

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>054087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>SIERRA VISTA HOSPITAL, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823 SACRAMENTO COUNTY</b>		
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	<p>Health and Safety Code 1280(a) 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.</p> <p>Health and Safety Code 1280(c) 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.</p> <p>71233(c). Pharmaceutical Service General Requirements (c) A pharmacy and therapeutics committee shall be established. The committee shall consist of at least one physician, one pharmacist, the director of nursing service or her representative and the administrator or his representative. (1) The committee shall develop written policies and procedures for establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of drugs and chemicals. The pharmacist, in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p>			

Event ID:43VJ11

3/18/2008

12:38:35PM

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	<p><b>Continued From page 1</b></p> <p>(2) The committee shall be responsible for the development maintenance of a formulary of drugs for use throughout the hospital.</p> <p>Based on observation, staff interview and record review the facility failed to ensure that written policies and procedures were developed or implemented to ensure safe and effective use of drug administration.</p> <p>The facility failed to protect patients from receiving medications in error. On 03/16/07 Patient #20 was given Zyprexa 100 mg (the wrong medication and 10 times the usual dose) as a result of multiple system failures summarized as failure of the facility to do the following:</p> <ol style="list-style-type: none"> <li>1. Develop policies governing the amount of medications dispensed and allowing access to medications without any systems for tracking or accountability.</li> <li>2. Implement their policy for checking the medication administration records (MARs) against "Corresponding Pharmacy Patient Medication Profiles daily."</li> <li>3. Implement their policy for removing discontinued medications from patients' cassette.</li> <li>4. Control and limit access to medications with narrow therapeutic index such as lithium and valproic acid (by placing it as floor stock).</li> <li>5. Check one hundred percent of medications</li> </ol>			
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	<p><b>Continued From page 2</b></p> <p>filled as indicted by the facility policy.</p> <p>6. Implement their policy for "High Risk Medications"</p> <p>7. Develop policies addressing stability of medications with shortened shelf life, such as insulin.</p> <p>Medications were available for use in large amounts with no system for tracking and accountability contributing to medication errors. On 03/21/07, it was discovered that on 03/16/07, Patient #20 was given Zyprexa 100 mg (the wrong medication and 10 times the usual dose) as a result of multiple system failures which included transcription error, and the presence of large quantities of Zyprexa available to nursing staff.</p> <p>Immediate Jeopardy (IJ) was called on 03/22/07 at 1:00 p.m. The facility submitted an acceptable interim Plan of Correction (POC), but due to multiple failures in implementing the plan of correction, the IJ was not lifted until 03/30/07 at 6:30 p.m. after multiple inspections.</p> <p>Findings:</p> <p>1. On 03/21/07, it was discovered that on 03/16/07, Patient #20 was given Zyprexa 100 mg in error (wrong medications and 10 times the usual dose) instead of Seroquel 100 mg. Review of medical record for Patient #20 revealed that on 03/16/07, Patient #20 had an order for Quetiapine (also known as Seroquel, an antipsychotic medication) in</p>				

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	<p><b>Continued From page 3</b></p> <p>addition to Zydys (orally disintegrating olanzapine, also known as Zyprexa).</p> <p>The medication, Seroquel 100 mg, was transcribed and administered in error as Zyprexa 100 mg. The availability of large amounts of Zyprexa to nursing staff contributed to administration of the wrong medication.</p> <p>Review of the pharmacy computer profile revealed that the orders were entered into the pharmacy computer system on the same day, 03/16/07, but the time the orders were processed and the amount dispensed were not indicated.</p> <p>On interview, the Director of Pharmacy (DOP) stated that the cassettes are filled with "about 10 days worth" of medications, but that was not documented anywhere or specified in any policy.</p> <p>On 03/21/07, at 3:30 p.m., a licensed facility nurse on Station C-D stated on interview that the pharmacy usually supply them with about one week's worth of medications. The nurse added that the pharmacy staff provides additional medications on Fridays to make sure there is enough to last through the weekend.</p> <p>On 03/21/07, at approximately 4:00 p.m., another facility licensed nurse on nursing Station A-B stated that they get about 1 week's worth of medications and sometimes, they get "huge amounts." The nurse was asked to clarify the huge amounts; the nurse stated that sometimes they get about 2 weeks worth of medications and it would be</p>			
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	<p><b>Continued From page 4</b></p> <p>"hard to look through all these bags" to find the medication needed.</p> <p>* Approximately at 3:30 p.m., on 03/21/07, the medications drawer (cassette) for Patient #40 was randomly selected for evaluation. In the drawer, seven tablets of Zyprexa (olanzapine) 10 mg were found and the label on the plastic bag did not include the instruction for use or the amount dispensed. The physician order revealed that Zyprexa was to be given 15 mg at time of sleep.</p> <p>Another bag was found in the drawer to have 10 tablets of Zyprexa 20 mg; the label on the medication bag did not include the instruction for use or the amount dispensed. Review of the physician order revealed that on 03/21/07 at 10:00 a.m., Zyprexa was changed from 15 to 20 mg to be given at bedtime.</p> <p>Seventeen tablets of Zyprexa different strengths (10 mg and 20 mg) were available in the drawer. In addition, the MAR was not modified to reflect the current order.</p> <p>* Seventeen tablets of Gemfibrozil (medication to control cholesterol) 600 mgs (mg) were found in Patient #40' s cassette one day after the filling day, 03/20/07. The medication was ordered to be given twice every day; one-week supply would be 14 tablets. It was not possible to determine what was administered to the patient in the absence of the amount dispensed.</p> <p>* On 03/21/07, approximately at 4:00 p.m.,</p>			
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	<p><b>Continued From page 5</b></p> <p>randomly, selected cassette for Patient #41, on nursing Station A-B, revealed a bag containing 18 tablets of Geodon (antipsychotic medication), filled on 03/20/07. Review of the physician order revealed instructions to administer the medication two tablets every day. There was no instruction on the label for direction of use, and the amount that was dispensed was not indicated. In the absence of the amount dispensed, it was not possible to know what was given to the patient.</p> <p>* Twelve tablets of 25 milligrams Phenergan (medication used for nausea, vomiting among other uses) were found in Patient #41's cassette. The order was written on 03/19/07 at 10:18 a.m. to give Phenergan 25 mg 1 tablet by mouth every six hours as needed for nausea (x 2 days) for 2 days. The medication cart was filled on 03/20/07, time not specified. The order was written for 2 days (a total of 8 tablets). However, on 03/21/07 around 5:00 p.m., the bag had 12 tablets still available for use. In the absence of the total amount dispensed, it would not be possible to know how many tablets the patient was given or if the patient received any of these medications at all.</p> <p>* Similarly, a bag containing lithium carbonate 300 milligrams was found to have 9 tablets. There was no direction of use on the label, and the amount that was originally dispensed was not indicated. Review of the medical record for Patient #41 revealed that the medication was ordered on 03/19/07 to be given 300 mgs at time of sleep. In the absence of the amount dispensed, it was not possible to know if the correct dose was given to</p>			

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	<p><b>Continued From page 6</b></p> <p>the patient.</p> <p>The amount of medications dispensed were not documented anywhere. Furthermore, there were no checks or balances to ensure that the medications, when used, were given according to physician orders such as the right medication and right dose for example.</p> <p>2. On 03/21/07, the Director of Pharmacy was asked about their system of evaluating medication use. He stated that the pharmacy staff check the medication administration record (MAR) for any missing documentation for billing purposes. He also added that "omissions" not documenting medication administrations were communicated to the nurses. The DOP stated that the MARs were not obtained regularly at specific frequency or at a specific time intervals. He also stated that the MARs come back to the pharmacy when the nurses are done with them, when the sheets are full.</p> <p>The DOP stated that they did not have a system in place to reconcile medication and added that they do not have time; they are so busy</p> <p>Review of the policy "Medication Error, Pharmacist Role in the Prevention of" revised 10/2004 and signed on September, 2006 revealed that " The Pharmacist will review and reconcile all MARs against Corresponding Pharmacy Patient Medication Profiles daily."</p> <p>On 03/22/07 at approximately 10:30 a.m., the DOP</p>			

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	<p><b>Continued From page 7</b></p> <p>was interviewed regarding the daily checks of the MAR; the DOP was not aware of the policy or that he was supposed to perform a daily check of the MARs. The Director of Clinical Services checked the policy and stated that the policy predated them.</p> <p>3. Discontinued medications were not removed from the patient cassettes upon processing of medication orders.</p> <p>Approximately at 3:30 p.m., on 03/21/07, the medications drawer (cassette) for Patient #40 was randomly selected for evaluation. The medication cart was filled on Tuesday, 03/20/07. In the cassette, in a small plastic zip lock bag, seven tablets of Zyprexa (olanzapine) 10 mg were found. The label on the bag did not include direction for use.</p> <p>Review of the physician order revealed that Zyprexa was to be given 15 milligrams at time of sleep.</p> <p>Another bag was found in the drawer to have 10 tablets of Zyprexa 20 mg. Review of the physician order revealed that Zyprexa was changed from 15 to 20 mg to be given at bedtime on 03/21/07 at 10:00 a.m. The discontinued medication (Zyprexa 15 mg) was not pulled from the cassette as outlined by the facility plan of correction for deficiencies identified on September 2006 Survey.</p> <p>Seventeen tablets of Zyprexa in two different strengths (10 mg and 20 mg) were available in the drawer.</p>			

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	<p><b>Continued From page 8</b></p> <p>The facility's policy indicated the, "Discontinued medications shall be removed from the relevant medication cassettes..."</p> <p>4. The facility policy permitting free access of large quantities of dangerous medication such as lithium and valproic acid to nursing staff (floor stock with no accountability for use) did not promote patient safety or safe distribution and administration of medication.</p> <p>Review of the facility policy for floor stock developed on 07/31/2001 revealed the floor stock was put in place "to prevent excessive entries into the pharmacy night locker and pharmacy..."</p> <p>The policy did not ensure safety of medication distribution and administration when high risk medications such as valproic acid and lithium were placed as floor stock with no accountability for their use. Lithium has a narrow therapeutic index meaning that the toxic levels of lithium are close to the therapeutic levels. The availability of such medications in the absence of tracking and accountability put patients at risk of receiving dangerous medications in error.</p> <p>5. On 03/21/07, at 5:30 p.m., the DOP was interviewed regarding the plan of correction from the previous survey indicating that the DOP would check 100% of medications dispensed. The DOP was not aware that he was supposed to do cart fill audit. But he offered that he checked all medications and that the checks were evidenced by initials on each bag of medications in patient's</p>			
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	<p><b>Continued From page 9</b></p> <p>cassettes.</p> <p>Olanzapine 20 mg bag was filled on 03/21/07, for Patient #40 did not have the pharmacist initial on it. There were multiple examples of medications dispensed between 03/21/07 and 3/23/07 that lacked the pharmacist initial.</p> <p>6. The facility failed to ensure that the policies for "High Risk Medications" were implemented.</p> <p>On 03/23/07, at 12:30 p.m., the medication storage on Station C-D was inspected. In the medication refrigerator there were multiple insulin vials in use, but none of these vials had a patient specific label (patient's name).</p> <p>There were five additional sealed insulin vials (not in use); however, none of them had a patient specific name or pharmacy label.</p> <p>Review of the facility's policy for "High Risk Medications" revised 09/04 and signed September 2006, revealed that insulin was recognized by the Pharmacy and Therapeutic Committee as a "high risk" medication and that to "reduce the potential of medication error..." associated with this medication use, the pharmacy will "prepare, label, and dispense the high risk medication as patient specific with an alert sticker on the vial. "</p> <p>7. The facility failed to develop policy regarding the stability of medications with short use duration.</p> <p>Review of the facility Policy "Multi- dose Injectables</p>			

Event ID:43VJ11

3/18/2008

12:38:35PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>054087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/30/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>SIERRA VISTA HOSPITAL, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823 SACRAMENTO COUNTY</b>		
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	<p><b>Continued From page 10</b></p> <p>and Liquids" revealed instruction that the nurse may administer multi-dose injectable and liquids up until the manufacturers' indicated expiration dates..." The policy did not address medications that have modified stability (shortened shelf life) such as insulin.</p> <p>Only one of four licensed nursing staff, interviewed on 03/23/07 at 4:30 p.m., knew the expiration date for insulin when in use. The nurses did not know that insulin had modified stability after opening.</p> <p>Allowing access to medications in large quantities in the absence of any tracking or accountability, dispensing medication without double checking, transcribing medications in error, leaving discontinued medications in patients cassettes, and failure to implement policies such as reviewing the MAR for accuracy on daily bases presented a system breakdown that contributed to administration of the wrong medication, Zyprexa, in a massive dose to Patient #20.</p> <p>The violation(s) has caused or is likely to cause serious injury or death to the patient(s).</p>			

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