	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060300	0.14		(X3) DATE SUP COMPLETE 04/08	
	ROVIDER OR SUPPLIER Medical Center		I ADDRESS CITY, STA Ub Highway 18, Ap	TE. ZIP CODE ple Valley, CA 92307-2208 SAN	I BERNARDINO COUNT	Υ
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	of Public Health dunners of Public Health and Safety purposes of this means a situation noncompliance with licensure has cause injury or death to the REGULATION VIOL. Title 22 70223 Requirements (b) A committee assigned responsibility of written policies with other appropriate, appropriate,	mbor. antiated partment of Public Health: HFEN mited to the specific facility ad does not represent the action of the facility. Code Section 1280.1(c) section "immediate jeous on in which the licer one or more requirement, or is likely to cause, a patient. ATION. Surgical Service Geon of the medical staff should be a section of the medical staff should be actional or the section of the medical staff should be actional or the section of the medical staff should be actional or the section of the	For pardy" nsee's nts of enous eneral all be ntation all be and by the ed by	INITIAL COMMENTS: St. Mary Medical Center personal and professional accountability, innovation commitment to quality (S Excellence). SMMC is or to the requirements of the Conditions of Participation relevant Federal and State document is submitted as correction of the deficient entity reported incident in during the investigation won April 8, 2010. Preparation and/or exect Correction does not consugreement by the provide facts alleged or conclusic Statement of Deficiencie Correction is prepared as because it is required by and state law. None of the SMMC pursuant to its Plashould be considered and deficiency existed or that should have been in place survey. The provider sul Correction with the intensinal action or procee Provider, its employees, directors, or shareholder Correction is submitted the established by state and	al development, a, teamwork, and a MMC Core Value of committed to adhering e Medicare in and all other te laws. This is evidence of cies identified for umber CA00224633 which was completed ution of this Plan of stitute admission or er of the truth of the cons set forth on the is. The Plan of ind executed solely in provisions of federal he actions taken by an of Correction admission that a the additional measures ce at the time of the bmits this Plan of tion that it is a party in any civil or indings against the agents, officers, is. This Plan of oneet requirements	

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5/22/2014

3:16:05PM

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

side! - CEC

COSING CONTE

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 4

Any deticency statement ending with an asterisk (*) denotes a detackney 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 or 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.

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU			IPLE CONSTRUCTION	(XJ) DATE SUR COMPLETI	
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	feiled to follow the Surgical Fire Preve Patient A's safety of the patient 's face. FINDINGS' Patient A received 1 on the face and up when the physician device used for burn other tissues by mea while the patient was (a tube) into the morpatient's right cheek a During an inferview manager, on April 7 she was not in the C she and the Risk M was already bandag were taken. The su soon as the Bovie eng. During an inferview v 7, 2010 at 9:20 AM machine was taken. Biomedical maintena 2010. The machine noted. She also stat checked out with a stated, "The phy anesthosiologist know the Bovie" She also Prevention Of Policy a	st and deep 2nd of per lip on engaged the Bovie in gent and ele so receiving a surgical public causing a flash and upper lip. With the Operating of the procedure was a flash and treated and treated in glash that Biomed he in January, to problems noted wiscian did not a taled that the was going stated that the was going stated that the "S	degree burns 2010, cautery (a the skin or ctric current) via cannula or fire on the Room (OR) , she stated e. and when the patient No pictures wern that as sish fire. ger, on April the Bovie checked by no problems ad previously 2010 and it then She tet the g to engage urgical Fires,		TITLE 22 70223 SURGICAL SERVI GENERAL REQUIREMENTS: SMMC has an effective governing by legally responsible for the conduct or hospital as an institution and ensure medical staff are held responsible for maintaining quality provided to patie ensures that Quality Assurance Perf Improvement (QAPI) programs focus prevention of surgical errors, and ensurgical care services are achieved highest standards of medical practic patient care. SMMC has established and procedures to prevent surgical specifically the Policy and Procedure "Surgical Fires, Prevention of effect 24, 2010. The following plan of correction deta actions undertaken by SMMC to condeficiency listed on the State 2567 a provides credible evidence of compit the SMMC Policy and Procedure title "Surgical Fires, Prevention of and to patient safety. IMMEDIATE ACTION(S) TAKEN: Upon cauterization of the basal cell right side of the nose, a spark was mad then a flame around Patient "A" (approximate size of a ½ dollar). In the surgeon instructed the anesthes turn off the O2 (oxygent). The surgeor removed the nasal cannula, placed sponge on the operating site, and the circulating RN pulled off all the drap surgeon and anesthesiologist perfor assessment of the burned area.	ody If the s that If ints, omnance ses on sures that at the e and d policies ires, e titled ave March on the rect each and ilance to ed or ensure on the holiced is cheek amediately, ilokogist to on a wet lie es. The	02/26/10
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	minute prior to en did not follow the facility and control patient 2010, noted Patient 2010, noted Patient minor surgery on his carcinoma (skin control patient) and skin control patient and circulating nurse removed 477/2010 at 1:40 Patient care himself also stated that pintment to an area	A's clinical record on April 7, it A, a 58 year old female, had been nose to remove a basal cell encer) on 2010, wed a detailed timeline of the that the anesthesiologist turned or the flame appeared, and the oved the sterile drapes We with the plastic surgeon on the for approximately 2 weeks. He the patient was "still applying a about the size of the tip of an		TITLE 22 70223 SURGICAL GENERAL REQUIREMENT Subsequently, Patient "A" w OR#1 to Post Anesthesia Compatient and family about the for Arterial Blood Gases (AB Monoxide tests were ordered anesthesiologist; carbon monegative and Anesthesiologinformed the patient and family subsequents. On February 26, 2010, upon event, SMMC Risk Manager Initiated an invastigation into collaboration with the Surgic Leadership Team to ensure processes were implemented other patients that could be same outcome.	S (Continued): as transferred from are Unit (PACU). alogist notified the incident. Orders (G) and Carbon d by noxide results were ist immediately nilly members with a discovery of the ment immediately a this event in all Services immediate and for the safety of	02/28/10
	stated "No but the tome". During an intervier anesthesiologist streaming was given used. The Bovie worked it up and be surgical team known.	w on 4/8/2010 at 2:40 PM, the ated that in this case, "no that the Bovie was going to be was not holstered, the physician igan using it ", without letting the w. The anesthesiologist slated		On February 26, 2010, the I Services Director initiated 1: to the Surgical Services state awareness of the risk of sur reinforce the policy and processing the staff member of the requirements when elused with an open oxygen a stop supplemental oxygen a before and during cautery under the staff member of the requirements when elused with an open oxygen of stop supplemental oxygen a before and during cautery under the staff members of the requirements oxygen and during cautery under the staff members of the st	1 verbal education if members to raise gical fires and to cedure titled of. During this is were made aware lectro-cautery is felivery system to at least one minute	Initiated: 02/26/10 Completed 03/10/10
	Review of the fac Prevention Of "da Electrocautery, note	eam did not follow the facility sitity P&P titled "Surgical Fires, ted May 2009, under Use of ed. "stop supplemental oxygen efore and during use of the		On February 26, 2010, en in containment strategy was in five (5) steps listed below at electro-cautery is used with delivery system during case head/neck surgeries:	nitiated to ensure the re followed when an open oxygen	Initiated: 02/26/10 Completed 03/10/10

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	unit, if possible " During a telephone April 9, 2010 at 2:30 told her "it was ain stated that it was it still discolored but clit blistered again, aboves originally "covere you could see the sent pictures taken of 2010, showing the dee The facility's failure the patient's face has serious injury or death This facility failed to described above that serious injury or death serious injury or death that facility failed to described above that serious injury or death serious injury or death 1280.1(c)	PM. she stated If nost a 3rd degree healing nicely, the cosed, and then this but the size of a quebed by a 4 X 4 gausswelling involved." 2010 p 2nd degree burn, to prevent the suns caused, or is likely to the patient, and the patient the deficiency of the patient, and the patient, and the patient the deficiency of the patient the patient, and the patient	burn". She wound was past week, arter coin. It is pad, and The patient and sical fire on ely to causa, ency(ies) as y to cause, and therefore within the		TITLE 22 70223 SURGICAL SERVI GENERAL REQUIREMENTS (Cont 1. The surgeon announces aloud anesthesiologist the intent to "a the cautery". 2. The anesthesiologist will ackno and announce aloud "the oxygi being turned off". 3. The anesthesiologist will give th surgeon notification when it is proceed (i.e., after one minute being turned off). 4. Thereafter, the surgeon will no anesthesiologist when finished cautery and, 5. The anesthesiologist will notify surgeon and the OR nursing st oxygen has commenced. On March 8, 2010, the Vice Preside Medical Affairs (VPMA) referred the involving Patient "A" to the Anesthe: Department and on March 17, 2010 Surgery Department for Peer Revier screening. The case was reviewed a disposition obtained with a recomme to follow up with a presentation to the Executive Committee (MEC) during scheduled meeting on May 11, 2010 On March 20, 2010, the Intertin Dire Perioperative Services Department and revised the Pollcy and Procedu "Surgical Fires, Prevention of" Rev Included "when electro-cautery is us open oxygen delivery system, to sto supplemental oxygen at least one in before and during cautery use", to a policy meets the guidelines from As of Pertoperative Registered Nurses and American Society of Anesthesia	United): Lo the inergize overledge earlis he safe to of oxygen lifty the with the the fall that of case side to the word initial endation he Medical the next (a). Sector of reviewed re titled visions sed with an opphalmute ensure this sociation (AORN)	03/08/10
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	unit, if possible ". During a telephone April 9, 2010 at 2:30 told her "it was alrested that it was I still discolored but of it bilistered again, aboves originally "cover you could see the sent pictures taken of 2010, showing the deal The facility's failure the patient's face has serious injury or dealth I serious injury or deal constitutes an immuning of Health 1280, 1(c).	DPM, she stated limst a 3rd degree neeting nicely, the osed, and then this but the size of a quied by a 4 X 4 gau swelling involved on March 12, 2010 ap 2nd degree burnto prevent the surs caused, or is like to the patient. Description:	he physician burn" She wound was a past week, larter coin. It zo pad, and The patient and April 9, gical fire on bity to cause, and therefore within the		TITLE 22 70223 SURGICAL SERVI GENERAL REQUIREMENTS (Cont The revised policy was reviewed and approved by the Interim Director of Perioperative Services Department, President/Chief Nursing Officer (VP/ Senior Vice President/Chief Operatir (SVP/COO), Chief Executive Officer March 20, 2010 In addition, this pol approved by the Medical Executive Committee (MEC) and Board of Trust (BOT) as noted below: 1. Medical Executive Comm 2. Board of Trustees On May 11, 2010, the VPMA presen MEC the recommendations from the 2010 Anesthesia Department Peer If their review and approval as follows 1. Establish a clear commun process between surgeor anesthesiologist and OR he/she is ready to start or cautery unit (Bovie) for ca include head/neck surger require the delivery of sur oxygen. 3. Mandatory training for OF Medical Staff in regards to Policy and Procedure title "Surgical Fires, Prevention On May 4, 2010, the Chief of Surge and Chief of Anesthesia (COA) dev and sent a memorandum to the anesthesiologists and surgeons incl OB/GYN reinforcing the importance implementing fire precautions in the setting.	Inved): Vice CNO), ng Officer (CEO) on icy was stees stees stees March 8, Review for intention I and to the Team that ngaging ses that ies and optemental R staff and o the off. ry (COS) eloped	03/23/10 03/24/10 05/11/10
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	April 9, 2010 at 2: told her "it was a stated that it was still discolored but it blistered again, al was originally "cover you could see the	Interview with the page 15 most a 3rd degree to healing nicely, the wolcoaed, and then this poout the size of a quantered by a 4 X 4 gauze swelling involved." The on March 12, 2010 ar	physician purn". She ound was past week, ter coin. It pad, and he patient		TITLE 22 70223 SURGICAL GENERAL REQUIREMENT On May 4, 2010, the Anesth implemented a new process compliance with the establis which includes: After the su communicates aloud to the and OR Team that he/she is engaging the cautery unit, the anesthesiologist will also an Team that he/she is going to by documenting in the anestime the oxygen was stopped.	S (Continued): lesiologist to demonstrate shed process legeon anesthesiologist a ready to start ne nounce to the OR o stop the oxygen thesia record the	05/04/10
	The facility's failure the patient's face h serious injury or deal This facility failed the described above the serious injury or deconstitutes an inconstitutes an inconstitutes.	to prevent the surgices caused, or is likely that to the patient. to prevent the deficient at caused, or is likely that the patient, and manediate jeopardy we	to cause, to cause, to cause, therefore		On May 18, 2010, the surge involved in the care of Patile in-service to the Surgery Demembers present with regain the OR. The members withey need to establish a cle process between the surge enesthesiologist and OR staddition, a copy of the policitiled "Surgical Fires, Preveshared with the department."	int "A" provided an apartment rds to surgical fires are apprised that are communication on, aff present. In y and procedure inton of was	05/18/10
	meaning of Heat	th and Safety Code	Section		On July 19, 2010, the Chief who was directly involved in Patient "A", provided an insensity of the Patient of t	n the care of service to the service to the service to the service as einvolving the attent suffered a seedure. The "Surgical Fires, ed and every	07/19/10

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	April 9, 2010 at 2: told her "it was a stated that it was still discolored but it blistered again, a was originally "coveyou could see the sent pictures taken 2010, showing the discolored above the patient's face a serious injury or dead to the s	a Interview with the patient, of 30 PM, she stated the physicial almost a 3rd degree burn". Statement healing nicely, the wound was closed, and then this past wee bout the size of a quarter coin, are always as a swelling involved". The patie on March 12, 2010 and April eep 2nd degree burn. The to prevent the surgical fire on the patient of the patient to prevent the deficiency (ies) are transported to the patient, and therefore the patient of the pati	nn 1999 It 1800 It 1800 1800 1800 1800 1800 1800 1800 180	TITLE 22 70223 SURGIC GENERAL REQUIREMENT Perioperative Services is received initial education of Employee Orientation (NE precautions are a componemployees who work in the Services Departments. In Perioperative Services state annual reorientation as a employment. The staff me complete the annual reorientity medical leave or varequired to complete such getting back to their norm. QUALITY ASSURANCE IMPROVEMENT MONITY. The Interim Director of Perioperative of designee of the Medical Executive Confollowed as evidenced by and Surgeon documentated. The Interim Director of Perioperative of such audits for consecutive months and compliance was achieved Performance Improvement monitored on a periodic brongoing compliance/sust	NTS (Continued): taff members during New O). Fire in OR eent for those eent for those eent for those addition, aff members receive requirement for embers unable to entation due to location time are education prior to al assignment. PERFORMANCE DRING: enoperative Services berformed monthly lases involving head aquired the delivery This was done to locass as approved mmittee was the Anesthesiologist ion. erroperative Services documented the at least three (3) until 100% I. Thereafter, Int Indicators were lassis to ensure	Initiated: 05/01/10 Completed 04/30/11

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	April 9, 2010 at 2: told her "it was a stated that it was still discolored but it blistered again, a was originally "coveyou could see the sent pictures taken 2010, showing the d. The facility's failure the patient's face his serious injury or deathscribed above the serious injury or deconstitutes an in	a interview with the patient, on 30 PM, she stated the physician almost a 3rd degree burn". She healing nicely, the wound was closed, and then this past week, bout the size of a quarter coin. It ared by a 4 X 4 gauze pad, and a swelling involved". The patient on March 12, 2010 and April 9, eep 2nd degree burn. In to prevent the surgical fire on has caused, or is likely to cause, the to the patient. It o prevent the deficiency (ies) as and caused, or is likely to cause, eath to the patient, and therefore mediate jeopardy within the lith and Safety Code Section.		TITLE 22 70223 SURGICAL GENERAL REQUIREMENT REPORTING PROCESS: The outcome of these audits the Performance Improveme Committee (PIAC), the Medi Department, and Medical St Department meetings on a r scheduled basis as part of the Quality Assurance Performat (QAPI) program and for their recommendations. The PIA Quality Committee of the Bo Medical Executive Committee Board of Trustees (BOT). RESPONSIBLE PERSON(s) Chief of Staff Chief of Surgery Chief of Anesthesia Chief Nursing Officer Vice President Medica Director of Perioperative	s (Continued): was presented to ent Advisory cal Staff Surgery aff Anesthesia egularly ne hospital wide ince Improvement or review and C reports to the eard (QCB), see (MEC) and the	
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