### CALIFORNIA HEALTH AND HUMAN SERVICES INCY DEPARTMENT OF PUBLIC HEALTH

		(X1) PROVIDER/SUPPLII IDENTIFICATION NU	ì	(X2) MULTIPLE CONSTRUC	( * /	ATE SURVEY DMPLETED		
		050424		A BUILDING B WING		05/21/2009		
	OVICER OR SUPPLIER GREEN HOSPITAL	<u> </u>	•	SS, CITY STATE, ZIP CODE TORREY PINES ROAD, LA JOLLA, CA 92037 SAN DIEGO COUNTY				
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL F	REFIX (EACH CO	IOVIDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE CROS CED TO THE APPROPRIATE DEFICIENT	i		
	The following reflect Department of Pul Reported Incident inve	blic Health during estigation		;				
	Category. State Mo Object in Patient		of Foreign:		ETOF <b>(VED</b>			
	Representing the C	, HFES and	t of Public	•	EC 1 1 2009			
	1280.1 (c) For purpieopardy" means a noncompliance with licensure has caused injury or death to the p	situation in which the one or more reque dor is likely to ca	ne licensee's urements of	PICENT SAN DIEGO	ORGENIA OFFICE			
	clinical privileges, a other subjects or staff and governin medical staff shall a of enforcement of by-laws, rules and restrict within the soright of staff members any special class of the staff members.	ff, by vote of the man the governing body have provide formal prapplications and ppointments, assisted properties and provide the provided by and establication its by-laws. Mean regulations shall reproperties of their licensuries or assign staffer category of staffer.	nembers and shall adopt occedures for credentials, gnment of shall adopt the medical opriate. The shall amend or deny or the the voting members to membership					
Event ID:	based upon whether s	such statt members h	old an	9 31.41 <b>AM</b>				
Event ID:	RY DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESE		_ <del>_</del>	TITLE Admin Dir	(X6) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution pray 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

Catherine M, Fay.

12/8/09

Quality/PI

#### CALIFORNIA HEALTH AND HUMAN SERVICES DEPARTMENT OF PUBLIC HEALTH

	<del></del>	<del></del>				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURY COMPLETE	
			A BUILDIN	G	1	
050424			B WING	B WING		/2009
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADDRESS	S. CITY STATE.	ZIP CODE	<del></del>	
SCRIPPS	GREEN HOSPITAL	10666 NORTH 1	ORREY PINE	S ROAD, LA JOLLA, CA 92037 S	AN DIEGO COUNT	Υ
W 41 15	2011111220127		!			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL	1D ' PRĒĒIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	FAG .	REFERENCED TO THE APPROPRIA	TE DEFICIENCY)	DATE
	15	<del></del>				
	Continued From page					
	!	or D.D.S degree or clinical			ĺ	
	psychology license.			Process	}	
	Bosed on intention	and record review, the facility		Scheduling	ot oak a dula a .	Completed
	i .	and record review, the lacimy at health care providers were		Effective immediately we will reperform any procedures that n	not schedule or	5/22/09
		devices prior to the use of the		lumbar drain placement (i.e., o	pen or stented	
		As a result, a health care		aneurysm repair or aneurysm appropriate credentialing and	Clipping) until	
	· ·	wrong end of a lumbar CFS		process is developed	Col vice training	
	[cerebral spinal fluid]	catheter drain, into the spinal		Educate schedulers on new pr	rocass and decision	Completes
		The health care provider had		before shift begins.	ocess and decision	Completed
		ice before. The insertion of a		Implement immediately news	\ \	0
	1	er drain procedure was not		Implement immediately new paschedulers to ensure appropri	ate detail is	Completed
	-	e health provider's privileging		translated to schedule for all c	ases and verify	
	4	procedure listed on the surgery	į	appropriate credentialing by pl effectively immediately. Educa	1ysician. Policy	
	_	the incident. When the health ed to remove the lumbar drain		new process before shift bega	n on 5/22:	
	-	theter was sheared off, and		communicated with appropriat 5/22.	e physicians on	Į
	· ·	ntimeter [cm] of the catheter		٠ <b>٠_</b>	}	
	1 * *	days after discharge from the	;	Review all cases scheduled fo appropriate detail is on scheduled		Completed 5/22/09
	facility, Patient A w	as re-admitted with diagnoses		appropriate credentialing.	ne and winnin	5/22/09
	that included, "Rule ou	t meningitis."		Davidous ett fisture een statu		
	5			Review all future cases to ens detail and credentialing. Cance	el any cases not in	Completed 5/22/09
		P.M., the Department called	'	compliance with new process		
	- ' '	ecause of the facility's failure nealth care providers would be		Responsible Person		
		ently used specialized medical	}	Manager, Peri-Op Services	1	
	•	sing the device in surgery; the				
	-	eges for MD 1 did not clearly			•	
	state that he had	been approved to place the				
	lumbar CFS drain,	which MD 1 described as,	i			
		sertion of the lumbar CFS drain		:	ļ	
		ted on the surgery schedule as	İ			
	1 '	7:10 P.M., the Department			l	
	,	ble plan of correction and the		· 		
	immediate jeopardy wa	as abated. The plan of				
Event ID	:E9YS11	11/25/2009	9.31.4	41AM		
LABORATO	RY DIRECTOR'S OR PROVID	FR/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE		X6) DATE

12/08/09

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> G:\QRM\MSWord\DPHS\MR#700452870 DPHS Action Plan - Fgn Object

### CALIFORNIA HEALTH AND HUMAN SERVICES PINCY DEPARTMENT OF PUBLIC HEALTH

AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER (DENTIFICATION NUM)  050424	BER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING B WING		COMPLE	(X3) OATE SURVEY COMPLETED	
000427				U 141110		05/2	21/2009	
NAME OF PR	OVIDER OR SUPPLIER	s	TREET ADDRESS, CIT	Y, STATE, ZIP	COOE			
SCRIPPS	GREEN HOSPITAL	11	0666 NORTH TORE	REY PINES	ROAD, LA JOLLA, CA 92037 S	AN DIEGO COUN	NTY	
		_	_					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FL SCIDENTIFYING INFORMATIO		ID REFIX TAG ;	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETE DATE	
	Continued From page	2		,				
	correction included the		!					
	correction included the	tollowing elements						
	1. Effective immed	iately the facility	would not					
	schedule or perforn							
	require a lumbar dr	- '	_				1	
	credentialing and i	•					1	
	developed.		;					
	2. Implement imme	ediately a new pro	cess with				Ì	
	surgery schedulers t	to ensure appropriate	e detail is				į	
	translated to sched	ule for all cases	and verify					
	appropriate credentiali						İ	
	3. Review all case so							
	to verify appropriate		edule and					
	confirm appropriate cr	<del>-</del>					:	
	4. Review all future						i	
	detail and credential	•	es not in				1	
	compliance with new p							
	5. Enhance core pri							
	specialty procedure	-	=					
	Chairman and to b		emergency					
	Credentialing Committ		rogram for	į.			ĺ	
i	6. Develop in-service lumbar drain placemer	_	rogram ioi					
	7. Work with Anest		to ensure (	!				
	appropriate existing i							
	physicians as well	~		i				
	cover all new items in		1					
	8. Through PI/Risk		te monthly '					
	audit for full year to		•				Ĺ	
	steps above.	<b>,</b>	]					
	,			1			}	
			!					
	Findings:		[	1				
	_		ļ	!			}	
	Patient A was admitted	d to the facility on 4/28/	<b>′0</b> 9					
	50.00.0		1105/0000	0.24:44	^**	<del></del>	<del></del> _	
Event ID			11/25/2009	9 31:41/		<u> </u>		
LABORATO	RYDIRECTOR'S OR PROVID	ER/SUPPLIER REPRESEN	TATIVE'S SIGNATUR	₹E	TITLE		(X6) DATE	

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State-2567

### CALIFORNIA HEALTH AND HUMAN SERVICES ENCY DEPARTMENT OF PUBLIC HEALTH

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPL	E CONSTRUCTION	I '	(X3) DATE SURVEY COMPLETED	
		A BUILDING 3 WING		<del></del>				
050424					05/2	1/2009		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS.	CITY STATE, ZIP	CODE			
SCRIPPS	GREEN HOSPITAL		10666 NORTH TO	DRREY PINES	ROAD, LA JOLLA, CA 92	037 SAN DIEGO COUN	ITY	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY I LSC IOENTIFYING INFORMA	-ULL	ID PREFIX . TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE ACTION REFERENCED TO THE APPI	ON SHOULD BE CROSS-	(X5) COMPLETE DATE	
	Continued From page	9.3		<del></del>		<del></del>	<del>                                     </del>	
	with diagnosis that aneurysm, status discharge summary underwent a thoracic patient was discharge. The patient was discharge to discharge diagnos meningitis, malnutrit the transfer summary.  On 5/21/09 at 3:00 [MD 1] that inserted immediately prior interviewed. MD 1 s lumbar cerebrospina more than 30 years, performed about 15 thirty years; the last	t included expandition post thoracic stem of the facility re-admitted to the mission of headache, rudache, and rule out a skilled nursing es that include ion, and cardiomy on said that he had been of these procedures st time being about the cardiomy and the surgery on said that he had been of these procedures time being about	the patient repair. The on 5/1/09 facility on it local CSF 09 Patient A facility with daseptic opathy per are provider to Patient A 4/29/09 was en putting in and off" for that he has in the last it two years					
Event II	ago, when he, "help was asked to descripperating room) at MD 1 said that just surgeon asked MD Patient A. The lumstand in the operation never seen this type further stated that particular device be to go through the pigmented [darkened the end to be inserted]	ibe what happened the time of the ever prior to starting the 1 to insert a lumb abar drain tray was an groom. MD 1 said of catheter drain be because he had not fore, he took about brochure. The cath do and that he as	in the O.R. nt [4/29/09]. surgery, the par drain in set out on a that he had fore. MD 1 nt used this 10 minutes seter had a sumed was er	9 24-44	ΔΝΑ			
Event ID	E9Y\$11		11/25/2009	9 31:41	AM			
ABORATO	RY DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESE	NTATIVE'S SIGNA	TURE Shi 6	TITLE	- /	(X6) DATE 2/8/09	

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## CALIFORNIA HEALTH AND HUMAN SERVICES ENCY DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050424	A BUILDING B WING		05/2	1/2009
NAME OF DO	OVIDER OR SUPPLIER	STREET ADDRE	SS CITY, STATE, ZIP CO	ne .		
	GREEN HOSPITAL	1		DE PAD, LA JOLLA, CA 92037	SAN DIEGO COLA	ITY
		10000 1101(1)	TOME TIMES NO	AD, CA 00CDA, OA 32037	SAN DIEGO COUN	
(X4) IO PREFIX TAG	, (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SCIDENTIFYING INFORMATION)		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFFRENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETE DATE
	Continued From page	÷ 4	<del>- </del>	<del></del>	<del></del> _	<del> </del>
	types of catheters a	re used. He noted that there				
		n the pigmented end, as he				!
		al end of a drainage catheter				1
	He did not notice that	at the other end of the catheter				1
	also had holes. MD	1 then inserted the pigmented				
	end of the catheter,	thru the trocar, into the spinal				
	column of Patient A	A. MD 1 then realized that he				
		catheter backwards when he				
		r end of the catheter also had				
	, -	e then realized what had				
	1 ' '	to remove catheter drain, but				!
	1	catheter drain sheared off	1			:
	(approximately 3.5					1
	· ·	MD 1 mentioned that one of his				,
	•	he same mistake with this type				
	without breakage	been successful in removing it				İ
	Williout breakage		;			
	Joint review of Par	tient A's medical record was				
		Patient A was discharged				
	1	5/1/09, and then re-admitted on				
	· ·	generalized weakness,				
		dache" per the history and	'			 
	1	nsultation report, Patient A was	1			
	l ·	out meningitis." On 5/13/09 at	1			Ì
	11:00 P.M., a CT (co	omputerized tomography) of the	1			i i
	lumbar spine with the	he use of a contrast material	•			i i
	was performed. Per	the radiologist's report, the CT	1			
	•	mm opaque foreign body				
		ter tip marker just beneath the				
	- X	the plane of the L3 - L4 disc."				1
	1	n MD1 on 5/21/09 at 3:00 P.M.,				
	1	retained tip of the lumbar drain				]
	•	position by the ligaments, and				
	that there would be no	attempt to remove the		•		j
Event ID:	F9VS11	11/25/20	09 9.31:41 <b>A</b> M	- <del></del>		
				<del></del>	· <del></del> _	
_ABORATOR	LY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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#### CALIFORNIA HEALTH AND HUMAN SERVICES **DEPARTMENT OF PUBLIC HEALTH**

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		}		A BUILDING		1		
		050424		B WNG			21/2009	
		<u> </u>				03/21		
NAME OF PROVIDE			TREET ADDRESS, CIT		**			
SCRIPPS GREE	SCRIPPS GREEN HOSPITAL 10666 NORTH T				ES ROAD, LA JOLLA, CA 92037 SAN I	DIEGO COUNT	Υ	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID .	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FU	LL P	REFIX	(EACH CORRECTIVE ACTION SHOULD B	BE CROSS-	COMPLETE	
TAG	REGULATORY OR (	SC IDENTIFYING INFORMATIO	)N)	TAG	REFERENCED TO THE APPROPRIATE D	EFICIENCY)	DATE	
		<del></del>						
Col	ntinued From page	5	:	!				
catt	neter piece.		1		<b>A</b>			
; !					Credentialing Enhance core privileges to ensure a	ll applicable		
MD	t's credential file	e with approved privi	leges was		speciality procedures. List already re		Completed	
		s privileged to do, "re			Chairman . Reviewed/approved by (		,	
		There was no listin	_		Committee. Reviewed/approved by	Medical	}	
		scement of a lumbar (	•		Executive Committee 5/29/09	ĺ		
					Responsible Person:	)		
	The Department and MD 1 jointly reviewed his approved privilege sheet. When asked if the				Head, Anesthesia; Manager, Medic			
1 .				Training/Education  Develop in-service training/proctoring program for fumbar drain placement and new kits. Specialist				
		ar drain placement wa	and the second s					
		gories for which he						
i		ed that his listed priv	-		,			
	· ·	ent of a lumbar CSF		on kits on 5./28/09				
		e insertion of the lun			Work with Anesthesiology leadershi	n to encure		
,		not listed on the	<b>.</b> .		appropriate existing items are being			
		ed that, "Had he			with physicians as well as staff. Imp	lemented		
<del>-</del>		d have reviewed the i			process to cover all new items in O.	R.		
1		ain. MD 1 said that h		l	Monitoring	į		
		reviewing the product			Completed review 5/22/09. Schedul	ed appropriate		
		e insertion. MD 1 s		I	in-services as required. Based on fir	Completed		
	•	n" [lumbar drains] and	, ,	i	perform any other procedures where	e in-		
can	be "tricky and they	are a sophisticated dra	ain.		service/training may be lacking.			
				ļ	Responsible Person	}		
		cility's medical staf		!	Head, Anesthesiology; Manager, Pe	eri-Op		
Arti	cle VI, Clinical	Privileges, "6.1 Ex	ercise of	İ	Services			
Clir	nical Privileges - E	Except as otherwise p	provided in	j	Through Performance Improvement	t/Risk		
the	se Bylaws, a n	nember providing in	dependent	l	Management, complete monthly au	dit for one	Ongoing	
clin	ical services at th	nis hospital shall be	entitled to		year to determine compliance with a	all steps		
	exercise only those clinical privileges specifically				above.		i	
	_	approved privileges for	•	ţ	Monitoring Process	1		
	not clearly state that this provider had been approved to place the lumber CSF drain.			I	Audits to be completed monthly (be			
			i	:	week of May 26th) for one year to el			
			ļ	Į	appropriate compliance with new pr	rocess.		
MO	1 was not familia	r with a specialized o	device that	i	Responsible Person			
1		ly. The insertion of t		İ	Admin Director, Quality/Performar	nce	•	
	·	on the privileging sheet	i		Improvement			
Was	a not deally listed t	ar are brivileding arrest		ļ		<b>\</b>		
Event ID:E9YS	511		11/25/2009	9 31	41AM			
	·	ER/SUPPLIER REPRESENT			TITI F			

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Object

State-2567

participation.

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# CALIFORNIA HEALTH AND HUMAN SERVICES ENCY DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE	CONSTRUCTION	·	(X3) OATE SURVEY COMPLETED	
050424			B WING		05/2	05/21/2009		
NAME OF PROVID SCRIPPS GRE	ER OR SUPPLIER		STREET ADDRESS. 10666 NORTH TO		CODE ROAD, LA JOLLA, CA 92	037 SAN DIEGO COUN	TY	
(X4) ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR	N SHOULO BE CROSS	(X5) COMPLETE OATE	
Co	ontinued From page	6	_ <del></del>	<del></del>				
prohoto climate prohoto climate prohoto climate prohoto prohot	D 1. The facility's loviding independent spital shall be endical privileges specified to develop a edical staff assignated to the insertional fluid] catheter are familiar with metable the device in surfused, or is likely eath to the patient, mediate jeopardy or is Safety Code sections.	nt clinical service titled to exercise edifically granted." formal procedure nment of clinical on of a lumbar CS or ensure that healt edical devices prior gery is a deficience to cause, serious and therefore conwithin the meaning	s at this only those The facility to evaluate privileges of [cerebral to the use by that has injury or institutes an	!				
							<u> </u>	
Event ID:E9Y			11/25/2009	9 31:41/				

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

TITLE

(X6) DATE

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