Course Dimmes Dimmes <thdimes< th=""> <thdimes< th=""> Dimes</thdimes<></thdimes<>		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 050324		(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
SCRIPPS MEMORIAL HOSPITAL - LA JOLLA 9388 GENESEE AVENUE, LA JOLLA, CA 9237 SAN DIEGO COUNTY MAID PHERM EMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY ALL THE STATEMENT OF DEFICIENCIES) (EACH DEPICENCY ALL THE STATEMENT OF Public Health during a complaint/Jadverse investigation visit: Image: Complaint Intake Number: CA00224687 - Substantiated Representing the Department of Public Health: Image: HFEN The inspection of the 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 jeoparty" 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 dealt to the patient. The investigation was timited to the specific incident reported and does not represent the findings of a full inspection of the facility. Background regarding incident: The following circumstances contributed to the retained foreign body: Representing the California Department of Public Health and Safety Code Section 1279. 1(c), "The facility shal inform the patient or the party responsible for the patient or the patient or the party responsible for the patient or the party responsible for the patient or the patient or the party responsible for the patient or the			050324						
PREFIX TAS EACH OBFICIENCY MUST BE PRECEDEOR BY PLL REGULATORY OR USE DIRATIFYING INFORMATION) PREFIX TAS EACH OBFICENCE ACT /// SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) The following reflects the findings of the Department of Public Health during a complaint/adverse investigation visit: The following reflects the findings of the Department of Public Health during a complaint/adverse investigation visit: Image: Complaint/adverse investigation visit: Complaint Intake Number: CA00224687 - Substantiated CA DEPT OF PUBLIC HEAITH Image: Complaint/adverse 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. Background regarding incident: The following circumstances contributed to the retained foreign body: Entity Reported incident Number: CA00224687 Category: Retention of a foreign object in a patient. Surgeon was urgently called to the patient's ICU beckide while intensivist was pumping blood into the patient Representing the California Department of Public Health: Manityn Hutcheson, HFEN. Surgeon was urgently called to the DR Health and Safety Code Section 1279, 1 (c), "The facility shall inform the patient or the party responsible for the patient of the addiverse event by Urgent transfer of the patient to the OR			a jolla		•				
of Public Health during a complaint/adverse investigation visit: Complaint Intake Number: CA00224687 - Substantiated Representing the Department of Public Health: HEN 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. Entity Reported incident Number: CA00224687 Category: Retention of a foreign object in a patient. The investigation was limited to the specific incident reported and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Manityn Hutcheson, HFEN. Health and Safety Code Section 1279. 1(c), "The facility shall inform the patient of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTI)	IN SHOULD BE CROSS	(X5) COMPLETE DATE	
responsible for the patient of the adverse event by		of Public Health during investigation visit: Complaint Intake Num CA00224687 - Substa Representing the Dep Market And Free investigated and findings of a full inspection was lin event investigated and findings of a full inspection noncompliance with licensure has caused injury or death to the p Entity Reported Incide Category: Retention of The investigation incident reported findings of a full inspection Representing the O Health: Marilyn Hutch Health and Safety facility shall inford	a complaint/adverse aber: ntiated artment of Public Hea FEN hited to the specific fa does not represent f ction of the facility. Code Section 124 section "immediate n in which the one or more requ d, or is likely to car batient. ent Number: CA00224 of a foreign object in a was limited to and does not re action of the facility. California Department reson, HFEN. Code Section 1279 n the patient or	alth: ncility the 80.1(c): For e jeopardy" licensee's uirements of use, serious 4687 patient. the specific epresent the nt of Public nt of Public		UCENSING SAN DIFGO NOR Background regarding in The following circumsta to the retained foreign b Surgeon was u the patient's IC intensivist was blood into the Patient's exsan Urgent transfer the OR Simultaneous of and intubation Large volume towels utilized	S 1 Cong & CERTIFICATION RTH DISTFCT OFFICE ances contributed body: rrgently called to CU bedside while s pumping patient nguination r of the patient to draping. prepping of patient of lap sponges and I to pack abdomen		
Event ID:GYGH11 8/4/2010 9:01:10AM		the time the report is			<u> </u>				
				<u> </u>				(X6) DATE	

Any deficiency statement ending with an astensk (*) 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 ara 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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL IDENTIFICATION N			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		050324		B. WING 05/14/2010				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS	, CITY, STATE,	ZIP CODE			
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	Continued From page The CDPH verified patient or the party of adverse event by the f Health and Safety C this section, "imm situation in which with one or more caused, or is likely death to the patient. Title 22 70223 (b) (2) (b) A committee of assigned responsibilit (2) Development, n of written policies with other appropria dministration. Polic governing body. Pro- the administration a appropriate. Based on interview failed to ensure implemented the po- to the use of blue (Patient A) during staff also failed complete a count of surgery. As a re- undetected in Patie period of four mont was hospitalized th	that the facility responsible for the time the report was n tode 1280.1 (c). For mediate jeopardy" the licensee's n requirements of li y to cause, serio of the medical st y for: maintenance and in and procedures in riate health profe- ies shall be appro- bocedures shall be nd medical staff w and record review that Operating blicy and procedure e towels for 1 san surgery. The Ope to implement the f towels used during suit, a blue tow ent A's abdominal hs, during which tir	patient of the made. r purposes of means a oncompliance icensure has us injury or aff shall be mplementation consultation ssionals and oved by the approved by there such is v, the facility Room staff e with regard mpled patient, erating Room policy and g Patient A's vel was left cavity for a me, Patient A		 a. How the correction will be accomplished, both tempor permanently. The policy and procedure: C Sponge, Needle, Instrument, Items will be followed by Or Room staff. The OR Staff was educated immediately regarding the following items in the above The emergent nature of procedure or an unexpectange in the condition patient may necessita of counts to preserve or limb. In such cases may be omitted on or surgeon; however an be taken at the end of case and read by the to document the abser retained foreign bodie the patient leaves the A postoperative radio will be performed be patient leaves the room following circumstant of the more body cavitie 	Counts: and Small berating policy: of a pected on of the te omission patient life te of the te of the te omission the te te of the te omission patient life te of the te of the te of the te of the te of te of the te of the te of te of the te of the te of the te of te of te of te of te of te of te o		
Event ID	to non-healing subsequently required	post surgery. d a second surgery o	Patient A on 4/7/10, 	9:01	entered			

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

TITLE

(X6) DATE

eso224 B WHG OST14/2010 NAME OF PROVIDER OR SUPPLIER SCRIPPS MEMORIAL HOSPITAL - LA JOLLA STREET ADREES. CTV, STATE, 2P CODE 9888 GENESEE AVENUE, LA JOLLA, CA 9203T SAN DIEGO COUNTY STREET ADREES. CTV, STATE, 2P CODE 9888 GENESEE AVENUE, LA JOLLA, CA 9203T SAN DIEGO COUNTY DVAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCEMENT & EPRECEEDCO BY FLL, REGULATORY OR LSC DENTFYING INFORMATION) PREFIX PREFIX PROVIDERS PLAN OF CORRECTION (EACH OCRECTIVE ANTON SOLUTE ECRECE PREFIX PROVIDERS PLAN OF CORRECTION (EACH OCRECTIVE ANTON SOLUTE ECRECE PREFIX PROVIDERS PLAN OF CORRECTION (EACH OCRECTIVE ANTON SOLUTE ECRECE PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX (EACH OCRECTION ANTON SOLUTE ECRECE PROVIDERS PLAN OF CORRECTION (EACH OCRECTION ANTON DEFINITION PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX		STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		ER/CLIA MBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SCRIPPS MEMORIAL HOSPITAL - LA JOLLA sease GENESSEE AVENUE, LA JOLLA, CA 22037 SAN DIEGO COUNTY 0010 SUMMARY STATEMENT OF DEPICIPANCES D 02010 (2ACH DEFCINY VIIST BERGETEDD 3 PLUL REQULATORY ON LSC DENTFYING INFORMATION) D 02011 (2ACH DEFCINY VIIST BERGETEDD 3 PLUL REQULATORY ON LSC DENTFYING INFORMATION) D 02012 Continued From page 2 at which time, the surgeon discovered and removed the blue lowel from Patient A's abdomen. 0 When three or more permanent scrub reliefs occur units of blood or blood products are given (except open heart cases) 0 When a full baseline count was not competed Patient A, an 80-year-old-male, was admitted the patient and admitted him for a gastroenterology (digestive system) consultation. The ED physician diagnosed the patient with an acute gastrointestinal bleed and thypovolemic (low blood volume) shock. 0 When a full baseline count was not competed 0 On 12/18/09, Patient A went emergently to the intensive care unit. The patient wont to surgery with, "a known high-risk of death and complications, and the option of continued non-sperative management", per the Operative Report. 0 Non-radiopque items will not be placed onto the sterile field after a cavity is opened after a cavity is open			050324		B. WIN G	·	05/14	/2010
Øn ib PREFIX Tag Summary statement or deficiencies (EXCH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC DENTFYING INFORMATION) D PREFIX Tag PROMORES FLAM OF CORRECTION (EXCH DEFICIENCY) (ps) countere Date Continued From page 2 at which time, the surgeon discovered and removed the blue lowel from Patient A's abdomen. 0 When three or more permanent scrub reliefs occur 0 Findings: 0 When three or more permanent scrub reliefs occur 0 When three or more permanent scrub reliefs occur Patient A, an 80-year-old-male, was admitted from a skilled nursing facility on 12/14/09, per the Emergency Department (ED) physician diagnosed the patient and admitted hin for a gastroenterology (digestive system) consultation. The ED physician diagnosed the patient with an acute gastrointestimal bleed and hypovolemic (low blood volume) shock. 0 Only towels with radiopaque markers should be used in the wound. If lowels are used in the operating room (CR) for an exploratory (abdominat surgery) after, "Partially exsanguinating (bleeding out) from uncontrollable bleeding in the intensive care unit." The patient wort to surgery with, "a known high-risk of death and complications, and the option of continued non-operative management", per the Operative Report. 0 Non-radiopque items will not be placed onto the sterife field after a cavity is opened Patient A had an inflammatory mass which was actively bleeding and had ereded (worn through) into the gastrodoucenal arter (a small abdominal artery) and into the pertoneum (abdominal cavity), per the Operative Report. Patient A required a partiel gastrectory (Stomach Terroval): a partiel gastrectory 0 Non-radiopque items the process of implementat	NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS	CITY, STATE, Z	IP CODE		
PREFIX TAG CACH DEF CIENCY MUST BE PRECEDED B YFULL REGULATORY OR LSC DENTIFYING INFORMATION PREFIX TAG REFERX TAG REFERX REFERENCED TO THE APPROPRIATE DEFICENCY COMPLETE DATE Continued From page 2 at which time, the surgeon discovered and removed the blue towel from Patient A's abdomen. When eight or more permanent scrub reliefs occur When eight or more units of blood or blood products are given (except open heart cases) When a full baseline count was not competed Patient A, an 80-year-old-male, was admitted from a skilled nursing facility on 12/14/09, per the Emergency Record. According to the notes, the Emergency Department (ED) physician assessed the patient and admitted him for a gastroenterology (digestive system) consultation. The ED physician diagnosed the patient with an acute gastrointestinal bleed and hypovolemic (low blood volume) shock. On 12/18/09, Patient A went emergently to the operating room (OR) for an exploratory laparotomy (abdominal surgery) after, "Partially exsanguinating (bleeding out) from uncontrollable bleeding in the intensive care unit." The patient went to surgery with, "a known high-risk of death and complications, and the option of continued non-operative management", per the Operative Report.	SCRIPPS	MEMORIAL HOSPITAL - L	A JOLLA	9888 GENESEE	AVENUE, LA	JOLLA, CA 92037 SAN DIEGO COUI	NTY	
 at which time, the surgeon discovered and removed the blue towel from Patient A's abdomen. Findings: Patient A, an 80-year-old-male, was admitted from a skilled nursing facility on 12/14/09, per the Emergency Record. According to the notes, the Emergency Department (ED) physician assessed the patient and admitted him for a gastroenterology (digestive system) consultation. The ED physician diagnosed the patient with an acute gastrointestinal bleed and hypovolemic (low blood volume) shock. On 12/18/09, Patient A went emergently to the operating room (OR) for an exploratory laparotomy (abdominal surgery) after, "Partielly exsanguinating (bleeding out) from uncontrollable bleeding in the intensive care unit." The patient wont to surgery with, "a known high-risk of death and complications, and the option of continued non-operative management", per the Operative Report. Patient A had an inflammatory mass which was actively bleeding and had eroded (worn through) into the gastroductenal artery (a small abdominal artery) and into the perioneum (abdominal cavity), per the Operative Report. Non-radiopque items will not be placed onto the sterile field after a cavity is opened indication: Other Opportunities have been identified and are in the process of implementation: 	PREFIX	(EACH DEF:CIENC)	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETE
Roux-en-Y gastrojejunostomy (surgical connection Larger laparatomy sponges jejunum) and duodenectomy (a removal of the first part of the small intestine and the formation of a new connection between the middle of the small Inew connection between the middle of the small Larger laparatomy sponges Larger laparatomy sponges Larger laparatomy sponges 		at which time, the sit the blue towel from Pa Findings: Patient A, an 80-ye a skilled nursing Emergency Record. Emergency Department the patient and adment (digestive system) of diagnosed the patient bleed and hypovolemit On 12/18/09, Patient operating room (OR (abdominal surgery) (bleeding out) from intensive care unit." with, "a known complications, and non-operative mana Report. Patient A had an actively bleeding ar into the gastroduodia artery) and into the per the Operative partial gastrector Roux-en-Y gastrojej between stomach a jejunum) and duode part of the small in	urgeon discovered a titient A's abdomen. ar-old-male, was an facility on 12/14/0 According to the nent (ED) physicial itted him for a gas consultation. The E of with an acute gas consultation. The E the with an acute gas consultation. The E the with an acute gas consultation. The E the vith an acute gas consultation. The E the sector of a the acute gas of an exploratory after, "Partially ex- uncontrollable blee "The patient went high-risk of the option of agement", per the inflammatory mass and had eroded (w enal artery (a small e peritoneum (abdor Report. Patient A my (stomach re- junostomy (surgical and part of small i enectomy (a remova ntestine and the for	dmitted from 19, per the notes, the in assessed troenterology D physician astrointestinal shock. ently to the y laparotomy ksanguinating eding in the t to surgery death and continued e Operative which was orn through) abdominal minal cavity), required a emoval); a connection intestine, i.e. I of the first rmation of a		 permanent schooccur When eight of units of blood products are g (except open cases) When a full b count was not Only towels with radio markers should be use wound. If towels are u open wound, they shot included in the count a miscellaneous item, at be easily distinguished other towels. An additional process was implemented and staff was educated im Non-radiopq items will no onto the ster after a cavity Other Opportunities have be identified and are in the product 	nub reliefs r more l or blood given heart baseline t competed opaque d in the used in the uld be as a nd should d from change the OR mediately: ue of be placed ile field r is opened cen cess of	

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

TITLE

(X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLI IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION			JRVEY TED
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	subcutaneous tissue skin) with normal Patient A transferred to According to the Int surgery began at 9: P.M. The record refle 1 and Circulating Nut count of sponges, items and instrument the two final counts, per	haining portion of the choledochojejund bile). Following the gated the abd (the layer directly saline and closed to the ICU in critical of raoperative Report, 54 A.M, and conclu- ects that Scrub Teo rise (CN) 1 conduct Sharps (needles its. ST 2 and CN er the documentation went numerous he surgery to inclu- d an MRI (magnet omen and a CT (scan of the a transferred to a si Physician A docum- hat Patient A had and the biliary ste duct to keep it t intestine. A returned to the treatment. The on of the tissue to econdary to a bi- duct drain placeme	sotomy (to procedures, omen and y under the d the skin. ondition. Patient A's ded at 1:02 chnician (ST) ed the initial etc), small 2 conducted h. radiologic ude a biliary ic resonance (computerized bbdomen on killed nursing nented in the a significant ent (a device open) had facility and patient had hat lines the le leak and		Adm Serv c. A d pro defi Man revi staf basi poli the Ser issu Me Ris Saf	Evaluation of paper d opposed to the use of draping Evaluation of addition circumstances in which needs to be ordered to be orde	towels for nal ch an x-ray person ion. rgical oring nce of Lines will ing by OR on a daily he above e attention of , Surgical on. These h the OR ership and cekly OR	
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LABORATO	ORY DIRECTOR'S OR PROVID	ER/SUPPLIER REPRES	ENTATIVE'S SIGNA	TURE		TITLE		(X6) DATE

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050324				B. WING		- 05/1/	05/14/2010	
	OMDER OR SUPPLIER	l 	TREET ADDRESS,				·····	
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	Continued From page	4			d The date the immed	lists estimation -f	<u> </u>	
	another facility (Facility epatient's persist hospitalization at Facility facility, response and an abdomin On 4/1/10, Patient facility, "obviously jat CT scan showed the be an abscess in the are." On 4/7/10, Patient A Operative Report. The report that the patient the surgery performed investigations include scans, drains, and	A's physician referre lity B) for further tes stent bile leak. Di acility B, Patient A hal abscess drained. A returned to the E undiced", per the ED patient had, "what a he abdomen where A returned to surgery he surgeon document ent developed a bile formed on 12/18/ ed, "multiple and ext treatment with antibio stent bile leak and r	ts due to uning the had CT ED at the report. A ppeared to his drains y, per the leak after (09. The ensive CT otics." The		 d. The date the immediate correction of the deficiency will be accomplished. Normally this will be no more than thirty days (30) from the date of the exit conference. Education began with staff on April 8, 2010 and is continuing. 			
Event ID	perform a second exp According to the C Patient A had, "an o (under the liver) quadrant" The s anastomosis (the su parts), performed retained sponge anastomosis". performed during to quadrant debridement hemicolectomy (remo	Operative Report date obvious mass in the i area in the rig urgeon dissected the urgical connection of on 12/18/09, and, at the base	ed, 4/7/10, infrahepatic ght upper bile duct two body "found a of the procedures ight upper ction, right lon), and a	9:01:1	0AM			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPI IDENTIFICATION N		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OMDER OR SUPPLIER		STREET ADDRESS	, CITY, STATE, ZI	P CODE		
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	Continued From page	e 5					
	surgeries), spoke about Patient A on 4/16/10 at 8:25 A.M. The surgeon stated that on 12/18/09, Patient A was in the ICU, "essentially bleeding to death." Physician 1 stated that the patient received several units of blood at full pressure. The physician took the patient to surgery as an emergency measure. Physician 1 said that when he opened the patient's abdomen there was so much blood that he was, "trying to scoop it out with my hands." The physician stated that in order to locate the source of the bleeding he said to the Scrub Technician (ST 2), "Get me towels." Physician 1 added, "I packed the abdomen full of towels to try to compress the bleeding." Physician 1 said that it took several towels to staunch the flow and added, "Had there been a sterile mop there, I would have used it." According to Physician 1, Patient A had extensive and prolonged surgery. At the conclusion of the surgery, the physician flushed the abdomen and looked for retained foreign objects but did not see any. Physician 1 said that over the course of the next						
	four months. Patier treatments to try to not healing as well	nt A had extensi determine why th as expected. Seve the retained su the was reluctar jery because of th 4/7/10 decided that	ive tests and le patient was eral CT scans orgical towel. In to take the le risks to the				
	Physician 1 said that the patient's abdomen		1				
Event ID	GYGH11		8/4 /2010	9:01:1			

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

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				A. BUILDING			
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-	Continued From pag	 le 6					<u>}</u>
	The physician said		d sav about the	ļ			
	first surgery was that, "The patient was dying, it was an, uncontrolled environment", and "we used						
	what was available to			ł			
	ST 2 said during a	in interview on	4/16/10 at 9:30)			
	A.M., that as soon	_					
	patient during the						
	tone in the room of	•	-				
	said, "I handed the	•	-				
	'Blue towel in' ", for	-	, ,				
	record it on the						
{	According to ST 2 operating room (OF						1
1	lining the back ta			ł			
	placed for use duri						
	made from a lig						[
	measure 15 x 24 in						
1	were not supposed	to be used insid	de a patient, but				
	said that the surged	on had to stop t	the bleeding and				
	there were no gree	n towels (radiop	aque towels that				[
	can be seen with x						
ļ	said that although						
	"Blue towel in" for			ĺ			
l	because of the acti						1
	at the time. ST 2						
	she had added the						
	board during the s						
Į	that the count w						l
	giving Physician 1a						[
							Ì
	patient's abdomen during the surgery, but failed to include the towel(s) in the final count.						
	On 4/16/10 at 10:00	A.M., CN 1 talked	about				
Event I			8/4/2010	9:01:	10AM		
LABORAT	ORY DIRECTOR'S OR PROV	DER/SUPPLIER REP	RESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL IDENTIFICATION N			LE CONSTRUCTION	(X3) DATE SU COMPLE	
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	information back t marked it on the boa	CN 1 said that in d never seen blue ey were not routi he procedure. If a ing a surgical pr l out, "Towel i repeated what wa oard to be include the procedure. C T 2 calling out, "B d any towels on the l 1 said that sh gical team used ar urgery. CN 1 said CN 2) relieved he id the final count a with CN 2 on 5/1 hat she took over ind was responsible CN 2 confirmed th bount board as being t said that blue t de the patient. Cl nician called out, " should have re- o the Scrub Te ard for the final count nd complete	towels used inely counted surgeon used ocedure, the n" and the as said and d in the final N 1 said that lue towel in," e white board e could not ny radiopaque that another er during the at the end of 4/10 at 11:00 from CN 1 e for the final hat no towels g used during owels should N 2 said that Towel in," the epeated that chnician and unt. CN 2 said communication				
	Nurse was vital to patient at the conc ''This should never ha	prevent items being lusion of a surger	j left inside a				
Event ID	 :GYGH11		8/4/2010	9:01:1	IOAM	······	

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM 050324			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		030324		B. WING 05/14/2010				
			STREET ADDRESS,					
SCRIPPS	MEMORIAL HOSPITAL - I	LA JOLLA	9888 GENESEE	AVENUE, LA	JOLLA, CA 92037 SAN DIEC	30 COUNTY		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEEDED I LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-COU REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	Continued From pag The facility's poli "Counts: Sponge, I Items," effective dat procedure for the Under the section, with radiopaque ma wound. If towels are should be included item, and should be towels." Patient A had emer 12/18/09 to repair a in a massive loss procedure, Physiciar towels" in an effort staff did not record count board. ST handing Physician 1	icy and proceed Needle, Instrument e January 2009, use of towels d Procedures, 1.7, arkers should be e used in the operation in the count as a e easily distinguish gency surgery at ruptured abscess of blood. During 1 said that he to stop the flow the use of any 2 said that he	t, And Small addressed the uring surgery. "Only towels used in the n wound, they miscellaneous hed from other the facility on the facility on the surgical used, "several of blood. OR towels on the remembered					
	if the surgeon use said that he called failed to ensure that use of the towel of when CN 2 and S both said that towel as required in the fact Following the initial delayed healing with infection. Patient admissions to hosp first surgical procest scans failed to ide the patient's abd radiopaque. Finally,	d any more towe out, "Towel in" it CN 1 heard and in the count board T 2 completed the swere not include ility policy. surgery, Patient th persistent bile A required thre ital for treatment edure. Several X- ntify the retained lomen because	els. ST 2 also for CN 1, but d recorded the d. As a result, the final count, ad in the count A experienced drainage and e subsequent related to the -rays and CT blue towel in it was not o surgery					
Event ID	GYGH11		8/4/2010	9:01:1	IOAM			

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

TITLE

(X6) DATE

UALIFURNIA MEALTH AND HUMAN SERVICES AGENCY

STATEBURG 01/1 PROVERSUPPLEACLA IDENTIFICATION INVERSE 02/1 DATESURVEY COMPLETED 03/1 DATESURVEY COMPLETED NOPEXING CORRECTION 05324 03/1 DATESURVEY COMPLETED 05/14/2010 NAME OF PROVIDER OR SUPPLIER 55/14/2010 05/14/2010 05/14/2010 SCRIPPS MEMORIAL HOSPITAL - LA JOLLA STREET ADDRESS, CTV. STATE, IP/ CODE 05/14/2010 (24) D SUMARY STATEMENT OF DEPOENCIES RECELLOR WITHING AFFORMATON PROVIDER SUMARY STATEMENT OF DEPOENCIES RECELLOR WITHING AFFORMATON 0 (24) D SUMARY STATEMENT OF DEPOENCIES RECELLOR WITHING AFFORMATON 0 PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, RECELLOR WITHING AFFORMATON 0 (24) D SUMARY STATEMENT OF DEPOENCIES RECELLOR WITHING AFFORMATON 0 PROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, RECELLOR WITH ADD CORRECTION (EACH CORRECTION BIOLES (COMPLETE CONCERTE THE ACTION SHOULD BE CROSS, RECELLOR WITH ADD SHOULD BE CROSS, RECELLOR WITH ADD CORRECTION (COMPLETE BE CROSS BE CONTENT SHOULD BE CROSS, RECELLOR WITH ADD STREET ADDRESS, RECELLOR WITH ADD STREET ADDRESS, RECELLOR WITH ADD STREET ADDRESS, RECELLOR WITH ADDRESS, RECELLOR WITH ADDRESS, RECELLOR WITH ADDRESS, RECELLOR WITH ADDRESS, RECE			······································				<u> </u>			
150324 B WHO DS114/2010 Nume OF PROVISER OF SUPPLER STREET AGREES, CIT: STATE, ZP CODE SERIEST CODE SE										
NAME OF PROVIDER OR SUPPLER STREET AGDRESS, CITY, STATE, JP CODE SCRIPPS MEMORIAL HOSPITAL - LA JOLLA STREET AGDRESS, CITY, STATE, JP CODE (24) ID SUMMARY STATEMENT OF DEPCIENCIES ID PRETX RECHOROCKULUS I & PRECEDED & PRUL PREVX 1x6 RECHOROCKULUS I & PRECEDED & PRUL PREVX 1x6 Continued From page 9 ID PREVX 0x717/10, and underwent a second surgical procedure during which time, Physician 1 Idscoverad the relained blue towel. 1x6 The facilitys failure to ensure that OR staff followed the towel(s) during the surgery on the count board, is a deficiency that has caused, or is likely to cause, sentus injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1 (c). This facility failed to prevent the deficiency/(ss) as described how that to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1 (c).			050324				-			
SCRIPPS MEMORIAL HOSPITAL - LA JOLLA 9889 GENESEE AVENUE, LA JOLLA, CA 92037 SAN DIEGO COUNTY (04)10 USUMMARY STATEMENT OF DEPORENCIES (EACH DEPORENCE WUSTE ER RECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PERIX TAG PROVIDERS PLANOR CORRECTION (EACH CORRECTIVE AJTORY OR LSC IDENTIFYING INFORMATION) DO PERIX TAG PROVIDERS PLANOR CORRECTION (EACH CORRECTIVE AJTORY OR LSC IDENTIFYING INFORMATION) DO PERIX TAG PROVIDERS PLANOR CORRECTION (EACH CORRECTIVE AJTORY OR LSC IDENTIFYING INFORMATION) DO PERIX TAG PROVIDERS PLANOR CORRECTION (EACH CORRECTIVE AJTORY OR LSC IDENTIFYING INFORMATION) DO PERIX TAG Continued From page 9 on 47/710, and underwent a second surgical procedure during which time, Physician 1 discovered the retained blue towel. The facility's failure to ensure that OR staff followed the policy and procedure, firstly by using a non radiopaque towel inside Patient A's abdominal cavity, and secondly by not recording the use of the towel(s) during the surgery on the count board, is a deficiency that nas caused, or is likely to cause, sentous injury or death to the patient, and therefore constitues an immediate jeopardy within the meaning of He Health and Safety Code Section 1280.1(c). This facility failed to prevent the deficiency(les) as described above that caused, or is likely to cause, sentous liquy or death to the patient, and therefore constitues an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c). Identify the patient and therefore constitues an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c). Identify the patient and therefore constitues an immediate jeopardy within the meani	=		030324				05/1	4/2010		
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on 4/7/10, and underwent a second surgical procedure during which time. Physician 1 discovered the retained blue towel. The facility's failure to ensure that OR staff followed the policy and procedure, firstly by using a non radiopaque towel inside Patient A's abdominal cavily, and secondly by not recording the use of the towe(s) during the surgery on the count board, is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1 (c). 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).	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION	SHOULD BE CROSS-	COMPLETE		
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Event ID:GYGH11		procedure during discovered the retained The facility's failure the policy and pro radiopaque towel cavity, and secondly towel(s) during the s deficiency that has serious injury or de constitutes an im- meaning of the He 1280.1 (c). This facility failed to described above that serious injury or dea constitutes an im- meaning of Healt	which time, P ed blue towel. to ensure that OR a becedure, firstly by to inside Patient A's by not recording th surgery on the coun caused, or is like ath to the patient, a mediate jeopardy ealth and Safety C o prevent the defici at caused, or is like ath to the patient, a mediate jeopardy	hysician 1 staff followed using a non s abdominal le use of the t board, is a ly to cause, and therefore within the code Section iency(ies) as ely to cause, and therefore within the						
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	Event ID):GYGH11		8/4/2010	9:01:1	10AM				

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(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be accused 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