

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: 552667	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/03/2011
NAME OF PROVIDER OR SUPPLIER HUNTINGTON PARK DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 5942 RUGBY AVENUE HUNTINGTON PARK, CA 90255		
(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 Department of Public Health during Initial Certification survey. Representing the Department of Public Health: Sylvia Villaflores, REHS, HFE I Belinda Rarela, RN, Sr. HFEN	V 000			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to clean and disinfect the patient's treatment chair in accordance with their Infection Control for Dialysis Facilities policy and procedure. Findings: On January 3, 2011 at 11:35 a.m., Patient 1 was observed sitting in the dialysis treatment chair with Staff B by the chair side. Patient 1 had a glove on one hand and applying pressure over one access site. Staff B, who was wearing personal protective equipment (PPE) including a face shield, gown and gloves, had one gloved	V 122		1/3/11	

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 122	<p>Continued From page 1</p> <p>hand and applying pressure over one access site. The blood was observed oozing from the access site. Staff B changed the gauze, applied pressure over the site, then cleaned the patient's left upper arm.</p> <p>At 11:55 a.m., the patient left and Staff B discarded the soiled blue Chux and protective chair covering. There was visible blood spill on the arm rest/chair table and the patient side of the chair. Staff B wiped the arm rest/chair table and the side of the chair, discarded the wipe, and then proceeded to clean the rest of the equipment.</p> <p>During a concurrent interview on January 3, 2011 at 11:55 a.m., Staff B (Patient Care Technician) stated she used the wipe with 1:100 bleach solution to clean the patient chair.</p> <p>At 12:10 p.m., two plastic containers with 1:100 bleach solution were observed by the clean sink in the treatment area.</p> <p>A review of the facility policy and procedure titled, Infection Control for Dialysis Facilities dated as last revised in September 2010, indicated, "For gross blood spills, a 1:10 bleach solution must be utilized. After all visible blood is cleaned with the 1:10 bleach solution, teammates are to use a new disposable towel soaked with 1:10 bleach solution and clean the area a second time.</p> <p>On January 3, 2011 at 3:10 p.m., Staff A (RN) and Staff C (Clinical Services Specialist) were interviewed. Staff A stated they did not mix the 1:10 bleach solution. Staff C stated the staff has to mix both concentrations daily.</p>	V 122			
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL	V 715		1/24/11	

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V 715	<p>Continued From page 2 ADHERE TO P&P</p> <p>The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that their policy and procedure on AV Fistula Graft Cannulation with Safety Fistula Needles and Administration of Heparin was implemented.</p> <p>Findings:</p> <p>On January 3, 2011 at 7:54 a.m., Patient 1 was observed seated on the treatment chair. A tourniquet was noted around the patient's left upper arm above the access sites. The fistula needles were clamped with blood in the tubing, syringes at the end of the tubing and blood specimen tube on the chair table. Staff B, who was wearing personal protective equipment (PPE), was facing the hemodialysis machine and priming the intravenous (IV) tubing with normal saline solution.</p> <p>At 7:57 a.m., the tourniquet was still around the patient's left upper arm while Staff B continued to prime the IV tubing.</p> <p>At 8 a.m., Staff B finished priming the tubing then faced the patient with hemodialysis blood line on</p>	V 715			

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V 715	<p>Continued From page 3</p> <p>hand. Staff B replaced the blood lines by the hemodialysis machine, turned back to the patient and removed the tourniquet, took the blood lines back then attached the blood lines to the fistula needles then initiated the hemodialysis treatment.</p> <p>During an interview on January 3, 2011 at 1:30 p.m., Staff B stated she forgot to remove the tourniquet after cannulation (insertion of the fistula needles).</p> <p>A review of the facility policy and procedure titled AV Fistula Graft Cannulation with Safety Fistula Needles and Administration of Heparin dated as last revised in September 2009 indicated, "Apply a clean tourniquet for cannulating AV fistula or graft...Remove tourniquet post cannulation (#14). Tourniquet should be left in place only for the short time required to distend the access for needle cannulation. Prolonged compression may lead to stenosis (abnormal narrowing) of the vessels (#21)."</p>	V 715			