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	The following reflects the of Public Health during Complaint Intake Number CA00300836 - Substant Representing the Depara Surveyor ID # 22779, H The inspection was lime event investigated and findings of a full inspect Health and Safety purposes of this means a situation noncompliance with licensure has caused injury or death to the para	an inspection visit: ber: ntiated artment of Public Hea HFEN ited to the specific fa does not represent th tion of the facility. Code Section 128 section "immediate in which the one or more requ , or is likely to cau	lth: cility ne 00.1(c): For jeopardy" licensee's irements of				
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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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Event ID:	noncompliance with licensure has caused injury or death to the p Deficiency Constituting T22 DIV5 ART3-70223 (b) A committee of assigned responsibility (2) Development, ma of written policies a with other appropria administration. Policie governing body. Pro- the administration an appropriate. T22 DIV5 ART3-70223 (d) Prior to commisurgeon if a gene administered, shall v site and side of the ascertain that a reco the patient's medical reco (2) Appropriate scru- needs of the patien within 72 hours prior to The above regulations by:	in which the one or more requi- l, or is likely to cau- atient. Immediate Jeopardy (b)(2) If the medical stat- for: aintenance and imp- ind procedures in ate health profess es shall be approv- cedures shall be a d medical staff who (d)(2) mencing surgery the ninistering anesthes ral anesthetic is erify the patient's in body to be operat- ord of the following ecord: eening tests, base t, accomplished an surgery. s were NOT MET as	ise, serious if shall be olementation consultation ionals and red by the pproved by ere such is he person ia, or the not to be dentity, the ed on, and appears in ed on the d recorded s evidenced	8:40:2		a will be temporarily and ermanent hed by revising the blicy to include the t images or studies iewed by the e Time Out". f were provided nged process. ition of the person correction. ervices of the monitoring recurrence of the of time out audit helude the relevant resent at the time e Out" audits are imum of 30 cases in any of the nmediately sent to w. This information hd presented to the mance tee.	3-15-12
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/15/2012
PREFIX (EACH DEFICIENCY		S, CITY, STATE, ZIP CODE Mesa Dr, Fullerton, CA 92835-3809 ORANGE COUL 2012 JUN 28 AM 11 05 ID PROVIDER'S PLAN OF CORRECT PREFIX TAG REFERENCED TO THE APPROPRIATE D	ION (X5) BE CROSS- COMPLETE
the hospital failed procedure to have properly labeled and surgery. This failure wrong kidney. Findings: On 2/10/12, the hos a wrong site surgery. The hospital stated Commission's Safety procedure. Review of Goals for Hospital conduct a preproce pre-procedure verific Out" is an ongoing p and confirmation. The verification process is documents and rela are: - Available prior to the - Correctly identified, patient's identifiers - Reviewed and are expectations and wit the intended patient, p Among items listed should be included i process are labeled results (for example, ra	n, interview and record review, to follow their policy and relevant images and results displayed prior to a patient's resulted in the removal of the pital notified the Department of they had adopted the Joint of Goals as their policy and f the Joint Commission's Safety 2012 showed hospitals should dure verification process. The ation, usually called a "Time process of information gathering e purpose of the pre-procedure s to make sure that all relevant ated information or equipment start of the procedure , labeled, and matched to the e consistent with the patient's th the team's understanding of rocedure, and site. by the Joint Commission that in the pre-procedure verification diagnostic and radiology test adiology images and scans,	 a) How the corrections will be accomplished, both temporar permanently. The temporary and permanent corr plan includes: the surgical services department developed a standardiz preoperative checklist to confirm the relevant documentation, imaging stipathology reports are available befinstart of the procedure. The process for scheduling an oper procedure was standardized to include requesting of relevant images and stop of relevant images and stop of start of the procedure. b) The title or position of the responsible for the correction Director of Surgical Services c) A description of the monitoring process to prevent recurrent deficiency. The universal protocol time out aud was revised to include the relevant and studies present at the time of start of Physician Peer Review. This information is then aggregated and presented to the Patient Safety Per Improvement committee. 	ection red at the udy and ore the rative ude the studies. re person n. it form images urgery. red with a ariations mediate s
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	or pathology and displayed.	biopsy reports	s) properly				
	On 2/14/12, review procedure titled Un Wrong Person/Proced Procedures, effective Out" process "Relev properly labeled and this policy and proc 2003 Joint Commiss Wrong Site, Wrong Surgery which also studies should be av process.	iversal Protocol dure; Site/Side Op 9/5/11, showed fo vant Images and displayed." As a r cedure the hospita ion Protocol for p Procedure, Wro showed images an	To Prevent perations Or or the "Time results are reference for al used the Preventing ong Person d diagnostic				
	pre-operative diagnos kidney and umbilical diagnosis was lapa nephrectomy (remova umbilical hernia (a bu the belly button). During an interview Manager stated the	vas admitted to the on 12 with a f the right kidney. R (operating room) ord showed the is was neoplasm I hernia. The p aroscopic hand-as al of a kidney) ar ilging of the abdom on 2/14/12, the pathologist notifie noved during the s	hospital, St diagnosis of The patient on 12. e patient's of the right ost-operative sisted right nd repair of inal lining at Regulatory d MD 1 on surgery was				
	and asked the staff axial tomography) scar						
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6/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDING		(X3) DATE SUF COMPLET	
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diagnostic studies do 1's office at the time was identified that f kidney. Review of a showed the patient 12, was benign rem After the surgery, from Hospital B whe studies. Review of Hospital B showed of CAT scan which show mass consistent of According to the R was not a part of the Jude Medical Cent performed. At the time reports at his office. On 2/14/12 at 0850 RN 1 functioned as the operation. RN 1 state starting, so she asked In the OR, RN 1 wrow allergies. According arrives in the room the used a digital x-ray x-rays. The viewing according to RN 1 the a chest x-ray. RN 1 state films pertinent to the usually the surgeon at	spital where the patient had ne. These results were at MD of the surgery. At that time it the neoplasm was in the left pathology report, dated 12, 's right kidney, received on al tissue (normal kidney). the hospital obtained records are the patient had the kidney the diagnostic studies from on 11, Patient D had a wed the patient had a left renal with renal cell carcinoma. egulatory Manager this report e patient's medical record at St er, where the surgery was e of the surgery, MD 1 had the hours, RN 1 was interviewed. the circulating nurse during the ted she was 10 minutes late and RN 2 to interview Patient D. ote the patient name, OR side, to RN 1 when the patient his is asked again. The hospital system that holds the patient's monitor was in the room and be only film in the system was ted about 90% of the time e case are in the room and and assistant surgeon view the		1		
films. RN 1 stated assistant surgeon calle Event ID:4PPX11	prior to the surgery, the ed in sick so MD 1 was 6/14/2012	8:40:2	7AM		

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090158 R. VINC 02/15/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE It E Valencia Mess D.F., Statict. ZP CODE 04/10 SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER OF SUPPLIER 0/41 ID PREXX SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER OF UND TE SUMMARY STATEMENT OF DEFICIENCIES D 0/41 ID PREXX SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER OF UND TE COUNTY UII Z D D D D D D D D D D D D	and a second second second	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		(X3) DATE SU COMPLET	
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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF PUBLIC HEALTH

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	Continued From page has caused, or is lik death to the patient immediate jeopardy and Safety Code Secti This facility failed to described above that serious injury or deat constitutes an imm meaning of Health 1280.1(c).	kely to cause, serio t and therefore co within the meaning on 1280.1(c). prevent the deficie caused, or is likel th to the patient, ar nediate jeopardy	nstitutes an g of Health ency(ies) as y to cause, nd therefore within the					
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