CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a complaint/adverse investigation visit: Complaint Intake Number: CA00197340 - Substantiated Representing the Department of Public Health: [redacted], HFEN 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. The following reflects the findings of the Department of Public Health during investigation of Complaint No. CA00197340. The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Barbara Ruger, RN, HFEN Health & 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		**T22 DIV5 ART3-70213(a)** **Nursing Service Policies and Procedures** **T22 Div5 ART3-70223(b)(2)** **Surgical Services Requirements** The hospital failed to ensure the hospital's policies and procedures for prevention of wrong site procedure/surgery and hand off communication were followed which resulted in an additional surgery and prolonged pain for the patient. **Corrective Action:** 1. The hospital conducted an interdisciplinary Sentinel Event Root Cause Analysis using The Joint Commission RCA template. An action plan with specific risk reduction strategies was formulated, based on the identification and analysis of issues relative to: a. Process b. Medical Staff and Human Resource c. Information Management d. Leadership e. Communication f. Controllable Environmental Factors g. Equipment Factors 2. The case was reviewed and rated by the Medical Staff Peer Review Committee a. The case review and peer review rating was presented to the Medical Executive Committee for approval of rating and action plan.	9/31/09

Event ID:H1GX11 3/16/2010 3:29:40PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Byron J Achmeyer TITLE CEO (X6) DATE 4-1-10

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.

Completion Date per Marie Trenkath 4/23/10

Accepted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 1 licensure has caused, or is likely to cause, serious injury or death to the patient. Deficiency Constituting Immediate Jeopardy The above regulations were NOT MET as evidenced by: T22 DIV5 ART3-70213(a) Nursing Service Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained, and implemented by nursing service. T22 DIV5 ART3-70223(b)(2) Surgical Service General Requirements (b) A committee of the medical staff shall be assigned responsibility for: (2) Development, maintenance and implementation of written policies and procedures 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 above regulations were NOT MET as evidenced by: Based on interview and record review, Hospital A failed to ensure the hospital's policies and procedures for prevention of wrong site procedure/surgery and hand off communication were followed which resulted in an additional surgery and prolonged pain for the patient. This		b. The involved physicians' cases are being monitored as part of the Medical Staff Peer Review process as a Focused Professional Practice Review. 3. The Nursing Staff directly involved in the event underwent Human Resource disciplinary action which ranged from written disciplinary warnings up to termination. 4. The Preoperative/Procedural Checklist was revised to include: a. "Operating surgeon performed History and Physical" b. "X-rays/imaging studies available for review or not applicable" 5. The OR Staff completed a competency validation by direct observation and return demonstration on the use of the STENTOR program for viewing diagnostic tests on the computer in the OR. a. Computers were placed in each OR to allow staff to project CD's from the imaging studies 6. The OR Staff was re-educated on the importance and expectation on their role as a patient advocate and speaking up in all situations required to prevent any compromise of patient safety. 7. The Universal Protocol policy requirements and expectations were reviewed with all OR Staff with emphasis on: a. A Verbal and Audible Time Out which is interactive and involves all OR Team members	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Byron T Arbuckle TITLE: CEO (X6) DATE: 4-1-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2 resulted in the patient having an unnecessary surgery. Findings: An overview of the findings shows that Patient B was diagnosed with a right sided kidney stone while in Hospital B's ED (Emergency Department). After being discharged from the ED, the patient was seen in MD #2's office. An H & P (physician's history and physical) done in the office and subsequently faxed over to Hospital A incorrectly identified the kidney stone as on the left side. However, a CAT scan (type of X-Ray) faxed over to Hospital A showed the kidney stone as on the right side. The patient subsequently had a stent (a man-made tube inserted into the duct to counteract localized flow constriction, such as could be caused by a kidney stone) placed on the left side by MD #1. After the surgery the patient continued to have flank pain and now additionally, bladder pain and MD #1 discovered the stone was on the right side. The family requested another physician and MD #3 subsequently removed the left stent and placed a right stent. Prior to Patient B's first surgery, the hospital failed to implement several procedures that help safeguard patients from wrong site surgery as shown in the following: 1. On 8/5/09, review of the hospital's policy and procedure for "Universal Protocol: Prevention of Wrong Site, Wrong Procedure, Wrong Patient Surgery/Procedure" showed the preoperative RN was to review the consent, verify the correct site and document on the pre-operative		b. Site/Side Marking requirements c. Availability and review of all imaging studies in the OR 8. The Handoff Communication policy was revised to include a section that documents specific requirements of Nursing staff involved in handoff communication for patients undergoing diagnostic testing, procedures in the Cath Lab, OR, GI Lab and involving Emergency Department transfers to inpatient units. a. The SBAR (Situation, Background, Assessment & Recommendation) tool will be completed by sending healthcare provider and faxed to receiving unit during department transfers. b. A follow-up interactive report is required by telephone or at the bedside prior to or at the time of transfer. c. OR Nursing Staff were educated at a Department Staff meeting regarding the revised Handoff Communication policy and related expectations. **Completion Date**: 1. Root Cause Analysis: 7/28/09, 9/9/09 2. Medical Staff Peer Review: 7/29/09 – ongoing 3. Human Resource Disciplinary Process for Staff: on or before 7/31/09 4. Revision of Pre-Procedure/Preoperative checklist: 7/31/09 5. Competency Validation for OR Staff on use of OR STENTOR: 3/23/10	8/1/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Byron F Arbuckle	CEO	4-1-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 3 checklist. Review of the medical record showed the preoperative nurse's section of the preoperative checklist was blank. On 7/24/09, Patient B was admitted to the hospital with a diagnosis of kidney/ureteral stone (a ureter is the duct or passageway for urine to pass between the kidney and the bladder). The admitting nurse's notes on 7/24/09 showed the patient complained of low back and right sided pain. At 2030 hours on 7/24/09, the patient had surgery performed by MD #1 for placement of a left stent. An H & P (done on 7/23/09) faxed over from MD #2's office prior to surgery showed the patient had left side pain and a left kidney stone. A CAT scan (type of X-ray) report (taken on 7/20/09) that faxed over from another hospital prior to surgery, showed in the dictated report the patient had a right kidney stone. On 7/25/09, MD #3 (a new physician on the case) documented in the physician progress notes that the patient had a left stent placement on 7/24/09; however, the kidney stone was on the right side and the patient had bilateral flank pain. On 7/26/09, MD #3's progress notes showed the patient and family were again informed the stent was placed on the wrong side. On 7/27/09, Patient B had a surgical procedure for removal of the left stent, placement of right stent and lithotripsy (shock waves used to shatter stones.) On 7/25/09, the patient received 1 mg of hydromorphone by IVP (intravenous push) for pain at 0122 hours, 0530 hours, 0930 hours, and 0945 hours after which the hydromorphone was		6.-7. OR Staff Role as Patient Advocate & Requirements related to Universal Protocol policy and procedure: 7/31/09 8. Handoff Communication Policy revision: 9/7/09 a. Nursing Staff was educated on the policy revision: 9/28/09 **Monitoring:** 1. Monthly audit of a minimum sample of 30 charts for compliance with a) Time Out elements and b) Site/Side Marking Requirements. a. Reported monthly to the Surgery Department, the Surgical Action Committee and the Performance Improvement /Patient Safety Committee. 2. Monthly audit of a minimum sample of 30 charts for the accuracy and completeness of the Preoperative/Pre-procedural Checklist a. Reported monthly to the Surgery Department and the Performance Improvement/Patient Safety Committee. **Persons Responsible:** Director Perioperative Services, Chief Nursing Officer, Executive Director Quality Services, Program Manager, Clinical Risk Management & Patient Safety, Director Medical Staff Services, Department of Surgery Chair	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Byron J Schweizer | TITLE: CEO | (X6) DATE: 4-1-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 4			

increased to 2 mg IVP for severe pain. The patient received two mg of hydromorphone on 7/25/09 at 1200, 1500, 1830, and 2130 hours. Further review of Patient B's medical record showed a Nursing Flowsheet with a pain section that included a 1 to 10 pain intensity scale section (with 10 being the most severe pain). The patient's pain level was assessed at 0700, 1200, 1500, 1830, and 2130 hours and ranged from 8 to 10 on the pain scale. Additionally on 7/25/09, Patient B was started on a belladonna and opium suppository every 6 hours to relieve bladder spasms

On 7/26/09, Patient B received 2 mg of hydromorphone at 0052, 0340, 0700, 1315, 1613, 1910, and 2200 hours for pain levels that ranged from 8 to 9 on the pain scale.

On 7/27/09, the patient received hydromorphone 2mg at 0110, 0415, 0730, 1715, 2020, and 2320 hours and on 7/28/09, the patient received hydromorphone at 0230, 0857, and 1200 hours.

On 8/6/09 at 0930 hours during an interview regarding the first stent placement procedure, RN #1 stated during the preoperative process, when she was at another patient's bedside, the OR (operating room) nurse RN #2, came and took the patient to the OR. RN #1 stated she shouted out "Don't take the patient yet I'm not done, but they kept on rolling." I didn't complete the preoperative checklist and did not mark on the "Timeout Sheet."

On 8/10/09 at 1350 hours, the OR nurse RN #2 was interviewed. RN #2 stated the case was an

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Byron F Arbuckle | TITLE: CEO | (X6) DATE: 4-1-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 5 emergency. When asked if the preoperative nurse had an opportunity to check the chart, RN #2 was not sure if RN #1 checked the chart. RN #2 stated she checked the chart and everything was present. RN #2 stated the patient stated the pain was on the left side. On 8/7/09 at 0920 hours during an interview, MD #1, the physician that performed the procedure on 7/24/09 stated the procedure was not an emergency. 2. On 8/5/09, review of the hospital's policy and procedure "Staff Communication During Hand Off" showed hand-off communication was to be done when patients are transferred to surgery. On 8/5/09, the medical record for Patient B was reviewed. The initial nursing assessment, completed on 7/24/09 at 1854 hours, showed the patient complained of right sided pain. The record also showed the patient was transferred from the nursing unit to the preoperative holding area on 7/24/09 at 2030 hours. On 8/6/09 at 0930 hours, an interview was conducted with RN #1, the preoperative nurse for Patient B. RN #1 stated, on the evening of 7/24/09, she was told there was an add-on surgical case and they wanted the patient right away. She stated she usually called the nursing unit for a report on the patient from the sending nurse but the patient was already on the way to the preoperative area so she did not receive report on the patient.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Byron F Achweizer | TITLE: CEO | (X6) DATE: 4-1-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050226	A. BUILDING _____ B. WING _____	08/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE, ANAHEIM, CA 92801 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 6 Further review of the patient's record showed at 2030 hours on 7/24/09, the patient had surgery performed by MD #1 for placement of a left stent. An H & P (done on 7/23/09) faxed over from MD #2's office prior to surgery showed the patient had left side pain and a left kidney stone. A CAT scan report that faxed over from another hospital prior to surgery taken on 7/20/09, showed in the dictated report the patient had a right kidney stone. On 7/27/09, Patient B had surgery for removal of the left stent and placement of a right stent. The facility failed to ensure the policies and procedures to prevent wrong site surgery were followed. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Byron F Schweizer | TITLE: CEO | (X6) DATE: 4-1-10

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.