### CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

INVESTOR THROUGH OR SUPPLIES MISSION HOSPITAL REGIONAL MEDICAL CENTER  SUBMARY STATEMENT OF DEPICEMENTS  The following reflects the findings of the Department of Public Health during an Inspection visit  COmplaint Intake Number:  CADDZ25145 - Substantiated  Representing the Department of Public Health: Surveyor ID # 06793, HFEN  The Inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.  Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jacopardy" 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 dealth to the patient.  DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY  T22 DIV 5 CH1 ART3 - 70223(b)(2) Surjical Service General Requirements  (b) A committee of the medical staff shall be assigned responsibility for:  (2) Development, maintenance and triplementation of with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures thall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.  Event ID/GRNY811  SYSSODY  SUBMINISTED A STATE, 270 CORST.  TATATE 270 CORST.  PROFEX TRY STATE, 270 CORST.  THE FOUNDAM SIGNAL MESSION USED, A SUBMINISTED OR A SUBMINISTED OR A STATEMENT TO THE PROFESSION USED.  TATATION MESSION USED.  THE FOUNDAM SIGNAL MESSI			(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	- · · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MISSION HOSPITAL REGIONAL MEDICAL CENTER    CONTIDER   SUMMARY STATEMENT OF DEDICATIONS     FREE   PROVIDER'S PLAN OF CORRECTION     FREE   PROVIDER'S PLAN OF C			050567				06/29	<del>)/201</del> 0	
CAN ID PRICES   SUBMARY STATEMENT OF DEPICEMONES   PROVIDERS PLAN OF CORRECTION   COMPLETE   PREVIOUS CONCESTIVA ACTION SPACES   COMPLETE   C	NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS,	CITY, STATE, ZIP	CODE		•	
The following reflects the findings of the Department of Public Health during an Inspection visit:  Compleint Intake Number: CA00225145 - Substantiated Representing the Department of Public Health: Surveyor ID # 06793, HFEN The Inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): For 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 dealth to the patient.  DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIV 5 CH1 ART3 - 70223(b)(2) Surgical 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 administration and medical staff where such is appropriate.  Event (D:GRNYS11)  The locovering ATM APPROPRIATE DEFICIENCY  The Occurrence  The	MISSION I	IOSPITAL REGIONAL MEI	DICAL CENTER	27700 MEDICAL	CENTER ROA	d, Mission Viejo, ca 92691 orai	IGE COUNTY		
Complaint Intake Number: CA00225145 - Substantiated Representing the Department of Public Health: Surveyor ID # 08793, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jacpardy" means a situetion in which the licensee's noncompliance with one or more requiriments of licensure has caused, or is likely to cause, serious injury or death to the patient.  DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY  T22 DIV 5 CH1 ART3 - 70223(b)(2) Surgical Service General Requirements (b) A committee of the medical staff shall be assigned responsibility for: (c) Development, maintenance and implementation of written policles and procedures in consultation with other appropriate health professionals and administration. Policles shall be approved by the governing body. Procedures shall be approved by the administration: Policles shall be approved by the administration: Policles shall be approved by the appropriate.  The Occurrence  "A 71 year-old female was admitted to Mission Hospital for a surgical removal of an L3-4 interbody graft and implantation of new hardware. The surgical count was correct. On the routine post operative x-ray to ascertain placement, a small relative foreign body was visualized. After further tests, the patient was returned to surgery for removal of a single 8x5 mm metal screw cap which was part of the breakaway portion of the implanted hardware." All this occurred on 12010.  At that time, the breakaway portions of the hardware were not included in the formal surgical count. However, the surgical count the was returned to surgery for removal of a single 8x5 mm metal screw cap which was part of the breakaway portion of the implanted to the patient was returned to surgery for removal of a single 8x5 mm metal screw cap which was part of the breakaway portion of the hardware. The surgical count was returned to surgical count was retur	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL.	PREFIX	(EACH CORRECTIVE ACTION SHOULD I	E CROSS-	COMPLETE	
Representing the Department of Public Health: Surveyor ID # 06793, HFEN  The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.  Health and Safety Code Section 1280.1(c): For purposes of this section "Immediate Jeopardy" means a situation in which the licenseer's noncompilance with one or more requirements of licensure has caused, or is likely to cause, serious linjury or death to the patient.  DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY  T22 DIV 5 CH1 ART3 - 70223(b)(2) Surgical Service General Requirements  (b) A committee of the medical staff shall be assigned responsibility for:  (2) Development, maintenance and implementation of written policles and procedures in consultation with other appropriate health professionals and administration. Policles shall be approved by the administration and medical staff where such is appropriate.  Event ID:GNY811  3/25/2011  Sinch Hospital for a surgical removal of an L3-4 Interbody graft and implantation of new hardware. The surgical count was correct. On the routine post operative x-ray to ascertain placement, a small retained foreign body was visualized. After further tests, the patient was returned to surgery for removal of a single 8x6 mm metal screw cap which was part of the breakaway portion of the implanted hardware. All this occurred on the implanted hardware. All this occurred on the implanted hardware, and the surgical count. However, the surgeon conducted his own count, as per his personal practice, and the two screw caps were counted. It remains unknown how one of the screw caps was retained.  Event ID:GNY811  Size All Mission Hospital implanted hardware. The surgical count was correct. On the routine post operative x-ray to ascertain placement, a small retained foreign body was visualized. After further tests, the patient was returned to surgery for removal of a single 8x6 mm metal screw cap which was part of the broakway portion of the implanted hardware. All this occur				tnemba		The Occurrence			
Event ID:GNY811 9:32:49AM		of Public Health during an inspection visit:  Complaint Intake Number: CA00225145 - Substantiated  Representing the Department of Public Health: Surveyor ID # 08793, HFEN  The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.  Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jaopardy" 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.  DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY  T22 DIV 5 CH1 ART3 - 70223(b)(2) Surgical 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		citity he  10.1(c): For Jeopardy" Ilcensee's Iraments of ise, serious  MMEDIATE Ical Service If shall be blementation consultation identical sand wed by the approved by	"A 71 year-old female was ad Mission Hospital for a surgical of an L3-4 interbody graft and implantation of new hardware surgical count was correct. Or routine post operative x-ray to placement, a small retained foody was visualized. After fut the patient was returned to so removal of a single 8x5 mm recap which was part of the bre portion of the implanted hard this occurred on At that time, the breakaway put the hardware were not include formal surgical count. However, and surgeon conducted his own of per his personal practice, and screw caps were counted. It unknown how one of the screw		rgical remote and ware. The ct. On the ray to ascend foreign ter further to surgery mm metal se breakaw hardware. 2010.  vay portion owever, the own count, e, and the total decided in count, e, and the total decided in the count, e, and the total decided in the ct.	cal removal nd re. The On the to ascertain foreign further tests, surgery for metal screw reakaway dware." All 2010.  portions of uded in the ever, the i count, as ind the two It remains	

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Any/deficiency statement ending with an esterisk (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 disclossable 90 days following the date of survey whather 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 evaluable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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### CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

D1111   D41111   D1 1   D1 1		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	CATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		050567		B. WNG		06/29	06/29/2010	
MANE DE DEV	OVIDER OR SUPPLIER		STREET ADDRESS, C	TY STATE	ZIP CODE	•	-	
****	OSPITAL REGIONAL ME	DICAL CENTER		•	OAD, MISSION VIEJO, CA 92691 ORA	NGE COUNTY	•	
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERÊNCED TO THE APPROPRIATE (	BE CROSS-	(XS) COMPLETE DATE	
	Continued From page	1						
	The above regulation by:  Based on medical recreation of policies, implementation of policies resulted in a metalined implant tab undergo the risks anesthesia and possible returned to the op a second surgery removed.  Findings:  On 8/22/10, medical revealed a discharge physician documentation physician documentation of the Cross-link was measured to the Cross-link was measured to the Cross-link was measured to the preakaway tab."  On 6/22/10, during in the breakaway tabs with a tool that hold the preakaway tabs with a tool that hold the preakaway tabs.	cord review, staff into the facility falled dicies addressing the ms that had a poly a surgical proceddilic breakaway table after surgery on and complications be infection when serating room the satio have the retail record review for the summary in dight and complications for the two breakaway stained and she unto the removed during the breakaway are removed durings the breakaway.	erview, and to ensure the counting otential for fure. This the from an the fure and to the fure and the the the fure and the the the fure and the t		The patient was x-rayed is room to check the placern hardware. At that time, it was seen floating in the east confirming MRI was consurgeon spoke with the placern spoke with the placer the part in or to return and remove the cap. The the family agreed to return and remove the screw cap. The surgery department of their management staff are an incident report; thus the notification to your office of that time. During a routing "unplanned return to surger return to surgery for a retained body was noted. CDPH with immediately notified on Applications and changes and procedure were	nent of the ne screw ca pidural spanducted. The attent and the option to arm to surge surgeon and to surgery of the proper lid not notified proper lid not occupated foreign and actions on ion of the rective in policy	p ce. he ry nd the m	
[1	they are removed. The	e physician stated	that during		and procedure work			
ļ:	the tool removing eac counted then with the st	th of the breakaway	tabs and					
Event ID:GI			3/25/2011		49AM			
ABORATORY	DIRECTOR'S OR PROVIDE	BISLIPPLIER REPRESENT	TATIVE'S SKINATII	RF	TITLE		X61 DATE	

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Any deficiency statement ending with an asterisk (\*) denotes a descioncy 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 data 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 data that a 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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# CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

SAME OF PROVIDED OR SUPPLIED   STREET ADDRESS, GTY, STATE, 29 CODE   STATE ADDR		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLE IDENTIFICATION NU		(X2) MULTIPLE	E CONSTR	NUCTION	(X3) DATE SUR COMPLETE	
MISSION HOSPITAL REGIONAL MEDICAL CENTER  27799 MEDICAL CENTER ROAD, MISSION VIELO, CA 82691 ORANGE COUNTY    Continued From page 2   placed them on the Mayo/instrument stand. However, an x-ray taken in the PACU (Post Anesthesia Care Unit) showed a metallic foreign body to the right within the spinal canal and the pellent had to be returned to the operating room to ramove the metal tab.    On 8/22/10, during interview, staff stated these breakaway tabs were not included in the count and there was no policy/procedure in place addressing these breakaway tabs were not included in the count and the policy discribed for liquy to the pellent for liquy to the pellent as a result of a retained foreign body. The "Purpose" also stated "There will be a count performed for all sungical procedures in which the possibility exists that is sponge, instruments, sharps, and miscellaneous items on all surgical procedures in which the possibility exists that s procedures of miscellaneous items and the potential for being retained in a surgical locision. In violation of its own policy, the facility failed to folicw the protocol to account for the breakaway tabs that had the potential for being retained.    Review of the medical record reversied annesthesia reports documenting Petient 1 had undergone general anesthesia for the Initial surgery and again for the second surgery to remove the retained object on 100 to			060567			_		06/29	/2010
### A PROVIDERS PLAN OF CONSECTION    Continued From page 2	NAME OF PRI	OVIDER OR SUPPLIER		STREET ADDRESS	CITY, STATE, ZIP	CODE			
Continued From page 2 placed them on the Meyo/instrument stand. However, an x-ray taken in the PACU (Post Anesthesia Care Unit) showed a metallic foreign body to the right within the spinel canel and the patient had to be returned to the operating room to remove the metal tab.  On 6/22/10, during interview, staff stated these breakeway tabs were not included in the count and there was no policy/procedure in place addressing these breakeway tabs. However, review of the policy addressing these breakeway tabs the weaver, review of the counts we is account for all items and to lessen the potential for injury to the patient as a result of a retained foreign body. The "Purpose" elso stated "There will be a count performed for all aponges, instruments, sharp, or inscellaneous items on all surgical procedures in which the possibility exists that a sponge, instrument, sharp, or inscellaneous item could be retained." In addition, the policy described "inscellaneous items out the potential for being retained.  Review of the medical record revealed anesthesia reports documenting Petient 1 had undergone general anesthesia for the initial surgery and again for the second surgery to remove the retained object on 10 of the counts.  PEXPLOR REPREMENTED THE APPROPRIATE DEPRIZENCY.  APPROPRIATE DEPRIZENCY.  OR And Sterille Processing staff were inserviced about the Meditronic Crosslink Deformity set (tray) (April 12-14, 2010).  The instrument tray count sheet for this device was changed. A picture of this break off tool was placed on the count sheet for this device was changed. A picture of this break off tool was placed on the count sheet. A reminider was given to SPD staff to inspect and confirm that the device was fully functional and ready for use (April 13, 2010).  The Meditronic Crosslink 5.5 titanium decrements as the second miscellaneous items on the count sheet the device was fully functional and ready for use (April 13, 2010).  The OR documentation system (Picts) for the surgical counts was revised to include a category	1		DICAL CENTER	27700 MEDICAL	CENTER ROA	d, Missi	ON VIEJO, CA 82681 ORAN	IGE COUNTY	
placed them on the Mayo/instrument stand. However, an x-ray taken in the PACU (Post Anesthesia Care Unit) showed a metallic foreign body to the right within the apinal canal and the pelient had to be returned to the operating room to remove the metal tab.  On 6/22/10, during interview, staff stated these breakaway tabs were not included in the count and there was no policy/procedure in place addressing these breakaway tabs. However, review of the policy addressing the counts to be performed during a surgical procedure revealed the purpose of the counts was to account for all items and to lessen the potential for injury to the pattent as a result of a retained foreign body. The "Purpose" also stated "There will be a count performed for all aponges, instruments, sharp, or miscellaneous items on all surgical procedures in which the possibility exists that a sponge, instrument, sharp, or miscellaneous items on all surgical procedures in which the possibility exists that a sponge, instrument, sharp, or instruments that have the policy described "inscellaneous items" as items other than sponges, sharps, or instruments that have the potential for being retained in a surgical incision, in violation of its own policy, the facility failed to follow the protocol to account for the breakaway tabs that had the potential for being retained.  Raview of the medical record revealed anesthesia reports documenting Petient 1 had undergone general anesthesia for the little surgery and again for the second surgery to remove the retained object on 110.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH	CORRECTIVE ACTION SHOULD E	E CROSS-	COMPLETE
Anesthesia Care Unity showed a metallic foreign body to the right within the spinal canal and the patient had to be returned to the operating room to remove the metal tab.  On 8/22/10, during interview, staff stated these breakaway tabs were not included in the count and there was no policy/procedure in place addressing these breakaway tabs. However, review of the policy addressing the counts to be performed during a surgical procedure revealed the purpose of the counts was to account for all items and to tessen the potential for injury to the patent as a result of a retained foreign body. The "Purpose" also stated "There will be a count performed for all aponges, instruments, sharps, and miscellaneous items on all surgical procedures in which the possibility exists that a sponge, instrument, sharp, or miscellaneous tems other than sponges, instrument, sharps, or instruments that have the potential for being retained in a surgical incision. In violation of its own policy, the facility failed to follow the protocol to account for the breakaway tabs that had the potential for being retained.  Review of the medical record revealed anesthesia reports documenting Petlent 1 had undergone general anesthesia for the initial surgery and again for the second surgery to remove the retained object on 100.		Continued From page	2						
Event ID:GNY811 9:32:49AM		placed them on However, an x-ray Anesthesia Care Un body to the right wi patient had to be ret remove the metal tab.  On 6/22/10, during breakaway tabs were there was no policy, these breakaway ta policy addressing ti during a surgical proof the counts was to lessen the potential result of a retained also stated "There wi sponges, instruments items on all surgic possibility exists that or miscellaneous it addition, the policitems" as items oth instruments that he retained in a surgical policy, the facility fa account for the bropotential for being retain Review of the medic reports documenting general anesthesia for the second surgication in the second surgical policy and the medic reports documenting general anesthesia for the second surgical object on 110.	the Mayo/instrum taken in the Fit) showed a mel thin the spinal caumed to the operation of the count of the count of the counts to be account for all the for injury to the procedure revealed the account for all the for injury to the procedures in a sponge, instrument could be reproduced in the count of the count performant of the count performant of the count performant of the count of the co	ACU (Post allic foreign nal and the allic foreign nal and the sing room to tated these a count and addressing lew of the performed purpose of ans and to patient as a "Purpose" med for all alscellaneous which the nent, sharp, or for being a for being a for the count of the count		<ol> <li>3.</li> </ol>	were inserviced about Medtronic Crosslink set (tray) (April 12-1 The instrument tray for this device was a picture of this break placed on the count reminder was given to inspect and conflidevice was fully fun ready for use (April The Medtronic Crostitanium deformity swas labeled to indic screws to be countered added to miscellane (April 13, 2010). The OR documentar (PICIS) for the surgives was revised to includate and the properties of the surgives (May 2010).  a. Prior to this counts had in only those it AORN list, seponge, needs	out the count the count she changed. A to SPD strm that the ctional and 13, 2010). Islink 5.5 et contained and cours count tion system cal counts de a sellaneous reak away revision, thincluded ems on the such as edle, and	et A as aff
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Any deficiency sistement ending with an asteriak (\*) 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 data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisits to continued program participation.

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## CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		050567		B. WING			06/29	/2010 ,
NAME OF PR	OVIDER OR SUPPLIER	<del></del>	STREET ADDRESS	S, CITY, STATE,	, ZIP CODE		•	_
Mission	HOSPITAL REGIONAL ME	DICAL CENTER	27700 MEDICAI	L CENTER R	OLƏIV MOISSIM ,MAO:	, CA 92691 ORAN	GE COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIV	B PLAN OF CORRECTI PE ACTION SHOULD BE THE APPROPRIATE DE	E CROSS-	(X5) COMPLETE DATE
	Continued From page The facility's failure to the established polimiscellaneous items retained during a suithat has caused, or injury or death to constitutes an immeaning of Health 1280.1(c).  This facility failed to described above that serious injury or deat constitutes an immeaning of Health 1280.1(c).	o ensure the implexicy regarding accomplexity regarding accomplexity to cause the patient and safety Comprevent the deficience caused, or is likely to the patient, and contains the deficience of the patient, and contains the patient, and contains the patient, and contains the implementation of the patient, and contains the patient, and contains the patient, and contains the patient according to the patient, and contains the patient according to the patient according	counting for large for being a deficiency isse, serious defined therefore within the defection incy(les) as y to cause, and therefore within the		5. A list of has beed discussed were indiculted for count point of the surface of the common staking of placement of the control of the country sent to point of	geon did not for practice regard for the control of hardware close. The surface time. This control of the contr	amunity nat these ellaneous away tabs ded in the its. s items and These lists o a revised follow arding the sure e in OR argeon the post case was review if so that x- ber vill be attient collicy d and ical (July ecutive ), and the	
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Any delicionity substitute it along with an asterior () delicions a delicionity which the interest provide sufficient protection to the patients. Except for rursing 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 clied, an approved plan of correction is requisits to continued program participation.

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### CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

ratement of deficiencies ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE BURVEY COMPLETED	
	050567	B. WENG		06/29	/2010 ,
ME OF PROVIDER OR SUPPLIER RISSION HOSPITAL REGIONAL MI	STREET ADDRESS EDICAL CENTER 27700 MEDICAL	•	P COÒE AD, MISSION VIEJO, CA 92691 OR	ANGE COUNTY	
REFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUR REFERENCED TO THE APPROPRIATE	D BE CROSS-	(XS) COMPLETE DATE
the established po- miscellaneous items retained during a su- that has caused injury or death to constitutes an immeaning of Health 1280.1(c).  This facility failed to described above that serious injury or deal constitutes an imm	to ensure the implementation of slicy regarding eccounting for with the potential for being regical procedure is a deficiency or is likely to cause, serious		8. OR contacted Me inquire if there has reports or similar Medtronics formathere have been in (April, 2010). An was sent to MedSthe tools used to tabs, under the Scholar Device Act. (April B. Responsible Part Surgical Services C. Monitoring  The circulating RN is responded and the presence miscellaneous items prior documents on the intraoperative record. The RN verifies the presence miscellaneous items prior documents on the intraopeas appropriate. Any cour reported immediately and followed — including x-ray close. Monitoring is ongo become part of Standard  D. Actions were cor 28, 2010, or as in Monitoring continudescribed.	d been any occurrences. Ily replied that no such report for report for related to break off the afe Medical 2010)  Ty - Director designee  To closure and to closure any to closure and to closure and to count policy s — prior to bing and has work.  Typical to be to the count policy of any to closure and to count policy to closure and to cl	ts of d
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