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	California Department the investigation event. Complaint Number: CA The investigation vicomplaint and the represent the finding facility. Representing the Depa Galen Gattis, RN/HFEN Health & Safety Copurposes of this means a situation noncompliance with of licensure has caserious injury or death.  Title 22 - 70713 - Use of the finding facility in the serious injury or death.  Title 22 - 70713 - Use of the finding facility in the findi	of a complaint/ .00197618  vas limited to the investigation is of a full inspector interest of Public Heart of Public Heart one or more in which the one or more in used, or is likely to the patient.  of outside resources: is not employ in the patient of outside resources: is not employ in the patient of the series of such agreement with the pets of the standard of each such delineated in voorized representation or the cet. The agree	alth during self-reported the specific does not although the specific groups and specific pital, there a service an outside lards and terms the specific pital, there are specific pital		RECEIVE CA DEPT OF PUBLI FEB 26 LICENSING & CERTI SAN DIEGO NORTH DIST	2010	
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that other sa of survey wh the date thes participation	cy statement ending with an as feguards provide sufficient prof lether or not a plan of correction se documents are made availat	tection to the patients. Exemples by the provided. For nursing	cept for nursing hork homes, the above fir	es, the findin ndings and p	gs above are disclosable 90 da lans of correction are disclosab	ys following the date le 14 days following	crif
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TO SECURE A SECURE A SECURE ASSESSMENT ASSES		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 050424	Education of the Control of the Cont			(X3) DATE SURVEY COMPLETED 10/15/2009		
	ROVIDER OR SUPPLIER GREEN HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE  10666 NORTH TORREY PINES ROAD, LA JOLLA, CA 92037 SAN DIEGO COUNTY					
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	administrator of rimplementation and through dated and be retained by the action and evaluation of action and evaluation of Findings:  The facility failed aware that a spice required disassed processing and prior. An outside contrastraining staff regarding instrument and was debris was discovered instrument. Between twelve (12) patient procedure where was either used, or set. As a result of that staff had known required disassembly of the 12 patients blood borne pathogens.  On 8/6/09 at 10:15 informed that, "With colored-debris/old blood borne pathogens."	responsibility The outside resonsultant, shall appeared to signed reports we administrator for performance.  To ensure that ecialized surgical mbly before to use of the actor was responsulted and the vered on the ween 8/1/08 and the specialized was in the instructional that the special that the special that the special special to so the special special that the special special that the special spe	pprise the plans for assessment which shall refollow-up staff were instrument cleaning, instrument the specialized 7/31/09, as surgical instrument tray to ensure instrument tray to ensure instrument exposed to the specialized to ensure instrument tray to ensure instrument tray to ensure instrument exposed to the specialized to ensure instrument tray to ensure instrument exposed to the specialized to ensure instrument exposed to ensure instrument exposed to ensure instrument was be red end on a specialized to ensure the specialized the specialized to ensure the specialized to ensure the specialized the spe		Process Sterilization of equipment effective immedia. Review of scheduled OR cases for the nexthours and continuing on a rolling 48 hour schedule.  - Surgical instrumentation of each case be opened and inspected.  - Removable components will be disassembled and instruments will go through the complete cleaning and sterilization process.  Responsible Person Admin Director, Surgical Services  Surgical instrumentation, frequently used for emergency procedures, including add-on orthopedic procedures, will be identified.  - Surgical instrumentation will be open inspected.  - Removable components will be disassembled and instruments will go through the complete cleaning and sterilization process.  - Surgical technicians will inspect instrumentation prior to using in the optical.  Responsible Person Director, SPD/Supply Chain  Infection control consultation regarding the effectiveness of the sterilization.  - Notify patients and their physicians of event  - Offer blood borne pathogen blood test patients  - Arrange to pay for the blood borne test.  - Patient testing by non-Scripps Health laboratory services.  Responsible Person	se will or ned and perative  f the sting to	Initiated on 8/6/2009 Completed 9/4/09 Initiated 8/6/09 Completed 9/4/09 Initiated 6/6/09 Ongoing Initiated 8/6/09 Completed 8/30/09	
		,	0/0/0045		Manager, Epidemiology			
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Cath Any deficienthat other sa of survey wh	feguards provide sufficient prot lether or not a plan of correction se documents are made availab	lerisk (*) denotes a deficie ection to the patients. Exc is provided. For nursing	ncy which the institute tept for nursing homes homes, the above find	on may be on the standard of t	Admin Dir  Quality/PI  excused from correcting providing it is determined gs above are disclosable 90 days following the da lans of correction are disclosable 14 days followin of correction is requisite to continued program	i ate	X6) DATE  2/23/09  10  CIAL	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	ED
	ROVIDER OR SUPPLIER GREEN HOSPITAL	STREET ADDRES		ZIP CODE ES ROAD, LA JOLLA, CA 92037 SAN	31 32 400	5/2009 TY
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	manipulating the in the, "Surgeon of debris/old blood" instrument. Per the staff members (surgery technicians Department (SPD) they were unawinstrument separated Administrative Di Representative (MR) operating room [OR] specialized instrument present during the 7/31 On 8/6/09 at 10:40 Sterile Processing the sterile processing the sterile processing instruments, and representative come together." The SI sterile processing sheath came off Director state of representative had binder related to the not provided any staff within the passpecialized instrument traumatic hip/femur fractions.	ment while the surgeon was strument and at that point, noticed the red colored on the shaft of the Administrative Director, OR surgeon, registered nurses, and Sterile Processing staff members all stated are that the specialized into two parts. Per the rector, a Manufacturer's was always present in the whenever the tray with the at was used. The MR was 1/09 surgical procedure.  O.A.M., the Director of the Department [SPD] stated and staff wash and dry the at the manufacturer's in and, "puts the kit PD Director stated that the staff, "Were not aware the the screwdriver." The SPD of the manufacturer's not provided a manual or the instrument tray, and had in-service education to SPD at 12 months related to the not tray used to repair a		New instrumentation received in SPI disassembled, photographed and er Instrument photo catalog along with manufacturer's instructions.  Responsible Person Admin Director, Surgical Services  - The photo catalog will be crea as a reference for SPD or OR disassembling, cleaning and strequipment  - Creation of an education track sheet to easily identify employed new equipment  - Inventory "on consignment" in to evaluate the need to keep or instrument kits.  Responsible Person Director, SPD/Supply Chain  Monitoring The Director, SPD/Supply chain will:  - Maintain a cleaning reference processed in the consignment instrument in tracking log  - Review consignment instrument inventory routinely to remove infused instrument kits  Purchase computerized software for inventory, photos, manufacturer's recommendations and employee trainess of the presons Director, SPD/Supply Chain and Admin Director, Surgical Services	ted and used staff when erilizing spread e training on strumentation delete	Initiated 8/10/09 Ongoing  Initiated 8/10/09 Ongoing  Initiated 8/10/09 Ongoing  Budgeted for 2010
	stated, "No one specialized instrument	in OR knew that this came apart until the				
Event ID:		2/2/2010	9:19:1	13AM		
	RY DIRECTOR'S OR PROVIDE	RUSUPPLIER REPRESENTATIVE'S SIGNAL	TAY	Admin Dir Quality/PI		(X6) DATE 2/23/09
Any deficier	ncy statement ending with an as	sterisk (*) denotes a deficiency which the instection to the patients. Except for nursing ho	/ /-			19 Cynt

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/SUPPLIES (DENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		050424		A. BUILDIN B. WING	G	10/15/2009			
NAME OF PROVIDER OR SUPPLIER SCRIPPS GREEN HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE  10666 NORTH TORREY PINES ROAD, LA JOLLA, CA 92037 SAN DIEGO COUNTY						
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	incident on 7/31/05 training by the until now."  On 8/10/09 at 9:2 Representative (MR the incident occurr screwdriver was of gel-like material that fresh blood." Minstrument came ap that the OR and S this specialized ins 1 stated it was the provide in-service trawith regard to provide in-service trawith regard to provide in-service trawith regard to provide instruments supplied stated he had not written procedure the instruments in stated that the irrapart in the OR, SPD for processi instruments should cleaning, they ne autoclaved, and sterile conditions who OR  Manufacturer's Repreduring a phone in P.M., he "Typi presentation one winstrument tray is bit in the procedure of the conditions one winstrument tray is bit in the procedure of the conditions who or th	manufacturer's remanufacturer's remanufacturer's remanufacturer's remanufacturer's remanufacturer's remanufacturer's remanufacturer's remanufacturer and responsibility of aining to OR and oper use and composition of the specialized transtrument should decontaminated, are not be reassembled to be applicated to b	epresentative enufacturer's esent when eated, "The lack-colored, blood, not knew the not aware if not know eart. MR the MR to SPD staff cleaning of r. MR 1 y with any g cleaning ay. MR 1 be taken and sent to eated the hold after eart when ead under opened in  2] stated, 09 at 4:10 in-service after an						
	TAGE  Continued From page 3  incident on 7/31/09, there was no in-service training by the manufacturer's representative until now."  On 8/10/09 at 9:20 A.M., the Manufacturer's Representative until now."  On 8/10/09 at 9:20 A.M., the Manufacturer's Representative until now."  On 8/10/09 at 9:20 A.M., the Manufacturer's Representative (MR 1) who was present when the incident occurred on 7/31/09 stated, "The screwdriver was coated in a black-colored, gel-like material that appeared to be blood, not fresh blood." MR 1 stated, he knew the instrument came apart, but he was not aware that the OR and SPD technicians did not know this specialized instrument came apart. MR 1 stated it was the responsibility of the MR to provide in-service training to OR and SPD staff with regard to proper use and cleaning of instruments supplied by the vendor. MR 1 stated he had not provided the facility with any written procedure manual regarding cleaning the instruments in the specialized tray. MR 1 stated that the instruments should not be reassembled after cleaning, they need to be apart when autoclaved, and then reassembled under sterile conditions when the tray is opened in OR  Manufacturer's Representative 2 [MR 2] stated, during a phone interview on 8/10/09 at 4:10 P.M., he "Typically gives an in-service"								
Car Any deficience that other safe of survey whe	therine Fay  by statement ending with an as eguards provide sufficient protection there or not a plan of correction	derisk (*) denotes a deficie ection to the patients. Exi in is provided. For nursing	incy which the institution to the community of the commun	ion may be eas, the finding	Admin Dir <u>Quality/PI</u> excused from correcting providing it is determ	nined he date lowing			

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200	ROVIDER OR SUPPLIER G GREEN HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE  10666 NORTH TORREY PINES ROAD, LA JOLLA, CA 92037 SAN DIEGO COUNTY							
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	typically separated reassembled when MR 2 stated it was SPD a manual instrument tray), (the for these."  MR 1 and MR 2 vertically documentation or extraining was provided staff related to cleas pecialized instrument on 7/31/09.  On 8/10/09, the identifying 12 patient required use of the was reviewed with (ICN). The ICN is A.M., that no possible in the second in th	sure it took place. emonstrated remove constrated remove edialized instrument very single one of ed the instrument from the screwdrithe tray is open, "not typical to go (related to a ne) facility has been as to facility or facility provided to facility or facility provided to support to the lifection Constaled, on 8/10/0 post-operative infect to any hip/femu previous 12 mo previ	val of the t. I may on them in sheath is ver and specialized been asking or ovide any in-service and SPD sing of the the incident a listing argery that The listing introl Nurse 9 at 10:10 tions were ar fracture on this. The 12 identified sed on the did and 1 that required							
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that other sa of survey wh	ncy statement ending with an as afeguards provide sufficient pro- helher or not a plan of correction ase documents are made availal n.	tection to the patients. Ex n is provided. For nursing	cept for nursing ho homes, the above	mes, the finding findings and pl	gs above are disclosable 90 d ans of correction are disclosa	ays following the date ble 14 days following	cnt			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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	Continued From page Review of facility	5 documentation related t	o OR		- <del>-</del>			
	and SPD staff hi dates reflected that members were hired	re and in-service ed 26 of 106 (24.5%) OF d after 8/1/08, and 7 members were hired	ucation R staff of 21 after ucation					
	in-services betwee For SPD, the fa presentations betwee None of the presentations SPD staff were	n 8/1/08 through 7/ cility conducted 22 in- een 8/1/08 through 7 entations given to OR	/31/09. service //31/09. R and cialized				;	
	received appropriate contracted resource and processing construment is a design likely to cause, so patient, and therefore	eficiency that has cause erious injury or death re constitutes an imm meaning of the Health	outside sembly urgical ed, or to the nediate					
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ny deficienc at other saf f survey whe	eguards provide sufficient pro- ether or not a plan of correction	tection to the patients. Except for n is provided. For nursing homes	nursing homes/ , the above findin	the findings ab	Quality/PT sed from correcting providing it is soove are disclosable 90 days follow of correction are disclosable 14 day correction is requisite to continued	wing the date ays following	2/23/09 Cruf	

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