

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:  <b>552620</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/10/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOSTER CITY DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1261 E HILLSDALE BLVD, SUITE 2 FOSTER CITY, CA 94404</b>		
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>The following reflects the findings of the California Department of Public Health during the recertification survey from 3/7/11 through 3/10/11.</p> <p>Representing the California Department of Public Health: Artemis Tumaneng, Health Facilities Evaluator Nurse, and Stella Tannehill, Health Facilities Evaluator Nurse.</p> <p>The facility's census at the time of the survey was 25.</p> <p>The following Conditions for Coverage were not met:</p> <p>494.80 Patient Assessment 494.110 QAPI</p> <p>Common Abbreviations, Acronyms and Terms used:</p> <p>AT - (Actual Time) the exact time recorded in the computer system when the RN entered the assessment data he collected.</p> <p>Central Venous Catheter or short peripheral catheter - a catheter with two lumens inserted under the skin into a large vein in the neck or groin used for hemodialysis treatment. Cross-contamination is the physical movement or transfer of harmful bacteria from one person, object or place to another. CSS - Clinical Services Specialist EDW - Estimated Dry Weight</p>	V 000			

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 000	Continued From page 1 ESRD - End Stage Renal Disease PCT - Patient Certified Hemodialysis Technician  Hemodialysis treatment - a therapy that uses hemodialysis machine and a dialyzer to remove extra fluids and waste products of the body that kidneys could not excrete.  Heparin - medication used to prevent blood clots.  Intravenous medications - medications given through the veins.  Medication vial septum - a rubber membrane that covers a medication vial (a small glass or bottle) where needle and syringe are inserted to aspirate the medication.  P&P - policy and procedure  Flowsheet History - print out of the actual time the staff entered the data collected in the computer  TTE - Time Treatment Ended  TTS - Time Treatment Started  TD - (Time Documented) - the time typed in or entered by RN in the electronic record	V 000			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE  Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.	V 113			

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V 113	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure one staff sanitized his hands between changing gloves after removing the dressing from the catheter ports and before inserting a new catheter port cap; and failed to ensure one staff did not touch the dialysis machine during treatment without wearing gloves.</p> <p>According to the CDC, handwashing is the most important measure to prevent cross contamination, which can lead to the transmission of infection.</p> <p>Findings:</p> <p>1. During observation of Patient 2 on 3/7/11 at 1:50 PM, Registered Nurse 1 (RN 1) was wearing gloves and mask when he clamped Patient 2's clothing away from the catheter access site, placed a disposable barrier pad under the catheter ports, and removed the dressing from around the two catheter ports. RN 1 then removed his gloves, put on clean gloves and connected new catheter port caps to the catheter without sanitizing his hands. RN 1 flushed the ports and connected the bloodlines from the dialysis machine to the catheter.</p> <p>When RN 1's failure to sanitize his hands between changing his gloves was brought to his attention by the surveyor on 3/7/11 immediately following the observation, RN 1 said, "I can do that."</p> <p>2. In an observation on 3/7/11 at 2:30 PM, PCT (Patient Certified Hemodialysis Technician) 2</p>	V 113			

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V 113	Continued From page 3 touched the dialysis machine screen without gloves while Patient 4 was having hemodialysis treatment on Station 1.  In an interview on 3/7/11 at 2:30 PM, PCT 2 said he forgot to wear gloves but he was aware that he should be wearing gloves when touching the machine.  Review of the facility's policy and procedure (P&P), Infection Control for Dialysis Facilities, indicated under Teammate Hygiene, "1. Hand hygiene is to be performed... prior to gloving, after removal of gloves..." Under, Treatment/Patient Safety, the P&P indicated, "8. Teammates will wear disposable gloves when ...touching the patient's equipment at the dialysis station...9. Gloves should be worn when...touching the dialysis delivery system during...a dialysis treatment...10. Gloves should be changed when going from a 'dirty'...task to a 'clean'...task."	V 113			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS  [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and  This STANDARD is not met as evidenced by: 2. During inspection of drug storage on 3/8/11 at 4:05 PM, while accompanied by the Clinical Services Specialist (CSS), the following was found:	V 143			

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V 143	<p>Continued From page 4</p> <p>*In the medication cupboard, there was a multi-dose vial of lidocaine 1% (used to numb dialysis needle sites) that had an open date of 10/22/10 marked on the vial in pen. Also observed were six 30 milliliter vials of concentrated sodium chloride with expiration dates of 2/2011.</p> <p>*On the door of the medication refrigerator, there was a multi-dose vial of PPD solution (positive protein derivative- used to test for tuberculosis exposure) with an opened date of 11/29 marked on the vial in pen, and there was an open multi-dose vial of PPD solution that was not marked with an open date.</p> <p>*On a shelf in the medication refrigerator, there was a syringe with medication in it that was labeled Epogen, and a syringe with medication in it labeled Hectoral (a medication to treat vitamin D deficiency). Both had printed label dates of 3/4/11 and a patient's name.</p> <p>When concurrently interviewed on 3/8/11 at 4:05 PM, the CSS said open vials of drugs were only held for use for 30 days after opening, unless otherwise indicated by the manufacturer. The CSS checked the pharmaceutical insert that was with the PPD solution, and said it indicated that the PPD solution should be disposed of 30 days after opening. She was not sure about the lidocaine and there was no pharmaceutical insert with it. She removed the lidocaine and PPD solution for disposal.</p> <p>The CSS said the syringes of medication should not have been held when they were not used. She said the patient whose name was on the</p>	V 143			

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V 143	<p>Continued From page 5</p> <p>label had been there the day before, and she was sure that was when the medication had been drawn up in to the syringe. The CSS said the printed label on the syringes was only the date the labels were printed. She said labels were printed ahead of the date the medication was to be given, but the medication was drawn up on the day it was to be given. The CSS said the nurse who drew up the medication into the syringe should have written that date on the label.</p> <p>During interview on 3/9/11 at 4:40 PM, the Facility Representative said that lidocaine had a preservative and had to be disposed of 30 days after opening the vial.</p> <p>Review of the facility's Medication Policy 1-06-01, indicated, "...12. All unopened ...vials are stored according to the manufacturer's directions. Do not use any ...vial that has ...expired. ...25. Medications containing a preservative must be discarded 30 days after opening or as directed by the manufacturer... Each vial is labeled with the date, time, and initials of the person opening the vial and the discard date. Medications are stored in the original vial and are not drawn up and stored overnight in a syringe or any other container... 27...medications with an expiration date of month and year are considered expired the last day of the stated month... 28. Disposal of expired medications...are removed from the treatment and inventory areas and disposed of per state/local regulations..."</p> <p>Based on observation, interview, and record review, the facility failed to ensure aseptic</p>	V 143			

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V 143	<p>Continued From page 6</p> <p>technique was used when preparing and administering intravenous medications and ensure all expired medications were not available for use. Failure to practice aseptic technique during preparation and administration of intravenous medications had the potential to contaminate the medications and caused infection to patients.</p> <p>Findings:</p> <p>1. In an observation and interview on 3/7/11 at 3:00 PM, RN 1 was preparing intravenous medications. He took 1 vial of Epogen (medication to treat anemia) and without wiping the rubber septum, inserted the needle in the vial. He did the same thing with the other vial of Epogen. When asked what is the facility's policy in preparing the medication, he said, "I did not use the alcohol swab to clean the septum because the vial and the needle were sterile." In continued observation, RN 1 went to Station 1 to give the medication. He had 2 syringes of medication to be given to the patient. He wiped the saline port with alcohol prep pad and administered the medications in two syringes without wiping the saline port between each medication administration. When asked what was the facility's policy in medication administration, he said, "I was oriented to use one alcohol prep pad.</p> <p>Review of the facility's Preparation and Administration of Intravenous Epogen dated May 2010 indicated, "Remove the vial cap and clean the vial stopper with an alcohol prep pad...If administering more than one (1) syringe of EPO (Epogen), cleanse the infusion line with a fresh</p>	V 143			

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V 143	Continued From page 7	V 143			
V 310	<p>alcohol prep pad prior to each injection."</p> <p>494.50(b)(1) PERSONNEL HEALTH MONITORING RECORDS</p> <p>4 Records 4.4 Personnel health monitoring records A file must be kept of the results of medical examinations of personnel that are required by OSHA or other regulatory agencies.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 (RN 1) of 11 staff whose records were reviewed was screened for tuberculosis by chest x-ray when there was a history of a positive tuberculosis exposure test.</p> <p>Tuberculosis (TB) is a highly contagious disease, which is sometimes fatal and is spread from person to person by droplets from coughing.</p> <p>Findings:</p> <p>During review of employee health records, one registered nurse (RN 1) had a documented history of a positive test for exposure to tuberculosis. There was no indication in the record to indicate active tuberculosis in the lungs was ruled out by chest x-ray.</p> <p>When interviewed on 3/9/11 at 11 AM, the Facility Administrator said she thought the facility where the RN previously worked had documentation of a chest x-ray. The previous facility was within the same corporation.</p> <p>The Facility Administrator was unable to provide documentation of a chest x-ray to rule out active</p>	V 310			

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V 310	Continued From page 8 tuberculosis for this RN by the end of the survey.  Review of the facility's policy and procedure, Tuberculosis Monitoring and Follow-up, indicated, "... 3. Teammates who provide documentation of a positive TST (test to determine exposure to tuberculosis)...will be exempt from baseline and annual TST when the following documentation is provided: Medical follow-up (evaluation to exclude latent TB infection and active TB disease) and documentation of a negative chest x-ray completed within the last six months..."	V 310			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU  The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all equipment was maintained according to the manufacturer's recommendations, when the patient lift was not checked for full safety functions. Failure to maintain equipment had the potential of equipment breakdown during patient care which could harm the patient.  Findings:  During the initial tour observation on 3/7/11 at 9:30 AM, the patient lift did not have a sticker to indicate when regular maintenance was done.	V 403			

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V 403	Continued From page 9  In an interview on 3/9/11 at 2:55 PM, the Biomed said the patient lift had not been checked since the clinic opened in June 2009. He said the patient lift did not require maintenance.  Review of the manufacturer's maintenance guidelines, Care and Maintenance of Your Patient Lift, indicated "The X Lift is designed for minimum maintenance; however, a six (6) month check and lubrication should ensure continued safety and reliability....It is important to inspect all stressed parts, such as slings, spreader bar and any pivot for slings for signs of cracking, fraying, deformation or deterioration....All sling metal parts should be inspected every three (3) months, and if wear is apparent, replacement must be made."  Review of the facility's March 2008 Use of a Mechanical Device for Lifting Patients indicated, "Regular maintenance of a lift device and/or any accessories is necessary to ensure proper and safe operation."	V 403			
V 412	494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED  The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 random patient (Patient 6) knew how to disconnect from the dialysis machine in the case of an emergency, when the facility recognized a language barrier prevented Patient 6 from fully understanding her training for emergency disconnection from the hemodialysis	V 412			

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V 412	<p>Continued From page 10</p> <p>machine, but did not arrange a training session with both the Patient 6 and her daughter, the patient's preferred interpreter.</p> <p>Findings:</p> <p>Patient 6 was randomly chosen for interview on 3/9/11 at 3:02 PM. Patient 6 said her primary language was Russian, but she was able to speak some English. The questions asked of Patient 6 required rewording at times for her to understand them, but after doing this, she was able to give relevant and appropriate answers.</p> <p>When Patient 6 was asked what she would do if there was a fire while she was on dialysis and she had to stop dialysis immediately, Patient 6 replied, "I don't know." The question was reworded, but Patient 6 still could not give an answer.</p> <p>During concurrent interview, on 3/9/11 at 3:02 PM, PCT 3 said he had just gone over emergent disconnection from the dialysis machine with Patient 6 a couple of days earlier. PCT 3 lifted a bag that held emergency bloodline clamps and scissors from where it was hanging in the station and showed it to Patient 6. She looked at it and shook her head and said, "I don't know."</p> <p>Review of Patient 6's record indicated she was admitted to the facility on 2/23/11. There was a form titled, Emergency Evacuation Acknowledgment, that gave a brief, one paragraph description of the procedure for emergency disconnection from the dialysis machine and evacuation from the facility. The last sentence on the form read, "The emergency</p>	V 412			

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V 412	<p>Continued From page 11</p> <p>evacuation plan, including the hand pump procedure, and the emergency disconnect procedure, have been explained and/or demonstrated to me." The form was signed by Patient 6 on 2/23/11, as were all her admission papers. There was no witness signature in the designated space on the form.</p> <p>Review of the form, Emergency Procedure Patient Instructions, for Patient 6 found under the column, 1st Quarter (Jan., Feb., March), a list of questions that included: "Patient able to comprehend state of emergency? Is the patient physically/mentally sound? Can patient perform the following? -Emergency blood return procedure -Emergency disconnect procedure -...Can patient identify emergency exit door location? ...Can patient leave unassisted?" These questions were all checked off under the column for yes. There was no staff signature on the form and Patient 6 had not signed in the space designated for patient signature.</p> <p>During interview on 3/9/11 at 3:44 PM, the Facility Administrator (FA) said Patient 6's admission process included telephone calls over three days. The FA said the telephone conversations were done through both Patient 6's daughter, who spoke Russian and English fluently, and the patient. The FA said the emergency procedure, "cut and clamp," was covered with patients on the very first day in the facility, and Patient 6's learning needs were also assessed the first day she came in for dialysis. Patient 6 had been receiving dialysis for a long time, and was not accompanied by her daughter. The FA said they asked Patient 6 if she wanted her daughter to be present and she did not. The FA</p>	V 412			

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V 412	Continued From page 12 said she had a concern about Patient 6's level of understanding, and that was why the Emergency Procedure Patient Instruction form was not signed by the patient. The FA said the patient would receive emergency training the next quarter, and had made no arrangement to meet with the daughter and the patient for emergency training. The FA said the Social Worker (SW) sat with Patient 6 to evaluate her English.  When interviewed on 3/9/11 at 4:19 PM, the SW said she had assessed Patient 6, who was taking English classes. The SW said she realized Patient 6 did not understand the discussion about advance directives, because Patient 6 was "so unsure." The SW said she informed Patient 6 about the language interpretation telephone line, but Patient 6 said she preferred to use her daughter as an interpreter. The SW said she planned to talk with Patient 6's daughter to arrange a meeting to go over advance directives, but did not see this as an urgent need. The SW said normally she had nothing to do with emergency training, but she would help to coordinate a meeting.  Review of the facility;s policy and procedure, Termination of Dialysis in an Emergency, indicated: "...Emergency take off kits are to be available at each dialysis station and stored within patient's reach... 1. Turn off the dialysis system. 2. Clamp blood lines and vascular access tubing. 3. Cut or disconnect lines between clamps. 4. Secure tubing to patient's arm. 5. Evacuate patient to a safe area."	V 412			
V 500	494.80 CFC-PATIENT ASSESSMENT	V 500			

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V 500	Continued From page 13  This CONDITION is not met as evidenced by: Based on observation of care delivery, interview with staff, and record review, the facility failed to comply with the Condition for Coverage for Patient Assessment as evidenced by the facility's failure to ensure comprehensive assessments on patients when RN 1 (Registered Nurse 1) did not do pre and post dialysis treatment assessments on six of 8 patients observed during treatment (Patient 5, 6, 4, 8, 7, and 2) to monitor changes in patients' fluid management, and did not identify high risk levels of fluid retained post treatment. Patient 4, 5, and 7 had post dialysis weight of at least 1kg over their prescribed dry weight. Patient 5 was admitted to the hospital for respiratory distress due to fluid overload (V 504).  Failure to perform pre-assessment could lead to ineffective removal of extra fluids in the body. Failure to perform post-assessment could lead to undetermined efficacy of the hemodialysis treatment. These practices could result in fluid overload and complications, such as respiratory distress and congestive heart failure.  The cumulative effect of this systemic problem could compromise the health and safety of all patients receiving hemodialysis treatment in the facility.  An IJ (Immediate Jeopardy) was called on 3/9/11 at 11 AM and was abated at 2:47 PM on the same day.	V 500			
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX	V 503			

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V 503	<p>Continued From page 14</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(2) Evaluation of the appropriateness of the dialysis prescription,</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician's hemodialysis prescription was implemented for 2 of 5 sampled patients (Patients 2, and 3), when: *Patient 2 had eight hemodialysis treatments with a blood flow rate (BFR) that was less than the BFR ordered by the physician, and *Patient 3 received two hemodialysis treatments with a dialysis flow rate (DFR) 600, when the physician's order was for DFR 500; and *Patient 3 was given a heparin (medication to prevent blood clotting) infusion of 2500 units during one hemodialysis treatment when the physician order was for heparin 1000 units per hour for two hours, or 2000 units total infusion during hemodialysis treatment.</p> <p>Failure to implement the prescribed BFR can lead to inadequate removal of extra fluid from the blood and ineffective treatment.</p> <p>Implementing a DFR that is higher than that prescribed by the physician can result in complications such as muscle cramping and low blood pressure from a too rapid exchange of electrolytes (salts or minerals that can conduct electrical impulses in the body) between the dialysate and the blood.</p>	V 503			

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V 503	<p>Continued From page 15</p> <p>Failure to implement the physician's orders for heparin administration may lead to inadequate blood clotting resulting in bleeding during or after the hemodialysis treatment.</p> <p>Findings:</p> <p>1. Record review on 3/7/11, indicated Patient 2 was admitted to the facility on 3/3/10. Patient 2 had a right internal jugular catheter inserted 10/26/10 that was used for hemodialysis treatment. Review of the physician's current hemodialysis prescription dated 1/5/11, indicated BFR 350.</p> <p>Review of twelve Post Treatment Records for Patient 2 between 2/9/11 and 3/7/11, found the administered BFR was recorded approximately every half hour. For eight treatments, the BFR was 300 or less, as follows:</p> <p>*On 2/9 and 2/11/11, the BFR was consistently 250 with one recorded BFR 260.</p> <p>*On 2/14, 2/16, 2/18, 2/21, and 2/25/11, the BFR was maintained consistently at 300 throughout the treatments.</p> <p>*On 2/23/11 the BFR was consistently 300 except for one recorded BFR 280.</p> <p>None of Patient 2's Post Treatment Records between 2/9 and 2/25/11 indicated the prescribed BFR 350 was attempted, and there was no documentation to explain why the administered BFR was less than the prescribed BFR 350. There were no documented problems with venous or arterial pressures. There was no indication the physician was notified of the continued failure to implement the hemodialysis treatment with the prescribed BFR 350.</p>	V 503			

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V 503	<p>Continued From page 16</p> <p>During interview with the Facility Administrator (FA) on 3/8/11 at 4:30 PM, she said the physician should be notified if they were unable to achieve the prescribed BFR. The FA said the reason the BFR could not be achieved should be documented. The FA checked Patient 2's Post Treatment Records between 2/9 and 2/25/11 and could not find a reason for the BFRs less than what was prescribed.</p> <p>When interviewed on 3/10/11 at 10:35 AM, the FA said the physician should be called when the BFR could not be achieved for a patient with a catheter, because they may need to administer activase (an enzyme to decrease clotting), or replace the catheter.</p> <p>2. Record review on 3/9/09 indicated Patient 3 was admitted to the facility on 9/24/09. The physician's current hemodialysis prescription dated 2/2/11 indicated dialysis flow rate (DFR) 500, and the heparin infusion order was 1000 units per hour for two hours of treatment (a total of 2000 units heparin infusion).</p> <p>Review of Patient 3's twelve Post Treatment Records between 2/7/11 and 3/7/11 found that for two treatments, on 2/18 and 3/4/11, the DFR was consistently recorded at 600 throughout the treatment. There was no documented reason for either treatment to explain administering a DFR above the prescribed DFR 500.</p> <p>Patient 3's Post Treatment Record dated 2/23/11 indicated he was administered a heparin infusion totaling 2500 units over two hours rather than the prescribed 2000 units.</p>	V 503			

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V 503	Continued From page 17  During interview with the FA on 3/10/11 at 10:35 AM, she said she thought the dialysis machine had been set manually at DFR 600 in error. The FA said when the nurse did rounds, he should be checking for the correct flow rates. The FA said the delivery of 2500 units of heparin over two hours was a problem. The FA checked Patient 2's physician orders and said Patient 2 should have received 2000 units heparin infusion on 2/23/11.  Review of the facility's P&P, Prescription Verification and Safety Checks, indicated under Prescription Verification, "4. Verify on patient electronic treatment record the following prior to every dialysis treatment... Blood flow and dialysis flow...heparinization (systemic loading dose and intradialytic ( given during the hemodialysis treatment) infusion..."	V 503			
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS  The patient's comprehensive assessment must include, but is not limited to, the following:  Blood pressure, and fluid management needs.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments on patients when RN 1 (Registered Nurse 1) did not do pre and post dialysis treatment assessments on six of 8 patients observed during treatment (Patient 5, 4, 7, 6, 8, and 2) to monitor changes in patients blood	V 504			

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V 504	<p>Continued From page 18</p> <p>pressure and fluid management, and did not identify high risk levels of fluid retained post treatment. Patients 4, 5 and 7 had post treatment weight of at least 1 Kg over their prescribed dry weight. Patient 5 was admitted to the hospital for respiratory distress due to fluid overload.</p> <p>Failure to perform pre-assessment could lead to ineffective removal of extra fluids in the body. Failure to perform post-assessment could lead to undetermined efficacy of the hemodialysis treatment. These practices could result in fluid overload and complications, such as respiratory distress and congestive heart failure, which could compromise the patient's health and safety.</p> <p>Respiratory Distress is a life-threatening condition caused by swelling in the lungs due to failure of the heart to remove fluid from the lung circulation. Congestive Heart Failure (CHF) is a condition that results when the heart does not pump enough blood out of the lungs and into general circulation. It may cause chest pains, breathing difficulty, high blood pressure and swelling. One of the causes of CHF is fluid overload.</p> <p>An IJ was called on 3/9/11 at 11 AM and was abated at 2:47 PM on the same day.</p> <p>Findings:</p> <p>1. At 1:40 PM, Patient 5 was in Station 15 receiving hemodialysis treatment. The computer indicated the hemodialysis treatment was started at 12:50 PM with no entry for pre assessment. Patient 5 was receiving oxygen via an oxygen concentrator by nasal canula at two liters a minute (2/Lit/Min).</p>	V 504			

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V 504	Continued From page 19  Record review on 3/8/11, indicated Patient 5 was admitted to the facility on 9/2/08 with diagnoses including end stage renal disease, hypertensive kidney disease, and recurrent congestive heart failure. His current hemodialysis prescription dated 2/4/11, included a dry weight of 55 kilograms (Kg). Patient 5 had PRN (as needed) orders dated 11/01/10, for oxygen (O2) via O2 concentrator by nasal canula at 2/Lit/Min to be given for SOB (shortness of breath), tachycardia (heart rate above 100), and chest pain.  Review of Patient 5's Post Treatment record nurse's documentation dated 3/7/11, indicated RN 1 noted both the pre and post assessment were done at 1 PM. Patient 5's hemodialysis treatment began at 12:50 PM and ended at 3:50 PM.  The pre assessment indicated: Respiratory: clear GI: No complaints Cardiac: regular rate and rhythm Edema: none noted Mental: alert and oriented  The post assessment indicated: Respiratory: clear GI: No N/V (nausea/vomiting) Cardiac: 75 Edema: none Mental: Alert  The 3/7/11 Post Treatment Record indicated the PCT (Hemodialysis Certified Technician) noted at 1:50 PM that Patient 5 "c/o (complained of) SOB and was given O2 pre treatment. RN aware." RN	V 504			

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V 504	<p>Continued From page 20</p> <p>1 made no notation indicating he assessed Patient 5's SOB. RN 1 made no notation regarding Patient 5's use of O2 or indicating Patient 5's response to the O2 treatment. There was no documentation of the rate at which the O2 was administered to Patient 5.</p> <p>Review of the 3/7/11 computer printout that recorded the actual time assessment entries were made in the Post Treatment Record, indicated RN 1 inputted Patient 5's pre assessment note on 3/7/11 at 4:36 PM (three hours and 46 minutes after the dialysis treatment was begun), and inputted the post assessment note at 4:37 PM, one minute later.</p> <p>Record review of Patient 5's Post Treatment Records from 2/2/11 through 3/4/11, indicated that on 2/28/11, the PCT noted, "SOB RN aware," at 3:45 PM, when the hemodialysis treatment ended. There was no documentation by RN 1 to indicate he assessed Patient 5's SOB at that time, or that O2 was administered as ordered. RN 1 noted his post assessment of Patient 5 at 4 PM, and indicated respiratory, "clear." RN 1 did not check Patient 5's O2 saturation level to see if it was adequate. There was no notation Patient 5's SOB had resolved.</p> <p>Record review indicated Patient 5 was hospitalized on 12/26/10, and 1/5/11. Review of the emergency department physician's note dated 12/26/10 (a Sunday) indicated Patient 5 complained of SOB for the past two to three days. His O2 saturation was 85% (reference range 90% or above). Patient 5's admission diagnoses were: end stage renal disease, respiratory distress due to fluid overload, chronic obstructive pulmonary</p>	V 504			

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V 504	<p>Continued From page 21</p> <p>disease, and stable anemia.</p> <p>Review of Patient 5's three Post Treatment Records for the week prior to his 12/26/10 admission to the hospital for respiratory distress due to fluid overload, indicated that on both 12/20/10 and 12/22/10, indicated his post treatment dry weight was 56.7 Kg, 1.7 Kg above the prescribed dry weight. During both treatments, the PCT noted Patient 5 complained of SOB and that the RN was aware. On 12/22/10, the PCT noted Patient 5 was given O2, but did not indicate the rate of O2 administration.</p> <p>RN 1's notes on the 12/20 and 12/22/10 Post Treatment Records, did not include an assessment of Patient 5's complaint of SOB. RN 1's notes did not indicate an assessment of the O2 saturation, on either 12/20 or 12/22/10, and did not indicate O2 was administered to Patient 5 on 12/22/10. There was no indication the physician was notified that Patient 5 did not meet the prescribed dry weight post treatment on either 12/20 and 12/22/10.</p> <p>Patient 5's Post Treatment Record for 12/24/10 (Friday), indicated the PCT noted "c/o SOB, RN aware," at 9:50 AM. The 12/24/10 treatment began at 9:55 AM. RN 1 noted a pre assessment at 10 AM, in which he indicated Patient 5's lungs were clear.</p> <p>There was no indication in the notes that RN 1 assessed Patient 5's experience of SOB, no indication an oxygen saturation was obtained, and no indication oxygen was administered as ordered for SOB.</p>	V 504			

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V 504	<p>Continued From page 22</p> <p>At 10:20 AM on 12/24/10, the PCT noted, "No complaints..." RN 1 noted the post treatment assessment at 11:30 AM. Patient 5's treatment ended at 12:25 PM. Review of the computer printout of the actual times assessment data was inputted into the computer indicated RN 1 entered his pre assessment note at 1:40 PM, and his post assessment note at 1:42 PM.</p> <p>Patient 5's Post treatment Record on 12/24/10 indicated the post treatment dry weight was 56.4 KG, 1.4 Kg. more than the prescribed dry weight of 55 Kg.</p> <p>RN 1's note did not indicate an assessment of the reason Patient 5's dry weight was not met, or an assessment of how the extra fluid might affect Patient 5, who was not scheduled for another hemodialysis treatment for two days, on Monday. This placed Patient 5 at risk of complications due to fluid overload. There was no indication the physician was notified that Patient 5 did not meet his dry weight. There was no notation indicating Patient 5 was counseled regarding his fluid status.</p> <p>Record review of the emergency department physician's note dated 1/5/11, indicated Patient 5 was admitted to the hospital with acute congestive heart failure. Patient 5's chief complaint was SOB. The physician noted Patient 5 was, "unable to catch his breath...can speak in 3-word sentences...O2 sat saturation is noted to be markedly low at the 70s on room air..."</p> <p>Review of the two Post Treatment Records for Patient 5 preceding his hospital admission on 1/5/11, indicated that on 12/31/11 the PCT noted,</p>	V 504			

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V 504	<p>Continued From page 23</p> <p>"MIN (minimal) SOB. O2 at 2 LPM/Nasal Canula (2 liters per minute)," at 11:25 AM. There was no indication RN 1 was notified, or that RN 1 assessed Patient 5's SOB. The Post Treatment Record on 1/3/11, indicated Patient 5's post treatment weight was 56.6 Kg, 1.6 Kg above his prescribed dry weight. There was no indication RN 1 evaluated the reason for Patient 5's failure to attain his prescribed dry weight, nor was there any indication the physician was notified. There was no documentation that Patient 5 was counseled regarding his fluid status.</p> <p>During interview with the CSS on 3/10/11 at 2:04 PM, she said that a nurse in critical thinking would know when a patient was more than 1 KG over the prescribed dry weight, the nurse should contact the physician for further direction, Sometimes the patient would be scheduled for an additional treatment the next day.</p> <p>Fluid removal to achieve fluid balance is an integral component of hemodialysis treatments to prevent under- or overhydration, both of which have been demonstrated to have significant effects on intradialytic (during dialysis) morbidity (diseased state) and long-term cardiovascular complications. [Journal of American Society of Nephrology (JASN) February 1, 1999. vol 10 no.2 392-403].</p> <p>2. Patient 4 was admitted to the facility on 11/10/10 with diagnosis of ESRD. Her 11/15/10 dialysis prescription included EDW 61.5 Kg and dialysis time of 3 hours 15 minutes.</p> <p>During observation on 3/7/11 Patient 4 came in at 2 PM and went straight to Station 1. PCT 2</p>	V 504			

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V 504	<p>Continued From page 24</p> <p>prepared the patient for dialysis and proceeded to initiate the patient's dialysis treatment at 2:10 PM. The patient was not provided pre treatment assessment by an RN.</p> <p>In an observation at 2:30 PM on 3/7/11, Patient 4 was in Station 1 receiving hemodialysis treatment. The computer screen showed she started hemodialysis treatment at 2:10 PM. The screen did not indicate that pre assessment was done.</p> <p>A 3/7/11 review of the computer print out of the Post Treatment record under Pretreatment Data Collection and Assessment (PDCA) on 3/7/11, indicated RN 1 did the pre assessment at 3:40 PM, one hour and 30 minutes after the treatment was initiated.</p> <p>Review of 2/23/11 Post Treatment record indicated Patient 4 came in with actual weight of 68 Kg. Patient 4's treatment started at 1 PM. Under section PDCA indicated the time entered by RN for pre assessment was 1:10 PM.</p> <p>Further review of the Post Treatment sheet indicated that PCT 1 removed 4.5 liters (L) of fluids during the treatment and Patient 4's weight after dialysis was 63.5 Kg. which was 2 Kg. over her dry weight. There was no documentation to show that RN 1 thoroughly assessed the patient so she could achieve her dry weight at the end of the treatment. There was no documentation by PCT 1 that the RN was informed the patient did not achieve her dry weight. There was no documentation by RN 1 to indicate the doctor was notified that the patient did not achieve dry weight and went home with an extra 2 Kg. of fluids in her</p>	V 504			

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V 504	<p>Continued From page 25</p> <p>body which put Patient 4 at risk of fluid overload.</p> <p>Review of the 2/25/11 Post Treatment sheet indicated she came in for hemodialysis treatment with a weight of 66.8 Kg. The patient's treatment started at 1 PM, RN 1 entered the time of pre assessment as 1:10 PM. The treatment ended at 4:15, RN 1 entered post assessment time as 4:30 PM. The patient's weight post treatment was 63.1 Kg. (1.6 Kg over her prescribed dry weight). This was not identified by RN 1. There was no documentation if the doctor was informed that the patient did not achieve the prescribed dry weight which could put her at risk of fluid overload.</p> <p>3. At 2:35 PM, Patient 7 was in Station 11 receiving hemodialysis treatment. The computer screen showed he started treatment at 2:04 PM. In continued observation, RN 1 went to Patient 7 to do the pre-assessment at 2:43 PM after 41 minutes of dialysis treatment.</p> <p>Patient 7 was admitted to the facility on 2/9/11 with diagnosis of ESRD, hypertension (high blood pressure), coronary artery disease (blocked vessels supplying the heart muscle), and mild aortic valve disease (valve between the heart chamber that failed to open completely to let the blood flow in one direction). His 2/8/11 dialysis prescription included EDW was 96.5 Kg. and dialysis time of 3 hours 15 minutes.</p> <p>Review on 3/8/11 of Patient 7's 3/7/11 Post Treatment record, indicated he came in for hemodialysis treatment with a weight of 100.9 Kg. The patient started treatment at 2:04 PM and the pre assessment time recorded was 2:20 PM. The treatment ended at 5:05 PM, RN 1 did the post</p>	V 504			

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V 504	<p>Continued From page 26</p> <p>assessment at 5:15 PM. The record indicated the patient had post treatment weight of 98.6 Kg. (2.1. Kg over his dry weight).</p> <p>There was no documentation by RN 1 if the doctor was notified that the patient did not achieve dry weight and went home with an extra 2.1 Kg. of fluids in his body which put Patient 7 at risk of fluid overload which could exacerbate his other conditions like hypertension, coronary artery disease and mild aortic valve disease that could lead to Congestive Heart Failure.</p> <p>4. On 3/7/11 at 2:30 PM Patient 6 was in Station 4 receiving hemodialysis treatment. The computer screen showed she started hemodialysis treatment at 1:45 PM with no entry for pre assessment. In continued observation at 2:40 PM, Patient 6 still had not been assessed and the treatment was on-going for 55 minutes.</p> <p>Patient 6 was admitted to the facility on 2/25/11 with diagnosis of ESRD. Her 2/22/11 dialysis prescription included EDW (estimated dry weight) of 86 Kg. The 7/21/10 Discharge Summary from the hospital indicated she was in hospital for gastrointestinal (GI) bleed.</p> <p>Review on 3/8/11 of the Post Treatment record from 2/23/11 to 3/4/11 showed RN 1 did the pre and post assessment of Patient 6 with the following results:</p> <p>Respiratory - clear GI - no complaints Cardiac - regular rate and rhythm Edema - none noted Mental - oriented x 3 (oriented to time, place and</p>	V 504			

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V 504	<p>Continued From page 27 person)</p> <p>In an interview on 3/7/11 at 2:40 PM, Patient 6 said she had not been assessed before and after treatment by RN 1 since she was admitted two weeks ago. She said that RN 1 has not listened to her lungs and heart with the stethoscope nor ever looked at her legs for signs of edema (swelling of parts of the body due to accumulation of fluids). She said she was never asked if she felt nauseous or vomited at home. She said she was hospitalized before because she was vomiting blood. She said she was surprised that RN 1 was not assessing her. She added, "The facility where I came from, the nurse assessed the patients before and after dialysis and asked me if I'm ok at home when not in dialysis."</p> <p>5. On 3/7/11 at 2:30 PM, Patient 8 was in Station 6 receiving hemodialysis treatment. The computer screen showed she started hemodialysis treatment at 2:03 PM without pre-assessment by RN 1 and the treatment was on-going for 27 minutes.</p> <p>In an interview on 3/7/11 at 2:30 PM, Patient 8 said she has not been assessed by RN 1 before the hemodialysis treatment. She said RN 1 was busy attending to other patients.</p> <p>Review of the 3/7/11 Post Treatment record indicated the patient started treatment at 2:03 PM. RN 1 documented that he did the pre-assessment at 2:15 PM.</p> <p>6. On 3/7/11 at 2:45 PM, Patient 2 was in Station 14 receiving hemodialysis treatment. The computer screen showed he started hemodialysis</p>	V 504			

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V 504	<p>Continued From page 28</p> <p>treatment at 2:00 PM. The computer screen did not show an entry that a pre assessment was done by RN 1.</p> <p>Record review on 3/8/11 indicated Patient 2 was admitted to the facility on 3/3/10 with diagnoses including end stage renal disease. Review of the Post Treatment Record dated 3/7/11 indicated RN 1 performed a pre assessment at 2:10 PM and a post assessment at 5:45 PM. The treatment began at 1:59 PM and ended 5:26 PM. Review of the computer print out that recorded the actual times entries were inputted on 3/7/11 indicated RN 1 inputted the pre assessment at 4:56 PM and the post assessment at 6:18 PM.</p> <p>Review of the Post Treatment Record dated 2/25/11 indicated RN 1 noted Patient 2's pre assessment at 1:10 PM and his post assessment at 1:25 PM. Patient 2's treatment began at 1 PM and ended at 4:16 PM. Review of the computer print out that recorded actual input times indicated RN 1 entered the pre assessment data at 1:18 PM, 18 minutes after the treatment was begun, and the post assessment data at 4:40 PM.</p> <p>On 3/7/11 at 1:30 PM, there were two patients coming off dialysis and two patients were starting dialysis treatment. This only allowed RN1 a 3.7 minutes assessment time for each patient. At 1:45 PM, RN 1 had three patients starting dialysis and two coming off dialysis, which gave him three minutes for each patient assessment. At 2 PM, there two patients being taken off and two patients starting.</p> <p>In an interview on 3/7/11 at 2:50 PM, RN 1 said he was not able to do the pre-assessment of the</p>	V 504			

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V 504	<p>Continued From page 29</p> <p>six patients. He said he initiated treatment for patients who had Central Venous Catheter (CVC) because the patients would be late on their scheduled treatment. He said that pre assessments were not done because he did not have enough time.</p> <p>In an interview on 3/8/11 at 3:00 PM, the CSS said there was no specific P&amp;P to address the failure of the treatment to achieve the patient's prescribed dry weight. It depends on the doctor's order and the nurse's clinical judgement to call the doctor if the weight after dialysis was more than 1 kg. so the doctor could order extra treatment to remove extra fluids or adjust the dry weight.</p> <p>On 3/8/11, a review of the facility's Pre/Post Dialysis Treatment Data Collection dated December 2006 indicated, "PURPOSE: To obtain information for planning the dialysis treatment and for reviewing the patient's response to the treatment.... 5. A registered nurse will complete the patient assessment pre dialysis. The assessment done by the registered nurse may include, but is not limited to: Cardiac status, Respiratory status and Peripheral edema (swelling of tissues usually in the lower limbs due to the accumulation of fluids). 6. Findings that may preclude the discharge of the patient will be reported to the licensed nurse immediately. 7. The licensed nurse notifies the physician as needed of changes in patient status.</p> <p>In an interview on 3/8/10 at 3:40 PM, the Administrator said she became aware that RN 1 was not doing the pre and post assessment of the patients on November 2010 when she</p>	V 504			

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V 504	Continued From page 30 observed that RN 1 was not using his stethoscope. She said that when she asked RN 1 why he was not using his stethoscope, he said, "I only use it when the patient has shortness of breath."  The facility's failure to monitor the patients' condition pre and post hemodialysis treatment and it's failure to resolve the problem that the facility had identified since November 2010, may have contributed to Patient 5 being hospitalized twice for exacerbation of congestive heart failure and respiratory fluid overload. The facility allowed RN 1 to continue to work by himself without back up help and he was still responsible for the assessment of the all patients the morning after the facility became aware of the problem on 3/8/11. IJ (immediate jeopardy) was called on 3/9/11 at 11AM in the presence of the Administrator, and the Clinical Services Specialist.  The facility submitted an acceptable plan of correction. RN 1 was suspended and will be assigned in another facility where he will not be working alone. RN 1 will go through a full retraining and orientation schedule before starting in another facility. All treatment sheets will be reviewed daily for compliance to prescription and assessments for one month. If compliance is found, one shift a day will be reviewed for two weeks. If compliance is found, one complete day weekly for two weeks. if compliance is found, two days per month will be reviewed going forward. IJ was lifted on 3/9/11 at 2:47 PM in the presence of the Administrator, Regional Director, and the Clinical Services Specialist.	V 504			
V 625	494.110 CFC-QAPI	V 625			

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V 625	Continued From page 31  This CONDITION is not met as evidenced by: Based on observation of care delivery, interview with staff, and record review, the facility failed to comply with the Condition for Coverage for Patient Assessment as evidenced by:  1. Failure to ensure the Quality Assurance (QA) program included the process of identifying problems of non-adherence to policy and procedure for pre and post assessment, create action plan when the problem was identified and evaluate the action plan if it was effective. This failure resulted in six of 8 patients (Patients 2, 4, 5, 6 , 7 & 8) not being assessed by the Registered Nurse before and after hemodialysis treatment. Three patients (Patients 4, 5 & 7) they went home after treatment with more than 1 kg. over their dry weight, putting these patients at risk of fluid overload. Patient 5 was admitted to the hospital twice for exacerbation of congestive heart failure and respiratory distress due to fluid overload. (V634)  2. Failure to ensure an immediate corrective action was implemented when the non-adherence to pre and post assessment policy and procedure was identified on November 2010. The problem continued without corrective actions which resulted in 4 patients (Patient 2, 4, 5 & 7) put at risks of fluid overload when they went home after treatment with more than 1 kg. over their dry weight and one patient (Patient 2) admitted to the hospital with exacerbation of CHF and respiratory distress due to fluid overload. Failure to immediately correct the problem of	V 625			

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V 625	Continued From page 32 non-adherence to P&P resulted to potential risks to 4 patients and one harm of a patient due to fluid overload and potentially threatened the health and safety of all patients in the facility. (V 640)	V 625			
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS  The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification.  This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the Quality Assurance (QA) program included the process of identifying problems of non-adherence to policy and procedure for pre and post assessment, create action plan when the problem was identified and evaluate the action plan if it was effective. This failure resulted in six of 8 patients observed (Patients 2, 4, 5, 6, 7 & 8) not being assessed by the Registered Nurse before and after hemodialysis treatment. Three patients (Patients 4, 5 & 7) went home after treatment with more than 1 kg. over their dry weight, putting these patients at risk of fluid overload. Patient 5 was admitted to the hospital twice for exacerbation of congestive heart failure and respiratory distress due to fluid overload. Cross reference V 504.  Fluid removal is usually achieved by ultrafiltration to achieve a clinically derived value for "dry weight." The majority of HD treatments incorporate a prescription for fluid removal	V 634			

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V 634	<p>Continued From page 33</p> <p>targeted to a patient's "dry weight." In most centers, dry weight is clinically determined and usually reflects the lowest weight a patient can tolerate without intradialytic symptoms and hypotension in the absence of overt fluid overload. [Journal of American Society of Nephrology (JASN) February 1, 1999. vol. 10 no. 2 392-403]</p> <p>Findings:</p> <p>In an interview on 3/8/11 at 3:40 PM, the Administrator said she became aware that RN 1 was not doing the pre and post assessments on November 2010. She said that she knew the problem when she asked RN 1 why he was not using his stethoscope and he replied, "I only used it when patient had shortness of breath". She said that after she identified the problem, she continued to monitor RN 1 and had verbal discussion with him about the importance of pre and post assessment but she did not notify the Medical Director nor talked about it in the QA meetings and Governing Body meetings.</p> <p>In a telephone interview on 3/10/10 at 1:20 PM, the Medical Director was told about the non-adherence of RN 1 with the pre and post assessment P&amp;P that resulted in adverse outcomes like patients going home more than 1 kg. over their prescribed dry weight putting them at risks of fluid overload and one patient hospitalized for respiratory distress due to fluid overload. He said that he was unaware of the problem even though he regularly visited the clinic to see his patients and regularly attended the QA and Governing Body meetings. He said that he became aware of the problem on 3/9/11</p>	V 634			

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V 634	Continued From page 34 when the Administrator informed him that RN 1 was not doing the pre and post assessment, and that RN 1 was inaccurately entering data in the computer. He added that an open communication regarding issues of staff's non-compliance was one of his expectations from the facility staff so the problems could be resolved. He acknowledged that as a Medical Director he was responsible in ensuring that all staff adhered to the facility's policy and procedure.  In an interview on 3/10/11 at 1:30 PM, the Administrator said the QA program included Adverse Occurrence Reporting which covered the "non-adherence to the policy and procedure". She said that the problem of RN 1 not adhering to the pre and post assessment P&P was identified by her when she worked on the treatment floor with RN 1. She added that she did not talk about it during the QA meetings when the Medical Director and other members of the inter-disciplinary team were present. So, the QA process which included identification of the problem, root-cause analysis and plan of action was not done.	V 634			
V 640	494.110(c) QAPI-QAPI-IMMEDIATELY CORRECT ANY IJ ISSUES  The facility must immediately correct any identified problems that threaten the health and safety of patients.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an immediate corrective action was implemented when the non-adherence to pre and post assessment policy and procedure was identified on November	V 640			

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V 640	<p>Continued From page 35</p> <p>2010. The problem continued without corrective actions, which resulted in three patients (Patient 4, 5 &amp; 7) being put at risk of fluid overload. These patients went home after treatment with more than 1 kg. over their prescribed dry weight. Patient 5 was admitted to the hospital twice with respiratory distress due to fluid overload and exacerbation of CHF.</p> <p>Findings:</p> <p>In an observation on 3/7/11 at 2:45 PM, there were 6 of 8 patients who did not have pre-assessments done before initiation of treatment as indicated in the computer record. (Cross reference V 504).</p> <p>In an interview on 3/7/11 at 2:50 PM, RN 1 said he was not able to do the pre-assessment of the six patients. He said he initiated treatment for patients who had Central Venous Catheter (CVC) because the patients would be late on their scheduled treatment. He said that pre assessments were not done because he did not have enough time.</p> <p>In an interview on 3/8/10 at 3:40 PM, the Administrator said she became aware that RN 1 was not doing the pre and post assessment of the patients on November 2010 when she observed that RN 1 was not using his stethoscope. She said that when she asked RN 1 why he was not using his stethoscope, he said, "I only use it when the patient has shortness of breath."</p> <p>Review of RN 1's personnel file on 3/8/11 indicated he had two written verbal warnings and</p>	V 640			

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V 640	<p>Continued From page 36</p> <p>discussion with the Administrator regarding the non-adherence to pre and post assessment P&amp;P. The written 11/8/10 Verbal Warning Discussion Notes indicated, "Specific Incident - Audited chairside snappy (electronic record): @ 10:00 am noted 4 pts. (patients) with pre-assessment not done before pts. are put on dialysis treatment. Specific Action Plan - Discussed with RN 1 the violation of the policy, pre-assessment of cardiac, respiratory and edema before pts. start dialysis treatment is crucial as the obtained pts. information is a function of a licensed nurse and assessment is needed in planning the dialysis treatment and for reviewing the patient's response to the treatment. Consequences for not meeting the action plan- Immediate and sustained improvement must be exhibited in the areas noted above. Failure to do so may result in additional disciplinary action, up to and including termination of employment." The 1/10/11 Verbal Warning and Discussion Notes indicated, "Specific Incident - Verbal discussion with RN 1 regarding issues with compliance to policy Pre and post assessment data collection. Specific Action Plan - Follow-up on previous verbal counseling discussion regarding data collection. Teammmate Comments - RN 1 has reported that all assessment are done in a timely manner with no problems." Further review of RN 1's personnel file showed no further follow-up on the identified problem of non-adherence to pre and post assessment P&amp;P.</p> <p>Review of the November 2010 to February 2011 QA meeting and Governing Body meeting minutes did not indicate that the identified problem of failure to do pre and post assessment by RN 1 which threatened the health and safety</p>	V 640			

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V 640	<p>Continued From page 37</p> <p>of the patients was discussed and brought to the attention of the inter-disciplinary team. There was no monitoring done to ensure RN 1's continued compliance with the pre and post assessment P&amp;P after his verbal and written warnings. There was no root-cause analysis as to why the problem existed and continued to be a problem. There was no action plan in place to protect the patients from harm of RN 1's failure to conduct an accurate pre-assessment in order to plan the patients hemodialysis treatment and post assessment to determine the efficacy of the hemodialysis treatment before the patients were discharged to their homes.</p> <p>On 3/8/11 at 3:40 PM, a meeting with the Administrator was conducted to discuss the following issues: RN 1 did not conduct accurate pre and post assessments, RN 1 entered incorrect data and times of pre and post assessments in the computer system, and potential patients' outcomes. The Administrator acknowledged the problem continued to exist but she did not implement a corrective action.</p> <p>Review of the staff schedule for February to March 2011 indicated the facility was open three days a week, Monday, Wednesday and Friday starting at 6 AM and ending at 5:30 PM. RN 1 was scheduled to work Monday and Friday by himself and on Wednesdays, with another RN for eight hours of the day.</p> <p>Observation on 3/9/11 found RN 1 was by himself during the first shift and another RN came in later for the second and third shifts.</p> <p>On 3/9/11, RN 1 continued to be responsible for</p>	V 640			

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V 640	Continued From page 38 performing the full duties of a licensed nurse, including pre-assessment, even though the problem of his non-adherence to the pre and post assessment P&P had been identified. This practice continued to threaten the health and safety of the patients receiving dialysis.	V 640			
V 684	494.140(b)(1) PQ-NURSE MANAGER-12 MO RN+6 MO DIALYSIS  (1) Nurse manager. The facility must have a nurse manager responsible for nursing services in the facility who must- (i) Be a full time employee of the facility; (ii) Be a registered nurse; and (iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate nursing services when RN 1 was the only RN assigned with no back up help, to perform duties of an RN to conduct pre and post assessments of the patients. This affected 6 of 8 observed patients. (Patients 5, 4, 7, 6, 8, and 2). Failure to provide adequate nursing services could potentially affect the health and safety of the patients being treated in the facility.  Findings:  During observation on 3/7/11 at different times, RN 1 did not perform pre and post dialysis treatment assessments on Patient 5, 4, 7, 6, 8, and 2. Cross reference V 504.	V 684			

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V 684	<p>Continued From page 39</p> <p>In an interview on 3/7/11 at 2:50 PM, RN 1 said he was not able to do the preassessment of the 6 patients. He said he initiated treatment for patients who had Central Venous Catheter (CVC) because the patients would be late on their scheduled treatment. He said that preassessments were not done because he did not have enough time.</p> <p>During observation on 3/7/11 at 1:30 PM, there were two patients coming off dialysis and two patients were starting dialysis treatment. This only allowed RN 1 a 3.7 minutes assessment time for each patient. At 1:45 PM, RN 1 had three patients starting dialysis and two coming off dialysis, which gave him three minutes for each patient assessment. At 2 PM, there were two patients being taken off and two patients starting.</p> <p>On 3/8/11, a review of the facility's Pre/Post Dialysis Treatment Data Collection dated December 2006 indicated, "PURPOSE: To obtain information for planning the dialysis treatment and for reviewing the patient's response to the treatment.... 5. A registered nurse will complete the patient assessment pre dialysis. The assessment done by the registered nurse may include, but is not limited to: Cardiac status, Respiratory status and Peripheral edema (swelling of tissues usually in the lower limbs due to the accumulation of fluids). 6. Findings that may preclude the discharge of the patient will be reported to the licensed nurse immediately. 7. The licensed nurse notifies the physician as needed of changes in patient status.</p> <p>In an interview on 3/8/10 at 3:40 PM, the Administrator said she became aware that RN 1</p>	V 684			

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V 684	<p>Continued From page 40</p> <p>was not doing the pre and post assessment of the patients on November 2010 when she observed that RN 1 was not using his stethoscope. She said that when she asked RN 1 why he was not using his stethoscope, he said, "I only use it when the patient has shortness of breath."</p> <p>Review of RN1's employee file indicated that on 11/8/10, his violation of the facility's policy on Pre and Post Dialysis Assessment Treatment Data Collection was discussed with him and a copy of the policy was given to him. A follow up discussion was conducted on 1/10/11 where in RN 1 "has reported that all assessments are done in timely manner with no problems". There was no further documentation to show that this was monitored and addressed.</p> <p>In an interview with the CSS and the Administrator on 3/8/11 at 11:30 AM, the CSS (Clinical Services Specialist) stated that nurses at other facilities had more patients and they were able to handle this. The Administrator said she was able to help with patient assessments as needed, but did not routinely assess patients. She further said, she was available to assist RN 1 if he requested help and he should know to request help if he needed it.</p> <p>The facility did not identify and consider RN 1's strengths and weaknesses and/or other factors that may have caused or contributed to RN 1's inability to perform the assessments. For example, RN 1's ability to organize and manage his time, and his ability to complete the pre and post assessment within a given time.</p>	V 684			

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V 684	Continued From page 41 There was no documented evidence to show that monitoring of the activities in the facility was done, to ensure patients were assessed and/or to identify that the same problem continued to exist and to implement corrective actions. The facility allowed RN 1 to continue to work by himself without back up help.	V 684			
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE  The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.  This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure accurate patient Post Treatment Records, when assessment documentation times noted by the RN did not match the actual times of computer data entry records for 2 of 5 sampled patients (Patients 5 and 2).  Findings;  1. During observation on 3/7/11 at 1:40 PM, Patient 5 was in Station 15 receiving hemodialysis treatment. The computer indicated the hemodialysis treatment was started at 12:50 PM with no entry for pre assessment.  On 3/8/11, review of the Patient 5's 3/7/11 Post Treatment Record indicated RN 1 noted both the pre and post assessment were done at 1 PM.	V 726			

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V 726	<p>Continued From page 42</p> <p>Patient 5's hemodialysis treatment began at 12:50 PM and ended at 3:50 PM.</p> <p>Review of the 3/7/11 computer printout that recorded the actual time assessment entries were made in the Post Treatment Record, indicated RN 1 inputted Patient 5's pre assessment note on 3/7/11 at 4:36 PM (three hours and 46 minutes after the dialysis treatment was begun), and inputted the post assessment note at 4:37 PM, one minute later.</p> <p>2. During observation on 3/7/11 at 2:45 PM, Patient 2 was in Station 14 receiving hemodialysis treatment. The computer screen showed he started hemodialysis treatment at 2:00 PM. The computer screen did not show an entry that a pre assessment was done by RN 1.</p> <p>Record review on 3/8/11 of Patient 2's Post Treatment Record dated 3/7/11 indicated RN 1 noted a pre assessment at 2:10 PM and a post assessment at 5:45 PM. The patient's treatment began at 1:59 PM and ended 5:26 PM. Review of the computer print out that recorded the actual times data entries were inputted on 3/7/11 indicated RN 1 inputted the pre assessment at 4:56 PM and the post assessment at 6:18 PM.</p> <p>Record review on 3/8/11 of Patient 2's Post Treatment Record dated 2/25/11 indicated RN 1 noted Patient 2's pre assessment at 1:10 PM and his post assessment at 1:25 PM. Patient 2's treatment began at 1 PM and ended at 4:16 PM. Review of the computer print out that recorded actual data input times indicated RN 1 entered the pre assessment data at 1:18 PM, 18 minutes</p>	V 726			

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V 726	Continued From page 43	V 726			
V 757	<p>after the treatment was begun, and the post assessment data at 4:40 PM.</p> <p>494.180(b)(1) GOV-STAFF # &amp; RATIO MEET PT NEEDS</p> <p>The governing body or designated person responsible must ensure that-</p> <p>(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients;</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an adequate number of qualified and trained staff was present during hemodialysis treatment to perform pre and post treatment assessment for 6 of 8 patients observed during treatment. (Patient 5, 6, 4, 8, 7 and 2). Patients 4, 5, and 7 went home with more than 1 kg. over their prescribed dry weight putting them at risk of fluid overload and other complications, like CHF(congestive heart failure). Patient 5 was hospitalized twice for respiratory distress due to fluid overload and exacerbation of CHF.</p> <p>Findings</p> <p>In an observation on 3/7/11 at 2:45 PM, there were 6 of 8 patients who did not have pre-assessments done before initiation of treatment as indicated in the computer record. (Cross reference V 504).</p> <p>In an interview on 3/7/11 at 2:50 PM, RN 1 said</p>	V 757			

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V 757	<p>Continued From page 44</p> <p>he was not able to do the pre-assessment because he initiated the treatment of catheter patients first. He said that if he would not do that, the patients will be late on their scheduled treatment. He said that it was hard for him to take care of 25 patients on his own to do the pre and post assessments, give medications, put on and take off patients with catheter and all other work he was required to do as the Charge Nurse. He acknowledged that he was overwhelmed, especially during turn-over of second and third shift when second shift patients were taken off and third shift patients were put on. He said that the Administrator was aware of the problem.</p> <p>In an interview on 3/8/11 at 2:45 PM, the Administrator said she was aware of the problem that RN 1 was not adhering to the pre and post assessment P&amp;P. She said that she had written warnings for RN 1 and reoriented him with the P&amp;P. She said that RN 1 told him that he was not given enough orientation when he was hired in February 2010. She added that when she heard from RN 1 that he did not get enough orientation, she called the administrator in the facility where RN 1 was oriented. She said that the administrator told her RN 1 received all the orientation he needed but he remained non-compliant with the pre and post assessment P&amp;P.</p> <p>In a concurrent interview, CSS said the problem with the nurse's non-adherence to the P&amp;P was not related to how many patients in the clinic. She said that the nurse should know how to prioritize his jobs and use his clinical judgment during patient treatment. Both the Administrator and the CSS acknowledged that RN 1 was not able to</p>	V 757			

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V 757	Continued From page 45 meet the fluid management needs of the patients because he did not adhere to the pre and post assessment P&P. She added that other clinics had more than 25 patients but did not have the same problem that he had.	V 757			