STREET ADDRESS, CITY, STATE 2P CODE 1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY SUMMARY STATEMENT OF DEPICENCIES SECULOPROPEROY MUST de PRECEDED BY TULL, PRETIX TAG The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00204312 - Substantiated Representing the Department of Public Health: Surveyor ID # 17108, MEDICAL CONSULTANT The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility, 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: 70233(a) Anesthesia Sentice General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate heath professionals and administration, Policies shall be approved by the governing body, Procedures shall be approved by the governing body, Procedures shall be approved by the deministration and medical staff where such is appropriate. The policies and procedures shall include provision for at least: The above regulation was NOT MET as evidenced by:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB: 050373		(X2) MULT A BUILDIN B WING	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED 04/08/2	
The following reflects the findings of the Department of Public Health during an inspection visit: The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA020204372 - Substantated Representing the Department of Public Health: Surveyor ID # 17103, MEDICAL CONSULTANT The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(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. To233(a) Anesthesia Service General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration, and medical staff where such is approved by the administration and medical staff where such is appropriate. The policies and procedures shall include provision for at least. The above regulation was NOT MET as evidenced Tao Representing actions nad execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.] In response to the deficiencies identified by the California Department of Public Health during their visit to LAC+USC Medical Center on April 8, 2010, the following actions have been carried out to ensure the highest level of patient care that meets the expectations of Health and Safety Code Section 70233 (a) Anesthesia Service General Requirements. Action: To address the observed deficiency outlined in the finding regarding lack of supervision and failure to meet standard of practice in the case of patient A, the following has been done: To determine if the CRNA, Attending	NAME OF PROVIDER OR SUPPLIER LAC+USC MEDICAL CENTER	12	200 NORTH STA	TE STREE		0033 LOS	
of Public Health during an inspection visit: Complaint Intake Number: CA00204312 - Substantiated Representing the Department of Public Health: Surveyor ID # 17108, MEDICAL CONSULTANT The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(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: 70233(a) Anesthesia Service General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. The policies and procedures shall include provision for at least: The above regulation was NOT MET as evidenced	PREFIX (EACH DEFICIE	NCY MUST BE PRECEEDED BY FU	;	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETE
	Complaint Intake Note CA00204312 - Subsequent Intake Note CA00204312 - Intake CA00204314 - Intake CA00204312 - Intake CA00	ring an inspection visit: Jumber: Department of Public Health D8, MEDICAL CONSULTAI D8 Ilmited to the specific facility. Stimited to the specific facility. By Code Section 1280 is section "immediate attention in which the arith one or more required used, or is likely to cause the patient. Stuting Immediate Jeopardy: State Service General Requires and procedures in maintained by the service in consultation the professionals and additional approved by the government of the service in consultation the professionals and additional approved by the actific where such is approperations.	h: NT lity e 0.1(c): For jeopardy" licensee's ements of se, serious rements shall be le person in with other ministration rraing body. dministration oriate. The		plan of correction does not admission or agreement by provider of the truth of the alleged or conclusion set of statement of deficiencies.] In response to the deficiencies.] In response to the deficiencies identified by the California Department of Public Heat their visit to LAC+USC Mc Center on April 8, 2010, the following actions have been out to ensure the highest patient care that meets the expectations of Health and Code Section 70233 (a) A Service General Requirer Action: To address the observed outlined in the finding reg of supervision and failure standard of practice in the patient A, the following here.	constitute y the facts facts orth on the lith during edical ne en carried level of e d Safety Anesthesia ments. deficiency jarding lack to meet e case of	
	I .	lation was NOT MET as	s evidenced		To determine if the CRN	A, Attending	10/30/1

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

CEO, LAC+USC Healthcare Network

04/11/11

Any deficiency statement ending with an attensit (*) benotes 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.

State-2567

Supplied in HEES

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050373		B. WNG		04/08	/2010
NAME OF PRO	VIDER OR SUPPLIER		STREET ADDRESS	CITY, STATE,	ZIP CODE	<u> </u>	
LAC+USC	MEDICAL CENTER	·	1200 NORTH ST ANGELES COUI		T, ROOM 1110, LOS ANGELES, CA 904	033 LOS	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	Based on interviews, record for Patient A review of policies and the surgical staff fails procedures for anest consultation prior to been implemented. (Certified Registered Patient A under consultation by the A had difficulty brear requiring endotrachea significant change in after surgery. Findings: On 5/10/10 review of A showed that Pathospital on 8/25/09 burns involving both and burns to the froundergone two pure debridement and skit A was again schedule elective procedure to an area of the right the right groin. A review of the purified in by CRNA X Patient A had a colours to the extrement to the extrement and the control of the pure statement and a colours to the extrement.	a review of the clo A, a 48 year-old m d procedures from ed to ensure that thesia care and n induction of anes This resulted in I Nurse Anesthet general anesthet supervising physicia athing while under I intubation. This r Patient A's neurole for the treatment a lower and upper nt of the chest. P rior surgical proc in grafting. On 9/1 uled for surgery to p provide a small lower leg, from a re-anesthetic asses and dated 9/10/09, diagnosis of "32% ities and neck,"	nale, and a the hospital, policies and nedical staff sthesia, had a CRNA ist) placing sia without an. Patient anesthesia, resulted in a ogical status of for Patient itted to the of gasoline extremities, atient A had redures for 1/09, Patient undergo an skin graft to donor site in sement form, revealed that Total Body 's/p gasoline'		or Faculty Physician had an negative clinical performance a focused peer review of 30 each was conducted by the Anesthesia services for each provider. No significant tredidentified. Both the Attending Staff and CRNA were counseled in with the Department Chair regal failure to comply with depair policy on Preoperative Evaluand the failure to document appropriate pre-anesthesial assessment. Both the Attending Staff and CRNA were also counseled writing by the Department regarding their failure to confuse the departmental policy on CR supervision and the failure Attending Anesthesiologistheen present at the time of anesthesial and the lack collaboration between the supervising anesthesiologisthesi	ce trends cases Chief of ch nds were d the vriting by rding their rtmental luation t an chair cmply with RNA of the t to have f induction c of	
Event iD:	burns." Patient A was	scheduled for surge	ry to 3/25/2011	2.46	3:40PM		ζ λ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE 04/11/11

CEO, LAC+USC Healthcare Network

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		ļ · ·	PLE CONSTRUCTION	(X3) DATE SURVI	
		050373		A. BUILDIN B. WING	G	04/08/	2010
	OVIDER OR SUPPLIER MEDICAL CENTER		STREET ADDRESS, 0 1200 NORTH STA ANGELES COUN	TE STREE	ZIP CODE T, ROOM 1110, LOS ANGELES, CA 900		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	Continued From page undergo "split thicknet CRNA X wrote: the Patient A had consper day for 40 years (patient with a sign could have impaired deficiencies that continuation impaired general health.	ess skin graft to the "Medical History" rumed 1/2 a pack and he was a "highificant alcohol allower function ald impact wound th.)	evealed that of cigarettes eavy drinker" buse history and vitamin healing and		To facilitate communication the CRNA, residents and supervising attending staff, Department of Anesthesia hissued portable phones to a supervising Anesthesiologis contact numbers are made to all care team members a staff daily.	the nas ill st and available	10/08/10
	The physical examino the medical recomplete airway brong inflammation in the clear to auscultation reflects that the lung of secretions or puring in the stomach, inserting place. The vital signature into the stomach inserting into the stomach, inserting into the stomach into	cord by CRNA X resed secretions" (not chial tubes that airway), and brown on both sides", gs and lower airwateumonia. CRNA resulte, tube placed we through the not size revealed a blook	revealed that bises in the may reflect reath sounds this finding mays are clear moted that a with its tip in use), was in digressure of		Policy: The Department of Anesthe maintains policies of CRNA Supervision and Pre-opera Assessment. Both policies reviewed by the Anesthesis Service and found to meet expectations for safe patie	tive were a Chief of Title 22	
	104/58 mm Hg (milli the range of 120/80 dehydration, a cond patients with burns, minute-this heart rat of approximately 70 100.3 F (Fahrenheit).	This reduced valualition that common a pulse of 122 bp e is above the norm 0-90 bpm) and a te	e may reflect ally occurs in m (beats per nal heart rate		Education: The Anesthesia Departme of CRNA Supervision was to all anesthesia providers transmittal placing specific on required supervision/ documentation of the pre-	emailed with a emphasis	
	The laboratory wor and reviewed by thospital's Pre-Anest 21,200 microliters of gm (grams) Hgb (h (These values reflect white blood cell coun	CRNA X and enter thetic evaluation for f WBC (white bloom moglobin), and Ali that Patient A had	ered into the corm revealed od cell), 7.9 burnin of 2.1 d an elevated		assessment and induction anesthesia. In addition, the importance communicating and documents and communication was	of e of menting	12/16/09
Event IC):KEE811		3/25/2011	3:4	8:40PM		
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CEO, LAC+USC Healthcare Network

04/11/11

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participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	1
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	OVIDER OR SUPPLIER MEDICAL CENTER		STREET ADDRESS 1200 NORTH ST ANGELES COU	ATE STREE	ZIP CODE T, ROOM 1110, LOS ANGELES, CA 900	033 LOS	
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	Continued From page protein content in the Patient A as having of Anesthesiology patient with a severe constant threat to life that the patient has of such severe nature patient for anesthesis of the patient. An patient has no dise An ASA score of 2 r disease or clinical rewith a planned anelow risk. The pre-operative reattending Physician, there was no physician, there was no physician R, the selection of the CRNA By "General department to practice the form supervision of Pre-anesthetic assess co-signed by M.D." of a staff anesthesion the pre-anesthetic A as is required procedure for anest Patient A contained a consultation or disconsistent and the pre-anesthetic assess co-signed by M.D."	an ASA 4, (Amerassessment level a systemic disease, a). The ASA score a clinical condition of the that the patient is a and this could lead a score of 1 metase and is otherwheat a compart of the that a patient or blem that does at the side of the that a patient or procedured a procedured and procedured and procedured for the physician signature present of the patient of the pati	ican Society of 4 is a which is a of 4 means or a disease is a high risk ad to death ans that the rise healthy. It has a mild not interfere e and is at lace for the gn; however, sent on the vidence that siologist had aware of the Patient A. "Supervision N " states It the CRNA under the ogist: " nt should be ten signature of or present n for Patient policy and al record for lentation that	•	at the Anesthesia Clinical C The discussion emphasized situations when a CRNA sh for additional help from a su attending. Monitoring: To ensure ongoing compliathe above actions the Department of Anesthesia has instituted the following monitoring process. To cases per month in which CRNA is involved in the parametric and the parametr	nce with artment of ne ss. ch a tient's domly ature on and the ne or clear mission to udit will be the il. Any he hesia	
- E	<u>{</u> :VEE911		3/25/2011	3-45	3:40PM		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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NAME OF PROVIDER OR SUPPLIER LAC+USC MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY (XA) ID PREFIX TAG CONTINUED FROM THE PROVIDER'S PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY PULL TAG COntinued From page 4 Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure. When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a CRNA to begin induction with a resident or alone is		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	1
LACHUSC MEDICAL CENTER 1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure. When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a			050373				04/08/	2010
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure. When interviewed at approximately 1015 hours on 5710/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a	NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS.	CITY, STATE, Z	OP CODE	<u> </u>	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure. When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a	LAC+USC	MEDICAL CENTER	·			r, ROOM 1110, LOS ANGELES, CA 90	033 LOS	
Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory velues, for this elective procedure. When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL.	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETE
discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure. When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a		Patient A, the labo surgery and anest	ratory values, or thesia procedures	had been				
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needed". "This permission should be documented on the anesthesia record." The anesthesia record revealed no written documentation of such authorization from MD R to CRNA X to begin anesthesia induction.		5/10/10, both Physici there was no docur to indicate that CR begin anesthesia impolicy and procedu states "All CRNAs present for induction faculty is busy with CRNA to begin induneeded". "This per on the anesthesia revealed no writt authorization from	ian R and CRNA X mentation in the me NA X had been a duction, as is requ me for CRNA sup- must have an an- on for all anesther another case, per iction with a residen mission should be record." The anest ten documentation MD R to CRNA	agreed that edical record authorized to sired by the ervision that esthesiologist sia". "If the mission for a tor alone is documented hesia record of such				
anesthesia induction Anesthesia induction occurred at 1143 hours with 100 mg of Propofol (a drug widely used by anesthesia providers to induce general anesthesia.) There was no documentation that the hospital policy, to document that CRNA X had been given authorization to proceed with induction by Physician R, had been obtained or entered into the medical record, as is required by the policy and procedure from the hospital.		100 mg of Proportion anesthesia providers. There was no dopolicy, to document authorization to Physician R, had be medical record, as	tol (a drug widel is to induce general ocumentation that that CRNA X had proceed with incen obtained or ent is required by the	y used by anesthesia.) the hospital is been given induction by ered into the		A. S. L. Lith		
Interviews with Physician R at 1115 on 5/10/10		Interviews with Physi	cian R at 1115 on 5/1					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

HILE

(X6) DATE 04/11/11

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	blood pressure ch 77/38 mm. Hg. At 1148 hours Phe was given IVP (intra hours. Phenylephri blood pressure in becomes dangerous	cian R was in ar services. Physicia sit to the operating to one on Patient A call from CRNA informed by CRN case". on 5/10/10, at a X stated that Physician room at the time to is required in the espital. an interview constitute the laryngeal mast ent A, but then left e. ryngeal mask ane esthesia record reveanged from 88/48 enylephrine 80mcg ivenous push) and a ne is a medication a patient whose billy low. IVP is rapid one one is a medication a patient whose billy low. IVP is rapid one is a medication a patient whose billy low. IVP is rapid one one is a medication a patient whose billy low. IVP is rapid one one is a medication a patient whose billy low. IVP is rapid one is a medication a patient whose billy low. IVP is rapid one one one of the property is rapid one one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low. IVP is rapid one of the patient whose billy low.	an R stated room for the when she X. MD R AX: "I am approximately ician R was hat induction policy and ducted with nately 1115 he operating k anesthesia the room, to esthesia was haled that the mm. Hg. to (micrograms) again at 1149 used to raise lood pressure d intravenous	Triple of the state of the stat					
Event IT		the medication, us 1000 cc of intraveno			40PM				

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	VIDER OR SUPPLIER MEDICAL CENTER		STREET ADDRESS, 1200 NORTH STA ANGELES COUN	TE STREET	P CODE , ROOM 1110, LOS ANGELES, CA 90	033 LOS	
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	Continued From page was also rapidly infutoralse a dangerou anesthesia). There was no docur that CRNA X discuteam of the medimaintain the blood preference of the maintain the blood preference of the maintain the blood preference of the medimaintain the blood preference of the medimaintain the blood preference of the maintain the blood preference of the medimaintain the blood preference of the medimaintaintaintaintaintaintaintaintaintaint	nentation in the measure or informed cations being admissure for the patient. The started and Epida A.X. 400 cc Lactated and chrine 40 mcg was admich 500 ml was na volume expander) as completed. The started are the operating round the intubate the airway at the intubate the airway at the control of the	edical record the surgical hinistered to hedrine were ringers was given by IV hinistered administered from for lunch ryngeal mask ay of Patient 37 the blood tiated by the were placed hterviews with 30 hours on				
Figure 10:		provide directivesa	3/25/2011	2.40	40PM		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		LE CONSTRUCTION	(X3) DATE SUI COMPLET				
	:	050373		B WNG		04/0	8/2010
	OVIDER OR SUPPLIER MEDICAL CENTER		STREET ADDRESS 1200 NORTH ST ANGELES COU	ATE STREET	P CODE ROOM 1110, LOS ANGELES,	, CA 90033 LOS	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROPRIES	SHOULD BE CROSS-	(X5) COMPLETE DATE
	Patient A development of the aim resulting in severe getting to the tissubrain). Physician S Anesthesia (a device without inserting a intubated the aim way 8/25/09. At that po as 40 beats per mineral resulting a severe control of the aim way severe getting to the tissue control of the aim way severe getting to the tissue control of the aim way severe getting to the tissue control of the aim way severe getting to the tissue control of the aim way severe getting to the aim way severe control of the aim way severe	elieve CRNA X. A became very elaryngeal mask S stated that he oped severe broway as a result of shypoxia (not enough of the severe brows of Patient A at 12 int, the heart rate who was a state of Patient A at 12 int, the heart rate	difficult to anesthesia thought that conchospasm of the pasm of th				
	Post-procedure note suffered severe anoxide Patient A remains facility. The facility failed to implemented the Physician Supervision to perform anest supervision of an anext (1) the supervision pre-anesthetic assess (2) CRNAs have induction of all assesses.	an inpatient at a o ensure that its policy and pro on of CRNAs, that thesia procedures esthesiologist and req sing physician sment for a patient, a an anesthesiologist anesthesia or hav	rehabilitation surgical staff ocedure for allow CRNAs under the uire co-sign the nd present for e a written				
Event ID	permission to begin in	nduction. This deficie	ancy has 3/25/2011	3:48	40PM		

ABOR	ATORY DIRECT	OR'S OR PR	OVIDER/SUPP	LIER REPRESEN	TATIVE'S SIGNATURE

TITLE

CEO, LAC+USC Healthcare Network

(X6) DATE 04/11/11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
		050373		B. WING		04/08	3/2010		
	OVIDER OR SUPPLIER MEDICAL CENTER			DDRESS, CITY, STATE, ZIP CODE RTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS IS COUNTY					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	D BE CROSS-	(X5) COMPLETE DATE		
	Continued From page	8							
	caused or is likely to to the patient, a immediate jeopardy and Safety Code section. This facility failed to described above that	nd therefore con within the meaning on 1280.1, subdivision prevent the deficie	nstitutes and g of Health on (c).						
	serious injury or dear constitutes an imm meaning of Health 1280.1(c).	th to the patient, a nediate jeopardy	nd therefore within the						
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

O4/11/11

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