POC accepted 6/14/11 N. Mullan RN, RSN

PRINTED: 05/27/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000109	A. BUILDING _____ B. WING _____	C 12/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTION PICTURE & TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint visit. Complaint Intake Number: CA00228605 - Substantiated Inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted] RN, HFEN 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. T22 DIV5 CH1 PART3-70223 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 governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient	E 264	**E264** *How the correction will be accomplished, both temporarily and permanently*	4/9/10

RECEIVED
2011 JUN 14 PM 2:34
HEALTH FACILITIES
INSPECTION DIVISION
ADMINISTRATION

Licensing and Certification Division

Jackie Mollett Admin Dir, Med Staff Services June 10, 2011

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

PRINTED: 05/27/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000109	A. BUILDING _____ B. WING _____	C 12/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTION PICTURE & TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)	(X5) COMPLETE DATE
E 264	Continued From page 1 care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to implement its written policy and procedure for counting sponges, sharps and instruments used for Patient 1's surgical procedure. The facility staff failed to sign the count sheet and the surgeon failed to appropriately use the Raytec sponge during Patient 1's surgical procedure, which resulted in the retention of a foreign object in Patient 1 and placed the patient at risk for possible additional complications to including infection in the surgical incision, damage to structures, nerves and blood vessels in and around the knee, blood clots in the leg and the need for repetitive surgery/anesthesia. Findings: On June 3, 2010, an investigation was conducted following an entity reported event regarding retention of a foreign object in Patient 1. The face sheet indicated Patient 1 was admitted to the facility on [redacted], 2010 with diagnoses which included ACL (anterior cruciate ligament) insufficiency of the right knee. (ACL is one of four primary ligaments around the knee joint which is an important stabilizer of the knee.) A review of the Operative Report dated [redacted], 2010 indicated Patient 1 underwent a surgical procedure of ACL reconstruction under general anesthesia and femoral nerve block. The Operative Report indicated the joint was entered through a 3 cm incision. The intraoperative	E 264	The retention of the sponge was reported to us on April 5, 2010. A staff meeting was held with all Surgery Department staff on April 9, 2010 reorienting them to the "Counting Sponges, Sharps and Instruments" policy which states that documentation of all counts on intra-operative nursing records must be initialed by both the scrub person and the circulating nurse. The surgeon stated on April 9, 2010 that he no longer will place Raytec sponges into incisions to help with pain relief. *The title and position of the person responsible for the correction.* The Surgery Department Manager is responsible for the correction *Description of the monitoring process to prevent recurrence of this deficiency.* The Surgery Department Manager or designee audits intra-operatvie records to assure that counts of sponges, sharps and instruments are signed by both the scrub person and the circulating nurse.	4/9/10

PRINTED: 05/27/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000109	A. BUILDING _____ B. WING _____	C 12/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTION PICTURE & TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)	(X5) COMPLETE DATE
E 264	Continued From page 2 Record under the section Nursing Focus II: Potential for Injury, dated [redacted] 2010 at 12:30 p.m., indicated the first and final sponge counts had been conducted and were correct, however it appeared the counts were completed by one person as evidenced by the style of the script. In a letter from the facility sent to the Department dated April 29, 2010, additional information was provided to the Department regarding the report of retention of a foreign object. The letter indicated ACL reconstruction surgery was performed on Patient 1 on [redacted], 2010 and the patient returned to the surgeon's office with concerns of a lump in the knee area on [redacted] 2010 (over two months later). A review of the X-ray report dated [redacted], 2010, indicated Patient 1 had a retained foreign object (Raytec sponge) in the right knee. The letter further indicated the surgeon subsequently reported that the patient underwent removal of the sponge at a different facility within one week of identifying the retained sponge. A review of the face sheet from the second general acute care hospital indicated Patient 1 was admitted on [redacted] 2010 with diagnoses which included leg pain status post ACL. The face sheet also indicated in the comments section, removal foreign body (sponge) right knee. The Operative Report dated [redacted], 2010, from the second general acute care hospital, disclosed Patient 1 had removal of foreign body, irrigation and debridement of right knee. The pre-operative diagnosis was a right knee retained foreign body status post ACL reconstruction. The operative report indicated the old skin incision was opened 3 cm in length which allowed visualization of a Raytec sponge. The sponge	E 264		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000109	A. BUILDING _____ B. WING _____	C 12/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTION PICTURE & TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)	(X5) COMPLETE DATE
E 264	Continued From page 3 was removed using tonsil forceps. During an interview with Employee A (the surgery department manager) on June 3, 2010 at 2:35 p.m., when asked if the the Intraoperative Record under the section Nursing Focus II: Potential for Injury, first and final sponge counts were signed/initialed by the same person, she stated yes. Employee A stated the licensed nurse (circulating nurse) signed/initialed the first and final sponge count for herself and the scrub tech. Employee A further stated the count should not have been counted as correct. A review of the facility's policy and procedure titled "Counting Sponges, Sharps and Instruments" dated October 2003, indicated count sheets shall be signed and dated by the circulator and scrub person. Employee A stated this policy was in effect during Patient 1's procedure. During an interview with Employee A on December 15, 2010 at 10:50 a.m., she stated the sponge count on the Intraoperative Record should be signed/initialed by each individual, the circulating nurse and the scrub tech as indicated by the policy and procedure. A request was made to observe a Raytec sponge used for Patient 1's procedure. Employee A revealed a pack of ten of the same type of sponges used in Patient 1's procedure and each sponge was 10.18 cm x 10.18 cm. When Employee A was asked how the surgeon managed to insert the 10.18 cm sponge into a 3 cm incision, she stated the sponge was saturated with anesthetic and stuffed into the incision. During a phone interview with the surgeon (Employee B) on December 15, 2010 at 11:30	E 264		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000109	A. BUILDING _____ B. WING _____	C 12/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTION PICTURE & TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)	(X5) COMPLETE DATE
E 264	Continued From page 4 a.m., he stated the sponge was bathed in anesthetic, placed along the edge of the skin and put inside the incision to help with pain relief. During an interview with the scrub tech (Employee C) on December 17, 2010 at 1:40 p.m., he stated the signature/initials on the sponge count for Patient 1's surgical procedure dated [redacted], 2010, was not initiated by him. Employee C further stated he had never signed the count sheet before, as this was done by the circulating nurse. When Employee C was asked how the surgeon managed to insert the 10.18 cm Raytec sponge into the 3 cm incision, he stated the surgeon "crammed the sponge" into the incision after it was saturated with the anesthetic. A review of the facility's policy and procedure titled Counting Sponges, Sharps and Instruments dated October 2003 indicated Raytec sponges were not to be utilized as packing or dressing. The facility's failure to implement its policy and procedure to prevent retention of the Raytec sponge used during a surgical procedure was a deficiency that caused, or was 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.	E 264		