STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1829 MULTIFLE CONSTRUCTION A BUILDING	-X3- DATE SURVEY COMPLETED
	050701	B WING	11/05/2009
MAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS CITY STATE ZIP CODE	
SOUTHWEST HEALTHCARE SY	ľ	CAL CENTER DRIVE, MURRIETA, CA 92562 RI	VERSIDE COUNTY
PREFIX EACH DEFICIE	A STATEMENT OF DEFICIENCIES INCY MUST BE PRECEEDED BY FULL OR USC IDENTIFYING INFORMATION	ID PROVIDER S PLAN OF C PREFIX (EACH CORRECTIVE ACTION S TAG REFERENCED TO THE APPROP	HOULD BE CROSS: COMPLETE
California Departr complaint investi 2009 The Si comprised of N licensure (Inland Rancho Springs Me	gation conducted October 26 outhwest Healthcare System i wo hospitals under the same Valley Medical Center and edical Center)	of Correction does not come admission or agreement Healthcare System (the truth of the facts alleged set forth in the Statement Deficiencies. The Hospithis Plan of Correction as state regulations. This F Correction documents the by the Hospital to address	onstitute an by Southwest Hospital) of the or conclusions at of tal is submitting s required by Plan of ne actions taken
HFEN, a HFEN, a HF The Department violation of the regu	EN was able to substantiate :	A. Administration detern three cited patients had a completed already, so cowould not affect them.	their C-sections
and immediate It of Patients 1, 2, and the mothers areas, was local immediate threat of three elective RSMC while the	2009, at 6:20 p.m., the CEC of Quality Outcomes, and strator, were notified a serious freat to the health and safety and 3, as well as their babies and babies in the surrounding entified. The serious and was due to the performance CSs in the OB CS room a recorded humidity in the room a risk for a fire to start during	humidity below the allow could affect any patient r or a C-section at Rancho Therefore, the Hospital to outlined below in section protect patients needing C-section. C. Actions to improve m monitoring of humidity in rooms (ORs) and C-sections	red minimum needing surgery o Springs. ook the actions as C. and D. to surgery or maintenance and the operating
Abbreviations used	rve Officer	* The CEO verbally a Chair of the Board of Go 10/28/09 that the operati	vernors on 11/16/09,
Event ID:E40411	1/5/2010		(X6) DATE
ABORATORY DIRECTOR'S OR PRO-		CEO IIILE	1.15.10

Any deliciency statement ending with an estetisk (f) 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 hursing names, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing names, the above findings and plans of correction are disclosable 14 days following the date these documents are thirde available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program bardicipation.

State-2567

SUTHWEST HALTHCARE SYSTEM SUMMARY STATEMENT OF DEPOCIENCES PREFAX SECULIDENCENT WAS THE SEPTICLE PROBLEM TO BE PROCEEDED BY TULL PREFAX SECULIDENCENT WAS THE SEPTICLE PROBLEM TO BE PROCEEDED BY TULL PREFAX SECULIDENCENT WAS THE SEPTICLE PROBLEM TO BE PROCEEDED BY TULL PREFAX Continued From page 1 CN - Charge Nurse CS - Cesaresen Section HYAC - Healing, Ventilation, Air Conditioning LLSD - Labor and Delivery OB. Obstetimes OR. Operations OR. Operation		T OF DEFICIENCIES OF CORRECTION	.X* PROVIDER/SUPPLIE TOENTIFICATION NU	MBE R	A BUILDING	IX? DATE SURVEY COMPLETED 11/05/2009
SOUTHWEST HEALTHCARE SYSTEM 25500 MEDICAL CENTER DRIVE, MURRIETA, CA \$2582 RIVERSIDE COUNTY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES SEMMARY STATEMENT OF DEFICIENCIES CONTROL OF THE SEMMARY STATEMENT OF DEFICE ON THE SEMMARY STATEMENT OF DATE COntinued From page 1 CON. Charge Nurse CS. Cesarean Section HVAC - Heading, Ventilation, Air Conditioning LED - Labor and Delivery OR - Obstelnes OR - Operations OR - Operatio	******* ()F 5%	DOMINED OF STIRRINGS		STREET ADDRESS CIT	V 67475 7/6 7005	
SUMMARY STATEMENT OF DESICIENCIES PREFIX SECULATION TO ISSUE DESCRIPTION OF SERVICE STORM AND COMPRESTION Continued From page 1 CN - Charge Nurse CS - Cesarean Section HVAC - Healing, Ventilation, Air Conditioning LED - Labor and Delivery OB - Obstetines OP - Operations OR - Operations OR - Operations OR - Operations A 014 1280.1 (c) For purposes of this section "immediate leopardy" means a situation in which the lecansee's noncompliance with one or more I requirements of licensure has caused or is likely to cause, serious injury or death to the patient T22 DIVS CH1 ARTS-70837 (a) General Safety and Maintenance and procedures for the safety and well-being of patients, personnel and visitors Based on observation, interview, and record review, the facinity failed to provide maintenance that shall include provisions and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors by failing to ensure the humidity in the CS OR at RSMC was within acceptable range prior to performing elective CSs on three Event IDE40411 1/5/2010 PREVIOURES PLAN OF COMPRESTION ACT ON STORM TARTS ACTORS SHOULD BE AC			£M.			DE COUNTY
Continued From page 1 CN - Charge Nurse CS - Cesarean Section HVAC - Heading, Verhilation, Air Conditioning L&D - Labor and Delivery OR - Obstelres ops - Operations OR - Operations Operations OR - Operations Operations OR	3001111			23300 WEDICAL CE	NIEN DNIVE, INDINICIA, CR 32302 NIVENS	
CN - Charge Nurse CS - Cesarean Section HVAC - Heating, Ventilation, Air Conditioning LAD - Labor and Delivery OB - Obstetincs ops - Operations OR - Operation	PREFIX	EACH DEFICIENC	Y MUST BE PRECEEDED BY	FULL P	REFIX EACH CORRECTIVE ACTION SHOULD	BE CROSS- COMPLETE
likely to cause, serious injury or death to the patient T22 DIV5 CH1 ART8-70837 (a) General Safety and Maintenance (a) The hospital shall be clean sanitary and in good repair at all times Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors Based on observation, interview, and record review, the facility failed to provide maintenance that shall include provisions and surveillance of services and visitors by failing to ensure the humidity in the CS OR at RSMC was within acceptable range prior to performing elective CSs on three Board of Governors at subsequent meetings. * The Chief Nursing Officer reviewed 11/05/09 and revised the policy on monitoring temperature and humidity in the peri-operative areas as follows: -The circulating RN (rather than a technician) must check and log temperature and humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. -The reading must be done before bringing a patient into the OR. -If a reading is out-of-range reading Event ID:E40411 1/5/2010 * The Chief Nursing Officer reviewed 11/05/09 and revised the policy on monitoring temperature and humidity in the peri-operative areas as follows: -The circulating RN (rather than a technician) must check and log temperature and humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. -The reading must be done before bringing a patient into the OR. -If a reading is out-of-range reading		CN - Charge Nurse CS - Cesarean Section HVAC - Heating, Venication L&D - Labor and Delife OB - Obstetrics ops - Operations OR - Operations OR - Operations A 014 1280.1 (c) For purposes of jeopardy" means	in Itilation, Air Conditionin very Ings Medical Center f this section a situation in	"immediate which the	due to humidity problems. The Governors met three times, of 11/06/09, 11/16/09, and 12/14 discuss the humidity issues at Hospital. At each of those met the CEO presented to the Bostovernors the findings identified the November survey, and the Hospital had taken to add findings. Subsequently, the E Governors directed the CEO aleadership team to continue implementing process improvementioring and acting on the interest of the continue of the center	ne Board of n 14/09, to t the setings, ard of ied during se actions ress the Board of and senior ements for
and Maintenance (a) The hospital shall be clean, sanitary and in good repair at all times Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors Based on observation, interview, and record review, the facility failed to provide maintenance of services and procedures for the safety and well-being of surveillance of services and procedures for the safety and well-being of patients, personnel, and visitors by failing to ensure the humidity in the CS OR at RSMC was within acceptable range prior to performing elective CSs on three Event ID:E40411 Include provision and surveillance of services and procedures for the safety and well-being of patients, personnel, and visitors by failing to ensure the humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. -The circulating RN (rather than a technician) must check and log temperature and humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. -The circulating RN (rather than a technician) must check and log temperature and humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. -The reading must be done before bringing a patient into the OR. -If a reading is out-of-range reading		likely to cause, se			Board of Governors at subsec	
good repair at all times Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors Based on observation, interview, and record review, the facility failed to provide maintenance that shall include provisions and surveillance of services and procedures for the safety and well being of patients, personnel, and visitors by failing to ensure the humidity in the CS OR at RSMC was within acceptable range prior to performing elective CSs on three —The circulating RN (rather than a technician) must check and log temperature and humidity in peri-operative areas before each case rather than just before the first case of the day to confirm temperature and humidity are in range. —The reading must be done—before bringing a patient into the OR. —The reading must be done—before bringing a patient into the OR. —If a reading is out-of-range reading Event ID:E40411 1/5/2010 4:29-18PM			-70837 (a) Gener	al Safety	and revised the policy on mor temperature and humidity in the	nitoring he
Based on observation, interview, and record review, the facility failed to provide maintenance that shall include provisions and surveillance of services and procedures for the safety and well being of patients, personnel, and visitors by failing to ensure the humidity in the CS OR at RSMC was within acceptable range prior to performing elective CSs on three Event ID:E40411 Interview, and record the day to confirm temperature and humidity are in range. The reading must be done before bringing a patient into the OR. If a reading is out-of-range, staff must document the out-of-range reading		good repair at include provision and procedures for	all times Mainten and surveillance (the safety and w	ance shall of services	-The circulating RN (ra a technician) must check and temperature and humidity in peri-operative areas before ea	ther than log
Eveni ID:E40411 1/5/2010 4:29:18PM		review, the fall maintenance that surveillance of service safety and well and visitors by fail the CS OR at 1	citity failed to shall include provinces and proceduring being of patients, ling to ensure the RSMC was within	provide isions and es for the personnel, humidity in acceptable	the day to confirm temperatur humidity are in range. The reading must be of before bringing a patient into the	done the OR.
		runge phor to periorin	ing elective Cos on th		must document the out-of-ran	ge reading

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

TITLE

(X6) DATE

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 hiddings above are disclosable 90 days following the date of survey whether or not a pian 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.

State-2567

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	•	(X2-MULTIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		0.000		A BUILDING		
		050701		9 AING	11/0	5/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET AUDRESS	CITY, STATE ZIP CODE		
SOUTHW	EST HEALTHCARE SYST	EM	25500 MEDICAL	CENTER DRIVE, MURRIETA, CA S	2562 RIVERSIDE COUNTY	
PREFIX TAG	!EACH DEFICIENC	Atement of deficiencies Y Must be preceeded by LSC IOENTH YING INFORMA	FULL	PREFIX LACH CORRECTIVE	PL4N OF CORRECTION E ACTION SHOULD BE CROSS- HE APPRIPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page	e 2		on a log.		
	potential for fire in and baby in the companies in the sa (newborn nursery, L&D rooms) The event constitute because the facility likely to cause in the same in t	geries in a room low Patients 1 October 26, 2009, in the room was elective CS on Coorded humidity in failed practice resulthe OR, and injury OR, as well as mane suite as the two triage rooms.	and 2 had when the 25% and October 28, the room lied in the 7 to mother and three S OR and three	Operations of the and initiate a work and initiate a work —A Plant O member must imrand take appropriout-of-range level —-If any OR humidity reading to be used until P has brought the te humidity levels be appropriate range —Ongoing of	perations staff mediately investigate ate action to bring the back into range. has a temperature or that is not within the that room is not lant Operations staff emperature and/or ack within the	
	Findings;			forwards those co Administrative Le	oncerns to	
	October 28, 2009, the OB Manager, to observed to be 20	he humidity in the % The manager	room was stated no		Governors approved e humidity monitoring	11/16/09
	CSs were done cancelled a previo the low humidity of the room. Ouring an interview 28, 2009, at 3.05 recorded a humidity a.m., she reported it to	with OB Tech 1 pm, the tech of 25% in the i	for fire in on October stated she	Log to use to doct temperature and I peri-operative are each case, and, w and/or humidity re	Temperature/Humidity ument (1) all humidity readings in as prior to the start of when temperature eadings are not within larges, (2) that Plant	11/05/09
Event ID:	40411		1/5/2010	4 29 18PM		

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

State-2567

STAC (BX)

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 050701	IX21 MULTIPLE A BUILDING B VANG			RVE Y (ED)	
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTE	1	ADDRESS CITY STATE ZIP O	111001200			
PREFIX EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF BEACH COPRECTIVE ACTION REFERENCED TO THE APPRI	SHOULD BE CROSS-	.X5) COMPLETE DATE	
Continued From page	3		t-of-range readings b			
reported it to plant ops		De	fore any case procee	eds in that OR.		
	midity log for the CS OF 29, 2009, indicated the started October 26, 2	low me	* The Director of Me ervices faxed an educ emorandum from the e changes to the poli- sysicians on the Medi	cational CEO regarding cy to all	11/05/09	
October 29, 2009. CSs were performed 26, 2009, and or performed in the room. The record for October 29 and Nov.	O9, 22% (plant ops notice and administrator awarded). RSMC delivery room log indicated two non emerging the non emergent CS on October 28, 2009. Patient 1 was reviewed ember 3, 2009 Patient logicale, was admitted to RSO9, for a repeat CS, we	wified, ed	* On 11/05/09, the Formen's and Cardioval adership team providucation on the revise m to all OR and L&D ducation continued profil 100% of appropriatucated; no staff memor shift without first be ducation of OR and Loluded: (1) review of the emperature/Humidity monstration on the umperature/humidity myces.	ascular Services ded initial ded policy and new o nursing staff. dier to each shift ate staff were aber began his or eing educated. &D nursing staff the revised a new Log, and (3) ase of monitoring		
25%. The labor and Patient 1 was not in lab The labor notes presented to L&D a	delivery summary indicator on amual indicated the patest 11:20 am, "for sched OR at 12 p.m., and the b	ated the the content of stated with the content of state with the content of the	* On 11/05/09, Plant anagers provided inition e revised procedure to e Plant Operations stantinued prior to each appropriate staff were aff member began his thout first being educt Plant Operations stantinue of the new were procedured.	ial education on to all members of faff. Education shift until 100% re educated; no sor her shift rated. Education ff included: (1)	11/05/09 & 11/08/09	
Event iD:E40411	1/5/2	2010 4.29°18PI		3 (-)	 '	
ABORATORY DIRECTOR'S OR PROVIDE	R'SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE		(X6) DATE	

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State 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	BER	(XZ) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SUI COMPLET	
	050701		8 WHG	11/0	5/2009
NAME OF PROVIDER OR SUPPLIER	·	STREET ADDRESS CIT	Y, STATE ZIP CODE		
SOUTHWEST HEALTHCARE SYST	EM :	25500 MEDICAL CE	NTER DRIVE, MURRIETA. CA 92562	RIVERSIDE COUNTY	
PREFIX LEACH DEFICIENC	TATEMENT OF DEFICIENCIES V MUST BE PRECEEDED BY F LSC IDENTIFYING INFORMAT		ID PROVIDER'S PLAN O REFLY LEACH CORRECTIVE ACTIO FAG REFERENCED TO THE APPR	N SHOULD BE CROSS.	(X5) COMPLETE DATE
Continued From pag	e 4		expected response tin		
		when the	documentation require	ments.	
patient was taken on oxygen. The intraoperative bovie (an electrica heat to (1) make and destroying to bleeding blood vess and turned on. The operative reposition of the operative reposition of the perative r	nursing record in a cautery machine a surgical incision issue, or (2) clasels) was set up in ort, dictated by the indicated the initial	edicated a that uses by burning ose small the room	D. The Hospital implet following steps to monwith the corrective action. * The Chief Nursing developed a report for Directors to use to aggin that temperature and hocked and document case, that Plant Opera being notified if reading range, and that Plant Obringing the levels bac	itor compliance ons: Officer of Department regate and report aumidity levels are ted before each tions staff is gs are out of Operations staff is	•
October 29 and No	nale, was admitted 009, for a repeat	viewed on Patient 2, to RSMC CS, when room was	documenting that action case proceeds in that of the case proceeds in that of the case proceeds in that of the case procedure assure compliance with policy and procedure.	on before any OR. tors use the new ggregated data in the OR logs to the revised	11/05/09, 12/14/09 & ongoing
The labor and Patient 2 was not in la	delivery summary bor on arrival	indicated	completeness of docur audits began on 11/5/0 until all staff were educ	mentation. Daily 7 99 and continued cated.	5 5
The labor note presented at 3:30 pwalked to the OR was delivered at 5:03	p.m., for a, "scheo at 4:30 p.m., and	fuled CS."	Department Directors I aggregating data from weekly. The Directors Women's, and Cardiov are responsible for rep	the OR logs of Perioperative, rascular Services orting compliance	tā.
The anesthesia rowas placed on oxygen	ecord indicated this in the OR	e patient	data on a monthly basi Pillar, Patient Safety C Executive Committee,	ouncil, Medical and Board of	enter management Section
The intraoperative nur	sing record indicated a		Governors. The Nover data was reported to the	•	
Event ID E40411		1/5/2010	4:29 18PM		
LABORATORY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESEN	TATIVE'S SIGNATUR	E TIFLE		(X6) DATE

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_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER'SUPPLIEDENTIFICATION NO		-	TIPLE CONSTRUCTION	IX3: DATE SURVEY COMPLETED	
		060704		A BUNDA	NG		
		050701		B MING		11/05/2009	
NAME OF PR	NOVIDER OR SUPPLIER		STREET ADDRESS	CITY, STATE	SIE CODE		
SOUTHW	EST HEALTHCARE SYST	EM	25500 MEDICAL	CENTER D	PRIVE, MURRIETA, CA 92562 RIVERS	IDE COUNTY	
1X41-1D		ATEMENT OF DEFICIENCIES		ıσ	PROVIDER'S PLAN OF CORRE	KOTON (X	(5)
PREFIX		y must be preceeded by LGC identifying informa		PREFIX	EACH CORRECTIVE ACTION SHOUL		PLETE
120	REGULATOR	EGG IDENTIFYING INFORMA	i i i	160	REFERENCED TO THE APPROPRIATE	DEFILIENCY) UA	ME
	. Continued From page	e 5			Governors on 12/14/09. After	r three	
	bovie was set up in the				consecutive months of meeti compliance, the Patient Safe	•	
	~ L _				will determine further auditing	•	
		operative report, dict	•		reporting requirements.	•	
	· •	Iguration to contro					
	(an electric spark	• • •			The Hospital hereby also req	uests an	
	the lissue, without		lly louching		informal conference with the		
	the tissue, closing sma	all blood vessels)			administrator/district manage	r to	
	3. The record for	r Patient 3 was re	eviewed on		discuss the following addition		
	October 29 and No		Patient 3.		information, which indicates		
		nale, was admitted			Hospital was in compliance v	vith this	
	on October 28, 20 the recorded hum	009 for a repeat	CS, when		rule:		
	22%.	idity in the CS	room was		–The Hospital was monito	~	
	EL 70.				humidity in the ORs daily bef		
	The labor and	delivery summary	indicated		case of the day and notifying		
	Patient 3 was not in la	· .			Operations if humidity levels		
					the acceptable range. When		
	,The labor notes	indicated the pati	ent walked		low atmospheric humidity led		
	into the OR at 7	35 am (35 minute	s after the		maintaining the minimum hu	•	
	staff obtained a hi	umidity reading of	22%), and		in the ORs at RSMC, the Hos		
	the baby was delivered	d at 8:01 a.m.			self-reported the humidity iss 'CDPH on 10/28/09 in order to		
					program flexibility so that the	•	
			he palient		could resume surgeries at R		
	was placed on oxygen	in the OR,			the meantime, the Hospital c		
					rescheduled, or moved 24 su		
	The intraoperative	•	ndicated a		the IVMC ORs during that we		
	bovie was set up in the	e room and turned on				: : -	í
	_				-The citation mistakenly s	states that	
	The operative repo	•			two C-sections were perform		- 1
	on October 28, 2				10/26/09 when the humidity		- 1
	used fulguration to		•		30%; Plant Operations staff h		- 1
	spark that jumps for				the humidity level back into p		1
	without the bovie actua	any touching the tissu	€ ,		range prior to the start of the	first	I
Event ID	E40411		1/5/2010	4 29	18PM		

Any deficiency statement ending with an asterisk (*) dehotes 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.

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

(X6) DATE

PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LEACH CORRECTIVE ACTION SHOULD BE CROSS- COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLM IDENTIFICATION NUMBER	٠ (X2) MULTIPLE CONSTRUCTION	(X3/DATE SURVEY COMPLETED
SOUTHWEST HEALTHCARE SYSTEM COMMITTED SOUTHWEST HEALTHCARE SYSTEM COMMITTED SOUTHWEST HEALTHCARE SYSTEM COMMITTED COMMITTED COMMITTED COMMITTED PREFORM TAD PROVICES PLAN OF CORRECTION ICAGN COMMITTED TAD PROVICES PLAN OF CORRECTION TAD PROVICES PLAN OF CORRECTION ICAGN COMMITTED TAD PROVICES PLAN OF CORRECTION TAD COMMITTED COMMITTED TAD PROVICES PLAN OF CORRECTION TON OF COMMITTED TAD PROVICES PLAN OF CORRECTION TON ORTHORITY TAD COMMITTED TAD PROVICES PLAN OF CORRECTION TAD COMMITTED TAD PROVICES PLAN OF CORRECTION TON ORTHORITY TAD COMMITTED TAD PROVICES PLAN OF CORRECTION TON ORTHORITY TAD				BUILDING	_
### A The purpose of the policy stilled. Temperature/Humiday Monitoring, Pen-Op. Two looper 29, 2009. The purpose of the policy makes the following a The purpose of the policy makes as a both were associated with principals of fire safety. **A The purpose of the policy was to monitor the temperature areas, as both were associated with principals of fire safety. **Description of the policy makes the beginning of the first case, and. **Description of the policy makes the beginning of the first case, and. **Description of the policy makes to the policy was to monitor the temperature areas, as both were associated with principals of fire safety. **Description of the policy makes to monitor the temperature areas, as both were associated with principals of the safety. **Description of the policy makes to monitor the temperature areas, as both were associated with principals of the safety. **Description of the policy makes to monitor the temperature areas, as both were associated with principals of the safety. **Description of the policy makes to monitor the temperature areas, as both were associated with principals of the safety. **Description of the policy makes the temperature areas, as both were associated with principals of the safety. **Description of the policy makes the proper range of the proper range of the proper range of the proper range of the properative with OR RN ton November. **ZEROND PROVINCE CORDINATION OF The Authority Monitoring Proposed whith the Temperature with the Temperature with Monitoring Policy (Humidity Monitoring Policy (Humidity Monitoring Policy (Humidity Monitoring Policy (Humidity Monitoring and the fire of the the that time, nursing staff checked the humidity Monitoring Policy (Humidity Mo		050701	;	3 WING	11/05/2009
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Continued From page 6 closing small blood vessels) The pre-scheduled CS records were reviewed on October 30, 2009, and indicated the following The pre-scheduled CS records were reviewed on October 30, 2009, and indicated the following a. Patient 1 was scheduled for an October 26, 12009, CS on September 22, 2009, b. Patient 2 was scheduled for an October 26, 12009, CS on September 22, 2009, and. c. Patient 3 was scheduled for an October 28, 12009, CS on September 22, 2009, and. c. Patient 3 was scheduled for an October 28, 12009, CS on September 22, 2009, and. c. Patient 3 was scheduled for an October 28, 12009, CS on Detober 6, 2009 The facility policy titled, "Temperature/Humidity Monitoring, Pen-Op." was reviewed on October 29, 2009 The policy indicated the following a. The purpose of the policy was to monitor the temperature and humidity levels in the penoperative areas, as both were associated with principals of fire safety b. The expected perioperative humidity range was 35-80%. c. A staff member would record the readings on a log each day before the beginning of the first case, and. d. A surgical case would not begin until the humidity in the OR was in the proper range During an interview with OR RN ton November Event ID E40411 EVENTIO E40411 TAS REFEME CTO The Averopacia fe beginned. The period The Averopacia fe beginned. The period The Averopacia fe beginned. The Temperature/Humidity Monitoring, Peri-Op Policy (Humidity Monitoring, Peri-Op Policy	SOUTHWEST HEALTHCARE SYS	TEM 2550	MEDICAL CE	NTER DRIVE. MURRIETA, CA 92562 R	VERSIDE COUNTY
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During an interview with OR RN 1on November Event ID E40411 1/5/2010 4 29 18PM	numicity in the OR wi	as in the proper range			
	Dunng an interview w	with OR RN 1on November		iotorior are ionoming re	, , , , , , , , , , , , , , , , , , ,
	Event ID E40411	1	/5/2010	4 29 18PM	
		DER/SUPPLIER REPRESENTATION	VE'S SIGNATURE	TITLE	IX61 DATE

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 commuted program participation.

CALIFORNIA HITALTH AND HUMAN SERVICES AGENCY

STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	1	SUPPLIERICLIA TION NUMBER	1X2: MULTIPLE CONSTRUCTION	KEIDATE SURVEY COMPLETED
			A Buit DING	
	050701		B WING	11/05/2009
NAME OF PROVIDER OR SUP	PLIE R	STREET ADDRESS	CITY STATE ZIP CODE	
SOUTHWEST HEALTH	CARE SYSTEM	25500 MEDICAL	CENTER ORIVE, MURRIETA, CA 92562	RIVERSIDE COUNTY
(X4:1D ·	SUMMARY STATEMENT OF DEFIC	(ENC.ES	ID PROVIDERS PLAN	OF CORRECTION (XS;
PREFIX EA	CHIDEFICIENCY MUST BE PRECEED BUSATORY ON LIST DENTIFYING IN	CED BY FULL	PREFIX IEACH CORRECTIVE ACTIC TAG REFERENCED TO THE APP	ON SHOULD BE CROSS- COMPLE
Continued	From page 7		*When the Char	ge Nurse in
4 2009.	at 1,40 pm, the R	N acknowledged	Women's Services lea	med at 9:00 a.m.
low hum	•	rease nsk for	on October 28 that the	
	fire in the OR, and		the C-section OR was	
• •	culator (the RN in the	•	immediately contacted	
surgical	case)," who should	be continuously	about the humidity leve	
checking	the humidity. The R	N stated a fire	the remaining C-section	ons scheduled for
rsk asses	sment was done as p	part of the time	that day.	
out proce	dure before the surgic	al case started.		ey, the American
but it did no	ot include the humidity leve	l	Society of Heating, Re	
			Conditioning Engineer	
The fac	ility document title	o, "Procedural	published its determina	
Checklist	With Fire Risk As	sessment," was	scientific research find	
reviewed	on November 4,	2009. The	risk of infection or fire	
document	included location o	f the surgical	humidity levels as low	
procedure,	use of open flow o	xygen, and use	ASHRAE concluded th	
of a bovi	e as risks for fire. Th	ne document did	humidity requirement is	
not identify	low humidity in the room a	s a nsk.	holdover from the era	
			anesthetics were used	
According		(National Fire	rooms, and has propos	
Protection	Act) 99. Standard f		minimum humidity leve	
Facilities,	Anesthetizing location	are protected	patient treatment stays	
by mainta	•	ednay to ou	which sets national fire standards, also plans t	
greater than	1 35%		35% minimum humidit	
	. بمین می		follow the revised ASH	
		escheduled non	standard.	irvae numuny
	surgical procedures pe		stantianu.	
	vith low humidity and	· •	-Finally, the risks to	o adjoining areas
	use, in violation of th		in the unlikely event a	
• •	of fire safety, and A	SOVEN SISUASICS	the C-section OR were	
of practice			C-section OR is contain	
A	of the DSMA Aper all	an indicated the	fire compartment, sepa	
	of the RSMC floor pla OR was in the same		other areas by a one-h	
			smoke barrier wall and	
newborn f	nursery, two triage roo	ons and intee	Sitions builts wall alle	

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

(X6) DATE

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

1/5/2010

4:29:18PM

Event | D.E40411

	TENT OF PUBLIC REAL						
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI		- 1	CONSTRUCTION	COMPLET	
		050204		A BUILDING		-	
		0\$0701		B YANG		11/0	5/2009
	COVIDER OR SUPPLIER			S CITY STATE ZIP			
SOUTHW	EST HEALTHCARE SY	STEM	25500 MEDICAL	L CENTER DRIV	E, MURRIETA, CA 92562 R	IVERSIDE COUNTY	
			Į				•
	A		<u> </u>	iĎ	Dag. 100 dag		
PREFIX		V STATEMENT OF DEFICIENCIE INCY MUST BE PRECEEDED BY		BBECIX If)	PROVIDER'S PLAN OF EACH CORRECTIVE ACTION		IX5. COMPLETE
TAG	REGULATORY	OR LSC IDENTIFYING INFORMA	NTION)	TAG .	referenced to the appro	PRIATE DEFICIENCY	DATE
	Continued From p						
	could spread to the	•					
l	On October 29	2009, at 6.20 p.m.	the CEO				
	COO, Director	•	omes, and				
	Associate Admini	strator, were notified	a serious				
		hreat to the health	•				
	•	and 3, as well as	•				
	areas, was identifie	and babies in the d.	surrounding				
	The facility's fa	ailure to ensure i	maintenance,				
	including provi	sions and surve	illance of				
	services and	,	nsure the				
	humidity in the appropriate an		was within prior to				
		elective CSs is	•				
		or is likely to ca					
		to the patient an					
		immediate jeopardy alth and Safety Co					
	1280.1.	sith and delety of	de declion				
							•
Event ID:	F4O411		1/5/2010	4 29 18P	М		·

Any deficiency statement ending with an asterisk (1) 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 bited, an approved plan of correction is requisite to continued program participation.

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

(X6) DATE