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If continuation sheet 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION INTERIOR OF CORRECTION INTE	<u>Californ</u>	a Department of Pub	lic Health				·		
MISSION HOSPITAL REGIONAL MED CENTER MISSION WIELD, CA 92881 PRETEX INMANARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881) PRETEX ISOMEWARY STATEMENT OF DEPRISACISES (MISSION VIELD, CA 92881 PROVIDENCE OF CONSCIPLING (MISSION VIELD, CA 92881 PROVIDENCE OF MISSION VIELD, CAPPER OF MISSION VIELD, CAPPER OF MISSION VIELD, CAPPER TO PROPERTY COMPLETED OF MISSION VIELD, CAPPER TO PROPERTY CONSTITUTION OF MISSION VIELD, CAPPER TO PROPERTY COMPLETED OF MISSION VIELD AND OF COMPLETED OF MISSION VIELD AND OF COMPLETED OF MISS		IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		MBER:	A. BUILDING		COMPLETED		
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E 000 Initial Comments The following reflects the findings of the Department of Public Health during the investigation of COMPLINT NO: CA00186058. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. HSC Section 1280.1(a). If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1280 receives a notice of deficiency constituting an immediate lepoarty to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation. c) For the 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. Representing the Department of Public Health: DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIV 5 CH1 ART3 - 70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. The above regulation was NOT met as evidenced by: Based on medical record review, staff interview,	MISSION	HOSPITAL REGIONA	AL MED CENTER						
The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00188058. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. HSC Section 1280.1(a). If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation. c) For the 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. Representing the Department of Public Health: BEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIV 5 CH1 ART3 - 70213 (a) Written policles and procedures for patient care shall be developed, maintained and implemented by the nursing service. The above regulation was NOT met as evidenced by: Based on medical record review, staff interview,	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	I CORRECTIVE ACTION SHOULD BE COMPLE PATE		
a) HOW THE CORRECTION WILL BE ACCOMPLISHED, both temporarily and permanently. a) HOW THE CORRECTION WILL BE ACCOMPLISHED, both temporarily and permanently. Medication administration to patients from the Postpartum Unit of Mission Hospital Mission Viejo who go to see their children on the NICU (CHOC Children's Hospital at Mission – CHM) was stopped immediately. The policy and procedure was changed to reflect that any Mission patient going to see their children who are patients in CHM would not have any medications administered by the Mission staff while they were in the CHM units. The policy and procedure was changed to reflect that any Mission patient going to see their children who are patients in CHM would not have any medications administered by the Mission staff while they were in the CHM units. This requirement was added to the Unit Specific Orientation for new RNs in the Women's and Infants' (W and I) service. The five rights of medication administration to patients from the Postpartum Unit of Mission Hospital Mission CHM) was stopped immediately. The policy and procedure was changed to reflect that any Mission patient going to see their children who are patients in CHM would not have any medications administered by the Mission staff while they were in the CHM units. This requirement was added to the Unit Specific Orientation for new RNs in the Women's and Infants' (W and I) service. The five rights of medication administration were reviewed with the Staff of the W and I units. TITLE OR POSITION OF THE PERSON RESPONSIBLE FOR THE CORRECTION Executive Nursing Director of the Women's and Infants' Service.	E 000	Initial Comments			E 000				
ORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE		Department of Publinvestigation of COMINSPECTION WAS limit complaint(s) investigation of a full the findings of a full HSC Section 1280. facility licensed und of Section 1250 reconstituting an immor safety of a patient plan of correction, the licensee an admanded amount not to exceed olders (\$25,000) per compart of the purposes is performed in the licensee's noncomprequirements of licensee's noncomprequirements	Ilic Health during the MPLAINT NO: CA00 ted to the specific gated and does not relinspection of the factorial factor	epresent lility. a health), or (f) ciency e health ubmit a essess an nd ediate ore r is likely atient. lealth:		ACCOMPLISHED, both to permanently. Medication administration to the Postpartum Unit of Miss Mission Viejo who go to see on the NICU (CHOC Childr Mission – CHM) was stopped. The policy and procedure we reflect that any Mission patitheir children who are patient would not have any medicate administered by the Mission were in the CHM units. This requirement was added Specific Orientation for new Women's and Infants' (Was The five rights of medication were reviewed with the Staffunits. D) TITLE OR POSITION OF RESPONSIBLE FOR THE CORRECTION Executive Nursing Director and Infants' Service.	patients ion Hospi their child as change ent going at in CHN ions staff while to the Unit of the Work THE PE	from tal Idren bital at sately. d to to see M le they it ne ice. tration and I RSON	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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	implementation of established policies addressing medication administration causing serious injury to a patient.			c) DESCRIPTION OF THE MONITORING PROCESS			
	Findings: On 7/24/09, review of the policy "Medication Administration" revealed the directive "2. All medications must be administered according to the "Five Rights: 2.1 Right Patient 2.2 Right medication 2.3 Right dose 2.4 Right route 2.5 Right time." During interview on 7/24/09, staff stated Patient 1 had given birth to triplets on 4/5/09 at 0500 hours and spent a lot of time in the Neonatal Intensive Care Unit (NICU) where the infants were being cared for. Staff disclosed that on 4/4/09 at 2215 hours, the post-partum nurse had taken morphine sulfate (MS) from the post-partum unit on the second floor to the NICU on the fifth floor to medicate Patient 1. Patient 1 was skin-to-skin bonding with one of the triplets (Baby A) when the nurse administered the MS intravenously (IV). Both Patient 1 and Baby A had IV lines in place. Soon after the administration of the MS, Baby A became dusky, exhibited respiratory depression, and required intubation. Staff disclosed that during interview, the post-partum nurse stated she thought she gave the medication to Patient 1 but was not certain. During interview, staff stated "it is thought the nurse might have injected the MS into the baby's running IV instead of the mother's."			 The CHM staff will stop any Mission RN who comes to the CHM units to administer medications, and will immediately notify the Executive Nursing Director of W and I/ designee of any such incident. This is ongoing in the protocol and remains in effect. To date (Sept 09 – current), no attempts to administer medications to a Mission patient who came to see a patient on the CHM units have occurred. Any violation/near violation of the above will be discussed at the monthly collaborative meeting of the Maternal Infant Continuum of Care. Staff from W and I and the CHM meet for this meeting. Through the QRE system (incident reporting process), any medication variation from the five rights is reported and responded to immediately by the Executive Director/designee. This is an ongoing monitoring methodology for the five rights of drug administration. d) DATE OF CORRECTION 			
	During the interview on 7/24/09, staff disclosed that on 4/6/09 urine samples from all three bables were sent out to another laboratory for analysis and only Baby A was positive for MS.			All actions were completed on or before September 5, 2009. Monitoring is ongoing.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDINI	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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Medical record revidischarge summal In the discharge summal In the discharge sidocumented "The obvious sequelae further investigation a positive urine for morphineEntertail diagnosis was also of morphine to the the mother who was a time just shortly This information fare "Five Rights" of medication as per interest of medication as per interest of the medication as per intere	Medical record review for Baby A revealed to discharge summary for discharge dated 4/2 In the discharge summary, the physician documented "The baby recovered without a obvious sequelae on physical examination. further investigation, it was noted this infant a positive urine for opiates which turned out morphineEntertained in the differential diagnosis was also an inadvertent administration of morphine to the infant that was intended the mother who was skin to skin with the infant time just shortly prior to first symptoms." This information failed to show evidence the "Five Rights" of medication administration we followed prior to administration of the pain medication as per facility policy, in that the notal received the right patient received the		E 000			DATE	
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