State-2567

Ann Warner not

.....

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SU COMPLET	ED
		050006	B. WING		08/1	2/2011
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADORESS	, CITY, STAT	E, ZIP CODE		
ST. JOSE	EPH HOSPITAL	2700 DOLBEER	ST., EURE	KA, CA 95501 HUMBOLDT COUNTY		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<u>—</u> ———	(X5)
PREFIX TAG		MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DE		COMPLETE DATE
	The following reflects the of Public Health during	ne findings of the Department an inspection visit:		Compliant Number CA00277671 Penalty number: #110008611 E347 T22 DIV5 CH1 ART3-70223(b	o)(2)	
	Complaint Intake Numb CA00277671 - Substan Representing the Depa	tiated		Temporary and Permanent Correct Action: 1. The hospital policy, Surgical Count Sponges, Sharps and Instruments wa	ts:	8/12/11
	Surveyor ID # 16932, H	FEN ted to the specific facility does not represent the		reviewed, 7/27/11, and found to be ac addressing the need to count addition that are added to the surgical field. S are to be counted at the time they ent surgical field and recorded on the cou	dequate in nal items Such items ter the	
	purposes of this s means a situation noncompliance with c	in which the licensee's one or more requirements of or is likely to cause, serious		to keep the count current and accurat 2. Interview of surgical staff on 7/28/1 determine the department practice for visceral retractors when added to the field.	te. 1 to r counting	8/12/11
	Penalty number: #1100 E347 T22 DIV5 C	08611 CH1 ART3 - 70223 (b) (2)		3. "Fish" retractors added to the white the operating room and uniformity of p reviewed at the department morning r 7/28/11.	oractice	8/12/11
	assigned responsibility (2) Development, ma	the medical staff shall be for: intenance and implementation		 Review of Count Policy during staff on 8/1/11 regarding instruments, such and the requirement for counting at tir into the surgical field. 	as fish,	8/12/11
	with other appropria administration. Policies governing body. Proc	ad procedures in consultation te health professionals and s shall be approved by the edures shall be approved by medical staff where such is		 Interdisciplinary meeting on 8/10/11 Chief of Surgery, Medical Director of F Surgical Services Director, Quality Director Chief Medical Officer to review and int Surgical Count policies of Surgical Ser Diagnostic Imaging. 	Radiology, ector, and tegrate the	8/12/11
Event ID:Z		10/7/2011	11:21	:12AM		

LABORATO	BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE								TITLE		
	Λ	ha.	(1, 0)	Duid	v. F) al it.	D.	2 O			Plark
	ann	Na	ner RN	Mua	$\alpha/, G$	uning	MA	01-104	um_		<u>- 25/11</u>
Any deficie	ency statemen	t ending w	ith an asterisk (*) denot							s determined	•
that other s	safeguards pr	ovide suffi	cient protection to the pa	tients. Except for	r nursing ho	mes, the fin	dings abo	ve are disc	losable 90 days foll	lowing the date	
of survey w	vhether or not	a plan of	correction is provided. F	or nursing homes	, the above	findings an	d plans of	f correction	are disclosable 14	days following	
the date th	ese documen	ts are mad	le available to the facility	. If deficiencies a	are cited, an	approved p	ian of cor	rection is re	equisite to continue	d program	
participatio	n.) <		. lal)		_1.	9/1-	1 4 00	al	
			accord	11 4 K	$/ \chi$	ian	10-	Le.	VIII	V + 0	

-izd

t n vox

1 of 6

D50006 B. WING D8/12/2011 AME OF PROVIDER OR SUPPLIER ST. JOSEPH HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 2700 DOLBEER ST., EUREKA, CA 95501 HUMBOLDT COUNTY STREET ADDRESS, CITY, STATE, ZIP CODE 2700 DOLBEER ST., EUREKA, CA 95501 HUMBOLDT 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) COMPL DATE Continued From page 1 Based on observation, staff interview, and document review, the hospital failed to ensure that the operating room (OR) teams followed policy and procedures for accounting for all items placed inside the patients during surgical procedures. This failure resulted in Patient 1 having a retained foreign object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the B. WING 08/12/2011			(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MU A. BUILD		(X3) DATE SURVEY COMPLETED	
ST. JOSEPH HOSPITAL 2700 DOLBEER ST., EUREKA, CA 95501 HUMBOLDT COUNTY Image: Continued From page 1 Bit Reculutation of consections whole de cross- received beforemory must ne encetobe avruuit. PREVIDENT STALL PREVIDENT STALL Continued From page 1 Continued From page 1 Continued From page 1 Continued From page 1 Surgical Surgical Count Policy reviewed at document review, the hospital failed to ensure that the operating from (OR) teams followed policy and procedures for accounting for all items placed inside the patients during surgical procedures. This failure resulted in Patient 1 having a retained foreign object (a Visceral Retractor) that caused protograd post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the retained object. 6. Interdisciplinary consulting team of surgeon, OR nurse, and Risk Manager competed at three day assessment of perioperative surging and surgical three day of direct observation in the Surgical Services (Dening, closing and the outcoins). 9/12/11 8. Interdisciplinary consulting team of surgeon, OR murse, and Risk Manager competed at three day assessment of perioperative Nursing and Surgical the duricion in November 2011 using AGRN materials for education (ACRN. Preventing Retained Surgical Intervitions). 10/13/11 9. Ongoing Perioperative Nursing and Surgical THE VICLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (LI) NUTHIN THE MEANING OF HEALTH AD USCERAL RETRACTOR J HAD BEEN RETAINED IN A PATIENT AFTER SURGERY. REQUIRED RETRIEVING THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. 0. Implementaion			050006				08/1	2/2011
Uxel ID PREFER SLIMMARY STATEMENT OF DEFICIENCES (EACH DEPROFEMENT MUST ARE PRECEDED B YILL PREFER ID PREFER PROVIDER'S PLM OF CORRECTION (EACH DEPROFEMENT MUST ARE PRECEDED B YILL PREFER (20) Continued From page 1 Based on observation, staff interview, and document review, the hospital failed to ensure that the operating room (OR) learns followed policy and procedures for accounting for all items placed inside the patient 1 having a retained foreign object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the retained object. 6. Revised Surgical Count Policy reviewed at Surgical Services Staff meetings. 9/12/11 THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE DEOPARDY (U) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.1IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (A VISCERAL RETRACTOR IND BEEN RETAINED IN A PATIENT AFTER SURGERY. REQUIRED RETRIEVING THE FOREIGN DOJ. 0. Ongoing Perioperative services. Hereify Biophysical Services 0. Ongoing Perioperative Nursing and Surgical Tech education in November 2011 using AORN materials for education. (ORN). Preventing Retainal Sorgical Denvices 0. Ongoing Perioperative Nursing and Surgical Tech education in November 2011 using AORN materials for education. (ORN). Prev	NAME OF PR	OVIDER OR SUPPLIER	·	STREET ADDRESS	, CITY, STATI	E, ZIP CODE		
Image: Tase Iteration Definition of the Construction of the Conservalue on the Construction of the Conservalue on the Co	ST. JOSE	PH HOSPITAL		2700 DOLBEER	ST., EURE	KA, CA 95501 HUMBOLDT COUNTY		
Image: Tase Iteration Definition of the Construction of the Conservalue on the Construction of the Conservalue on the Co								
 Based on observation, staff interview, and document review, the hospital failed to ensure that the operating room (OR) teams followed policy and procedures for accounting for all items placed inside the patients during surgical procedures. This failure resulted in Patient 1 having a retained offerigin object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the retained object. THE VIOLATION OF LICENSING REOUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (JJ) WITHIN THE MEANING OF HEALTH AND SAFEF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (A VISCERAL RETRACTOR) HAD BEEN RETAINED INDURATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS SURGERY REQUIRED RETRINED THAT FOREIGN OBJECT (A VISCERAL RETRACTOR AND DEATH FOR LINE SURGERY REQUIRED RETRINED INTER ATTO THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FOR HE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. Findings: On 111 the hospital reported to the California Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. Record review on 8/10/11 indicated that Patient 1 	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY F		PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE CROSS-	(X5) COMPLET DATE
Based on observation, staff interview, and document review, the hospital failed to ensure that the operating room (OR) teams followed policy and procedures for accounting for all items placed inside the patients during surgical procedures. This failure resulted in Patient 1 having a retained foreign object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the retained object. 7. Review of staff competencies, 7/2011, for surgical services nursing and surgical tech annual competencies, 7/2011, for surgical count process (opening, closing and boservation of staff performance of each step in the surgical count process (opening, closing and the acounts). 8/12/11 THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (LI) Nurse, and Risk Manager competed a three day assessment of perioperative services. Interviews will hospital staff, surgeons, and anstensiologists as well as one day of direct observation in the Surgical Services 10/13/11 SAFETY CODE SECTION 1280.11N THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (A VISCERAL RETRACTOR) HAD BEEN RETAINED IN CREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. 9. Ongoing Perioperative Nursing and Surgical Image. ongoing 10. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing Retained object following an abdominal surgical procedure. Record review on 8/10/111 indicated that Patient 1 Implementation November		Continued From page	1			6 Revised Surgical Count Policy		04044
 the operating room (OR) teams followed policy and procedures for accounting for all items placed inside the pattents during surgical procedures. This failure resulted in Patient 1 having a retained foreign object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the additional risks of a second surgery to remove the retained object. THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (JJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.11N THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT AFTER SURGERY. THIS VIOLATION PLACED THE PATIENT AFTER SURGERY. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. Findings: On 11 the hospital reported to the California Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. Record review on 8/10/11 indicated that Patient 1 				•		Surgical Services Staff meetings.	eviewed at	1
retained object. 8. Interdisciplinary consulting team of surgeon, OR nurse, and Risk Manager competed a three day assessment of perioperative services. Interviews will hospital staff, surgeons, and anesthesiologists as well as one day of direct observation in the Surgical Services 10/13/11 CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (A VISCERAL RETRACTOR) HAD BEEN RETAINED IN A PATIENT AFTER SURGERY. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. 9. Ongoing Perioperative Nursing and Surgical Tech education in November 2011 using AORN materials for education (AORN: <i>Preventing Retained Surgical Items</i>). ongoing 0n11 the hospital reported to the California Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. 10 implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing		the operating room (OR) teams followed policy and procedures for accounting for all items placed inside the patients during surgical procedures. This failure resulted in Patient 1 having a retained foreign object (a Visceral Retractor) that caused prolonged post-operative pain and subjected Patient 1 to the				surgical services nursing and surg annual competencies to include di observation of staff performance o the surgical count process (openin	ical tech rect f each step in	8/12/11
MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (A VISCERAL RETRACTOR) HAD BEEN RETAINED IN A PATIENT AFTER SURGERY. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. 9. Ongoing Perioperative Nursing and Surgical Tech education in November 2011 using AORN materials for education (AORN: <i>Preventing Retained Surgical Items</i>). ongoing 10. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 11. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 12. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 13. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 14. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 15. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 15. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing 16. Implementation of public Health that Patient 1 had a retained object following an abdominal surgical procedure. ongoing 17. Implementation of Public Health that Patient		retained object. THE VIOLATION OF CONSTITUTED AN WITHIN THE MEA SAFETY CODE SE CAUSED, OR WAS I	LICENSING REQU IMMEDIATE JEOF NING OF HEA ICTION 1280.1 IN LIKELY TO CAUSE	JIREMENTS PARDY (IJ) LTH AND THAT IT SERIOUS		OR nurse, and Risk Manager competed a day assessment of perioperative services. Interviews will hospital staff, surgeons, and anesthesiologists as well as one day of dir observation in the Surgical Services		10/13/11
INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED VISCERAL RETRACTOR AND SECOND SURGERY REQUIRED RETRIEVING THE FOREIGN BODY. 10. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. ongoing Findings: 0n/11 the hospital reported to the California Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. 10. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation. Record review on 8/10/11 indicated that Patient 1 11. Implementation November 2011 of new quality monitoring indicator for auditing of count process by direct observation.		MEDICAL AND NUI IDENTIFY THAT A VISCERAL RETRACTO IN A PATIENT	IURSING STAFF F A FOREIGN OI CTOR) HAD BEEN AFTER SURGEI	DBJECT (A I RETAINED ERY. THIS		Tech education in November 2011 materials for education (AORN: Pro	using AORN	ongoing
On 111 the hospital reported to the California Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. Record review on 8/10/11 indicated that Patient 1		INCREASED RISK FOR COMPLICATIONS A DEATH FROM THE RETAINED VISCE RETRACTOR AND SECOND SURGE		ONS AND VISCERAL SURGERY		quality monitoring indicator for audi		ongoing
Department of Public Health that Patient 1 had a retained object following an abdominal surgical procedure. Record review on 8/10/11 indicated that Patient 1	{	Findings:						
	[Department of Public retained object follov	Health that Patien	it 1 had a				}
vent ID:ZXNK11 10/7/2011 11:21:12AM		Record review on 8/10/1	1 indicated that Patie	ent 1				·
	vent ID:Z	KNK11		10/7/2011	11:21	:12AM		

MIRA M Nozin 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.

KBR

10/25/11

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		050000		A. BUILD		-	
		050006		B. WING		08/1	2/2011
	ROVIDER OR SUPPLIER	ļ	STREET ADDRESS,				
ST. JOSE	PH HOSPITAL		700 DOLBEER	ST., EURE	KA, CA 95501 HUMBOLDT COU	ΙΝΤΥ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FO SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION REFERENCED TO THE APPROV	SHOULD BE CROSS-	(X5) COMPLE DATE
	Continued From page	2			Description of Manitaring D		
	was admitted to the repair of an abdom Surgical Record d Surgeon A was notific count of the instrume closure. Review of a scan report dated had a, "linear metallic near the surgical scar.	inal hernia. Revie ated //11, indic ed that both the firs nts was correct prior computerized topog //11 indicated that	ew of the ated that t and final to wound raphy (CT) Patient 1		Description of Monitoring P 1 Direct observation of the s process for each aspect of the opening, close and final coun 30 cases to have direct obser more aspects of the count pro Monitoring for correctness an process. Reported within the the Medical Staff Quality Corr	ongoing	
Patient 1 was readmitted to the 1 for surgery to remove the for Operation Record dated //11, patient had abdominal surgery to foreign object, which appeared retractor. The large sized viso removed. The string that was intact as was the ring." During interview on 8/10/11 at stated that he performed a hernia 1 (on //2011) that required the reinforce the abdominal wall. that during the procedure he used "viscera retainer" to hold the bow as he sewed the mesh into place.		ve the foreign obje ed 111 /11, indicate surgery to remove appeared to be sized visceral retr	ect. The d that the a, "bluish a visceral actor was		r <u>rection</u> : Services and Risk Programs er er		
		ed a hernia repair equired the use of a nal wall. Surgeon ure he used a device old the bowels out c	on Patient a mesh to A stated e called a,				
	Concurrent observation was labeled as a "Vis on the packaging. T colored, flat, vinyl ob measuring 10 inches the widest section. At 9 inch string that was ring that was approximation	ceral Retractor" and he "FISH" was a l ject shaped like a in length and 6.5 one end of the "FIS looped through a	a "FISH" baby blue flounder, inches at 5H" was a blue vinyl				
vent ID:Z	XNK11		10/7/2011	11:21	:12AM		
ORATORY	DIRECTOR'S OR PROVIDER	WSUPPLIER REPRESENT	ATIVE'S SIGNATL	IRE Rinh	TITLE	(X6) DATE
deficiency		erisk (*) denotes a deficience	which the institu	tion may be	excused from correcting providing it	is determined	a yri
			-	-	ngs above are disclosable 90 days fol		

State-2567

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050006		B. WING	·	(2/2011
		1	STREET ADDRESS				
	PH HOSPITAL				A, CA 95501 HUMBOLDT CO	DUNTY	
				,			
	<u> </u>					· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
	Continued From page	2 3					
	Surgeon A stated that the "FISH" was moved around in the abdomen as the surgery progressed and that the string and loop were supposed to be kept outside of the incisional area. Just prior to completely sewing the abdomen closed, the surgeon would remove the "FISH" by using the loop and string to pull it out through a small opening The opening was then sewn shut. Surgeon A stated that after Patient 1 went home her post-operative pain level did not decrease as expected. After monitoring the patient's pain fo two months, Surgeon A stated that he ordered a CT scan of the abdomen which identified that there was a foreign object in the patient. (On 2011) When he viewed the CT scan he realized that the "FISH" was still in the patient. Surgeon A performed a second surgery (on 2011) of						
	Surgeon A stated that most likely the s loop had been pulled into the abdomen of "FISH" was moved from one area to and that no one on the surgical team noticed the mesh was sewn in place the blue col "FISH" was not visible beneath it. Without and string to remind the team that the "F in the abdomen, it was forgotten. Surgeon A stated that usually all items use surgery that were placed inside the wou		n when the another and ced. When color of the but the loop "FISH" was used during				
	counted before the that nothing was left the incident did he reali	wound was closed inside the patient.	to ensure Not until				
Event ID:Z			10/7/2011	11:21:	12AM		<u> </u>
	Y DIRECTOR'S OR PROVIDE				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 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.

nector of Quality - Risk Programo

m

nn

10/25/11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI		(X2) MULTII			(X3) DATE SURVEY COMPLETED	
		050006		B. WING		08/1	2/2011	
	ROVIDER OR SUPPLIER EPH HOSPITAL	<u> </u>	STREET ADDRESS 2700 DOLBEER		CIP CODE A, CA 95501 HUMBOLDT CC	 DUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE	
	everything listed. E before the final clos "FISH" was not used it was usually broug surgery. Staff B st came in so late it v white board. It was counting of instruments During an interview Administrative Staff C she interviewed all of that only one of the s on the white board. part of the surgical te left in the abdomen of F Review of hospital p Sponges, Sharps an 2010, indicated that count instruments on	on 8/11/11 at 9:3 he procedure was , needles, knives beginning of the o the room after on a board on the As the surgeon g urgery, the tear Everything was co- ure. Staff B stat for every hernia rep th into the room ated that because was not usually wr to therefore, not inc ated that because was not usually wr to therefore, not inc ated that after f the OR staff and staff routinely wrote That staff member eam on the day the Patient 1. policy titled, "Surgid d instruments rev it was hospital all procedures in at an instrument	to count all s, sponges ne surgery. the surgery wall called jot close to n counted unted again ed that the pair and that late in the the "FISH" itten on the luded in the 3:45 p.m., the incident determined the, "FISH" per was not e FISH was cal Counts: ised March policy, "to which the could be					
Event ID:	ZXNK11		10/7/2011	11:21:1	2AM			
ABORATOR	AND DIRECTOR'S OR PROVIDE				Rich Program	ns	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined
hat 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
he date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program
naticipation

---

		(X1) PROVIDER/SUPPI IDENTIFICATION N 050006		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2011	
	ROVIDER OR SUPPLIER EPH HOSPITAL	<u> </u>		I, CITY, STATE, Z R ST., EUREKA	IP CODE A, CA 95501 HUMBOLDT COI	I	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCII Y MUST BE PRECEEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRC	SHOULD BE CROSS-	(X5) COMPLETE DATE
	Continued From page and procedures to pr retractor during a su Section 70223(b) (2 Code of Regulations or was likely to cau the patient, and ther jeopardy within the Code Section 1280.1. This facility failed to described above that serious injury or deat constitutes an imm meaning of Health 1280.1(c).	event the retention urgical procedure in) of Title 22 of the was a deficiency use, serious injury refore constitutes a meaning of Health prevent the defice caused, or is like the to the patient, a mediate jeopardy	n violation of the California that caused, or death to an immediate and Safety ency(ies) as the cause, and therefore within the				
Event ID:			10/7/2011	11:21:1	2AM		
Inn	AND DIRECTOR'S OR PROVIDE	Director	, of Qual	Ly + Re	n Programs		(X6) DATE
hat other sa of survey wh	afeguards provide sufficient pro nether or not a plan of correctio	tection to the patients. E n is provided. For nursin	xcept for nursing hi g homes, the above	omes, the finding e findings and pla	xcused from correcting providing i s above are disclosable 90 days f ans of correction are disclosable 1 of correction is requisite to continu	ollowing the date 4 days following	

participation.

*) +