

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: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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}	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a recertification revisit survey conducted 4/19/11 through 4/21/11.</p> <p>Representing the California Department of Public Health: Stella Tannehill, Health facilities Evaluator Nurse Andrea Kubovcik, Health Facilities Evaluator Nurse.</p> <p>The census on 4/19/11 was 181.</p> <p>Definitions of common dialysis terms used: PCT: Certified Hemodialysis Technician.</p> <p>RN: Registered Nurse.</p> <p>Arteriovenous fistula (AVF) is formed connecting the artery to the vein causing more blood to flow into the vein. As a result, the vein grows larger and stronger, making repeated needle insertions for hemodialysis treatments easier.</p> <p>AV graft (AVG) connects an artery to a vein using a synthetic tube, or graft, implanted under the skin The graft becomes an artificial vein that can be used repeatedly for needle placement and blood access during hemodialysis.</p> <p>Blood Flow Rate (BFR) is the rate at which blood flows through the dialyzer.</p> <p>Dialyzer - an artificial kidney usually composed of hollow fiber which is used in hemodialysis to eliminate waste products from the blood and remove excess fluids from the bloodstream.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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}	Continued From page 1 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. Clean sinks - are handwashing sinks dedicated only for handwashing purposes and should remain clean. Cross-contamination is the physical movement or transfer of harmful bacteria from one person, object or place to another. Dirty sinks - sinks designated for handling contaminated items like used saline bags. 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. Hemodialysis access - three basic kinds of vascular access for hemodialysis are AVF, AVG and a central venous catheter. Sharp Bins - container for used needles or any kinds of sharps. Stations - patient designated treatment area equipped with a chair and a table, a hemodialysis machine, tubings and other equipment.	{V 000}			
{V 111}	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.	{V 111}		5/15/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 111}	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the dialysis facility failed to provide and monitor a sanitary environment to minimize the transmission of infectious agents within the unit when patient property and medical equipment was stored on windowsills, and a hospital (contracted) environmental services staff emptied biohazard waste bags in the unit while patients were receiving dialysis treatment.</p> <p>Findings:</p> <p>1. On 4/19/11 at 11:40 a.m., during the initial tour of the Room 2 dialysis unit the following items were noted to be stored on the windowsill above Staion 20: an arm splint labeled with a patient's name, a PPE face shield labeled with a teammate's name, a styrofoam cup, one blue disposable glove, and a clear plastic box labeled "Emergency Suction Supplies" which contained a stethoscope and a length of plastic tubing.</p> <p>In a concurrent interview, RN 2-1 said that the PPE face shield should be hung with the rest of the staff PPE on a rack designated for that purpose. She removed the rest of the items from the windowsill and acknowledged they shouldn't have been stored there. She said that the arm splint was used for a patient who usually occupied that station.</p> <p>2. On 4/19/11 at 3:40 p.m. during another tour of the Room 2 unit, the belongings of the patient at Station 17 were observed stored in the windowsill above Station 18.</p> <p>In a concurrent interview, the licensed nurse who</p>	{V 111}			

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: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 111}	Continued From page 3 was taking care of the patient said that she would notify the family who was visiting with the patient at Station 17 that the belongings had to be removed from the windowsill. 3. On 4/21/11 at 11:30 a.m., the housekeeping staff was observed next to the nurses' station in Room 2 emptying red biohazard trash bags into a wheeled trolley. In a concurrent interview, the CSS told surveyors, "The trouble is, we're contracted with the hospital for environmental services. I'll talk to their supervisor and remind them again that their staff has to pick up the biohazard trash from the dirty utility room, not from the patient care area."	{V 111}			
{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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure two randomly observed staff used gloves when touching potentially contaminated hemodialysis equipment, and sanitized their hands before touching a computer keyboard that was used for more than one patient, when: *RN 1-1 failed to wear gloves when taking printed orders off the top of a dialysis machine that was in use with her bare hands and did not sanitize her hands before keying into the computer; and, *RN 1-2 removed a glove from her right hand	{V 113}		4/28/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 113}	<p>Continued From page 4</p> <p>after touching the dialysis machine screen and keyed into the computer keyboard without sanitizing her hands.</p> <p>These practices increase the risk of cross-contamination and the spread of infection from patient to patient.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During observation of treatment Room 1 on 4/19/11 at 12 noon, RN 1-1 picked up printed orders from the top of the Station 1 dialysis machine that was in use for a patient, and holding them in both hands began reading them. RN 1-1 then went to the computer keyboard that was used for both the patient in Station 1 and the patient in Station 2, and without sanitizing her hands, began keying on the keyboard. RN 1-1 still held the printed orders and one edge of them rested on the keyboard. CCHT 1-1 (certified hemodialysis technician) came to assist RN 1-1 on the keyboard. CCHT 1-1 quietly prompted RN 1-1 to wash her hands and she did. 2. During observation of treatment Room 1 on 4/19/11 at 12:25 PM, RN 1-2 wore gloves as she touched the screen of the dialysis machine that was in use at Station 11. RN 1-2 removed the glove of her right hand and without sanitizing her hand, keyed in a computer keyboard that was used for two patients. When the surveyor pointed this out to RN 1-2, she removed the other glove and sanitized her hands. 3. During observation of treatment Room 1 on 4/19/11 at 12:30 PM, RN 1-1 took printed orders off the dialysis machine that was in use at Station 	{V 113}			

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: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 113}	Continued From page 5 12 with bare hands. Without sanitizing her hands, RN 1-1 held the orders close to the computer keyboard that was used for two patients, and keyed on the keyboard. When the surveyor pointed this out to RN 1-1, she stopped keying on the keyboard. During concurrent interview, PCT 1-1 verified that the dialysis machine was considered dirty while in use, and that the computer keyboard was considered clean. Two other facility staff who were present agreed with PCT 1-1, Review of the facility's policy and procedure, Infection Control for Dialysis Facilities, indicated on page one, "1. Hand hygiene is to be performed ...after removal of gloves ...after patient and dialysis delivery system contact ...before touching clean areas..."	{V 113}			
{V 117}	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.	{V 117}		4/28/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 117}	<p>Continued From page 6</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the dialysis facility failed to ensure separation of clean and dirty areas to prevent cross contamination when the dirty utility rooms for both Room 1 and Room 2 stored clean, unused sharps containers (used in the patient care stations) on the counters next to the dirty sinks.</p> <p>Findings:</p> <p>1. Observation of the dirty utility room adjacent to treatment Room 1, while accompanied by RN 1-3 on 1/19/11 at 12:55 PM, found three unused, red sharps bins stacked inside one another on the counter next to the dirty sink. Next to them on the counter were stacked the bin lids.</p> <p>During concurrent interview with RN 1-3, she said the bins were stored there for use in the patient treatment stations when needed.</p> <p>During interview with the Clinical Services Specialist (CSS) on 4/20/11 at 10:20 AM, she said she had told staff in the past to remove the clean sharps bins from the dirty utility room but the bins kept showing up in there.</p> <p>2. On 4/20/11 at 1:45 p.m. during an inspection of the dirty utility room in Room 2 with a PCT (Patient Care Technician), six clean, new red</p>	{V 117}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 117}	Continued From page 7 plastic sharps containers were stored on the counter next to the dirty sink. When the surveyor pointed out to her that clean items for future use in patient care areas should not be stored in a dirty utility room the PCT said, "I don't know where we will keep them if not here."	{V 117}			
{V 407}	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the safety of random patients at 2 of 15 Stations in treatment Room 1 (Station 5 and Station 9), when dialysis access sites were covered and not in full view of staff. This failure placed patients at risk of undetected needle dislodgement or line disconnection going undetected, posing a risk for extensive blood loss due to bleeding. Findings: During the initial tour observation of treatment Room 1 on 4/19/11 at 11:40 AM the following was found: 1. A patient receiving dialysis treatment at Station 5 was fully covered on her chest area with no visible access site. When brought to the attention of staff, they uncovered a left chest catheter access site. 2. A patient receiving dialysis at Station 9 had no visible access site. When brought to the attention	{V 407}		4/28/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 407}	Continued From page 8 of staff, they uncovered a right arm AV fistula.	{V 407}			
{V 503}	<p>During concurrent interview, the staff person who uncovered the access sites said that the patient covered the access site when she got cold.</p> <p>494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX</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 observation, interview, and record review, the facility failed to implement the physician's dialysis prescription for 2 of 5 sampled patients (Patients 2, and 1), when the administered blood flow rate (BFR) was not in accordance with the physician's orders. In addition, for Patient 2, the facility continuously failed to achieve the dry weight indicated by the physician's prescription for 16 treatments, did not assess the reason, and did not notify the physician.</p> <p>The BFR affects the rate of water and waste removal from the blood. Weight is one of the components of the dialysis prescription and should be assessed post treatment to ensure the physician's ordered target weight is achieved.</p> <p>Findings:</p> <p>1. Record review of Patient 2's physician's</p>	{V 503}		4/28/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 503}	<p>Continued From page 9</p> <p>dialysis prescription dated 4/19/11 indicated BFR 300, and a target dry weight of 48 kilograms (Kg). Patient 2 had a left jugular central venous catheter access for dialysis.</p> <p>Observation of Patient 2 while she received dialysis on 4/19/11 at 12:15 PM, found the dialysis machine set at BFR 350.</p> <p>During concurrent interview on 4/19/11 at 12:15 PM, PCT 1-1 (Patient Care Technician) said sometimes they got a good blood flow so they increased the BFR to 350 and inform the physician after a couple of weeks and the physician would change the order.</p> <p>Record review on 4/20/11 of Patient 2's sixteen Post Treatment Records from 3/15 through 4/19/11 found that the BFR was maintained at 350 throughout the treatment on five occasions (3/17, 3/24, 4/7, 4/9 and 4/19/11) with no physician's order to do so.</p> <p>Record review of Patient 2's sixteen Post Treatment Records from 3/15 through 4/19/11, indicated her post treatment weights remained above the physician's prescribed dry weight of 48 Kg, and ranged between 50.3 and 53.3 kg. Patient 2's post weight was at least two Kg above 48 Kg five times (on 3/17, 3/24, 3/26, 3/29, and 3/31/11). Patient 2's post treatment weight was at least three Kg above 48 Kg five times (on 3/15, 3/19, 3/22, 4/7, and 4/14/11). Four times her weight was at least four Kg above 48 Kg (on 4/2, 4/5, 4/12, and 4/19), and was at least five Kg above 48 Kg on two occasions (4/9 and 4/16/11). None of the Post Treatment Records indicated the Registered Nurse (RN) had evaluated the</p>	{V 503}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 503}	<p>Continued From page 10</p> <p>reason Patient 2's target dry weight was not achieved; nor was there an indication the physician was notified or requested to re-evaluate Patient 2's target dry weight.</p> <p>Record review of the physician's progress notes for March and April, 2011 indicated he wrote, "reevaluate long term goals" on 3/22/11. On 3/31/11, the physician noted, "Demented. Stable tx (treatment)." The physician's note dated 4/5/11 read, "Seen on HD (hemodialysis). Asleep - no complaints." And on 4/14/11, the physician wrote, "Severe multiinfarct dementia. APL synd (antiphospholipid antibody syndrome). Cuffed catheter. Alternately sleeps + cries out for no reason." There was no indication in the record the physician was evaluating the post weights achieved for Patient 2, or was aware she was not meeting the prescribed target dry weight. There was no indication he re-evaluated the prescribed dry weight target for appropriateness.</p> <p>During interview with the CSS on 4/20/11 at 1:55 PM, she said when there was a trend of three treatments or more where the dry weight was not being achieved, the PCT should notify the RN and the RN should notify the physician. The CSS checked the record but could not find documentation that addressed Patient 2's post treatment weights being consistently above the prescribed dry weight.</p> <p>4. On 4/19 at 11:30 a.m., during the initial tour of Room 2, Patient 1's blood flow rate as noted on the screen of the dialysis machine was 350 ml/minute (milliliters). A concurrent review of her treatment sheet indicated that the physician's order for the treatment was 400 ml/min. When the surveyor alerted the PCT 2-1, she was</p>	{V 503}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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 503}	<p>Continued From page 11</p> <p>surprised at the discrepancy and adjusted the flow rate.</p> <p>A further review of the medical record revealed that the blood flow rate was 50 ml/min less than the prescribed rate for the treatments that Patient 1 had on 3/22/11 and on 4/12/11 too. There were no nursing notes to explain why the prescription had not been followed for these treatment days. A review of the dialysis facility policy "Prescription Verification and Safety Checks" indicated the following:</p> <p>4. "Verify on patient electronic record the following prior to every dialysis treatment.</p> <p>Prescribed:</p> <p>Dialyzer Dialysate Dry weight Blood flow and dialysate flow Length of treatment Heparinization (systemic loading dose and intradialytic infusion) Sodium modeling Specific orders for individual patient (labs, meds, etc.)</p> <p>During an interview on 4/20/11 at 2:50 p.m. the Clinical Services Specialist (CSS) was notified about the staff's failure to follow prescription blood flow rates for Patient 1's 3 treatments. She said, "What should have happened is that the PCT should have notified the RN, who would then notify the doctor about the inability to achieve the prescribed blood flow rate. It affects the KT/V (a measure of the efficacy of the dialysis treatment) so it is a big deal. What this tells me is that they didn't check the treatment information before the treatment, as outlined in our policy."</p>	{V 503}			

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: 052307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/21/2011
NAME OF PROVIDER OR SUPPLIER PACIFIC DIALYSIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2351 CLAY STREET, 4TH 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