**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER:**
CA040000254

**X2 MULTIPLE CONSTRUCTION**
A. BUILDING
B. WING

**X3 DATE SURVEY COMPLETED:**
07/14/2011

**NAME OF PROVIDER OR SUPPLIER:**
FRESNO SURGICAL HOSPITAL

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
6125 NORTH FRESNO ST
FRESNO, CA 93710

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 000</td>
<td>Initial Comments</td>
<td>The following reflects the findings of the Department of Public Health during an inspection visit:</td>
<td>A 000</td>
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<td></td>
<td>Complaint Intake number:</td>
<td>CA00246887 - Substantiated</td>
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<td></td>
<td>Representing the Department of Public Health:</td>
<td>HFEN</td>
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<td>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</td>
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<td></td>
<td>Health and Safety Code Section 1280.1(c): For purposes of this section &quot;immediate jeopardy&quot; 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.</td>
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<td></td>
<td>DEFICIENCY CONSTITUTES IMMEDIATE JEOPARDY</td>
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<tr>
<td>A 001</td>
<td>Informed Adverse Event Notification</td>
<td>The facility followed the Department of Public Health during an inspection visit:</td>
<td>A 001</td>
<td>Informed Adverse Event Notification</td>
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<td></td>
<td>&quot;Health and Safety Code Section 1279.1 (c), &quot;The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.&quot;</td>
<td>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</td>
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<td></td>
<td>T22 DIV5 CH1 ART3-70223(b)(2) Surgical</td>
<td>E 347</td>
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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:**

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**DATE:** 10-24-11

**TITILE:** 10-24-11
Continued From page 1

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.

This Statute is not met as evidenced by:
Based on staff interview, clinical record, and administrative document review, the facility failed to implement the facility "Counts of Sponges ..." policy and procedures. The facility failed to ensure staff accounted for all sponges after Patient 1's surgery on 09/09. This failure caused Patient 1 to have a second hospitalization for intravenous (IV) antibiotics; a third hospitalization for a second surgery on 09/09 to determine the cause of Patient 1's continued infections. The second surgery identified a retained lap sponge as the source of her infections.

On 7/13/11 at 2:15 p.m. during an interview, Patient 1 stated when she came home from the initial surgery on 09/09; she never began to get better during her recovery and continued to inform her physician of her pain, and weakness. Patient 1 stated her physician continued to place her on antibiotics (Cipro, Levaquin) for about 3-4 months making changes of the type of antibiotics until she collapsed at home and was admitted into a hospital for 11 days to be treated with IV antibiotics for infection. Patient 1 stated 2 days after discharge from the hospital she began to feel terrible again and continued on antibiotics as...
All OR staff are required to view a training video on Patient Safety and Retained Foreign Objects by October 28, 2011 in order to educate staff further on identification of risk factors for retained foreign objects and how to prevent an occurrence of retained foreign objects from occurring.

All operating room staff members were educated on the revisions of the operating room record as it pertains to documenting the count procedure, by the OR coordinator. The OR staff are also to be re-educated on the Policy and Procedure, Counts of Sponges, Needles and Instruments (TX 04.013), by October 28, 2011. The Policy and Procedure, Counts of Sponges, Needles and Instruments (TX 04.013), will be in effect for all patients having a surgical procedure performed at FSH. This process will be monitored to assure strict compliance going forward.

30 surgical procedures per month will be monitored concurrently by the OR Coordinator to assure that the Count policy is followed and appropriately documented on the operating room record. Monitoring criteria will include: All sponges, sharps and needles and instruments are counted and recorded when added to the operative field, counts are audible, all sponges are separated and visualized by both the scrubbed person and the circulating nurse when counting, all sponges on the field are x-ray detectable, and sponges are never cut. The results to the audits will be reported by the OR representative to the Hospital Wide Quality Committee on a quarterly basis. Ongoing concurrent monitoring will continue for a minimum of 6 months, until the quality committee has seen satisfactory compliance with all components of the Sponge, Needle and Instrument Count policy and procedure.
### PROVIDER OR SUPPLIER

**NAME:** FRESNO SURGICAL HOSPITAL  
**ADDRESS:** 6125 NORTH FRESNO ST, FRESNO, CA 93710

### SUMMARY STATEMENT OF DEFICIENCIES

**ID TAG**: E 347  
**DATE**: 07/14/2011

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Pathology: Surgeon 1 stated he was never informed at the time of surgery that the sponge count was incorrect.

The Operating Room record dated 07/09 documented Sponge counts were done twice intraoperatively, with both counts being correct, but lacked specific times as per the facility policy and procedure "Counts of Sponges, Needles, and Instruments." (pre-operative and when closure of vaginal cuff, anterior and posterior repair were completed) There was no indication the count was done audibly as required by the above policy.

The Pathology Report from the second surgery dated 09 documented the following operative findings: Gauze sponge trapped between mesh and bladder ... Clinical diagnosis: Retained sponge ... The First specimen "one tan-green gauze that measures approximately 15 x 7.5 x 0.8 cm "... " mucosal tissue that measure up to approximately 1.5 x 1.3 x 0.9 cm "..." the specimen is putrid "..."

The facility policy and procedure titled "Counts of Sponges ... " revision dated 12/24/08 (original date 1/1/92) indicated the Procedure for counting sponges and sharps will be followed for every operative or invasive procedure unless otherwise indicated per policy ... Definitions  
Beginning/Initial Count- indicated the sponge count done prior to incision and conducted by the RN and a scrub person ... Closing Count - indicated when closing any cavity ... Counts are performed ... Prior to start of surgery ... at closure of cavity or hollow organ, ... counts will be performed audibly and viewed concurrently as they are separated and counted by two individuals, on of whom is a registered nurse...
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Sponges must be x-ray detectible and are counted as precise number in package.

The facility's failure to ensure staff followed the "Counts of Sponges..." resulted in Patient 1 sustaining the retention of a foreign object (gauze sponge) for eight months. Due to the retention of the foreign object, Patient 1 suffered with pain and weakness since 09. She needed an additional hospitalization for antibiotics for 11 days and required a second surgery on 09 for removal of the gauze sponge. Patient 1 stated "I feel like I have been robbed of my life having to live with this."

This is a deficiency that has 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.