DEFARIN	TENT OF PUBLIC HEALT	<u>n</u>							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	1 ' '			(X3) DATE SURVEY COMPLETEO			
050726				B. WING					
	ROVIDER OR SUPPLIER	AL	STREET ADDRESS.		ESTO, CA 95355 STANISLAU	S COUNTY			
			THE CONTROLLE ROAD, MODES TO, ON SOCIAL STRAIGHTON OCCUPY TO						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS- COMPLETE			
	of Public Health durin  Complaint Intake Nur  CA00240051 - Subst  Representing the Dep Surveyor ID # 27709,  The inspection was lievent investigated an findings of a full inspection for this means a situation noncompliance with	nber: antiated  partment of Public Hear HFEN  mited to the specific fand does not represent the totion of the facility.  Code Section 128 section "immediate	cility he  30.1(c): For e jeopardy" licensee's irements of		Linda Over 3:58 pm 3/14/ acceptable P Shin	- Great Office 11 - Notefed OC & Ompbell, 14-1-			
	MD Medical Doc OR Operating Room ORT Operating R RN Registered Nurs RNM Registered Health and Safety facility shall infor	ng Officer Quality Management ctor Boom Technologist e Nurse Manager Code Section 1279.1 m the patient or patient of the adver	the party		LICENS:	3 2011			
Event ID	2RØB11		4/5/2011	8:22:5	66AM				
	\ <del>                                     </del>								

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

(X6) DATE 4-//-//

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI			
		050726		A. BUILDING 08. WING 08.			3/2010
NAME OF BO	DADED OD GUDDUED		OTDEET 4000500	0171/ 07475	715 0005		
	OVIDER OR SUPPLIER		STREET ADDRESS				
STANISLA	US SURGICAL HOSPITAL	-	1421 OAKDALE	ROAD, MOI	DESTO, CA 95355 STANISLAUS COUNT	ΓY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CRO		(X5) COMPLETE DATE	
	Continued From page	•1 · · ·			Stanislaus Surgical Hospital initiate following actions:	ed the	
	The CDPH verified patient or the party re adverse event by the ti	esponsible for the p	atient of the		On 8/20/2010 Stanislaus Surgica     Hospital voluntarily self reported the CDPH.		8/20/2010
	(c) For purposes jeopardy" means a s noncompliance with licensure has caused injury or death to the p  DEFICIENCY CO JEOPARDY	situation in which the one or more requ I, or is likely to ca atient.	ne licensee's uirements of		2. Revised the policy "Marking and Verification of Surgical Procedure/Universal Protocol". The revision is the circulator as the team member to the "time out". The surgical team in verbally agree the surgical site markinitials of the surgeon or physician actively involved and present in the	Site dentified to initiate nust ked with assistant	10/30/2010
Event ID:	Based on staff and physician interviews, clinical record and administrative document reviews, the facility failed to implement facility established policy and procedures titled "Marking and Verification of Surgical Procedure/Site Universal Protocol" revised 2/10/10. The facility staff failed to ensure the site of a surgical procedure was correct during the pre-operative (before surgery) time out (a brief period of time immediately before surgery, where the surgical team verified: the patient, signed informed consent, procedure, location on the patients body, and that the site of the surgery all corresponded). This resulted in the patient having a wrong site surgical procedure incision made, arthroscopic scope inserted and initial shaving of bone begun.  Findings:  Record review was conducted on 8/26/10 and had documentation that Patient 1 was admitted to the			8:22:	procedure.  The Nurse Executive, Director of C Services, updated the policy.  The policy was approved by the Go Board on 10/30/2010.  3. "Time out" script posters were p two locations in each operating roo circulator verbalizes the script durit out". The script includes patient's r verification of surgical site with corprocedure and the statement "Can y the site marking?"  Poster developed by Operating Roo Manager.  4. On 8/23/2010 a surgical staff me conducted. The updated policy and procedure was reviewed. The "times.	Overning Ove	8/23/2010
$\rightarrow$			4/5/2011				
LABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE	TITLE	_	(X6) DATE

(X6) DATE 4-11-11

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 an approved plan of correction is requisite to continued program

participation. State-2567

DEFT OF HILL LOCKED

AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILO	TIPLE CONSTRUCTION	COMPLET	3) DATE SURVEY COMPLETED	
	OVIOER OR SUPPLIER	050726 STREET ADDRE 1421 OAKDAL	,,	ZIP CODE DESTO, CA 95355 STANISLAUS COUN	<u> </u>	6/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETE DATE	
	surgical procedure to give more range of	was admitted for a be done to		script and the components of the t process were reviewed including t requirement for all staff and physi pause and actively participate in the out".	the cians to he "time		
	Policy and Procedure titled,  "Marking and Verification of Surgical Procedure/Site Universal Protocol," dated 2/10/10, page 2 of 3 indicated, "Procedure for Verifying the Surgical Site Prior to Marking" "1patient identifies the correct surgical site. 2. Review of the			Operating room employees signed the policy and it was placed in the personnel files.	8/30/2010		
				The meeting was conducted by the Manager.	e OR		
	ordersinformed const the Circulating Nurs can be called by	, includingPhysicians sent form3. Prior to incision, se will confirm:b. Time Out any member of the surgical team		5. The action plan report was pres the Performance Improvement/Ris Medical Executive Committees do month of October 2010.	sk and	10/30/2010	
	verbally agree at a	iologists, Circulating Nurse, and Surgical Assistant) must minimum on the following: i. g two identifiersii. Correct		The Director of Quality of Care protection plan report.	resented		
	surgical side (if ap site and v. Surgical surgeon or Physic	plicable) iii. Correct surgical I site marked with initials of the ian Assistant (PA) actively		Monitoring process: a "time out" a was developed and implemented of 8/24/2010. Random audits were of daily until 12/31/2010.	on	8/24/2010	
	On 3/2/11 at 3:07	p.m., during a telephone		On 1/3/2011 the random audits we converted to twice a week.	ere	1/3/2011	
	marked preoperatively leg was prepared for the room scrubbing	cated, that the left leg was by MD 1. The patient's right surgery while MD 1 was out of (a preoperative washing of the illed the preoperative time out.		The data will continue to be forward Quality Dept. and a report provide Performance Improvement/Risk Cand Medical Executive Committee	ed to the Committee	10/5/2010	
	(a cut into the skin for Sterile NS (normal s	ut, MD 2 made a small incision or surgery) on the right ankle. saline), (a special fluid without ne same salt content as the		The OR manager was responsible audits. The Director of Quality of reported compliance to the commit	f Care		
Event ID:		4/5/2011		2:56AM			
MODATO!	Market Proble be program	EDISTIDOLIED DEDDESENTATIVE'S SIG	LATURE	TITLE		(YE) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from objecting 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.

1108

State-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050726				(X2) MULTIF	PLE CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		B. WING		08/2	6/2010			
MÉ OF PROVIDER OR SUPPLIER STREET ADDRE				CITY, STATE, Z	IR CODE	_   50.2		
	US SURGICAL HOSPITAL				ESTO, CA 95355 STANISLAU	S COUNTY		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		·	421 OANDALL	NOAD, MODI	EUTO, OA 33333 GTANISEAU	3 000111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FOUND  SCIDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION : REFERENCED TO THE APPROI	SHDULD BE CROSS-	(X5) COMPLETE DATE	
			J.1,	.,	TEVENEROED TO THE METHOD	MINTE DEFIGIENCE	DATE	
	Continued From page	÷1						
	The CDPH verified	that the facility int	formed the					
	patient or the party re	-						
	adverse event by the ti	•	I					
	(c) For purposes	of this section	"immediate					
	jeopardy" means a s							
	noncompliance with	•	I					
	licensure has caused	•	se, serious					
	injury or death to the p	atient.						
		NSTITUTING IN	MEDIATE					
	JEOPARDY							
	Based on staff and	d physician interview	vs. clinical					
	record and administ							
	facility failed to	implement facility	established					
	, .	dures titled "Mar	•					
	Verification of Surg	-	I					
	Protocol" revised 2/10	•						
	ensure the site of a during the pre-operati							
	brief period of time	,						
	where the surgical te	•	• •					
	informed consent,	•	on the					
	patients body, and t		• •					
	corresponded). This	•	- 1					
	wrong site surgical arthroscopic scope is	•						
	bone begun.	riserted and initial	silavilly of					
	Findings:							
	Record review was	conducted on 8/26/4	10 and bad					
	documentation that Pa							
vent ID:2	2R0B11 (		4/5/2011	8:22:5	6AM	_		
	ADIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESEN		TURE	TITLE		(X6) DATE	
\				<del>-</del>	MAD		4/1	

Any deficiency statement enting 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.

State-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050726		B. WING		08/	08/26/2010	
	OMDER OR SUPPLIER LUS SURGICAL HOSPITAL			SS, CITY, STATE, ZIP CODE  LE ROAD, MODESTO, CA 95355 STANISLAUS 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)			
	Continued From page	2				0.		
	hospital on surgical procedure to give more range of  On 3/2/11, during Policy and Procedure to "Marking and Procedure/Site Unive page 2 of 3 indicate Surgical Site Prior identifies the correct	was admit be done to motion to the ankle.  review of the A itled, Verification of real Protocol," date of the Marking" "1 surgical site. 2. Respect form3. Prior se will confirmb. any member of the surgical site and Surgical Assiminimum on the gray two identifiers	Surgical ed 2/10/10, /erifying thepatient eview of the hysicians to incision, 'Time Out' he surgical regical teaming Nurse, stant) must following: iii. Correct ect surgical itials of the					
	involved and present in	•	, astrony					
	On 3/2/11 at 3:07 interview, MD 1 indices marked preoperatively leg was prepared for the room scrubbing (skin). MD 2 had cale Following the time out (a cut into the skin for Sterile NS (normal stany bacteria that has the	cated, that the lete by MD 1. The properties of the preoperative was alled the preoperative to the preoperative to the preoperative to the preoperation on the saline), (a special for the precipitation).	atient's right I was out of thing of the e time out mall incision right ankle. fluid without		A SCENSING	3 / A STEERING		
Event ID:	2R0B11		4/5/2011	8:22:56/	M			
$\leftarrow$	<del></del>							

ORATORY (NREG) OR SOM PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
050726				B. WING		08/26/2010		
NAME OF PROVIDER OR SUPPLIER STANISLAUS SURGICAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE  1421 OAKDALE ROAD, MODESTO, CA 95355 STANISLAUS COUNTY					
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPRDPR	OULD BE CROSS-	(X5) COMPLETE DATE		
	Continued From page human body) had the ankle joint to help a scope (medical equipod body through very inserted into the jodesired had been see the right leg tournique or stop bleeding) and if that was the legarthroscope had there the closure of the state the total time about 10 to 15 minute and dressing of the wrong legstopped. other leg."	en been injected in see it better. The ipment that can sign small incisions) int. A little more en. MD 1 had start let (a device used at that time, MD into the procedure es which included ong site (right ankle). The procedure is the procedure of the procedure is which included ong site (right ankle). The procedure is which included ong site (right ankle). The procedure is which included ong site (right ankle). The procedure is which included ong site (right ankle). The procedure is which included ong site (right ankle).	Arthroscopic ee into the had been blood than ted to adjust to decrease 2 had asked gery. The followed by 1 indicated had been the suturing telephone ened really incisionput			-		
On 11 at 3:20 p.m., the clinical reconvote had been reviewed. It indicated, that been prepared for surgery, the tindeen done, and surgery on the right ank begun. After the right leg was identified by MD 2 as the wrong site, the incision and covered by 8:15 a.m. The left prepped and draped and surgery continua.m.  The left surgical site was marked in prepatient verbally confirmed the left ankle in the operating room the right ankle was possible.			the right leg me out had the was then at 8:10 a.m. was closed ankle was ared by 8:28			2011		
Event ID:	D0D11		4/5/2011	8:22:5	6 AM	23NO #		

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 pursing homes, the findings above are disclosable 90 days following the day

TOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE 4-//-//

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.

CORATORYORE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
050726			B. WING		08/26/2010		
NAME OF PRO	OVIDER OR SUPPLIER						
STANISLA	US SURGICAL HOSPITAL		1421 OAKDALE R	ROAD, MODESTO, (	CA 95355 STANISLAUS COUN	ITY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY I SC IDENTIFYING INFORMAT	FULL		PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOULD I FERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETE	
	Continued From page	4					
	and prepped without viewing the marked consent was read ou staff failed to recognized for surgery.	surgical "left" and the left an	nkle. The ankle). The				
	The failure to follow to and the licensee's not requirements of licento cause, serious in The above facility Administrative Penalty.	oncompliance with one sure, has caused, njury or death to failure may res	one or more or is likely the patient.				
	This facility failed to described above that serious injury or deat constitutes an immeaning of Health 1280.1(c).	caused, or is likely thato the patient, an nediate jeopardy	y to cause, nd therefore within the				
					DEFT OF HEALTH SEES	SCES CONTRACTOR	
Event ID:	ROB11		4/5/2011	8:22:56AM	-		

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

CZO

(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.