The incident cited in the Statement of Deficiencies occurred in September 2007 when the hospital was licensed to and operated by a subsidiary of Tenet Healthcare Corporation. The incident was corrected by the prior licensee on January 2008, before the initial survey visit.

The Incident arose almost two years ago, and was followed by immediate corrective action. There has been no occurrence of any similar incident since phase one of the plan of correction was completed more than 20 months ago, in October 2007.

The hospital is now under new ownership, the University of Southern California (USC), and has continued the monitoring plan in order to prevent recurrence of the incident.

The following is the plan of correction that CDPH has requested, for the notice dated June 11, 2009 for facility license number 030000459.
physician of record was alerted when it was discovered that an incorrect diagnostic pathology report was attached to the wrong patient and a new report with the correct diagnosis had been submitted.

Patient 1 was being treated for infections and other complications of a fracture in the left leg. Preparing to implement another proposed course of treatment, tissue from Patient 1's left leg was collected and sent to the hospital's pathology laboratory for biopsy on 8/6/07. The results of that analysis identified the presence of an infection.

The pathology report for a biopsy performed on tissue from Patient 2's extremity was read and verified on 8/6/07. Patient 2's biopsy results diagnosed the presence of B-cell lymphoma. On 9/3/07, Patient 2's diagnosis of cancer was erroneously entered into Patient 1's medical record, and submitted to related areas of the facility via the laboratory's electronic system at 10:37 a.m. The error was discovered and Patient 1's correct diagnosis was re-submitted through the laboratory's electronic system at 10:46 a.m.

An examination of Patient 1's medical record on 7/28/08 produced no evidence the patient's physician, or other involved parties, were specifically made aware of the error and subsequent corrected diagnosis from the pathology lab.

Influenced by the diagnosis of cancer, Patient 1 elected to undergo a below-the-knee amputation of the left leg on 9/24/07. A post-surgical diagnostic pathology examination revealed "no malignancy" was present in the amputated leg.

The facility failed to ensure that a corrected
When Pathology issues a corrected report, Pathology notifies HIM so that HIM personnel can remove the original report from EPF. HIM staples original report with large "ERROR PLEASE DISREGARD. SEE CORRECTED REPORT", then HIM rescans the report with the proper subtitle. The corrected report is then signed by the Pathologist, a hard copy prints in HIM, and the HIM staff scans the revised report into the EPF system. These reports will now be getting inserted into their document subtitle list, first to be seen. Please refer to attached policy number, SP-127, dated January 14, 2008.

Education was completed for HIM and Pathology personnel when the policy was finalized on January 14, 2008.

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/MEDICAL IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
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<tr>
<td>USC UNIVERSITY HOSPITAL</td>
<td>1500 SAN PABLO ST</td>
<td>LOS ANGELES, CA 90033</td>
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<th>PATIENT TAG</th>
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<td>E 430</td>
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A biopsy report for Patient 1 was communicated in a manner that enabled the patient to make an informed decision about treatment versus amputation of the leg, based upon accurate information. The failure to ensure correlated laboratory test results were effectively communicated between the laboratory and related areas of the hospital resulted in amputation of Patient 1's leg.

Findings:

A review of the medical record of Patient 1 on 7/28/08 revealed a laboratory report indicating that on 8/7/07, at 8:02 a.m., a diagnostic analysis of tissue obtained from Patient 1's leg determined the patient had an "infection of its tibia."

Employee E stated during an interview on 7/28/08, at 9:15 a.m., that a pathologist inadvertently entered Patient 2's biopsy results in Patient 1's record. The diagnosis of Patient 2's tissue collected on 8/17/07 identified the presence of cancer. On 8/8/07, at 10:37 a.m., "Patient 1's verified pathology report reflected the diagnosis, "multiple myeloma...R-cell lymphoma."

Employee A declared on 7/28/08, at 11:10 a.m., "Within minutes" the error was discovered, and Patient 1's accurate diagnosis of "infection of II tibia" was entered into the laboratory's electronic system on 8/8/07, at 10:49 a.m. Patient 2's diagnostic report had not been affected, and no correction was needed.

On 7/28/08, at 11:50 a.m., Employee C disclosed the facility's computerized chart system documents in reverse chronological order (the newest report goes to the bottom), so the "oldest
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>ID</th>
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**Statement of Deficiency**

Report stays on top. Employee D acknowledged at 11:55 a.m. on 7/28/08, that their system had no notification process that would alert medical personnel to the presence of additional lab results.

A review of Patient 1's medical record, on 7/28/08, produced no evidence that facility staff were alerted to the erroneous and subsequently corrected diagnoses. The lab report itself did not contain notification that identified it as a revised or corrected report. Furthermore, there was no indication that any verbal or written communication was made to the physician of record, or to interested parties, alerting them to the change in diagnosis.

Both the erroneous and the corrected laboratory reports were processed through the facility's electronic system and entered automatically into Patient 1's record. All new chart entries were filed in reverse chronological order, with the most recent placed on the bottom. There was no system to specifically alert either the physician or any related parties to the presence of a corrected or new laboratory report.

When asked about the procedure for processing corrected reports, Employee E stated during an interview at 1:20 p.m. on 7/28/08, "We just send them through the electronic system; I figure it goes to Medical Records and filed as usual." Employee B added at 1:25 p.m. on 7/28/08, "We didn't have an actual process for corrected pathology reports."

The title or person responsible for the correction is Director, Health Information Management (HIM).

A description of the monitoring process to prevent further recurrence of the deficiency:

As part of the weekly quality check on ten (10) randomly selected medical records (six inpatient and four outpatient), one of our quality indicators is the compliance with policy #SP-127—"Corrected Reports in Cerner Millennium and EPR," which is the policy that was implemented to address this issue. This audit is performed under the supervision of the HIM Supervisors, and is logged in a binder in the HIM Supervisor's office.

Date of Plan Completion:

- Phase 1: October 2007.
- Phase 2: January, 2008.
the amputation of her left leg below the knee.

Further review of Patient 1’s medical record revealed a biopsy report of the surgically excised limb, “tissue from surgery,” on 9/24/07, yielded negative findings for cancer. The pathology report dated 10/2/07, verified at 9:26 a.m., there was "no malignancy seen" in the excised limb. It further confirmed the initial diagnosis of "infection of left tibia."

During an interview on 9/30/08, at 2:30 p.m., Patient 1 declared, "My doctor told me my leg infection was "limb threatening," and I was doing everything to avoid that." The patient added, "I always fought amputation by doing every alternate treatment they suggested."

An examination of the patient’s records supported evidence that Patient 1 repeatedly opted for treatments for the infected leg. Further review of the medical record showed the consultative report outlining the options of treatment versus a below the knee amputation, which Physician AA discussed with Patient 1 in October 2007, at that time Patient 1 “elected to proceed with limb salvage.” Following the erroneous diagnosis of cancer, a physician’s progress note documented on 8/15/07, "Patient has chosen to do trial of antibiotic treatment before opting for amputation..."

On 10/18/07, during an office visit, Physician AA informed Patient 1 of the error.

During an interview on 9/30/08, at 2:40 p.m., Patient 1 stated the diagnosis of infection was "the motivating factor to decide on amputation."

Employee A disclosed in an interview on 5/25/09, that the physicians decided the amputation was a
"good choice anyway," because Patient 1 had multiple left lower extremity infections since 2005.

The facility's policy and procedure entitled, "Critical Diagnoses (Critical Values) in Anatomic Pathology" (§890-152), provided on 5/29/09, stipulated, "...occasional diagnoses in surgical pathology and cytology require urgent contact of the physician to facilitate rapid intervention or treatment." The policy established a process to identify diagnoses that "qualify as critical," and which required immediate communication to the clinician of record. None of the case diagnoses on the list addressed erroneous reports, such as what had occurred with Patient 1.

The facility failed to provide a process to ensure the efficient exchange of information whereby changes, addenda, or corrections of laboratory reports were effectively communicated to all related parties. This failure to ensure corrected laboratory test results were effectively communicated between the laboratory and related areas of the hospital resulted in amputation of Patient 1's leg.