

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/13/2011
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NAME OF PROVIDER OR SUPPLIER LAC/Harbor-UCLA Medical Center	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 W Carson St, Torrance, CA 90502-2004 LOS ANGELES COUNTY
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The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number:  
CA00282925 - Substantiated

Representing the Department of Public Health:  
Surveyor ID # 21262, 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 death to the patient.

Health and Safety Code Section 1279.1(c). "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made."

The CDPH verified that the facility informed the patient or party responsible for the patient of the adverse event by the time the report was made.

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY

T22 DIV5 CH1 ART3 -70223 (b)(2), (c), (d) Surgical Service Requirements.

(b) A committee of the medical staff shall be

**A. New/Revised Processes & Procedures**

**Pre-operative Assessment and Testing**

1. Develop and implement new Hospital Policy # 314 A "Pre-anesthesia Assessment & Testing for Elective Outpatient and Same-day-admission Surgery Patients" that will establish a process of pre-operative assessment and testing for scheduled elective surgery, including:
  - a. Two business days prior to the Pre-anesthesia Assessment & Testing (PAT) Clinic appointment date, the Surgery Scheduling Center staff will review the patient's medical record to ensure there is a timely History & Physical (within 30 days prior to the date of the scheduled surgery) and will notify the appropriate surgical service to correct any cited deficiencies.
  - b. At PAT Clinic, the Anesthesiology Department provider staff is responsible for all of the following:
    - Assessing the patient.
    - Reviewing the pre-operative History & Physical (H&P) and the Scheduled Admission/Outpatient Surgery Referral Form for timeliness and appropriateness.
    - Reviewing the results of pre-operative diagnostic tests/procedures ordered and performed and documenting the date the tests/procedures were performed.
    - Ordering or re-ordering any diagnostic tests/procedures - including Blood Bank requests - as deemed necessary.

9/26/11

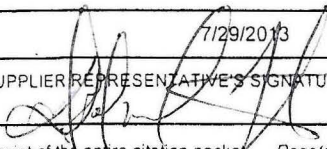
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

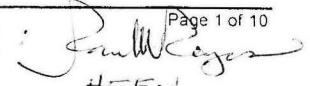


TITLE  
Chief Executive Officer

(X6) DATE  
8/13/13

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 10

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.

Approved:   
8/15/13 HFEN

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	<p>assigned responsibility for:</p> <p>(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 governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>(c) The responsibility and the accountability of the surgical service to the medical staff and administration shall be defined.</p> <p>(d) Prior to commencing surgery the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not to be administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record:</p> <p>T22 DIV5 CH1 ART3 -70233 (a)(1)(2)(3)(4), (b) Anesthesia Service General Requirements.</p> <p>(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. The policies and procedures shall include provision for at least:</p> <p>(1) Preanesthesia evaluation of the patient by an individual qualified to administer anesthesia as a licensed practitioner in accordance with his or her scope of licensure. Persons providing preanesthesia evaluation shall appropriately</p>		<ul style="list-style-type: none"> <li>• Formulating and documenting a plan for anesthesia.</li> <li>• Educating the patient and/or family/designated representative on the risks and benefits of the proposed plan for anesthesia, including possible alternatives.</li> <li>• Obtaining informed consent for anesthesia related to the surgery.</li> </ul> <p>c. If the patient misses his/her scheduled PAT Clinic appointment:</p> <ul style="list-style-type: none"> <li>• It is the responsibility of the PAT Clinic staff to promptly notify the Surgery Scheduling Center.</li> <li>• After notification by the PAT Clinic staff that the patient missed his/her PAT Clinic appointment, it is the responsibility of the Surgery Scheduling Center staff to promptly contact the patient and/or provider to identify the reason for the missed appointment and to initiate the rescheduling of the patient to PAT Clinic.</li> <li>• If the patient is not assessed by the Anesthesiology provider staff by 3 p.m. the business day prior to the scheduled elective surgery date, the scheduled elective surgery will be removed from the final elective surgery schedule.</li> </ul> <p>d. If the scheduled elective procedure is cancelled and rescheduled, the Surgery Scheduling Center must ensure that the patient has a scheduled PAT Clinic appointment no more than 30 days prior to the new</p>	

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	<p>document pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated.</p> <p>(2) Review of the patient's condition immediately prior to induction of anesthesia.</p> <p>(3) Safety of the patient during the anesthetic period.</p> <p>(4) Recording of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the amount and duration of all anesthetic agents, other drugs, intravenous fluids an blood or blood fractions.</p> <p>(b)The responsibility and the accountability of the anesthesia service to the medical staff and administration shall be defined.</p> <p>T22 DIV5 CH1 ART3 -70235 (a) (1) Anesthesia Service Staff.</p> <p>(a) A physician shall have overall responsibility for the anesthesia service. His responsibility shall include at least the:</p> <p>(1) Availability of equipment, drugs and parenteral fluids necessary for administer anesthesia and for related resuscitative efforts.</p> <p>T22 DIV5 CH1 ART3-70703 (h) Organized Medical Staff.</p> <p>(h) The medical staff shall develop criteria under which consultation will be required. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.</p>		<p>(rescheduled) elective surgery date.</p> <ul style="list-style-type: none"> <li>• If the preoperative H&amp;P and the Scheduled Admission/Outpatient Surgery Referral form were completed more than 30 days prior to the rescheduled date of surgery, the surgeon must provide a new H&amp;P and Scheduled Admission/Outpatient Surgery Referral form.</li> <li>• All the requirements for a timely and complete surgical H&amp;P and timely PAT Clinic assessment still apply.</li> </ul> <p>e. If the pre-operative anesthesia assessment occurred more than 48 hours from the time of the scheduled surgery, the Anesthesiology provider must update the pre-operative assessment before treatment or surgery commences including documenting the date of performance of diagnostic tests/procedures that were ordered as part of the pre-operative work-up.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>• Associate medical Director</li> <li>• Ambulatory Care</li> <li>• Chair, Department of Anesthesiology</li> <li>• Chair, Operating Room Committee</li> <li>• Chief Nursing Officer</li> </ul> <p>2. Revise and implement Hospital Policy # 314 Operating Room Protocol" to include the following:</p> <p>a. In the event an elective case is cancelled and rescheduled to a new date of operation that is more than 30 days later than the original date, the</p>	<p>2013 AUG 14 PM 12 25</p> <p>9/26/11</p>

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	<p>The above regulations were NOT MET as evidenced by:</p> <p>Based on medical record review and interviews, the hospital failed to adequately monitor and intervene appropriately for serious medical/surgical conditions when Patient B lost a large amount of blood (2500 cc) during the total right knee replacement surgery. In addition, the history and physical examination revealed that the laboratory studies and informed consent had been performed over five months prior to the surgery. Moreover, his blood was not tested to determine blood type or screened for antibodies. The failure to monitor and intervene in a timely manner during severe blood loss led to Patient B's loss of heart rate and blood pressure, and consequently, the patient's altered mental status.</p> <p>Findings:</p> <p>Medical record review for Patient B was initiated on [REDACTED] 11. The medical record showed the patient came to the hospital for the right knee replacement surgery (a surgical procedure whereby the diseased knee joint is replaced with an artificial knee implant) on [REDACTED] 11. According to the medical record and interviews with MD Q (orthopedist) conducted on [REDACTED] 11 at 1330 hours, Patient B had sustained a right knee injury in 2007. The patient had developed right knee joint and surgical infection requiring a prolonged post-operative treatment including surgical debridement (removal of dead, damaged or infected tissues), a rotational flap (provides the ability to mobilize large areas of tissue with a wide</p>		<p>patient must have a new pre-operative appointment to the Pre-anesthesia Assessment &amp; Treatment (PAT) Clinic. The Surgery Scheduling Center will be responsible for scheduling the PAT Clinic appointment and for notifying the patient of the new PAT Clinic appointment.</p> <p>b. Reference new Hospital policy 314 A "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-day-admission Surgery Patients".</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>• Chair, Department of Anesthesiology</li> <li>• Chair, Operating Room Committee</li> <li>• Chief Nursing Officer</li> </ul> <p>3. Develop and implement a universal pre-operative surgical H&amp;P form for outpatient and same-day-admission surgical cases to ensure performance of a consistent and complete surgical H&amp;P.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>• Acting Chief Medical Officer</li> </ul> <p><b>Operating Room Communication</b></p> <p>A. New/Revised Processes &amp; Procedures 9/26/11</p> <p>1. Revise and implement Hospital Policy # 314 "Operating Room Protocol" to include the following:</p> <p>a. New "OR Surgical Checklist (5Ws)", including when appropriate when the type and cross blood test was sent.</p> <p>b. Whenever there is a change in the managing anesthesiology personnel or surgical operating team leadership during the progress of a case, there will be a "hand-off" communication between the anesthesiology and surgical providers that will include the</p>

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	<p>vascular base for reconstruction), and a skin graft (involves the transplantation of skin) of the right knee. Patient B had undergone a surgical procedure on [REDACTED] 10, to remove surgical hardware from the right knee. At that time, Patient B was told he might require a total right knee replacement surgery because he had significant post-traumatic arthritis with severe persistent pain and scarring in the surgical area of the right knee. Patient B was offered a total right knee replacement surgery for which he came to the hospital on [REDACTED] 11.</p> <p>Review of the anesthesia record and the history and physical examination dated [REDACTED] 11, revealed the patient's laboratory work had been performed on [REDACTED] 11, over five months prior to the surgery. During an interview on 9/12/11 at 1400 hours, MD R (anesthesiologist) stated that the general guidelines for laboratory work for young and healthy patients did not require repeated laboratory work prior to a surgical procedure. MD R stated that she was unaware the laboratory work was not recent. MD R stated the laboratory work should be dated when placed into the pre-anesthetic assessment. Anesthesia was induced on [REDACTED] 11 at 1600 hours. A tourniquet (used to prevent blood flow to a limb allowing surgical procedures to be performed with improved precision, safety, and speed) for bloodless surgery (surgical operations expected not to need blood transfusion) was placed on [REDACTED] 11 at 1650 hours, and set at 300 mmHg pressure.</p> <p>MD Q stated that the early portion of the surgical procedure was not difficult; however, as the surgery progressed, the previous operations and infections</p>		<p>procedure being performed, the current stage and progress of the procedure, the current physiologic status of the patient, the current fluid intake and output measurements, and any problems being encountered in the conduct of the operation. This "hand-off" communication will be initiated by the newly participating provider, whether an anesthesiology provider or surgeon. Any change in Operating Room personnel will be communicated to the entire Operating Room team.</p> <p>c. Whenever there is a permanent change in nursing staff, there will be a "hand-off" communication between the incoming and outgoing nursing staff that will include patient status and case status, and when appropriate, counts, specimen status, blood product availability, and planned post-operative patient disposition. Any change in Operating Room personnel will be communicated to the entire Operating Room team.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>• Chair, Operating Room Committee</li> </ul> <p>2. Revise and implement Hospital Policy # 380 "Verification of Correct Patient, Invasive Procedure and Surgical Site" to include the following:</p> <p>a. As part of the final "time out" the "OR Surgical Checklist Reminder (5Ws)" will be used to ensure that appropriate antibiotics, blood availability, imaging and test results, patient positioning, site marking, equipment availability, and any other problems or concerns</p>		

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	<p>had resulted in considerable distortion of the anatomy. He stated that it took several hours to free up the structures in the right knee requiring a long tourniquet time which reached a total of 326 minutes by the end of the procedure. He stated that the patient was stable with no blood loss, but noted during the surgery, the popliteal (main artery in the posterior aspect of the knee supplies blood to the knee joint and muscles in the upper and lower leg) and vein in the right knee had been transected (surgically cut) during the total right knee replacement surgery.</p> <p>A note placed into the anesthesia record dated 9/11 at 1700 hours, by MD S (anesthesiologist) revealed "popliteal artery iatrogenic injury" (an injury caused by medical procedure). The operative note placed by MD T "the artery was completely transected in at least two places. Because the tourniquet was inflated, no bleeding was evident." At approximately 2230 hours, the tourniquet was released. The anesthesia record revealed 1000 cc (cubic centimeters) of blood loss.</p> <p>On 9/12/11 at approximately 1130 hours, MD T (vascular surgeon) was interviewed. He stated that he focused on performing the surgical procedure and did not recall being informed by MD S regarding a 1000 cc blood loss. However, RN 1 stated during an interview on 9/13/2011 at 1500 hours, he recalled hearing MD S tell MD T that 1000 cc of blood had been lost. RN 1 stated that MD S was going to order one unit of blood to be transfused immediately and have a second unit ready. However, RN 1 told MD S that no blood had</p>		<p>are being properly addressed prior to commencement of the operation.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Operating Room Committee</li> </ul> <p><b>B. Personnel Training/Notification</b></p> <p><b>Pre-operative Assessment and Testing</b></p> <p>1. New Hospital Policy # 314 A "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-day-admission Surgery Patients"</p> <p>a. Educate Anesthesiology Department provider staff on new "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-day-admission Surgery Patients" policy.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Department of Anesthesiology</li> </ul> <p>b. Educate Attending and Resident surgeons on new "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-day-admission Surgery Patients" policy.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Operating Room Committee</li> </ul> <p>c. Educate Surgery Scheduling Center staff on new "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-day-admission Surgery Patients" policy.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chief Nursing Officer</li> </ul> <p>d. Educate Anesthesiology providers on</p>	<p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p>

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	<p>been requested from the blood bank because the surgery was done under tourniquet, supposedly a bloodless surgery. RN 1 asked MD S to obtain blood specimen for a type and cross match. RN 1 stated that MD S was having difficulty obtaining blood for the type and cross match and it took "almost an hour" to obtain one half of a laboratory tube of blood to be sent to the blood bank. The tube of blood was sent to the blood bank at 2300 hours. RN 1 stated that the blood bank offered unmatched blood for Patient B at approximately 2330 hours; however, MD S refused the unmatched blood (universal donor blood that was not immunologically screened to match donor and recipient's antibody and antigen which can cause deadly transfusion reaction) from the blood bank. RN 1 stated that MD S wanted to wait for the typed and cross matched unit of blood for Patient B.</p> <p>Interviews with MD T revealed that a vascular repair would be required to repair the cut artery and vein in the right knee. It was elected to wait until the total right knee replacement surgery was completed in order to have a stable surgical field for the vascular repair. At 2300 hours, blood had not yet been received from the blood bank.</p> <p>At approximately 2330 Patient B was turned into the prone (face down) position to repair the vessels in the posterior (back) aspect of the right knee. The tourniquet was released and blood loss was noted by MD R "despite control of the proximal (near) artery." Exploration of the vessels revealed there were more vascular injuries than originally noted. According to the operative note, "it took longer to</p>		<p>the required documented elements of a complete and accurate Anesthesia Record, specifically including patient intake and output.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Department of Anesthesiology</li> </ul> <p>2. Revised Hospital Policy # 314 Operating Room Protocol"</p> <p>a. Educate Anesthesiology Department provider staff on revised "Operating Room Protocol" policy. 9/26/11</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Department of Anesthesiology</li> </ul> <p>b. Educate Attending and Resident surgeons on revised "Operating Room Protocol" policy. 9/26/11</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Operating Room Committee</li> </ul> <p>c. Educate Surgery Scheduling Center staff on revised "Operating Room Protocol" policy". 9/26/11</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chief Nursing Officer</li> </ul> <p>3. Universal Pre-operative Surgical History &amp; Physical Form for Outpatient and Same-day-admission Surgical Cases 9/26/11</p> <p>a. Educate Attending and Resident surgeons on new History &amp; Physical form.</p> <p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Operating Room Committee</li> </ul>	

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	<p>gain control of the bleeding." MD T noted "considerable oozing from the structures in the knee, including the boney structures." MD T asked MD S regarding the blood loss and was informed that 2500 cc of blood had now been lost; however, no blood had been infused for Patient B. MD T noted that bleeding "stopped abruptly" and MD S reported Patient A had no blood pressure or pulse. Patient B was rotated back into the supine (face up) position and CPR (cardiopulmonary resuscitation) was initiated on [REDACTED]11 at 0030 hours.</p> <p>Patient B was administered 4 units of O negative blood (universal blood) and later additional blood and blood products. After a total of 14 units of blood, 4 units of fresh frozen plasma and platelets, Patient B had a "gradually improving blood pressure and near-normalization of the heart rate." Marked abdominal distention was noted by the physicians. The abdomen was opened and an amount of fluid removed. During the ongoing resuscitation of the patient, a "four compartment fasciotomy" (opening the muscles in the right leg to allow the soft tissues to swell) was performed. Patient B was then rotated back to the supine position and the vascular surgical procedure was completed.</p> <p>On [REDACTED]11 from 0145 till 0200 hours, the anesthesia record revealed the patient had an oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage of the maximum it could carry) of 85% (normal range is 95-100%). The operative note revealed that Patient A had been placed on a ventilator. Multiple</p>		<p>b. Educate Anesthesiology Department provider staff on new History &amp; Physical form. <b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Department of Anesthesiology</li> </ul> <p>c. Educate Surgery Scheduling Center staff on new History &amp; Physical form. <b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chief Nursing Officer</li> </ul> <p><b>Operating Room Communication</b></p> <p>1. Educate Attending and Resident surgeons on revision to Hospital Policy # 314 "Operating Room Protocol" to include the new "OR Surgical Checklist Reminder (5 Ws)", including when the type and cross blood test was sent, and "hand-off" communication requirements. <b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Operating Room Committee</li> </ul> <p>2. Educate Anesthesiology Department provider staff on revision to Hospital Policy # 314 "Operating Room Protocol" to include the new "OR Surgical Checklist Reminder (5 Ws)", including when the type and cross blood test was sent, and "hand-off" communication requirements. <b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chair, Department of Anesthesiology</li> </ul> <p>3. Educate Nursing Department Operating Room staff on revision to Hospital Policy # 314 "Operating Room Protocol" to include the new "OR Surgical Checklist Reminder (5 Ws)", including when the type and cross blood test was sent, and "hand-off" communication requirements.</p>	<p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p> <p>9/26/11</p>

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7/29/2013

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/13/2011
NAME OF PROVIDER OR SUPPLIER  LAC/Harbor-UCLA Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 W Carson St, Torrance, CA 90502-2004 LOS ANGELES COUNTY		
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	<p>vasopressor drugs were administered to elevate the blood pressure for the patient. Blood pressure was recorded as 70-80%. The medical record revealed the pulse in the artery of the right leg (femoral artery) was not present by palpation (the examination of the body parts by using the sense of hand touch) or by Doppler determination (determination of blood velocity and volume flow in the artery). Patient B was then taken to the intensive care unit of the hospital due to no blood supply to the right lower extremity.</p> <p>On [REDACTED] 11, a below the right knee amputation and irrigation (washing off) of the abdominal wound were performed and a tracheostomy tube (stoma on the neck for ventilator hook-up/connection for breathing) and a percutaneous gastrointestinal feeding tube were inserted.</p> <p>On [REDACTED] 11, an above the right knee amputation was performed.</p> <p>On [REDACTED] 11, an above the right knee amputation site was revised surgically. As of [REDACTED] 11 at 1130 hours, Patient B was observed in the step-down unit (a telemetry unit where the patient needs to be on a cardiac monitor and has frequent vital signs taken) of the hospital with altered mental status (ranging from confusion to being non-responsive to painful stimuli, moving without purpose, not following verbal commands, staring blankly on the ceiling).</p> <p>On [REDACTED] 11, after Patient B had a tracheostomy and a PEG (percutaneous endoscopic gastrostomy</p>		<p><b>Responsible Individual:</b></p> <ul style="list-style-type: none"> <li>Chief Nursing Officer</li> </ul> <p><b>QI Plan and Monitoring</b></p> <p><b>Pre-operative Assessment and Testing</b> Quality Assessment staff to perform chart audit of 70 OR cases per month to monitor for compliance with documentation of the following elements of new policy #314A "Pre-anesthesia Assessment &amp; Testing for Elective Outpatient and Same-Day-Admission Patients":</p> <ul style="list-style-type: none"> <li>Plan of anesthesia</li> <li>Date of diagnostic tests,</li> <li>Updated physical assessment if the pre-operative assessment and testing was performed more 48 hours prior to the start surgery.</li> <li>Presence of anesthesia consent,</li> <li>Risks, benefits and alternatives explained to the patient.</li> </ul> <p>Collect data monthly until average 90% compliance is maintained for 4 consecutive months. Report audit results to the following:</p> <ul style="list-style-type: none"> <li>Anesthesiology Department Quality Improvement Committee</li> <li>Operating Room Scheduling Center</li> <li>Pre-operative Assessment &amp; Testing staff</li> <li>Surgery Quality Improvement Committee.</li> <li>Operating Room Committee</li> </ul> <p><b>Operating Room Communication</b> Quality Assessment staff to perform chart audit of 70 OR cases per month to monitor for compliance with documented performance of the "OR Surgical Checklist Reminder (5Ws)" as part of the final "time-out</p>	

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	<p>for enteral nutrition) tube insertion, he was discharged to the subacute unit of a skilled nursing facility as a ventilator dependent patient with complete bed rest and being nonverbal.</p> <p>On [REDACTED] 11, Patient B was admitted to the intensive care unit of another hospital (Hospital B) due to supraventricular tachycardia (abnormally fast heart rhythm).</p> <p>On [REDACTED] 12, Patient B was readmitted to the subacute unit of the skilled nursing facility, was transferred to Hospital B due to respiratory failure, and expired on the same day.</p> <p>This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).</p>		<p>Collect data monthly until average 90% compliance is maintained for 4 consecutive months. Report audit results to the following:</p> <ul style="list-style-type: none"> <li>• Anesthesiology Department Quality Improvement Committee</li> <li>• Surgery Quality Improvement Committee.</li> <li>• Operating Room Committee</li> </ul>

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