



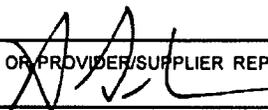
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050737	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER Garfield Medical Center			STREET ADDRESS, CITY, STATE, ZIP CODE 525 N Garfield Ave, Monterey Park, CA 91754-1202 LOS ANGELES COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00333414 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 28851, Pharmacy Consultant</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.3: 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>T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedure</p> <p>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>T22 DIV5 CH1 ART3-70263(g)(2) Parmaceutical Service General Requirements</p> <p>(g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory</p>			<p>RECEIVED 2016 JAN -7 AM 9:18</p>	

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



TITLE
CEO

(X6) DATE

01-06-16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 5

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.

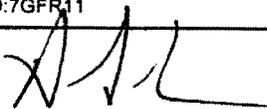
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DEPARTMENT OF PUBLIC HEALTH

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	<p>therapists. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours.</p> <p>(2) Medications and treatments shall be administered as ordered.</p> <p>Based on interviews and record reviews, the facility failed to implement its policies and procedures for medication administration and to prevent the administration of the wrong medication to a pregnant patient (Patient 1). On 11/7/2012, at 12 p.m., Patient 1, with term pregnancy (40 weeks), was to receive Lactated Ringer's solution (LR, a liquid solution of several salts dissolved in water) for hydration (the process of providing an adequate amount of liquid to bodily tissues). However, Nurse 1 retrieved a bag of LR with 20 units of Pitocin (oxytocin, a synthetic hormone that causes uterus to contract) and administered it to Patient 1 in error. Shortly after the administration of LR with</p>			

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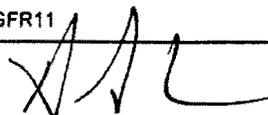
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	<p>Pitocin to Patient 1, the fetus (an unborn baby) developed severe bradycardia (abnormal slow heart rate). Subsequently, Patient 1 required a "crashed (emergency) primary cesarean section procedure (birth happens through an incision in the abdominal wall and uterus rather than through the vagina) under general anesthesia due to non-reassuring fetal status (suggest fetal, unborn baby, compromise or a declining ability to cope with the stress of labor)." The facility's failure resulted in an unplanned surgery for Patient 1 and placed the unborn baby at risk for bleeding in the eye, irregular heartbeat, seizures, slow heartbeat.</p> <p>Findings:</p> <p>On 1/17/2013, an announced visit was made to the facility to investigate an entity report incident relating to a medication error for Patient 1.</p> <p>A review of Patient 1's record indicated the patient was admitted to the facility on 11/7/2012 with diagnosis of term pregnancy in labor.</p> <p>A review of the Patient 1's clinical records indicated Patient 1 was to receive LR for pre epidural (epidural anesthesia, a regional anesthesia that provides pain relief to the lower half of the body) hydration at 12 p.m. However, Nurse 1 administered LR with Pitocin to Patient 1 in error at 12:05 p.m. Then, severe bradycardia was detected (by Nurse 1) with regards to the fetal heart rate. At 12:40 p.m., Patient 1 underwent emergent or crashed primary cesarean section operation for non-reassuring fetal status (or pattern, suggest</p>				

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	<p>fetal, unborn baby, compromise or a declining ability to cope with the stress of labor).</p> <p>According to the "First dose M.A.R." (MAR, abbreviation for medication administration record), Patient 1 received "LR 1000 ml for hydration" at 12:00 p.m.</p> <p>During an interview, at 11:35 a.m., on 1/17/2013, the director of labor & delivery stated that Nurse 1 should have noticed the pharmacy label on the IV bag indicating the fluid contained Pitocin as additive.</p> <p>According to the facility's nursing policy and procedure titled, "Medication Administration", dated "7/10", "medication administration will be administered according to the six rights of medication administration: right patient, right medication, right dose, right route, right time, right purpose & documentation... To prepare a dose for administration, the [nurse] shall check the pharmacy label (if attached)...against the MAR."</p> <p>During a concurrent interview, the director of labor & delivery also stated that the pharmacy department did not put the auxiliary label "Pitocin" on the compounded IV bag.</p> <p>During another interview at 1 p.m. on 1/17/2013, the director of pharmacy acknowledged that the auxiliary labels on those compounded Pitocin IV bags were missing. The director presented a copy of the auxiliary label for Pitocin IV bags that would have been used. The director further stated there</p>		<p>Action Plan: Education to all Labor and Delivery staff on the Medication Management Policy M1 and the 6 rights and the administration of Pitocin.</p> <p>Responsible Title: Director of Labor & Delivery</p> <p>Date Completed: Education to all Labor and Delivery staff on the Medication Management Policy M1 and the 6 rights and the administration of Pitocin was done at the staff meetings on 1/15/13 and one on one for those who could not attend the staff meeting.</p> <p>Ongoing Compliance: Ongoing education on Pitocin administration in yearly skills fair including demonstrated competency. Yearly education and competency on Pitocin administration completed 4/2013, 5/2014 and 4/2015.</p>	

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	<p>was no policy & procedures on putting the auxiliary labels on IV bags.</p> <p>According to the facility's nursing policy and procedure titled, "Performance Improvement - IV additive Service", dated "11/06", "...The pharmacy will maintain a uniform system for the labeling of sterile products, IV's ..."</p> <p>According to the Food & Drug Administration (FDA) labeling information on Pitocin," ...overstimulation of the uterus by improper administration [of Pitocin] can be hazardous to both mother and fetus ..." (<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=6d4b2c25-2e5d-49b5-93bc-2ae8a20916d1>)</p> <p>A review of Patient 1's discharge summary indicated the fetal heart rate was detected at about 15 beats per minute (bpm, normal fetal rate range between 110 to 180 bpm) and the surgeon was notified for this change of condition. Subsequently, the emergency primary cesarean section was performed because of the uncertainty of the fetal status.</p> <p>These deficiencies caused, or are likely to cause, serious injury or death to the patient, and therefore, constitute an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.</p>		<p>Action Plan: Education to all pharmacy staff on IV labeling for IV additives by memo. Performance Improvement - IV Additive Service Policy was revised to address color auxiliary stickers applied to admixtures, Pitocin.</p> <p>Responsible Title: Director of Pharmacy</p> <p>Completion Date: Memo education completed on November 12, 2012. Policy revision completed November 2015.</p> <p>Ongoing Compliance: Audit for presence of color auxiliary stickers completed monthly 2013, 2014, and 2015. No unlabeled Pitocin found on unit.</p> <p>Action Plan: Storage of Lactated Ringers with Pitocin was moved to an Omni Cell cabinet which requires the nurse to sign out the medication by patient.</p> <p>Responsible Title: Director of Pharmacy</p> <p>Completion Date: November 12, 2012</p>	

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