1, a controlled drug, Ativan 2mg/ml, was withdrawn by Registered Nurse 1 on March 07, 2008 at 10:31 p.m. from the MedSelect using the system over-ride function. However, Patient 1 was not prescribed Ativan 2mg/ml by the attending physician. Patient 1 was also administered additional controlled drugs of Xanax 0.5mg and 2 tablets of Vicodin by Registered Nurse 1 on March 07, 2008 that were not prescribed by the attending physician. Patient 1 experienced a cardiac (code blue) emergency approximately 6 hours later, at 4:15 a.m., on March 08, 2008 and was resuscitated but expired on March 09, 2008 from respiratory failure. On March 13, 2008 at 3:00 p.m., an immediate jeopardy (IJ) was called due to the facility's failure to systematically develop and monitor the over-ride withdrawal of medications such as federally controlled drugs from the automated MedStation. This failure to accurately account for federally controlled drugs resulted in undetected diversions			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 3 as well as a potential failure to protect patients from undue adverse patient outcomes. The IJ was lifted approximately 24 hours later on March 14, 2008 at 3:00 p.m., after onsite confirmation of implementation by observation, interviews, and document review of the facility's corrective action to effect ongoing and retrospective surveillance of the over-ride function use in the automated MedStation by patient care staff. Findings: 1. A record review for Patient 1 on March 12, 2008 revealed a 76 year old female admitted into the medical-surgical floor of the facility on March 06, 2008 with a primary diagnosis of new onset seizure disorder. It was also noted by a review of the admitting physician orders, as well as the listing of medications taken at home, that no controlled drugs or narcotics were prescribed. Further record review on March 12, 2008, of Physician 3's progress note, revealed that on March 06, 2008 at 4:15 a.m., a code blue emergency was initiated because Patient 1 was found unresponsive and not breathing with acute			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 4 respiratory failure. Physician 3 also noted that Patient 1 was given the controlled drug, Xanax, prior to the code blue incident. Patient 1 was successfully resuscitated and then transferred to the cardiac intensive care unit (CICU) on a mechanical ventilator where she expired approximately 4 days later on March 09, 2008 at 5:21 p.m. from respiratory failure. During an interview with Facility Administrator A on March 12, 2008 at 11:30 a.m., it was stated that on March 8, 2008, the House Nursing Supervisor, as well as Registered Nurse 2, were concerned about the nursing actions of Registered Nurse 1 that evening. Specifically, Registered Nurse 2 stated to the House Nursing Supervisor on March 8, 2008 that Patient 1 was calling out for Registered Nurse 1 for help around 11:00 p.m. that evening. Registered Nurse 2 notified Registered Nurse 1 and shortly thereafter, Registered Nurse 2 noticed that Patient 1 was suddenly quiet. A review of Patient 1's medication profile revealed no physician orders up to March 8, 2008 for any controlled drug sedatives, or pain medications such as Ativan, Xanax, or Vicodin. During this same interview on March 12, 2008, it was also stated by Facility Administrator A that while Registered Nurse 1 was on break, around 4:15 a.m., on March 8, 2008, a code blue emergency was called for Patient 1. The House			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 5 Nursing Supervisor observed Registered Nurse 1 immediately return from break to the floor and directly rushed to the automated, MedStation to obtain a vial of Narcan, an antidote for controlled drug, narcotic opiate overdose. The House Nursing Supervisor asked Registered Nurse 1, " What did you give the patient? " and Registered Nurse 1 stated, "Xanax", a benzodiazepine was given. An interview with Facility Pharmacist One on March 12, 2008 at 11:30 a.m., revealed that Ativan 2mg injection was removed by Registered Nurse 1 for Patient 1 on March 7, 2008 at 11:31 p.m., from the automated dispensing machine, MedStation, by using an over-ride function. Facility Pharmacist One also stated that Registered Nurse 1 obtained controlled drugs, Xanax 0.5mg and Vicodin from the MedStation that were prescribed for Patients 3 & 4 who were not assigned to Registered Nurse 1. Pharmacist One and Facility Administrator A stated during this same interview that Registered Nurse 1 admitted during a facility interview, that was conducted on March 11, 2008 at 1:00 p.m., that tablets of both controlled drugs, Xanax 0.5mg and two tablets of Vicodin were given to Patient 1 without an existing physician order but denied administering the Ativan injection to Patient 1. Registered Nurse 1 then stated that the Ativan was given to Patient 36 and he also intended to call Physician 1 to obtain a Xanax order for Patient 1. However, a facility conducted interview with Physician 1 revealed that neither Xanax or Vicodin were to be ordered for Patient 1 and Physician 2			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 6 stated that injectable Ativan was not ordered for his Patient 36. A review of Patient 1's medication administration record revealed that neither the Xanax 0.5mg or Vicodin tablets were charted as administered by Registered Nurse 1. A review of the facility policy for the automated MedStation revealed a procedure whereby licensed care staff could remove selected medications by using an over-ride function before a physician's order was reviewed and entered by the pharmacy department to allow for immediate medications administration such as with "STAT" orders or for control of emergency pain. Included in the facility's list of acceptable over-ride medications were controlled drugs such as codeine, Valium, Ativan, Demerol, Versed, morphine, and phenobarbital. However, further interview with Facility Pharmacist One and Two on March 13, 2008, at 1:00 p.m., revealed no current system in place for the facility to review, in a timely manner, either concurrently or retrospectively, the appropriateness and accuracy of each drug over-ride withdrawal by patient care staff (i.e. federally controlled drugs). A review of facility policy for medication management "3.300" revealed a current procedure			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050231	A. BUILDING _____ B. WING _____	03/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 N. GAREY AVE., POMONA, CA 91767 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 7 whereby, " medications shall be administered only upon the order of a person lawfully authorized to prescribe. " This violation involved the facility's failure to establish policies and procedures for safe and accurate medication use. The facility failed to systematically develop and monitor the over-ride withdrawal of medications, such as federally controlled drugs, from the automated MedStation resulting in undetected diversions as well as a potential failure to protect patients from undue adverse patient outcomes. For Patient 1, a Los Angeles County Coroner's case number of: 2008-02038 and Pomona Police Department case number of: 08-36279 has been assigned. This violation caused, or was likely to cause, serious injury or death to the patients and staff who could be affected by federal controlled drug diversion. The facility systemic practices involving these failures to establish facility policies and protocols also had a potential to affect all patients in the hospital.			

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