STATEMENT OF DEFICIENCIFS AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
060454			B. WANG		01/18	/2011
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD)	LESS, CITY, STATE,	ZIP CODI-		
UCSF ME	DICAL CENTER	505 Parnass	ius Ave, San Fra	ancisco, Ca 94143-2204 SAN FRANCIS	CO COUNTY	
(X4) ID PREFIX TAG	(EACH THE ICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECHEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE O	BE CROSS-	(X5) COMPLETE DATE
	The following reflects to of Public Health during	he findings of the Department an inspection visit:		The statements made in this Plan Correction are not an admission a	nd do not	
	Complaint Intake Numi CA00253999 - Substar			constitute agreement with the alle deficiencies herein.		
	Representing the Department of Public Health: Surveyor ID # 25730, HFEN			This Plan of Correction constitute Medical Center's written credible of compliance for the deficiencies	allegation	
	The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.			Corrective Action:		
	Health and Safety purposes of this means a situation noncompliance with	Code Section 1280.1(c): For section "immediate jeopardy in which the licensee" one or more requirements on is likely to cause, serious	s f	On 12/10/10, the Hematology Blo Marrow Transplant (HBMT) Mar counseled and re-educated in accommedical center policy the Nurse P (NP) about the requirements and pallergy verification prior to orderimedications.	nager ordance with ractitioner orocess for	12/10/10
	1279 1(b)(4)(A) Medication Error (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the			On 12/15/10, the HBMT Manager and re-educated the medical assist involved in the locident on the comethod of verification of patient a	ant rrect	12/15/10
	with a medication e	or serious disability associate	d	CA DEPT OF PUBLI	C HEALTH	
	to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in			APR 1 2 20	012	
	1	ug selection and dose.	,	L&C DIVISION SAN FRANCIS	ON SCO	
Event ID:	E2D I11	3/12/20	1 11:18			

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

THE CONTROL OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

(X6) DATE

(X7) DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

(X7) DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

(X7) DATE

(X7) DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X7) DIRECTOR'S OR PROVIDER SIGNATURE

(X7) DIRECTOR'S OR

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Mylinia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLF CONSTRUCTION	(X3) DAYE SUR COMPLETE	
050454							V2011
	OVIDER OR SUPPLIER NCAL CENTER		STREET ADDRESS, 505 Parnassus A	-	ZIP CODE ncisco, Ca 94143-2204 SAN FRANCIS	CO COUNTY	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST IX. PRECEEDED BY SCIDENTIFYING INFORMAT	FULL.	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
	Continued From page	1					
	T22 DIV5 CH1 ART Service General Requirements of equivestablished. The commone physician, one nursing service or administrator or his reports.	therapeutics commodated the composition, amittee shall consist pharmacist, the her representative presentative.	nittee, or a shall be of at teast director of		Beginning in December 2010 and implemented in January 2011, the case load for NPs working in the comodified and now consists of non 15 patients per 10 hour day and no 12 patients per 8 hour day. Also, I faculty added additional clinic day more mid-level providers, including physician assistant, to accommodate change in the NP case loads.	clinic was nore than more than the HBMT as and hired	12/2010 1/2011
	(1) The committee ship procedures for estable systems for procudispensing and use pharmacist in consume aith professionals responsible for implementations of approved by the government of the systems o	ishment of safe a rement, storage, of drugs and che altation with other and administration the developm procedures. Policie verning body. Proceadministration and research control of the	nd effective distribution, micals. The appropriate n shall be nent and s shall be edures shall		On 1/12/11, the HBMT manager g presentation to the clinic staff above event, the practice issues that lead medication error and the changes in NP patient case load. Additionally manager re-educated the clinic state providers about the correct use of "Summary Time Oriented Record" where allergy information is noted an outpatient electronic health reco	ut the to the made to the y, the ff and all electronic '(STOR) L STOR is	1/12/11
	These regulations were the hospital failed to allergios before present, which rosulted in anaphylactic reaction prolonged hospitalizativities of dally living Findings:	observation, and received Patient 1's libration of the critical patient 1 suffering on (allergic reaction and inability	cord review, ist of known for Patient g a severo ction) with		On 3/8/11, the Medical Director for Ambulatory Quality and Patient So presented the results of a survey of by UCSF Medical Center Patient So Program in the ambulatory practice the Agency for Healthcare Research Quality tool "Medical Office Survente Patient Safety Culture". Following presentation, the director met with to reinforce concepts of patient safe	afety conducted Safety es using th and ey on g the clinic staff	3/8/11
Event ID:E	2DJ11		3/12/2012	11:18	:42AM		
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGNAT	TURE	TITLE		(X6) DATE

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	OVIDER OR SUPPLIER DICAL CENTER	STREET ADDRESS, 505 Parnassus A		, ZIP CODE ancisco, Ca 94143-2204 SAN F	FRANCISCO COUNTY	*
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE
	Certification Coordin a primarily Chinese at the hospital's chronic leukemia. examined in the Cli who gave Patient Amoxicillin and told to have symptoms Patient 1 should h start taking the ar stated that on	1:15 PM, the Licensing & ator (LCC) stated Patient 1 was e-speaking woman being treated Hematology/Oncology Clinic for		In October 2011, during the new UCSF Medical Center record system known as "stands for Advancing Pati Excellence), the pharmacy implemented a warning all displays when a provider prescribe a drug for which documented allergy. The go-live with APeX in Sept. Monitoring: On 4/6/11, the HBMT Market and the standard stan	er electronic health APeX" (which ent-centered y APeX team ert for allergies that attempts to n the patient has a HBMT clinic will tember 2012.	10/2011
	symptoms of an breathing and loss was treated in the several days of hemodialysis. Pati and was then treapproximately 21 days	anaphylactic reaction (difficulty of consciousness). Patient 1 intensive Care Unit (ICU) for a ventilator and acute ent 1 was stabilized in the ICU eated on an inpatient unit for ays. Patient 1 was independent		audit from the prior 4 more compliance with checking information prior to order The results of the audits v Patient Safety Committee	onth period of gallergy ing medications. were reported to on 4/6/11.	
	ambulating, toileting anaphylactic reactio end of her inpa achieved this same	es of daily living (ADLs - bathing, g, dressing, etc.) prior to the n. The LCC stated that at the tient stay, Patient 1 had not be level of independence so she		Compliance with allergy with a focus on patient sa agenda item every other n Marrow Transplant Team	fety is a standing nonth for the Bone	Ongoing
	was transferred to a skilled nursing facility (SNF) for additional rehabilitation. The LCC stated that during an interview with the			The HBMT Manager regu NP patient case load to en with the modified patient	sure compliance	4/6/11 and Ongoing
Nurse Practitioner (NP) who prescribed the amoxicillin, NP stated she did not check the record for Patient 1's allergies before prescribing the amoxicillin. The LCC said the record indicated Patient 1 was allergic to amplicillin, an antibiotic in				Responsible Party: Direct Director of Pharmacy	or of Nursing and	

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UCSF MEDICAL CENTER CM4,10 PPREFIX SUMMARY STATEMENT OF DEFICIENCES 10 PROVIDER'S PLAN OF CORRECTION (MS) BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CRUSS COMPLETE DATE Continued From page 3 the same penicillin family.			030434		D WING		. 01/1	8/2011
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condition improved in the ICU.				I				
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NAME OF PROVIDER OR SUPPLIER UCSF MEDICAL CENTER .		SS, CITY, STATE, ZIP CODE 8 Avo, San Francisco, C	a 94143-2204 SAN FRAN	CISCO COUNTY	
PREHIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	1 '	PROVIDER'S PLAN OF CORR CH CORRECTIVE ACTION SHOU ERENCED TO THE APPROPRIAT	LD BE CROSS-	(X5) COMPLETE DATE
out of the ICU of Physical Therapy Initial 1's previous level of home. She of independently with a wheeled walker dependently with a wheeled walker dependent 1 was able twenty stairs to her her elderly husband. The Physical The Patient 1 had "implected implement 1 had "implected implement 1 had "implected implement 1 had "implected and the stain assistance of one pensitting and then stain assist of one person Patient 1's ability to tested at that time. Patient 1 be transferr (SNF) for further discharge to home with Patient 1 received treatments until indicated Patient 1 but she still needed PT. Patient 1 was 10.	ated Patient 1 was transferred in 14. On 14 a dial Evaluation indicated Patient of activity was independent at outd ambulate one block single point cane or a front inding on how she was feeling. To climb and descend the apartment where she lived with erapy Evaluation determined aired functional mobility 2/2 reased strength, balance and evaluation showed that on 1 needed the moderate erson to go from lying down to inding. She needed moderate to transfer from bed to a chair, walk or climb stairs was not The evaluation recommended ed to a Skilled Nursing Facility mobility training prior to her inher husband. Physical Therapy (PT) 10. The PT note of was making steady progress transfer to a SNF for continued is discharged to a SNF on	100A.	CA DEPT OF P APR 1. L&C DIVISAN FRAN	2 2012	H
the Nurse Manager	AM Patient 1 was wheeled, by (NM), from the dining room to elchair with no foot rests.	I			
Event (D:E2DJ11 I ABORATORY DIRECTOR'S OR PROVID	3/12/201		TITLE		s) DATE

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State-2567

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		050454	A. BUILDING			
		050454	B. WINO		01/18/2011	_
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRES	S, CITY, STATE, Z	IP CODE		
UCSF MED	DICAL CENTER	505 Parnassus	Ave, San Fran	icisco, Ca 94143-2204 SAN FRANCIS	SCO COUNTY	
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(X4) ID	1	ATEMENT OF DEFTCIENCIES	10	PROVIDER'S PLAN OF CORREC		
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	Continued From page	5				_
	Patient 1 was neatly	groomed and dressed, and				
	1	she wanted to stay in the				
		erview. The NM stated Patient				
	1	g so the NM provided a voice	Ì			
		1. The NM stated Patient 1	ł			
		very well and spoke English			1	
	fairly well.					
	0 44044 - 1 040 4	M D-1: 4 -1-1-1 1b-4 b-6	I			
		M, Patient 1 stated that before				
	_	ed at home with her husband.				
	1	d a girl come five days a week ooking and she				
		husband cooked on the other				
		ed she was able to shower by				
	'	the tub. She said she used a				
		two blocks. Patient 1 added	!			
	that she used a wal	ker when she felt tired. When				
	asked about her illn	ess, Patient 1 stated she took				
	some medicine which	h mede her very sick but she	į			
	didn't remember much	of her hospital stay.				
		d boon in the room and he				
	1	ner's answers to the interview				
	1 '	interview at 9:15 AM the son				
		Michigan but he had come to				
	1	with his parents. The son said the when she started taking the		CA DEPT OF PU	BLIC HEALTH	
	medicine (amoxicilli	_		CADEFICITO	A CONTRACTOR OF THE PARTY OF TH	
		d felt tired. During the night of				
	· ·	ard his mother fall and he went		APR 12	2012	
		the floor. The son noted his		AFR		
	I =	wollen, she was having trouble			The state of the s	
		s wheezing, and she was		L&C DIV	ISION	
	_	stated he woke his father and		SAN FRA	NCISCO	
	called 911.					
<u> </u>	<u>}</u>					
Event ID:		3/12/2012				_
LABORATOR	RY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN,	ATURE	TITLE	(X6) DATE	

Any deficioncy 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 disclossable 14 days following the dato those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
ı	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			\ \'\'\'\		COMPLETED		
]	OPOAT4			A. BUILDING B. WING				
	 	050454	,	a. minis		01/18/2011		
ľ	OVIDER OR SUPPLIER		STREFT ADDRESS, C	·				
UCSF MED	DICAL CENTER		505 Parnaesus Ave	e, San Franci	sco, Ca 94143-2204 SAN FRANCI	SCO COUNTY	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEFFED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN DF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) D/			
	Continued From page	6						
	The son stated the ambulance took Patient 1 to the facility's ED where they told him they thought his mother had an allergic reaction to the medicine (amoxicillin).				•	.		
	Patient 1's son said ICU and "went through The son said they expected the rash was the work son said the rash was the work and the work through.	gh a lot of pain an ven put two holes in round-the-clock dia lists who came all orst they had ever was gone now so anymore. He ad-	nd suffering." In Patiant 1's In Pat					
	The son confirmed had pre-hospital functional was close to that extinstead of a cane.	l abilities and he	thought she		•			
	Patient 1's son stated that her anticipated discharge date to home was 1/25/11, more than two months after taking the medication.				CA DEPT OF	PUBLIC HEALTI	Н	
	In an interview on 1 Nursing Assistant (C she (CNA) had regu	NA) caring for Pat	ent 1 stated		APR	2 2012		
she (CNA) had regularly cared for Patient 1 since her admission to the SNF. The CNA stated that on admission Patient 1 needed help to stand and she could not walk to the bathroom (approximately 10 feet). The CNA stated Patient 1 now stands and walks to the bathroom independently. The CNA said Patient 1 bathes, dresses, and feeds herself			ated that on and and she aximately 10 stands and The CNA		L&C D SAN FR	IVISION ANCISCO		
Event ID:	E2DJ11		3/12/2012	11:18:42	AM			
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESE	NTATIVE'S SIGNATI	IRE	TITI F	(X6) DA	TE	

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STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050454		B. WING		01/18/2011	
	OVIDER OR SUPPLIER DICAL CENTER		STREET ADDRESS, 505 Parmassus A	-	DE o, Ca 94143-2204 SAN FRANCIS	SCO COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PIRECEEDED BY I SCIDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN DE CORREC (EACH CORRECTIVE ACTION SHOULD RÉFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETE	
	Continued From page	7					
	independently which admission.	she could no	ot do on				
	Record review of P (MDS) assessment of still required limited perform all of the attexcept eating which locomotion on and of extensive assistance. In an interview on Practitioner (NP) who Patient 1 stated she who had prepared the for "No known alled usually asked patient prescribing any new she could not rememabout her allergies.	dated 1/19/11 indical assistance of one reas of activities of was supervision of the unit which respond to the unit which respond the arrow thought the medical check rigies. The NP is if they had aller modications but the second control of the co	ated Patient e person to daily tiving only, and quired more the Nurse moxicillin for cal assistant ted the box stated she rgies before he NP said				
	Record review of Findicated that on pawas marked "NKDA The medication list indicated that Patier and amoxicillin. Both updated on 2/21/07. page 4 on 10.	ngo 1 the section " (No known drug on page 4 of the nt 1 was allergic th of those allergie	for allergies g allergies), clinic record to penicillin s were last		CA DEPT OF PUBLI		
	The facility policy ldentification and stated "Modical staff must review part documentation prior to	Documentation" da (including Nurse I ient records fo	eted 11/07, Practitioners) or allergy		L&C DIVISION SAN FRANCI	ON SCO	
Event ID:I			3/12/2012	11:18:42A	***		
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGNAT	URE	TITLE	(X6) DATE	

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State-2567

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUI AND PLAN OF CORRECTION UNBER			(X2) MULTIPLE OR	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
	060464			A. BUILDING B. WING	· · · · · · · · · · · · · · · · · · ·	01/18/20	011
		L			_ 	L	
NAME OF PRO	OVIDER OR SUPPLIER		[CITY, STATE, ZIP CO!			
UCSF MED	DICAL CENTER		505 Parnassus A	ve, San Francisco), Ca 94143-2204 SAN FRANCIS	CO COUNTY	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	3	ID	PROVIDER'S PLAN OF CURRECT	пом	(X5)
PRLEIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I	BE CROSS-	COMPLETE
1AG	REGULATORY OR L	SC IDENTIFYING INFORMA	TION)	TAG R	EFERENCED TO THE APPROPRIATE D	EFICIENCY)	DATE
	Continued From page	8					
	policy also indicate	ed that for outp	atients, the				
	documentation of all	-	· .			1	
	medication list.	0.9100 00010 00 10					
	medication nst.						
	The facility failed to	thoroughty chack	Patient 1's	1			
	record for medication		i				
	medication which was		_				
	an affergic reaction.						'
	a sovere anaphylactic						
	to endure the pair						
	invasive medical int						
	1	e hemodialysis,				į	
	restraints to prevent]	
	these tubes. This					ı	
	months of medical		1				
	leaving Patient 1 wit	•	nt functional				
	deficits in her ability to	walk,				į	
	The facility's failure						
	procedure on A	• .					
	Documentation, is a	•				İ	
	is likely to cause,	, .					
	patient, and therefore	ore constitutes an	immediato				
	jeopardy within the	meaning of Health	and Safety	ļ			
	Code soction 1280.1.			}	The same of the same of		
					CA DEPT OF PUBLIC	CHEALTH	1
	This facility failed to	prevent the deficie	ency(ies) as		On Delin Or . Contra		
	described above that	caused, or is likel	y to cause,				
	serious injury or deat	th to the patient, a	nd therefore		APR 1 2 20	12	
	constitutes an imm				AFR 12 20	16.	
	meaning of Health						
	1280.1(c).	,			L&C DIVISIO	N	
					SAN FRANCIS		
	1			İ	SAN FILATOIS		
L	<u> </u>		<u>l</u>				
Event (D:	<u> </u>		3/12/2012	11:18:42AM			
LABORATOR	LY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESE	INTATIVE'S SIGNAT	URE	TUILE	(X6	B) DATE

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