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
	050040	A. BUILDING _____ B. WING _____	10/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COUNTY OLIVE VIEW-UCLA MEDICAL CENTER	**14445 OLIVE VIEW DRIVE, SYLMAR, CA 91342 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 the investigation of Complaint No: [redacted] Inspection was limited to the specific complaint(s) investigated and does not reflect the findings of a full inspection of the facility. Representing the Department: [redacted], Health Facilities Evaluator Supervisor. HSC Section 1280.1 (a) 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. c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's 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 T22 DIV5 CH1 ART3-70263(e) Pharmaceutical Service General Requirements (e) There shall be a system assuring the availability of prescribed medications 24 hours a day			

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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.

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	Continued From page 1 This Regulation was NOT MET as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the system for the availability of prescribed medications 24 hours per day was implemented. As a result, [redacted] was not available to the emergency room in appropriate doses for the treatment of Patient #1. Patient #1 died while in the emergency room. Findings: On [redacted] the medical record showed Patient #1 presented to the emergency room on [redacted] after [redacted] The emergency room physician ordered [redacted] to be given; however, the hospital only had three vials on hand. Prior to the administration of any [redacted] the patient had a [redacted] were administered, a hospital staff member was sent to get more [redacted] from a neighboring hospital. The patient's medical record showed the remaining dose (7 vials) of the [redacted] was given approximately one hour after it was ordered by the physician. After the remaining dose of [redacted] was given, the patient [redacted] that could not be sustained. The patient died in the emergency room despite the delayed administration of the full dose of [redacted] ordered by the physician. On [redacted] administrative staff stated that the three vials of [redacted] given to Patient #1 initially, had been obtained by administrative nursing staff from the night locker of the pharmacy. County			

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police were requested to make the run to a neighboring hospital to obtain the other vials, but they refused. A nurse went to get the [redacted] at the other hospital. On [redacted] hospital policies and procedures (P&P) were reviewed. Page 3 of P&P-106 stated the procedure was to call the pharmacist-on-call to come in to dispense drugs needed for immediate use that were not stocked in the night locker.

On [redacted] at approximately [redacted] hours, the Director of Pharmacy was interviewed. He stated the hospital had no pharmacist on-site from 12 midnight to 7 a.m. Pharmacy staff were assigned to be on-call during these hours and administrative nursing staff had access to a night locker. The Director stated based on the "List of Night Locker Drugs," there should have been four vials of [redacted] stocked in the night locker instead of the three found by the nursing staff on [redacted] There was a pharmacist on call; however, the pharmacist was not called for assistance. Hospital documents and pharmacy staff interviews revealed there was an additional 14 vials of [redacted] available in the main pharmacy of the hospital that could have been dispensed by the pharmacist-on-call for administration to Patient #1.

On [redacted] after a review of the care received by Patient #1, the hospital increased the quantity of [redacted] stored in the night locker to the 20 vials recommended by the manufacturer as the appropriate dose for an adult or child in a medical emergency. On [redacted], 20 vials were observed in the night locker refrigerator and an additional 10

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	Continued From page 3 vials were observed in the main pharmacy refrigerator. The violation(s) has caused or is likely to cause, serious injury or death to the patient(s). HSC Section 1279.1(a) (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Based on staff interview and medical record review, the hospital failed to report a medication error for Patient #1 within five days of the adverse event associated with the patient's death. Findings: On [redacted] administrative staff interview revealed Patient #1 presented to the emergency room on [redacted] after [redacted]. The emergency room physician ordered 10 vials of the [redacted] to be given; however, the hospital only had three vials on hand. The patient had a [redacted] While [redacted] efforts were administered, a hospital staff member			

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	Continued From page 4 was sent to get more [redacted] from a neighboring hospital. The patient's medical record showed the remaining dose of the [redacted] was given approximately one hour after it was ordered by the physician. The patient died in the emergency room despite the delayed administration of the full dose of [redacted] ordered by the physician. The hospital reported the adverse event for Patient #1 to the Department on [redacted] This was eight days after the initial five day reporting requirement. HSC Section 1279.1(a) (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Based on staff interview and medical record review, the hospital failed to report a medication error for Patient #1 within five days of the adverse event associated with the patient's death. Findings: On [redacted] administrative staff interview revealed Patient #1 presented to the emergency room on [redacted] after [redacted] of ar[redacted]			

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	Continued From page 5 The emergency room physician [redacted] to be given; however, the hospital only had [redacted] on hand. The patient had a [redacted] While [redacted] efforts were administered, a hospital staff member [redacted] from a neighboring hospital. The [redacted] showed the [redacted] of the [redacted] was given approximately one hour after it was ordered by the physician. The [redacted] in the emergency room despite the [redacted] of the [redacted] ordered by the physician. The hospital reported the adverse event for Patient #1 to the Department on 10/15/07. This was eight days after the initial five day reporting requirement.			

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