CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTIV	TENT OF PUBLIC TILALI					T	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050025		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/24/2009			
			1				
	ROVIDER OR SUPPLIER		STREET ADDRES			O COUNTY	7. 2
	ITY OF CALIFORNIA, SA CENTER	N DIEGO	200 WEST ARE	OR DRIVE, S	AN DIEGO, CA 92103-8976 SAN DIEG	O COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY R LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	The following reflect Department of Pureported incident investigations	ublic Health during					
	Entity Reported Incid	ent Number: CA0017	5878				
	Category: State Mor Sub-category: Ret patient.	itoring ention of a foreign	object in a		APR 2 7 2009		
	Representing the De	partment:	-		LICENSING AND CERTIFICA SAN DIEGO DISTRICT OFFICE	NOITH .	
	1 1 1 2 2						
	The inspection did full inspection of the	not represent the facility.	findings of a				
		vice General Requirer	nents		The involved Medical have been re-educated		February 6, 2009
	responsibility for :	medical staff shall			regarding MCP 505.2E, Medical Device Act Re and the manufacturer	porting,	
	policies and proces	ining, and impleme dures in consultatio professionals and a	n with other		lines for the placeme the central venous ca	nt of	
	Procedures shall be	pproved by the gove approved by the ere such is appropriat	administration		Responsible Party: De of Medicine, Residenc Program Director	•	
	failed to ensur	and record review e that the m or the insertion o	anufacturer's				
	venous catheter supervision was p	were followed, e rovided, for 1 of 1 Patient 1 required to remove a retaine	ven though (1) sampled an additional d guide wire		A review of this poli been discussed during Internal Medicine Mor & Morbidity conferenc specifically stressin	the tality e,	April 15, 2009
Event ID	:P9GG11		4/10/2009	9:31:	53AM		
							

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

Breadn Gategon, RN Regulatory Affairs - 1858. Director

TITLE

(X6) DATE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER April Department Summary Statement of certolencies Pull Preprix (EACH DEFICIENCY MEST ACE DELIVERY MINE AS EPRECE DELID BY PULL PREPRIX RECHARDON CHASE DELIVERY MINE AS PROBABLY AS A PRIL PROME PREPRIX CHION SHOULD BE CROSS- PART PREPRIX RECHARDON CHASE DELIVERY MINE AS PRICE DELID BY PULL PREPRIX RECHARDON CHASE DELIVERY MINE AS PRICE DELID BY PULL PREPRIX RECHARDON CHASE DELIVERY MINE AS PRICE DELID BY PULL RECHARDON CHASE DELIVERY MINE AS PRICE DELIVERY MINE AS A PRICE DELIVERY	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 1			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 WEST ARBOR DRIVE, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY MEDICAL CENTER 200 SPROWDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 200 CONTINUED From page 1 placement of catheters) from his right atrium (chamber of the heart). Patient 1 was admitted to the hospital on 1/21/09 with diagnoses that included end stage liver disease and hepatic encephalopathy (disease of the brain) according to the admission face sheet. A review of Patient 1's medical record was conducted on 1/29/09 at 3:00 P.M. Patient 1 was transferred from another local hospital for a liver transplant evaluation. According to the physician's order sheet, Patient 1 was considered to be in critical condition at the time of his admission. The decision was made to insert a multi-lumen central venous catheter into Patient 1's right femoral vein (located in the groin area). According to the Invasive Procedure was performed by a first year Intern with a third year Internal Medicine Resident in attendance for supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note 'The guide wire was left in the line." A physician's progress note, written on 12/2/109 at 5:00 AM, stated "called by Intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a cheat x-ray report, taken on 1/22/109 at 5:00 AM, the tip of the guide wire was left in the line." A physician's progress note, written on 1/22/109 at 5:00 AM, with tip of the guide wire was left i			050025		B. WING		02/2	4/2009
MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PROVIDENCE PLAN OF CORRECTION SHOULD BE GROSS-TAG PREFIX TAG PROVIDENCE PLAN OF CORRECTION SHOULD BE GROSS-TOTE DATE	NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRES	S, CITY, STATE,	ZIP CODE		
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placement of catheters) from his right atrium (chamber of the heart). Findings: Patient 1 was admitted to the hospital on 1/21/09 with diagnoses that included end stage liver disease and hepatic encephalopathy (disease of the brain) according to the admission face sheet. A review of Patient 1's medical record was conducted on 1/29/09 at 3:00 P.M. Patient 1 was transferred from another local hospital for a liver transplant evaluation. According to the physician's order sheet, Patient 1 was considered to be in critical condition at the time of his admission. The decision was made to insert a multi-lumen central venous catheter into Patient 1's right femoral vein (located in the groin area). According to the Invasive Procedure Note, dated 1/21/08, the central venous catheter procedure was performed by a first year Internal Medicine Resident in attendance for supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note "the guide wire was left in the line." A physician's progress note, written on 1/22/09 at 4:00 AM, stated "called by intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a chest x-ray report, taken on 1/22/05 at 5:00 AM, "the tip of the guide	PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-			COMPLETE
inspection of the guidewire for integrity and that the entire guidewire is removed. Patient 1 was admitted to the hospital on 1/21/09 with diagnoses that included end stage liver disease and hepatic encephalopathy (disease of the brain) according to the admission face sheet. A review of Patient 1's medical record was conducted on 1/29/09 at 3:00 P.M. Patient 1 was transferred from another local hospital for a liver transplant evaluation. According to the physician's order sheet, Patient 1 was considered to be in critical condition at the time of his admission. The decision was made to insert a multi-lumen central venous catheter into Patient 1's right femoral vein (located in the groin area). According to the Invasive Procedure Note, dated 1/21/08, the central venous catheter procedure was performed by a first year Intern with a third year Internal Medicine Resident in attendance for supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note "the guide wire was left in the line." A physician's progress note, written on 1/22/09 at 4:00 AM, stated "called by intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a chest x-ray report, taken on 1/22/09 at 5:00 AM, "the tip of the guide		Continued From pa	ge 1			Continued From page	L	
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A review of Patient 1's medical record was conducted on 1/29/09 at 3:00 P.M. Patient 1 was transferred from another local hospital for a liver transplant evaluation. According to the physician's order sheet, Patient 1 was considered to be in critical condition at the time of his admission. The decision was made to insert a multi-lumen central venous catheter into Patient 1's right femoral vein (located in the groin area). According to the Invasive Procedure Note, dated 1/21/08, the central venous catheter procedure was performed at 11:00 P.M. The procedure was performed by a first year Intern with a third year Internal Medicine Resident in attendance for supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note "the guide wire was left in the line." A physician's progress note, written on 1/22/09 at 4:00 A.M., stated "called by intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a chest x-ray report, taken on 1/22/09 at 5:00 A.M., "the tip of the guide wire & Document. The key is a Document of the Interview of the documentation of puidewire, in		with diagnoses to disease and hepa	hat included end itic encephalopathy	stage liver (disease of		Department of Medicin		
According to the Invasive Procedure Note, dated 1/21/08, the central venous catheter procedure was performed at 11:00 P.M. The procedure was performed by a first year Intern with a third year Internal Medicine Resident in attendance for supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note "the guide wire was left in the line." A physician's progress note, written on 1/22/09 at 4:00 A.M., stated "called by intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a chest x-ray report, taken on 1/22/09 at 5:00 A.M, "the tip of the guide Residency Program Director; Risk Managment, Manager; and Regulatory Affairs A Patient Safety Alert (PSA) has been prepared for circulation highlighting guidewire removal. The key issues included in the PSA - Protect your Patient During Central Line Insertion: Think "W.A.R.D." - Ward, Assess, Remove & Document. The key		conducted on 1/29 transferred from a transplant evaluatio order sheet, Patie critical condition at decision was made venous catheter in	709 at 3:00 P.M. Prother local hospital n. According to the nt 1 was considered the time of his admento insert a multi-luco Patient 1's right	Patient 1 was for a liver e physician's d to be in ission. The imen central		Procedure Note & Bill has been revised to it documentation of remoguidewire, inspection guidewire, and verbal to the RN. (Attachment Responsible Party:	ing form nclude oval of of handoff at A)	
supervision. According to an addendum, written by the Intern, on the Invasive Procedure Note "the guide wire was left in the line." A physician's progress note, written on 1/22/09 at 4:00 A.M., stated "called by intern who placed R (right) femoral TLC (triple lumen catheter), concerned guide wire may have been retained in vessel during procedure." According to a chest x-ray report, taken on 1/22/09 at 5:00 A.M. "the tip of the guide According to an addendum, written by has been prepared for circulation highlighting guidewire removal. The key issues included in the PSA - Protect your Patient During Central Line Insertion: Think "W.A.R.D." - Ward, Assess, Remove & Document. The key		1/21/08, the central performed at 11:0 performed by a fire	venous catheter pro 00 P.M. The pro st year Intern with a	ocedure was cedure was a third year		Residency Program Di Risk Managment, Manag Regulatory Affairs	rector; er; and	Anril 22
taken on 1122/00 at 0.00 A.M., the up of the guide		supervision. According the Intern, on the guide wire was less progress note, which is tated "called by international transformation of the supervision of the International TLC (triple lumen may have been procedure." According to the International Interna	ling to an addendum Invasive Procedure of tin the line." A ritten on 1/22/09 at tern who placed R (reatheter), concerned retained in vestrating to a chest x	n, written by Note "the physician's 4:00 A.M., ight) femoral guide wire ssel during c-ray report,		has been prepared for circulation highlight guidewire removal. T issues included in th Protect your Patient Central Line Insertio "W.A.R.D." - Ward, Ass	ing he key e PSA - During n: Think ess,	2009
								ows:

TITLE

(X6) DATE

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DEPARTM	ENT OF PUBLIC HEALT	1					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		050025		B. WING		02/24/	2009
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS,	CITY, STATE,	, ZIP CODE		
UNIVERSI MEDICAL	TY OF CALIFORNIA, SAN CENTER	I DIEGO	200 WEST ARBO	R DRIVE, S	SAN DIEGO, CA 92103-8976 SAN DIEG	SO COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	(X5) COMPLETE DATE	
	mechanism for clott blood products administered to Pa procedure to remove 9:53 A.M. Patient 1 plasma (the fluid p	right atrium (cham al Radiology was the d invasive procedure n patient 1's right note, written or ed that "IR (i erned about risks of patient" (defect ing blood). Theref to promote clo tient 1 in preparat the guide wire. Co received 2 units of rortion of two units i/09 at 10:37 A.M., (one of the centra i/22/09 at 11:18 A.M. of plasma cryopr factor VIII needed On 1/22/09 at an "Intravascular n Body Retrieval" in port. conducted, on 2/19 year Resident who ar insertion proced he watched the Integrate for the guide wire an	en contacted en to remove atrium. An 1/22/09 at interventional of procedure in body's fore, several titing were ion for the on 1/22/09 at fresh frozen of human Patient 1 I proteins in Patient 1 I proteins in Patient 1 resh frozen in Patient 1 res		Continued From page 2 (Attachment B) Physician Placing Centines: (1) It is imperative, advance catheter guidewire, that yethat the guidewire secure & that you the guidewire aft ment of the cathe (2) After removing the wire, inspect the wire is intact. wire removal & in on Form D1484 Inv. Procedure Note & Supervising Physician You are responsible to oversee the procedure performed. This inclusecuring, removing and inspecting the guidewidocumentation of the and informing the prin nurse that the procedure completed. Nurses: We strongly recommend the primary nurse recorded the line that guidelines were followed.	as you over ou ensure e is remove er place- ter. e guide- guide- Document psection asive Billing s: o activel being udes, d ire, procedure mary ure is that eive cian who t "WARD"	y
Event ID:F	20GG11		4/10/2009	0.31	53AM		
	Y DIRECTOR'S OR PROVID	ED/CLIDDLIED DEDDECE			TITLE	- /	6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050025			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/24/2009		
		050025		B. WING		02/2	4/2009
NAME OF PROVIDE	ER OR SUPPLIER		STREET ADDRESS,	CITY, STATE,	ZIP CODE		
UNIVERSITY O	F CALIFORNIA, SAN TER	DIEGO	200 WEST ARBO	OR DRIVE, S	SAN DIEGO, CA 92103-8976 SAN D	IEGO COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETE DATE
gui	ontinued From page ide wire would no le catheter. The Re tice this happening.	onger be visible ex			Continued From page documented.	3	30
Inte 1:3 pol cor cat res per "sig uns sup ins	licy of the facility mplete five super- theter insertions placed of the gned off" to supervised. The pervising resident ertion of a central artery.	sidency Program of ector indicated that for interns and vised femoral cerprior to completic ector further state se procedures the perform the end been "sign ral venous cathet	on 2/19/09 at at it is the residents to other venous on of their d that after individual is procedures d that the ed off" on er into the		Responsible Party: Risk Management, Mar Regulatory Affairs Monitoring of the In Procedure & Billing accomplished through Medical Center's on- physician documentat tracer tool. Any issidentified are share Leadership; the Department of the Departm	nvasive form is the UCSD going tion audit sues ed with artment rsing se Manager	s/
P.N ins ver beg sta wird furt at that Internal An Ada	interview was comertion procedure. In the commertion procedure that it is gan her internship ted that somehow the had migrated in the stated that a about 2:00 or 3:00 the shad not refer stated that she is not the guide with the commercial interview was commistrative.	who performed This was the ntern had performed in July 2008. she did not notice to the catheter. few hours after the A.M. on 1/22/09, moved the guide called the Reside that may have I vein.	the catheter third central ed since she The Intern e the guide The Intern e procedure, she realized wire. The ent to inform been left in		Actions will be take necessary. Responsible Party: Regulatory:Affairs	en as	

TITLE

(X6) DATE

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

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050025						02/24	4/2009
NAME OF PROVIDE UNIVERSITY OF MEDICAL CEN	F CALIFORNIA, SAN	DIEGO	STREET ADDRESS, 200 WEST ARBC		P CODE N DIEGO, CA 92103-897	6 SAN DIEGO COUNTY	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHOU TAG REFERENCED TO THE APPROPRIAT		TION SHOULD BE CROSS-	(X5) COMPLETE DATE
Co	ntinued From page	4					
wh		e expected to b staff is using pati					
revented The the "the spiral record and call into the wire record the	ntral venous contiewed with the life manufacturer's remaindered individual performance guide. So main exposed at his firm grip on the grip and fastener heter until springer acknowledged in exposed at his firm grip on the grip and fastener heter until springer acknowledged in acknowledg	recommendations atheterization insentern on 2/24/09 at ecommendations incoming the procedultiple lumen cat ufficient guide wire ub end of catheter uide wire Precautic must not be a wire guide is remothat by not removing follow the mainsertion of the centern insertion of the centern insertion insertion insertion insertion of the centern insertion	ertion was at 3:50 P.M. dicated that ure should heter over length must to maintain on: Catheter attached to ved." The g the guide anufacturer's				
of at add fail rec cat Thi ren	Administrative Set which time the verse penalty may lure to follo ommendations for heter even thought in the second second in the second in th	ras conducted with rvices on 2/24/09 a Director was notified by the manu insertion of a central supervision was second invasive projuide wire from Patie	at 4:00 P.M. ed that an he facility's facturer's tral venous s provided.				
				-			
Event ID:P9G0	G11	***************************************	4/10/2009	9:31:53	BAM		
Brenda	RECTOR'S OR PROVIDE	ER/SUPPLIER REPRESEN	NTATIVE'S SIGNAT	Latory:	Affairs TITLE	toril 27	(X6) DATE

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State-2567