

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/29/2011
NAME OF PROVIDER OR SUPPLIER DAVIES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 45 CASTRO ST. SOUTH TOWER 2ND FLOOR SAN FRANCISCO, CA 94114		
(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) COMPLETION DATE	
{V 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification revisit survey conducted 3/28 and 3/29/11. Representing the California Department of Public Health: Stella Tannehill, Health Facilities Evaluator Nurse Andrea Kubovcik, Health Facilities Evaluator Nurse The census on 3/29/11 was 82. 494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY) Isolation of HBV+ Patients To isolate HBsAg positive patients, designate a separate room for their treatment. For existing units in which a separate room is not possible, HBsAg positive patients should be separated from HBsAg susceptible patients in an area removed from the mainstream of activity. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure patients receiving hemodialysis in the isolation room were visually monitored, when two patients received hemodialysis in the isolation room, which did not have viewing windows, and staff were not present at all times in the room. Failure to keep patients receiving dialysis in view by staff at all times can lead to undetected patient bleeding or other complications.	{V 000}			
V 128		V 128		4/29/11	

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

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. (See instructions.) Except for nursing homes, the findings stated 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.

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V 128	Continued From page 1 Findings: The facility's isolation room is separated fully from the treatment room by full walls and a solid door. During the initial tour on 3/28/11 at 10:50 AM, while accompanied by the Facility Administrator, Stations 1 and 2 in the isolation room were occupied by patients receiving hemodialysis, and there was no staff member in the room. After the Surveyor greeted the patient at Station 1, introduced herself, and stated the purpose of the inspection, PCT 2 hurried in to the isolation room. When the surveyor pointed out to PCT 2 that he was not in the room while patients were receiving dialysis, PCT 2 said he just left the room to obtain supplies and then returned. Review of the facility's policy and procedure, Infection Control and Isolation Measures for Known or Suspected Hepatitis B Surface Antigen Positive Patients, indicated on page 2, "...8. When using a designated isolation room, the walls need to be made of a material that allows for visual monitoring of the patient(s) in the room (unless a teammate is continually present in the room)..."	V 128			
{V 146}	494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51	{V 146}		4/29/11	

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{V 146}	<p>Continued From page 2</p> <p>number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to implement procedures to prevent catheter related infections for 1 of 2 patients (Patient 7), when Registered Nurse 1 (RN 1) removed the catheter insertion site dressing, cleansed the site and removed his gloves. RN 1 proceeded to put on clean gloves without sanitizing his hands, then put a clean dressing on the catheter insertion site.</p> <p>Findings:</p> <p>During observation of Patient 7 on 3/29/11 at 12 noon, RN 1 while wearing gown, mask and gloves, removed the catheter site dressing, cleansed the catheter site with ExCept (a catheter site cleanser), wrapped the two catheter ports with Betadine wet gauze and then removed the gauze. RN 1 took off his gloves and put on clean gloves without sanitizing his hands. He then</p>	{V 146}			

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{V 146}	Continued From page 3 flushed the two catheter ports with saline, put a sterile gauze dressing over the catheter insertion site and covered it with a clear dressing. RN 1 drew blood specimens from the catheter ports, and connected the bloodlines from the dialysis machine to the catheter ports. He then wrapped the catheter ports with sterile gauze and taped it, leaving the connections accessible. When concurrently interviewed on 3/29/11 at 12 noon, RN 2 said he was not sure what the facility's policy was regarding sanitizing hands between glove changes while providing catheter care. He checked the policy, returned to the surveyor, and said RN 1 should have sanitized his hands between changing gloves. Review of the facility's policy and procedure, Central Venous Catheter (CVC) Cleaning and Dressing Change, indicated under procedure 6....With clean, gloved hands remove old dressing and discard... 9. Remove gloves and discard. Wash hands and re-glove. 10. Holding catheter with the non-dominant hand, and using aseptic technique, cleanse exit site with germicidal soaked gauze... 12. using fresh germicidal moistened gauze, clean catheter limbs starting at exit site and cleaning entire length of of catheter limbs...14. Remove gloves and discard. Wash hands and re-glove. 15. Place sterile gauze over catheter and exit site leaving connected or sealed catheter limbs accessible..."	{V 146}			
{V 503}	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following:	{V 503}		4/29/11	

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{V 503}	Continued From page 4 (2) Evaluation of the appropriateness of the dialysis prescription, This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement the physician's dialysis prescription for two random patients (Patients 12 and 13), when the administered dialysis flow rate (DFR) and/or the administered blood flow rate (BFR) were not in accordance with the physician's orders. Administration of a BFR less than what was ordered by the physician may lead to inadequate fluid removal and ineffective dialysis. Administration of a DFR less than that ordered by the physician may lead to decreased removal of toxins from the blood. Administration of a BFR higher than that ordered by the physician may lead to increased vascular pressure. Findings: 1. During the initial tour on 3/28/11 at 11 AM, while accompanied by the Facility Administrator, Patient 12's dialysis machine registered DFR 600 and BFR 300. Patient 12 had a left arm arterial-venous fistula for dialysis access. Concurrent review of Patient 12's physician's hemodialysis prescription dated 3/26/11, indicated DFR 800 and BFR 400. When interviewed on 3/28/11 at 11 AM, PCT 1	{V 503}			

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{V 503}	<p>Continued From page 5</p> <p>(Patient Certified Hemodialysis Technician) said it was her mistake. She said she set up the dialysis machine and Patient 12 started dialysis at 8:15 AM. PCT 1 said Patient 12's prescription had been changed since his last treatment. PCT 1 changed the DFR and the BFR dialysis machine settings to meet the physician's order.</p> <p>Record review on 3/29/11 of Patient 12's Post Treatment Record dated 3/28/11 indicated he had received dialysis with the incorrect BFR 300- 306 and the incorrect DFR 600 for approximately 135 minutes of his 204 minute treatment.</p> <p>During interview with the Facility Administrator (FA) on 3/28/11 at 12:25 PM, she said there was an RN Charge Nurse for eight patients. The FA said she expected the RN Charge Nurse to check dialysis settings for correctness when the patient's pre assessment was done before the dialysis treatment was initiated.</p> <p>2. During observation on 3/29/11 at 10:40 AM, while accompanied by the CSS, Patient 13's dialysis machine register BFR 350. Patient 13 had a central venous catheter for dialysis access.</p> <p>Concurrent review of Patient 13's physician's hemodialysis prescription dated 3/10/11, indicated BFR 300.</p> <p>The surveyor brought this to the attention of the PCT who was working with Patient 13, and he changed the dialysis machine BFR setting to 300.</p> <p>When interviewed on 3/29/11 at 10:40 AM, RN 2 said the nurse should have picked up the incorrect BFR setting when Patient 13's pre</p>	{V 503}			

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{V 503}	Continued From page 6 assessment was done. During concurrent interview, the CSS said the facility did not have a policy and procedure for flow rates. The expectation was that the physician's order would be followed. Record review on 3/29/11 of Patient 13's Post Treatment Record dated 3/29/11, indicated Patient 13 received dialysis with a BFR between 351 and 362 for 129 minutes of his 208 minute treatment.	{V 503}			