STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	552660	A. BUILDING ______ B. WING ______	02/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASADENA FOOTHILLS DIALYSIS	3722 EAST COLORADO BOULEVARD PASADENA, CA 91107

(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 CAPD Certification survey. Representing the Department of Public Health: Rosalinda Ramos, RN, HFEN Sylvia Villaflores, REHS, HFE CAPD - continuous ambulatory peritoneal dialysis.	V 000		
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to provide a safe environment by maintaining the Peritoneal Dialysis (PD) Training room locked when not in use. Findings: On February 11, 2011, at approximately 7:15 a.m., the PD training room door was found unlocked. At that time there was visitor in the waiting area. At approximately 7:30 a.m., together with the Registered Nurse (RN) and Administrative Staff,	V 401		

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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PASADENA FOOTHILLS DIALYSIS	**3722 EAST COLORADO BOULEVARD PASADENA, CA 91107**

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V 401	Continued From page 1 a tour of the PD room was conducted. The PD room door was unlocked and a patient was at the waiting area. Inside the PD room was a plastic tray that contained a bunch of keys on top of the desk. The keys opened the overhead cabinets that contained medications (Gentamicin, Heparin, Alcavis, ExSept, etc), supplies (needles, Tempa Dots, suture removal set, etc) and equipment (Glucometer, Lancing device). During a concurrent interview with the RN on February 11, 2011 at 7:30 a.m., she stated the PD training room should be locked when not in use.	V 401		
V 587	494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record. This STANDARD is not met as evidenced by: Based on record review and interview, the facility staff failed to review Patient 1's self-monitoring data to determine if the patient is following physician treatment orders, completing the Daily Home Dialysis Record to include medication administered, exchanges and drainage characteristics and plan on how to correct the concerns identified. Findings: On February 11, 2011, at 10 a.m., a review of the	V 587		

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PASADENA FOOTHILLS DIALYSIS	3722 EAST COLORADO BOULEVARD PASADENA, CA 91107

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V 587		V 587		

Continued From page 2

clinical record revealed Patient 1 started CAPD (continuous ambulatory peritoneal dialysis) training on January 10, 2011. The Patient Training Checklist indicated the patient completed training on January 21, 2011. Further review of the record indicated that a home visit was conducted on the same day by the PD Registered Nurse and found that Patient 1 had appropriate area to perform exchanges safely and keep the PD supplies.

The physician orders were reviewed on February 11, 2010. The physician order dated January 22, 2011, indicated four (4) fills a day, seven (7) days a week. The volume was 2500 ml, Calcium of 2.50, Magnesium of 0.5, Dextrose varied and the dwell time was four (4) hours. There was also an order of Epogen 5000 units subcutaneously every week. On January 21 through 28, 2011, the physician ordered Vancomycin 1000 mg intraperitoneal.

A review of The Daily Home CAPD Dialysis Record dated January 21 through February 7, 2011, revealed the following:

1. The patient's name was not written or printed on the submitted record and the first page had a name other than the patient.

2. There was no documentation the medication Epogen was administered consistently.

3. The daily documentation of the exchanges revealed the following:

Date	Times
1/21/11	once
1/22/11	2x

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V 587	Continued From page 3	V 587		

Date	
1/23/11	3x
1/24/11	3x
1/25/11	2x
1/27/11	3x
1/28/11	2x
1/30/11	2x
1/31/11	2x
2/01/11	2x
2/02/11	once
2/04/11	missing
2/05/11	missing
2/07/11	3x

4. There was a documentation of medication added on February 1 and 3, 2011, however, the name and amount was not noted.

5. The section under drainage characteristic (clear or cloudy) was not checked.

6. The section under temperature was blank and the section under blood sugar was not consistently filled out.

7. The record was signed and reviewed on February 8, 2011.

During an interview on February 11, 2011 at 11 a.m., the PD Nurse was unable to show written documentation the above concerns were address with patient during his clinic visit.