STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X*) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		050073		8 WNG		2009	
NAME OF PR	OMDER OR SUPPLIER		STREET ADDRESS, O	CITY STATE.	ZIP CODE		
KAISER FO	OUND. HOSPITAL & REHA	AB. CENTER -	975 SERENO DR,	VALLEJO	, CA 94589 SOLANO COUNTY		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PRÓVIDER'S PLAN ÓF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS- COMPLETE	Ē
	The following reflects to Department of Public Hinspection visit: Complaint Intake Number CA00187028 - Substant Representing the Department investigated and findings of a full inspection was limited the substant of licensure has caserious injury or death Penalty Number: 1100 Services Policies & Prof. (d) Policies and	ne findings of the lealth during an oper: Intiated artment of Public Health does not represent to tion of the facility. Code Section 128 section "immediate in which the one or more in sused, or is likely to the patient. O7711 CH1 ART3-70213(dipoedures the procedures of the patient oper procedures of the patient operations of the patient.	alth: 30.1(c): For yeopardy" licensee's requirements to cause.		Our medical center takes sall issues related to patient. We have thoroughly invest this unfortunate event in oridentify opportunities to it patient care and safety. It was determined that the preparation of the preoper packets by the Vision Servassistant was an individual practice issue whereby more one packet was being comfat one time. Staff was education focus on assembly of only packet at a time. Responsible party: Ophthalmology Manager An analysis of the event in that Patient 2, the wife of 1, was scheduled for a cats surgery with the same surgery with the sa	seriously safety. tigated rder to improve 5-15-09 vice all ore than impleted cated to one indicated Patient aract geon for 2009. ound	
medical treatment plan, shall be developed and implemented in cooperation with the medical staff. Based on interview and record review, the facility failed to implement their policy and			he medical review, the		with Patient 1's name/ider and placed in Patient 1's preoperative packet. Patie Scan (ultrasound biometry both Patient 1 and Patient	nt l's A-	
Event ID:	procedure which ensu	red pre-surgical	12/21/2010	4:20	on it.		

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement anding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined of survey whether or now...

the date these occuments are made available...

participation

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Affilia 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 discloseble 14 days following the date these occuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program

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AND PLAN OF CORRECTION DENTIF		(X1) PROVIDERSUPPLIERICLIA DENTIFICATION NUMBER-	A. 8	MULTIPLE CONSTRUCTION UKLDING MNG	(X3) DATE SURVEY COMPLETED
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	OVIDER OR SUPPLIER OUND, HOSPITAL & REHA	i i	ET ADDRESS CITY, S SERENO DR, VALI	LEJO, CA 94589 SOLANO COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECREDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAC	TIX FEACH CORRECTIVE ACTION SHO	OULD BE CROSS COMPLETE
	Continued From page	1	_	An additional label wi	th the
	identifiers. Pat surgery and when lens was replaced correct measurement second surgery with wrong lens. This for complications in infection, prolonged and patient discomfort. THE VIOLATI REQUIREMENTS IMMEDIATE JEOP MEANING OF HE SECTION 1280.1 IN WAS LIKELY TO COEATH TO THE AND NURSING SPRE-SURGICAL CORRECT LENS III THIS VIOLATION RISK FROM HAVI SURGERY TO INTRAOCULAR LENS FINDINGS: See Tag E26	implanted using Patienent 1 underwent of his lens was remove with one which his some patients for another patients for another patients required to removesulted in the increas related to surgery, in time for healing of the CONSTITUTED ARDY (IJ) WITHIN ALTH AND SAFETY INTHAT IT CAUSEINAUSE SERIOUS INJUIPATIENT, WHEN MATAFF FAILED TO EVERIFICATION THAT NPLANT WAS TO BE PLACED THE PATIENG TO HAVE A SINPLANT THE COMMENT OF THE	eataract ed, the ed, the ed the et A ve the ed risk including ine eye, NSING AN THE CODE D, OR RY OR EDICAL ENSURE THE	patient identifiers had adhered to the A-Scan placing it in Patient 1' Operative Packet. In p Patient 1's history and the surgeon referenced scan in Patient 1's pacactually belonged to P During the time-out (p Universal Precautions preparation for Patient procedure, the circular immediately communiconcerns about conflict identifiers on the A-scattempted to verify the accuracy. The lens immediately communicated to the H&P. The calculations were verified the H&P matched the calculations documen H&P were incorrect by they were calculated they were calc	been prior to s Pre- reparing l physical, d the A- ket, which ratient 2. per policy) in t 1's ting nurse dicated her etting ran and e scan plant fied against tions from scan. The ted on the teause using the t labels are tient nically
	(b) The planning shall reflect all process: assessment,	and delivery of patier elements of the nursing diagnosis,	nt care nursing	test results at the time performed.	_
Event ID	.59SC11		12/21/2010	4·22 17PM	
		ER/SUPPLIER REPRESENTAT		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 80 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
_		050073		B MNS		05/12	2/200 9
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS	CITY STATE.	ZIP GODE	<u> </u>	
KAISER F VALLEJO	FOUND. HOSPITAL & REH	AB. CENTER -	975 SERENO DR	, VALLEJO	, CA 94589 SOLANO COUNTY		
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	Continued From page	2			1 The was of the label w	10.0	
	planning, interven circumstances requishall be initiated to time of admission.	tion, evaluation ire, patient ad	vocacy, and		 The use of the label w discontinued. This chi procedure will reduce opportunity to miside the scan. 	ange in the ntify	5-12- 09
	Based on interview and record review, the facility failed to implement their policy and procedure which ensured pre-surgical verification of an intraocular lens to be matched and then implanted using Patient 1's identifiers. Patient 1 underwent cataract surgery and when his lens was removed, the lens was replaced with one which had the correct measurements for another patient. A second surgery was required to remove the wrong lens. This resulted in the increased risk for complications related to surgery, including infection, prolonged time for healing of the eye, and patient discomfort. THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.1 IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO ENSURE PRE-SURGICAL VERIFICATION THAT THE CORRECT LENS INPLANT WAS TO BE USED. THIS VIOLATION PLACED THE PATIENT AT RISK FROM HAVING TO HAVE A SECOND SURGERY TO INPLANT THE CORRECT INTRAOCULAR LENS.				2. Assure all A-Scans ar uploaded into the Ophthalmologic Imag Server (OIS) so they available digitally at to fithe procedure, and paper version will no be needed. - Time-out should be performed with verification using original source of calculation. - The A-Scan verifice will be documented the circulating number the cataract safety list, by checking of appropriate boxes designated section. The outpatient Ophthalm Staff (as appropriate) was educated by the department manager's email notification the new process. It was a discussed during a staff meeting.	ging will be he time the longer the ation ed by ese on check- off the in the hology es ent ction of	5-12- 09
Event ID	Findings:		12/21/2010	4:22	17PM		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIÉR REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an estensic (*) 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 order, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCES (X1, PROVIDER/SUPPLIE AND PLAN OF CORRECTION LOSS (X1, PROVIDER/SUPPLIE IDENTIFICATION NU.)		MBER A BUILDING		(X3) CATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIÉR STREET ADDRESS, I			8 WING 2009 55, CITY, STATE, ZIP CODE DR, VALLEJO, CA 94589 SOLANO COUNTY				
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	revealed that it Patient 2's name worksheet was precorded the mer correct lens was in 1's name was affix of the exam by sticker had Patient surgery, 09, on the worksheet medical record num different names included the size discovered during //09. A review of the Protocol. Patient, Briefings and Final //09, included the folio III. Policy Statement The pre-procedural process of information	investigation on 1's record re ted on //09 in act lens of the le intraocular lens on for Patient tient 2 a ophthalmology worksheet, dated included both Pa is for the exa prepared preopera asurements to inplanted in the ey ed to the upper a preprinted stic 1's name and in Patient 2's name and included inber. The discovery on the docum of lens to in Patient 1's is facility policy, title Procedure and S al Verification Policy werification was	department		Responsible Party Ophthalmology Ma Special Procedures Chief of Special Pro Monitorir 1. Audit monthly sample of pre packets assemi patient Ophtha Clinic to ensur secondary labe used and packe error-free. 2. Audit monthly sample of A-S performed on to determine th uploaded into The threshold of 95 reached for audits of in June, July, Augu September, and Oc Reports were made Risk Management, quarterly to Perfor Improvement Com measure of success achieved and monit discontinued.	nager, Manager, ocedures ag a random operative bled in out almology te that the el is not ets are a random cans the Ellex 3 hat all are OIS. Was completed st, tober 2009. monthly to and mance mittee. The was	Oct. 31, 2009
Event ID:	59SC11		12/21/2010	4-22-17	PM		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

INMEDIATION OF THE PROVIDER OR SUPPLIER KAISER FOUND. HOSPITAL & REHAB. CENTER. VALLEJO UXI ID SUMMARY STATEMENT OF DEFCEMPLES PREST ISA-O BERDIANO MOST OF SUPPLIER TAG Continued From page 4 verification which began when the decision to perform a procedure was made, continuing through all settings and interventions involved in the pre-procedure verification process was to make sure that "all relevant occuments," blood and related information implants or special supplies/feujulment are available prior to the stant of the procedure. The purpose of the patient's identifiers." During an interview on 6/12/09 at 10-15 a.m., the Vision Service Assistant stated patient records are prepared in the ophthemiology clinic before surgery. The preponted stickers are put in the upper right come of the patient. The Vision Service Assistant stated the record goes through many hands before getting to surgery. The assistant of the procedure of the patient. The Vision Service Assistant stated the record goes through many hands before getting to surgery. The assistant of not know how the error occurred. During an interview on 5/13/09 at 11:30 am, the Circulating Nurse stated the two names on the document were discovered during "time out", a mandatory period of time before surgery during which the surgical learn reviewed the patient needs to make a surgery during which the surgical learn reviewed the patient of the potential of the patient out. The patient out is a mandatory period of time before surgery during which the surgical learn reviewed the patient procedure was seen as a clerical error and the physician proceeded with the left eye lens implant on Patient 1	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DAYE SURVEY COMPLETED	
INCHER FOUND. HOSPITAL & REHAB. CENTER- VALLEJO INCHER OF SUMMARY STATEMENT OF DEPCRAPOISS INCHER OF SUMMARY STATEMENT OF SUMMARY STATEMEN		050073				/2009	
PREFIX REGULATORY OF LISC IDENTIFYING IMPORATION) Continued From page 4 verification which began when the decision to perform a procedure was made, continuing through all settings and interventions involved in the pre-procedure preparation of the patient, up to and including the time-out just before the start of the procedure Preparation of the patient, up to and including the time-out just before the start of the procedure available prior to the start of the procedure, and matched to the patient information implants or special supplies/equipment are available prior to the start of the procedure, and matched to the patient records are prepared in the ophthalmology clinic before surgery. The preprinted stickers are put in the upper right corner of the page to more easily see the name of the patient. The Vision Service Assistant stated patient. The Vision Service Assistant stated the record goes through many hands before getting to surgery. The assistant did not know how the error occurred. During an interview on 5/13/09 at 11:30 am, the Circulating Nurse stated the two names on the document were discovered during "time out", a mandatory period of time before surgery during which the surgical team reviewed the patient, procedure, site of operation and lens required. The presence of two names on the document was seen as a clerical error and the physician proceeded with	KAISER FOUND. HOSPITAL & REHA	B. CENTER -	•				
venfication which began when the decision to perform a procedure was made, continuing through all settings and interventions involved in the pre-procedure preparation of the patient, up to and including the time-out just before the start of the procedure. The purpose of the pre-procedure verification process was to make sure that "all relevant documents, blood and related information, implants or special supplies/equipment are available prior to the start of the procedure, and matched to the patient's identifiers." During an interview on 5/12/09 at 10:15 a.m., the Vision Service Assistant stated patient records are prepared in the ophthalmology clinic before surgery. The prepinted stickers are put in the upper right comer of the page to more easily see the name of the patient. The Vision Service Assistant stated the record goes through many hands before getting to surgery. The assistant did not know how the error occurred. During an interview on 5/13/09 at 11:30 a.m., the Circulating Nurse stated the two names on the document were discovered during "time out", a mandatory period of time before surgery during which the surgical learn reviewed the patient, procedure, site of operation and lens required. The presence of two names on the document was seen as a clerical error and the physician proceeded with	PREFIX (EACH DEFICIENCY	MUST BE PRECESDED BY	fuli	PREF.X 6	EACH CORRECTIVE ACTION SHOULT	DIBE CROSS COMPLETE	
out", a mandatory period of time before surgery during which the surgical team reviewed the patient, procedure, site of operation and lens required. The presence of two names on the document was seen as a clerical error and the physician proceeded with	Continued From page verification which be perform a procedure all settings in the pre-procedure up to and including start of the procedure verification which is and related inform supplies/equipment start of the procedure verification of the procedure vision of the procedure vision of the procedure of the vision of the vi	egan when the use was made, and intervention process and intervention of the time-out just dure. The purposition process are available pricedure, and matched who on 5/12/09 at element of the passant stated in the orange of the passant stated the relation is before getting not know how who on 5/13/09 at element of the passant stated the relationship of the passant stated the passant stated the relationship of the passant stated the relationship of the passant stated the passant stated the relationship of the passant stated the passant stated the passant stated the relationship of the passant stated the two	decision to continuing is involved the patient, before the use of the was to ents, blood or special or to the ed to the 10:15 a.m., ed patient on thalmology ed stickers he page to sticent. The ecord goes to surgery the error				
Event ID:59SC11 12/21/2010 4:22 17PM	out", a mandator surgery during or reviewed the parties on the clerical error and the left eye lens implant	y period of to which the surg itient, procedure, required. The period document was a the physician proc	me before site of coresence of seen as a seeded with				

Any deficiency statement ending with an astensk (*) 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 050073		A BUILDING		CCYPLET	(X3) DATE SURVEY COMPLETED 05/12/2009	
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NAME OF PROVIDE KAISER FOUN VALLEJO	ER OR SUPPLIER D. H ÖSPITAL & REHA	AB. CENTER -	STREET ADDRESS. (975 SERENO DR.		CODE A 94589 SOLANO COUNTY			
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Co	ntinued From page	5						
wa dis wr	aff stated that s investigated as	on 709 when a clerical error, in Patient 1 had release implant.	Management the event t was then ceived the Patient 1					
Pa un ste wa	able to see out ited he had to h	nat after surgery of the left eye. ave a second sur for the eye to h	he was Patient 1 gery and it					
pro an is ca an jec	ocedure to ensur intraocular lens a deficiency that use, serious inju	_	rification of rect patient is likely to					
as cai an jec	described above use serious injur		is likely to he patient,					
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