

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: 052773	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/16/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER SOUTH DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 14014 MAGNOLIA ST WESTMINSTER, CA 92683		
(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 FOLLOW-UP RECERTIFICATION survey.</p> <p>The surveyors entered the facility on 2/15/11 at 0800 hours. The census at the time of the survey was 96 in-center hemodialysis patients. The patient sample consisted of 14 patients.</p> <p>The Acting Facility Administrator was the facility coordinator for the survey.</p> <p>Representing the Department of Public Health: 22781, HFEN and 21177, HFEN.</p> <p>GLOSSARY</p> <p>AAMI - Association for the Advancement of Medical Instrumentation AP - Arterial Pressure BP - Blood Pressure BFR - Blood Flow Rate CHT - Certified Hemodialysis Technician CSS - Clinical Services Specialist DFR - Dialysate Flow Rate EDW - Estimated Dry Weight FA - Facility Administrator IV - Intravenous Kg - Kilogram (equal to 2.2 pounds) mL - milliliters PPE - Personal Protective Equipment P&P - Policy and Procedure RN - Registered Nurse TV - Television</p>	{V 000}			
{V 113}	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE	{V 113}			

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 113}	<p>Continued From page 1</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure gloves were worn by staff members or hand washing done when direct patient contact was made, gloves were changed between tasks and patients, and hands were washed per policy to prevent the possible transmission of infections.</p> <p>Findings:</p> <p>This standard was previously cited in the survey completed October 2010. The facility's Plan of Correction for this standard showed an in-service would be done for the teammates on the infection control policy. Patients and their visitors were also to be educated on the appropriate use of PPE. The facility's schedule showed there were approximately 14 direct care staff and six alternate direct care staff. Review of the In-service Log: "One-on-One" In-service, dated 10/15 to 11/10/10, which included the policy on infection control, and showed only 11 of the 20 direct care staff had received the in-service. There was no documentation provided to show the in-service had produced the intended result. CHT 2 had not received the in-service on infection control.</p> <p>The facility's Plan of Correction for the October 2010 survey, also showed an audit tool had been</p>	{V 113}			

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{V 113}	<p>Continued From page 2</p> <p>developed. The Charge RN or FA was to monitor the staff a minimum of 3 shifts per week to ensure correct infection control procedures were followed. An infection control audit sheet could not be provided. The results of the infection control audits were to be reported in the quality meetings. Review of the quality meetings showed no documentation the audits had been presented or discussed.</p> <p>Review of the Facility Policy 1-05-01 for Infection Control for Dialysis Facilities, last revised 9/10, showed hand hygiene was to be performed upon entering the facility, prior to putting on gloves, after removal of gloves, after contamination with blood or other infectious material. Also, after patient and dialysis delivery system contact, between patients, even if the contact was casual, before touching clean areas such as supplies, and before leaving the patient care area. It also showed gloves should be provided to patients, and gloves and gowns to visitors, if these individuals assisted with procedures such as inserting their own dialysis needles or holding access sites. Patients were encouraged to wash their hands after treatment, before leaving the treatment area. Only teammates with clean hands were to remove items from the supply cart. Gloves were to be removed and hands cleaned before and after touching the computer keyboard. This P&P was not implemented as follows:</p> <p>1. On 2/15/11 at 0817 hours, Patient 8 was observed holding her dialysis needle sites, to assist with clotting of the sites. The patient was not wearing a glove on the hand used to the sites. The patient was observed leaving the treatment area without washing her hands.</p>	{V 113}			

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{V 113}	Continued From page 3 2a. At 0930 hours on 2/15/11, CHT 2 was observed wearing gloves and assisting Patient 2 into his dialysis chair. After the patient was settled in the chair, CHT 2 went to the clean supply cart and got gauze pads and fistula needles which he placed on the patient's dialysis chair table. CHT 2 returned to the clean supply cart and got Patient 2's heparin syringe and placed it on the patient's dialysis chair table. CHT 2 returned to the clean supply cart and picked up another heparin syringe which he took to another patient station and placed it on the side table of the dialysis chair at that station. CHT 2 returned to Patient 2's dialysis station and removed the contaminated gloves he had been wearing during this observation. After removing the gloves, CHT 2 began using the computer keyboard beside Patient 2's chair. After using the keyboard, CHT 2 put on clean gloves. He had not cleaned his hands after removing the previous pair of gloves or before putting on the clean gloves. CHT 2 put the blood pressure cuff on Patient 2's arm, touched the dialysis machine screen to activate the blood pressure cuff, and went to the clean supply cart wearing the contaminated gloves. He got a paper thermometer, took it to the patient's dialysis station and returned to the clean supply cart for a roll of tape wearing the same contaminated gloves. CHT 2 removed the dressings covering Patient 2's needle sites from the previous treatment and removed his gloves. Without cleaning his hands, CHT 2 went to the clean supply cart and got more supplies, and put on a clean pair of gloves after returning to the	{V 113}			

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{V 113}	Continued From page 4 patient's station. After cleaning Patient 2's access sites prior to inserting the dialysis needles, CHT 2 picked up the package of fistula needles on the dialysis chair table, took them back to the clean supply cart and got a different package of needles and took them back to Patient 2's station. CHT 2 was wearing the same gloves used to clean the patient's access sites. 2b. At 0952 hours, CHT 2 was observed removing a used bag of normal saline from a patient's dialysis machine and placing it in the "dirty" (for used supplies) sink. Wearing the same contaminated gloves, CHT 2 removed a package of fistula needles and other supplies from a clean supply cart. The supplies were placed on a dialysis chair table at a station being prepared for the next patient. CHT 2 removed the gloves, made entries using the computer keyboard next to the dialysis station, rotated the dialyzer that was being primed for the next patient then made more entries using the computer keyboard. After using the computer keyboard, CHT 2 put on a clean pair of gloves. CHT 2 did not clean his hands during this observation.	{V 113}			
{V 115}	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and	{V 115}			

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{V 115}	<p>Continued From page 5</p> <p>prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.</p> <p>This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure staff and visitors were not leaving the treatment area to enter non-treatment areas while wearing personal protective equipment (PPE) such as gowns, masks and gloves which could possibly cause the spread of infection.</p> <p>Findings:</p> <p>This standard was previously cited on the survey completed in October 2010. The Plan of Correction submitted by the facility showed all teammates would be in-serviced on the infection control policy one-to-one basis by the FA. It also showed an audit tool was developed to monitor the staff a minimum of 3 shifts per week to ensure the infection control procedures were followed and teammates were wearing their PPE as required. The audit would be conducted for 30 days, and the results of the audits would be reported in the quality meetings. Patients and their visitors would also be educated on the use of PPE.</p> <p>The surveyors were shown audit sheets for Pre & Post Treatment Patient Assessment, Central Venous Catheter Procedures and Patient Dialysis Prescriptions. There was no audit form provided</p>	{V 115}			

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{V 115}	Continued From page 6 for infection control procedures. Review of the quality meeting minutes from the last meeting held in 2010, and minutes dated 1/31/11, showed audit results had not been reviewed. Review of the facility Policy 1-05-01 for Infection Control for Dialysis Facilities, last revised 9/10, showed PPE was not to be worn in non-treatment area. The facility failed to ensure implementation of this P&P as follows: 1. On 2/15/11 at 0910 hours, Patient 18, who was observed wearing a glove and holding her dialysis needle, was observed leaving the treatment floor and entering the patient waiting area still wearing the glove used to hold her sites. 2. On 2/15/11 at 1015 hours, CHT 2 was observed opening the door and leaving the treatment area to enter the patient waiting area. CHT 2 was wearing his gown, gloves and mask. CHT 2 re-entered the treatment area pushing a patient in a wheelchair. 3. On 2/15/11 at 1322 hours, Patient 2 was observed in a wheelchair with access clamps, to assist with clotting, over his dialysis needle sites. CHT 2 approached the patient and removed the access clamps. Holding the contaminated clamps in his hand and wearing his gown, gloves and mask, CHT 2 wheeled Patient 2 out of the treatment area through the door into the patient waiting area. CHT 2 returned to the treatment area in his PPE carrying the contaminated access clamps. 4. On 2/16/11 at 0840 hours, Patient 20 was observed leaving the treatment area and entering	{V 115}			

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{V 115}	Continued From page 7 the patient waiting area wearing the surgical mask used during preparation of her central venous catheter for the start and end of her treatment.	{V 115}			
{V 116}	<p>5. On 2/16/11 at 0908 hours, Patient 21 and a family member were observed leaving the treatment area wearing masks into the patient waiting area. The family member was observed putting on the mask after entering the treatment area, and wearing it while assisting the patient from the treatment area.</p> <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure supplies were not stored where they could receive possible blood splatters, and disposable items were not moved between patient stations which could possibly lead to the</p>	{V 116}			

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{V 116}	Continued From page 8 spread of infection. Findings: This standard was previously cited in the survey completed in October 2010. The facility's Plan of Correction showed an infection control audit tool would be implemented and assigned to Infection Control Managers. The managers would do a minimum of one random audit daily for 30 days to ensure infection control procedures were being performed. The results were to be reported in the quality meetings. The facility was unable to provide the surveyors with an infection control audit. 1. On 2/15/11 at 0805 hours, observation of the treatment area showed boxes of gloves on the computer carts between stations 7 and 8, 11 and 12, 13 and 14, 17 and 18, 21 and 22. Each computer cart was located between two patient dialysis stations where they were subject to possible blood splatters. CHTs were observed using the computer keyboards on the carts after removing their gloves and not cleaning their hands per policy prior to using the keyboard. CHTs were also observed removing clean gloves from the boxes after using the keyboards and not cleaning their hands.	{V 116}			
{V 122}	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL	{V 122}			

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{V 122}	<p>Continued From page 9</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure the cleaning and disinfection of contaminated treatment equipment was done per policy which could possibly cause cross-contamination and patient infections.</p> <p>Findings:</p> <p>This standard was previously cited on the survey completed October 2010. The facility's Plan of Correction showed all the staff members would be in-serviced on the infection control policy, and the correct cleaning techniques demonstrated. Also, an Infection Control Manager had been identified for each shift. The Infection Control Audit sheet would be implemented and assigned to the Infection Control Managers. A minimum of one random audit would be done daily, and the results would be reported in quality meetings. The Infection Control In-service conducted in October and November of 2010 showed only 11 of the 14 direct care staff and 6 alternate direct care staff had attended. No infection control audit sheets were provided by the facility.</p> <p>1. Review of the facility Policy 1-05-01 Infection Control for Dialysis Facilities, last revised 9/10,</p>	{V 122}			

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{V 122}	<p>Continued From page 10</p> <p>showed equipment to be disinfected included the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables, blood pressure equipment, television arms and control knobs or remote control devices. Also, the outside of sharps containers, IV (intravenous) poles as well as all work surfaces would be wiped clean with a bleach solution of appropriate strength. This was to be done after completion of procedures, before being used on another patient, throughout the work day, and after each treatment. This policy was not implemented as follows:</p> <p>On 2/15/11 at 0910 hours, CHT 12 was observed disinfecting a patient station to prepare for the next patient treatment. CHT 12 did not disinfect the blood pressure cuff and tubing, the TV set, the side of the dialysis machine (including the prime container), and did not open the dialysis chair to clean the crevices.</p> <p>On 2/15/11 at 0948 hours, CHT 12 was observed placing a blood pressure cuff on the right arm of Patient 5. The blood pressure cuff had been placed over the back of the chair touching the floor behind the dialysis chair.</p> <p>On 2/15/11 at 0952 hours, CHT 12 was observed disinfecting another patient station. The blood pressure cuff, the TV arm, and the sides of the dialysis chair were not disinfected.</p> <p>On 2/16/11 at 0825 hours, CHT 11 was observed disinfecting the dialysis machine after a patient treatment. The sides of the dialysis machine, the prime container, the IV pole and the TV arm were not disinfected. The dialysis chair was not</p>	{V 122}			

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{V 122}	Continued From page 11 opened and the crevices disinfected. On 2/16/11 at 0904 hours, CHT 11 was observed disinfecting a different treatment area. The sides of the dialysis machine, the IV pole and the prime container were not disinfected. On 2/16/11 at 0915 hours, CHT 14 was observed disinfecting a treatment area. The IV pole and prime container on the dialysis machine were not disinfected. The dialysis chair was not opened in order to clean the crevices, and the sides of the dialysis chair were not disinfected.	{V 122}			
V 250	494.40(a) DIALYS PROPOR-T-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure independent conductivity testing was completed on the dialysis machines before the start of patient treatments for two of two observed patients to ensure the dialysate solution concentration was correct to prevent possible harm to the patients (Patients 27 and Patient 28). Findings:	V 250			

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V 250	<p>Continued From page 12</p> <p>1. Review of the facility P&P 1-03-02 Prescription Verification and Safety Checks last revised 2/10, showed the staff should perform an independent manual test for the pH and conductivity of the dialysate solution in the dialysis machine. The dialysis machine was able to measure the conductivity of the dialysate, but was not able to perform a pH test. The manual conductivity test was done to ensure the dialysis machine measuring the conductivity of the dialysate solution was correct. If the conductivity of the dialysate solution is too high or too low, this could cause possible harm to a patient's blood cells, and the independent manual check was done to ensure patient safety.</p> <p>On 2/16/11 at 0842 hours, observation showed CHT 11 had started preparing the dialysis machine at Patient 27's station. Continuous observation of CHT 11 showed the CHT did not use the manual conductivity meter to test the pH (test to measure the acid and base in a solution) and conductivity of the machine. The pH/conductivity meter was observed to be on the supply cart. At 0907 hours, Patient 27 was seated in the station, and CHT 11 was observed completing the machine set up. The pH/conductivity meter was observed to be on the supply cart. Continuous observation showed the patient was connected to the dialyzer, and the treatment started at 0916 hours, without the manual test for the pH and conductivity being performed prior to the start of the treatment.</p> <p>2. On 2/16/11 at 0918 hours, CHT 11 was observed getting Patient 28's dialysis station ready prior to the patient's treatment. At 0940 hours, Patient 28 was seated in the dialysis</p>	V 250			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052773	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/16/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER SOUTH DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 14014 MAGNOLIA ST WESTMINSTER, CA 92683		
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V 250	Continued From page 13 station. Continuous observation of Patient 28's station, and the staff, showed Patient 28's dialysis machine was not manually checked for the pH and conductivity of the dialysate solution prior to the start of the patient's treatment at 1002 hours.	V 250			
{V 300}	494.50 CFC-REUSE OF HEMODIALYZERS & BLOODLINES	{V 300}			
	<p>This CONDITION is not met as evidenced by: Based on observation, facility policy review and record review, the facility failed to ensure the staff members priming reused dialyzers demonstrated competency regarding the process as evidenced by:</p> <p>Findings:</p> <p>This condition was previously cited in the survey completed in October 2010. The facility's Plan of Correction showed staff members were be in-serviced on a one-to-one basis by the FA on the priming of reused dialyzers, and a timer had been placed on each machine to remind the staff members to rotate the dialyzer position.</p> <p>Dialyzers were not being rotated during the recirculation process to ensure trapped air and germicide were removed from the dialysate side of the dialyzers. This can result in severe reactions to any germicide that reaches a patient's blood. Cross reference V353.</p> <p>The cumulative effect of the systemic failures resulted in the facility's inability to provide quality care in a safe environment.</p>				
{V 353}	494.50(b)(1) TEST FOR RESID GERM/MAX	{V 353}			

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{V 353}	<p>Continued From page 14</p> <p>TIME RINSE TO USE</p> <p>12.4.1 Testing for residual germicide: max time rinsed to use Residual germicide shall be measured by a test of appropriate sensitivity according to a written procedure to ensure that the germicide level is below the maximum recommended residual concentration. Completion of this step shall be documented, along with the signature or other unique means of identifying the person performing the test.</p> <p>A written policy should establish the maximum allowable time between rinsing the germicide from the dialyzer and beginning dialysis. The priming, removal, and residual testing process should be reinstated after a delay sufficient to bring concentrations of germicide above the recommended level (rebound). Additional rinsing should be performed to yield a germicide level below the maximum recommended concentration before initiating of dialysis.</p> <p>A rinse procedure should be defined and documented step by step, and all personnel should be familiar with and follow it.</p> <p>If heat disinfection is used, the dialyzer should be cool to the touch before it is primed with saline.</p> <p>This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure the rinsing procedure was performed to remove any possible air and germicide that might remain trapped in portions of the dialyzer that could possibly be infused into the patients. This problem was found for six of 13</p>	{V 353}			

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{V 353}	<p>Continued From page 15</p> <p>dialyzers for the second shift on 2/15/11 (Stations 2, 5, 7, 8, 11 and 19). The same problem was found for two of 11 dialyzers for the third shift on 2/15/11 (Stations 3 and 7), and four of 21 dialyzers for the second shift on 2/16/11 (Stations 12, 15, 20 and 23).</p> <p>Findings:</p> <p>This standard was previously cited on the survey completed in October 2010. The facility's Plan of Correction showed the teammates would be in-serviced on a one-to-one basis by the FA on the facility policy for the priming of a reprocessed dialyzer free of peracetic acid. The plan showed timers had been added to all stations to remind the teammates to rotate the dialyzers halfway through the priming procedure. The RNs would be responsible for compliance.</p> <p>Review of the facility Procedure 1-03-04A for Priming a Reprocessed Dialyzer, last revised on 1/10, showed after the dialysate lines had been attached to the dialyzer, the dialyzer was rotated by hand to ensure it was filled with dialysate and placed in the dialyzer holder with the venous (blue) end up. Recirculation was then started for 15 minutes. Approximately halfway through the recirculation procedure, the dialyzers were to be rotated so the arterial (red) end was up and the venous (blue) end down. This was done to reduce the possibility of any air and/or disinfectant being retained in a dead space of the dialysate compartment. The P&P was not implemented as follows.</p> <p>Per AAMI (Association for the Advancement of Medical Instrumentation) Rationale for the</p>	{V 353}			

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{V 353}	Continued From page 16 Development and Provisions of this Recommended Practice, A.12.4.1 Testing for residual germicide. Procedural steps had been identified by AAMI to follow to ensure no residual germicide remained in the dialyzer following rinsing. One step was air trapped in the dialysate side of the dialyzer may cause germicide to also remain trapped in portions of the dialyzer and the dialyzer should be rotated during the rinsing process. This action should normally release the trapped air and allow the germicide to be fully rinsed. The dialyzers at each of the following stations were observed with the venous (blue) end of the dialyzer still up at the completion of the recirculation cycle. On 2/15/11 observation of the treatment area from 0805 to 1006 hours, showed the 15 minute recirculation cycle for the dialyzers was completed for Stations 2, 5, 7, 8, 11 and 19. During observation on 2/15/11 from 1300 to 1330 hours, Stations 3 and 7 (different patient shift). On 2/16/11, observation of the treatment area from 0857 hours to 0945 hours, showed the 15 minute recirculation cycle for the dialyzers was completed for Stations 12, 15, 20 and 23. Timers were observed mounted on each dialysis machine but were not being used to ensure the dialyzers were rotated during recirculation.	{V 353}			
{V 503}	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following:	{V 503}			

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{V 503}	Continued From page 17 (2) Evaluation of the appropriateness of the dialysis prescription, This STANDARD is not met as evidenced by: Based on medical record review, and facility policy review, the facility failed to ensure physician ordered BFRs (blood flow rates), and DFRs (dialysate flow rates) were followed. To ensure the physician was aware of a patient's discharge status, that physician orders were in place for treatments done, documentation was complete regarding the administering of medications, and post-treatment assessments were completed in order to ensure patients were not being discharged with high blood pressure and extra fluid weight which could possibly cause hypertension and congestive heart failure for two of 14 patients (Patients 23 and 24). Findings: This standard was previously cited in the survey completed October 2010. The facility's Plan of Correction showed the Charge Nurse or FA would randomly audit post-treatment flow sheets a minimum of three times per week for 30 days to ensure staff were appropriately addressing and documenting interventions and resolutions for fluid volume, high blood pressure and other patient issues. The facility was to utilize the audit sheets to check for the correct performance of staff members. The Charge RN or designee was to routinely check each patient's status when making rounds, compare to physician orders and ensure any needed corrections were made. Staff	{V 503}			

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{V 503}	<p>Continued From page 18</p> <p>members not performing were to be reported to the FA for retraining. Results would be taken to the quality meetings and discussed with the QAPI team. Interventions would be adjusted as needed to bring all issues into compliance.</p> <p>The facility Policy 1-02-09 for Intradialytic Treatment Monitoring, last revised 9/08, showed treatment checks should be completed at least every 30 minutes, and at a minimum, staff should obtain and document blood and dialysate flow rates, and arterial and venous pressures. Significant changes were to be reported to the licensed nurse and documented, including the appropriate action taken and the patient response. The P&P was not implemented as follows:</p> <p>Review of patient treatment sheets was initiated on 2/15/11.</p> <p>1a. Review of the treatment sheets for Patient 23 from 1/17/11 to 2/14/11, showed the patient had physician's orders for a BFR of 350, a DFR of 600. The following was found:</p> <ul style="list-style-type: none"> * On 1/17/11, the patient had a BFR of 300 for the treatment. * On 1/24/11, Patient 23's BFR was 300 for the entire treatment. * On 2/2/11, the BFR was 300 for the first half of her three hour treatment. * On 2/9/11, the BFR was 300 for the entire treatment. * On 2/11/11, the DFR was 800 for the entire treatment. * On 2/14/11, the BFR ran from 250 to 300 for the entire treatment. <p>There was no documentation to show why the</p>	{V 503}			

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{V 503}	<p>Continued From page 19 ordered BFR and DFR were not met.</p> <p>1b. On 2/4/11, the treatment sheet showed Patient 23 received a 50 mL normal saline flush every 30 minutes for two hours of her three hour treatment. There was no documentation provided to show why the patient was receiving the saline flushes or a physician's order for the flushes.</p> <p>1c. Review of Patient 23's treatment for 2/2/11, showed the patient had a temperature of 99.6 and complained of chills. The patient was assessed by the RN, given medication (acetaminophen) and instructed to call the emergency room at the hospital if the fever increased or got worse. There was no documentation to show the patient's physician was notified of the patient's discharge status.</p> <p>Review of the medication orders for Patient 23 showed the patient could receive 650 mg of acetaminophen (Tylenol) every four hours for a fever above 100 degrees. On 2/2/11, the patient was given 650 mg. at 1320 hours and another 650 mg. at 1615 hours (three hours). There was no documentation to show the patient had a fever greater than 100 degrees.</p> <p>2a. Review of Patient 24's treatment sheets from 1/15 to 2/15/11, showed the patient had physician's orders for a BFR of 350, and DFR of 800. Treatment sheet review showed the following: * On 1/20/11, the DFR for the patient's treatment was at 600 with no documentation to show why it was not to physician's order. * Review of Patient 24's treatment sheets for the</p>	{V 503}			

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{V 503}	Continued From page 20 13 treatments from 1/15 to 2/15/11, showed for 9 of the 13 treatments (1/15, 1/18, 1/25, 1/27, 1/29, 2/1, 2/3, 2/5 and 2/10/11) the patient's BFR was 300 or less for half or all of the treatment. There was no documentation to show why the ordered BFR was not achieved. 2b. Review of Patient 24's 13 treatment sheets from 1/15 to 2/15/11 showed that for six of the 13 treatments the patient had been discharged from the facility without a completed post-treatment assessment of the patient documented on the treatment sheet. 3. The facility failed to ensure patients' EDWs were being evaluated to determine if the patients' goals needed to be adjusted, that blood pressures were being monitored and interventions done per policy, that fluid removal goals were consistent with patient fluid gains, and post-treatment assessments were being completed in order to determine the patients' status before being discharged. Cross reference V504.	{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, staff interview, facility policy and record review, the facility failed to ensure evaluation of patients' EDWs, pre/intra	V 504			

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V 504	<p>Continued From page 21</p> <p>and post blood pressures, that interventions were done or monitored to ensure the patients' needs were being met for four of 14 patients to prevent patients being discharged with increased blood pressures and possible fluid overload (Patients 23, 24, 25 and 26).</p> <p>Findings:</p> <p>This standard was previously cited in the survey completed October 2010. The facility's Plan of Correction showed RNs were to check for blood pressure medication orders when patients were hypertensive before, during, and after treatment. Blood pressures would be checked to assess medication administration effectiveness. The Charge Nurse or FA would randomly audit post-treatment flow sheets a minimum of three times per week for 30 days to ensure staff were appropriately addressing and documenting interventions and resolutions for fluid volume, high blood pressure and other patient issues. The facility was to utilize audit sheets to check for correct performance of staff members. The Charge RN or designee would routinely check each patient's status on rounds, compare to physician orders and ensure any needed corrections were made. Staff members not performing were to be reported to the FA for retraining. Results would be taken to the quality meetings and discussed with the QAPI team. Interventions would be adjusted as needed to bring all issues into compliance.</p> <p>The facility Procedure 1-09-07 for Hypotension, dated 9/07, showed for hypotension (low blood pressure) the patient was to be placed in a modified Trendelenburg position with the legs</p>	V 504			

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V 504	<p>Continued From page 22</p> <p>elevated and the head lowered, normal saline was to be administered with a bolus (amount to be given rapidly) of approximately 200 mL (milliliters) to increase intravascular volume (volume in the blood vessels). The fluid removal was also to be turned off and the patient was to be reassessed. This P&P was not implemented as follows:</p> <p>Review of patient medical records was initiated on 2/15/11.</p> <p>1a. Review of the nine treatment sheets for Patient 25 for 1/19 to 2/14/11, showed the patient had an EDW of 42.0 Kg. The patient started dialysis at the facility on 11/1/10 and had diagnoses that included congestive heart failure. Review of the facility hospitalization log showed Patient 25 was hospitalized from 1/24 to 1/30/11. The hospital diagnoses were increased blood pressure, headache and shortness of breath. The patient had previously been hospitalized on 1/10/11, with discharge diagnoses that included end stage renal disease with fluid overload. There was no documented intervention to show the physician was notified or the patient had been reassessed after her hospitalization to evaluate the patient's EDW for possible weight loss during the hospitalization and adjustment of the EDW if needed.</p> <p>1b. Review of Patient 25's treatment sheets showed the following: * On 1/19 and 1/21/11, the treatment sheets showed the patient was discharged at or 0.1 Kg. over the EDW. The pre and post assessments for these treatments showed the patient had facial swelling.</p>	V 504			

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V 504	<p>Continued From page 23</p> <p>* On 1/31/11, Patient 25 returned to dialysis after being hospitalized. The patient's pre-treatment weight was 40.3 Kg., 1.7 Kg. below her EDW. The patient was discharged at 40.3 Kg. and the assessment showed the patient had facial swelling before treatment, and had no swelling after treatment.</p> <p>* On 2/2/11, Patient 15 had a pre-treatment weight of 42.4 Kg, and was discharged at 40.4 Kg. The patient was assessed with periorbital (area around the eyes) swelling before treatment and no swelling after treatment.</p> <p>* For treatments on 2/4, 2/7, 2/9, 2/11 and 2/14/11, the patient was discharged at her EDW of 42.0 Kg.. The patient's systolic blood pressures increased during this time from 140-160's to 170-180's by 2/14/11.</p> <p>Review of the Nurse's Assessment dated 11/22/10, showed the nursing goal was to have Patient 25's blood pressure in an acceptable range of 130/90 post treatment, to monitor the blood pressure closely and decrease the dry weight as tolerated.</p> <p>1c. Review of the treatment sheet dated 1/19/11, showed Patient 15's last three blood pressures during the treatment had increased to 194/72, 195/82 and 198/83. The blood pressures were monitored at a 30-minute-interval. During the treatment, the systolic (top number) blood pressure ranged from 177-189 and the diastolic (bottom) blood pressure ranged from 69-84. There was no documented evidence of an intervention to address the increased blood pressure.</p> <p>A physician's order dated 11/1/10, for Patient 25</p>	V 504			

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V 504	<p>Continued From page 24</p> <p>showed Clonidine 0.1 mg could be given as needed for a systolic blood pressure higher than 190 or diastolic blood pressure higher than 110.</p> <p>On 2/16/11 at 1540 hours, an interview was conducted with RN 2. When asked what they would do if a patient's blood pressure increased, the RN stated if the systolic blood pressure was up to 190-200, the RN would be notified to check the patient.</p> <p>2a. Review of Patient 23's 11 treatments from 1/21 to 2/14/11, showed the patient's post-treatment weights were from 56.2 Kg. to 56.8 Kg. (.2 to .8 Kg. over her EDW). The pre and post-treatment assessments for those treatments showed diminished breath sounds, crackles and edema (swelling). There was no documentation to show the patient's EDW had been evaluated to determine if her EDW goal needed to be adjusted. Treatment sheet reviews showed the following:</p> <ul style="list-style-type: none"> * Review of the treatment sheets for Patient 23 from 1/15/11 to 2/11/11, showed the patient had physician's orders for an estimated dry weight (EDW) of 56.0 Kg. * On 1/17/11, the pre-treatment weight was 61.9 Kg. (5.9 Kg. over her EDW). The calculated fluid removal was for 5.9 Kg, but the actual fluid removal goal on the dialysis machine was set for 4.5 Kg. The patient was discharged at 57.4 Kg., 1.4 Kg. over her EDW. The patient's pre and post-treatment assessments showed she had diminished breath sounds and swelling in both legs and her face was puffy. There was no documentation to show the physician had been notified. * On 1/19/11, the pre-treatment weight was 61.6 	V 504			

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V 504	<p>Continued From page 25</p> <p>Kg., 5.6 Kg. over Patient 23's EDW. The patient's weight gain was figured as 4.2 Kg and 4.5 Kg. of fluid was removed. The patient was discharged at 57.8 Kg., 1.8 Kg. over her EDW. The pre-treatment assessment showed the patient had diminished breath sounds and periorbital (area around and under the eye) swelling. The post-treatment assessment showed the patient had crackles in her lungs and a puffy face. There was no documentation to show the physician was notified.</p> <p>* On 1/19/11 at 1506 hours, Patient 23's blood pressure decreased from 136/74 to 103/71. There was no documented follow up of the decreased blood pressure to ensure it had not decreased further until 1535 hours.</p> <p>* On 2/11/11, Patient 23's blood pressure increased from 157/99 at the start of treatment to 209/118 at the end of treatment. There was no documentation to show the blood pressure had been taken again to see if it was still elevated, and that the nurse and/or the physician were notified or that medications given.</p> <p>3a. Review of Patient 24's treatment sheets from 1/15 to 2/15/11, showed the patient had physician's orders for an EDW of 45.5 Kg. Treatment sheet review showed the following:</p> <p>* On 1/29/11 at 1030 hours, the patient's blood pressure was 168/83. The next blood pressure was not taken until 1130 hours, and had decreased by 62 points to 106/56. The fluid removal by the dialysis machine was not turned off. There was no documentation to show the patient had been assessed for symptoms or another blood pressure taken to ensure it was accurate. Another blood pressure was not taken for 30 minutes. The only documentation on the</p>	V 504			

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V 504	<p>Continued From page 26</p> <p>treatment sheet was "feels better." The treatment sheet also showed a post-treatment assessment had not been completed for the patient.</p> <p>* The treatment sheet for 2/12/11 showed the patient's EDW had been decreased to 43.0 Kg. The pre-treatment weight for 2/12/11 was 48.9 Kg. The patient was 5.9 Kg. over her EDW, and the calculated fluid removal was 5.9 Kg. The treatment sheet showed the actual fluid removal on the dialysis machine was set for 2.0 Kg. The patient was discharged to home 3.2 Kg. over her EDW. There was no documentation to show why the patient's fluid removal goal had been decreased from 5.9 Kg. to 2.0 Kg.</p> <p>3b. On 2/15/11 at 1119 hours, during observations in the treatment area, an alarm was sounding on Patient 24's dialysis machine. There was no response to the alarm; all staff members were caring for other patients. The alarm was for a low blood pressure of 84/39. The surveyor alerted the staff. The surveyor noted the fluid removal rate on the dialysis machine had been set to remove 2.0 Kg. of fluid per hour.</p> <p>RN 4 came and took another blood pressure, which was 73/40. RN 4 started giving the patient normal saline and asked for someone to get oxygen. The patient's blood pressure increased to 89/30. Additional normal saline was given, and the blood pressure increased to 95/39, and then to 108/50. (The patient was not placed in the Trendelenburg position). RN 1 came over and looked at the patient's machine. RN 1 stated she was going to decrease the patient's fluid removal, and reset the machine to remove 1.0 Kg. per hour. There was no evidence the physician was notified.</p>	V 504			

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V 504	Continued From page 27 The patient did not speak English, and when called to by the surveyor, the patient tried to lift her arm, but could barely respond. The other surveyor present in the facility, who spoke the same language as the patient, came to talk to the patient. The patient told the surveyor she felt sleepy and dizzy. The patient later told the surveyor she felt cold. RN 4 stated the patient had just been released from the hospital and she was going to test the patient's blood sugar level. On 2/16/11, Patient 24's treatment sheet for 2/15/11 was reviewed. The treatment sheet showed the patient had a fluid gain of 3.2 Kg. (Her EDW was 43 Kg., and her pre-treatment weight was 46.2 Kg.). When the total of 500 mL of normal saline used to prime the lines and to rinse back the patients blood were added to her fluid gain, the total fluid removal goal would have been 3.7 Kg. The fluid removal per hour for a total of 3.7 Kg. would have been approximately 1.23 Kg. per hour, not 2.0 Kg. as initially programmed into the machine. The patient had been on the dialysis machine for 17 minutes when her blood pressure decreased. The treatment sheet showed the patient had been given 300 mL of normal saline and the fluid removal on the dialysis machine had been turned off for one hour. There was no post-treatment assessment on the treatment sheet. Review of the nursing notes for 2/15/11 showed no documentation regarding the patient's low blood pressure during treatment or an assessment of the patient post treatment. The treatment sheet for 2/15/11, showed the blood sugar level done by the RN was 249.	V 504			

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V 504	<p>Continued From page 28</p> <p>There was no documentation the physician had been notified of the low blood pressure, and the patient's elevated blood sugar level.</p> <p>3c. Review of Patient 24's 13 treatment sheets from 1/15 to 2/15/11 showed that for six of the 13 treatments the patient had been discharged from the facility without a completed post-treatment assessment of the patient.</p> <p>4a. Review of Patient 26's treatment sheet dated 1/22/11, showed the patient had an EDW of 58.0 Kg. The patient's pre-treatment weight was 59.6 Kg., 1.6 Kg. over the EDW. The patient was discharged at 59.1 Kg., 1.1 Kg. over the EDW. The treatment sheet showed that 2.0 Kg. had been removed from the patient during treatment. Further review of the treatment sheet showed the patient had been taken off treatment to use the bathroom, but the amount of normal saline used to rinse back the patient's blood and to re-start the treatment had not been added into the total fluid to be removed from the patient.</p> <p>4b. The treatment sheet dated 1/25/11 showed Patient 26 had a pre-treatment weight of 63.6 Kg., 5.6 Kg. over the EDW. The calculated target fluid removal was figured at 5.6 Kg., but the actual fluid removal target on the machine was set at 3.0 Kg. The patient was discharged at 60.2 Kg., 2.2 Kg. over the EDW. The post-treatment assessment area on the treatment sheet had not been completed. There was no documentation to show why the patient's fluid removal goal had been decreased.</p> <p>4c. The treatment sheet dated 1/27/11, showed Patient 26's pre-treatment weight was 63.7 Kg.,</p>	V 504			

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V 504 {V 625}	Continued From page 29 4.7 Kg. over the EDW. The fluid removal on the machine was programmed to remove 3.0 Kg. The patient was discharged at 59.6 Kg., 1.6 Kg. over the EDW. The post-treatment assessment area on the treatment sheet had not been completed. 494.110 CFC-QAPI This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have an effective QAPI program as evidenced by: This condition was previously cited in the survey completed in October 2010. The facility's Plan of Correction showed the problems that were identified in the October 2010 survey had been addressed comprehensively by the QAPI team. Flow sheets were to be randomly audited a minimum of three times per week for 30 days to ensure staff members were addressing and documenting interventions and resolutions for blood pressure, fluid volume, and other patient issues. Audit sheets were be used to check for performance of staff members, and results would be discussed with the QAPI team. There was no documentation found during review of the QAPI meeting minutes for 10/10 and 1/11, to show the survey findings or the audit sheet results had been discussed by the QAPI team. * The facility failed to ensure physicians' orders were followed during patient treatments with regard to the BFRs, DFRs and administration of medications. There was no documentation to show why the ordered BFRs and DFRs were not	V 504 {V 625}			

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{V 625}	Continued From page 30 met during treatment, and a medication was given without documentation to show the patient met the guidelines for receipt of the medication. Cross reference V503. * Failure to review the problems identified during the survey completed in October 2010, in order to address the items, to develop actions to be taken, and to monitor the results of those actions. Cross reference to V113, V115, V116, V122, V353, V626 and V715. * No documentation was provided to show the audit forms had been reviewed and discussed with the QAPI team, or the identified problems had been addressed by the QAPI team. Cross reference to V626.	{V 625}			
{V 626}	494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The cumulative effect of these systemic failures resulted in the facility's inability to provide quality care in a safe environment. The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by	{V 626}			

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{V 626}	<p>Continued From page 31 CMS.</p> <p>This STANDARD is not met as evidenced by: The facility failed to provide information the issues identified during the survey completed October 2010 were discussed in QAPI team meetings in order to focus on issues, such as, failure to adhere to procedures that could increase the risk of patient hospitalization and mortality.</p> <p>Findings:</p> <p>This standard was previously cited in the survey completed October 2010. The facility's Plan of Correction showed the patient treatment schedule would be reviewed and adjustments made as necessary to ensure the CHTs had ample time to disinfect and prime dialysis equipment per policy. It also showed other problems identified included: hand washing, disinfection of dialysis machines, monitoring of blood pressures during treatment, BFRs and DFRs to physician orders had been addressed comprehensively by the QAPI team in order to identify any areas that could be improved.</p> <p>On 2/16/11 at 1400 hours, review was done of the last two QAPI meetings minutes, dated 10/10 and 1/11. The review showed that issues identified in the survey completed in October 2010 had not been presented at the QAPI meetings. There was no documentation provided to show the issues had been discussed with the interdisciplinary team and a plan of action developed.</p>	{V 626}			

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{V 626}	Continued From page 32	{V 626}			
{V 710}	<p>On 2/16/11 at 1600 hours, the findings were reviewed with the acting FA and the CSS. No further documentation was provided.</p> <p>494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR</p> <p>This CONDITION is not met as evidenced by: Based on record review and observation the Medical Director failed to provide oversight in the areas of patient care where deficient practices were identified. To oversee the facility's Plan of Correction was implemented to ensure staff members were following the facility's policies and procedures, that education was provided to all staff members with follow-up to ensure the outcome of the re-education was attained , with continued monitoring and evaluation done to improve performance and deliver safe patient care.</p> <p>Findings:</p> <p>This condition was previously cited in the survey completed in October 2010. The facility's Plan of Correction showed the Medical Director understood the oversight role of the Medical Director, and staff members would be in-serviced on polices and procedures including hand washing, disinfection of dialysis machines, priming of reuse dialyzers, monitoring of blood pressures during treatment, and BFRs and DFRs to physician orders. Review of the facility records showed staff education was not completed. Monthly audits were not completed. No documentation could be provided to show the QAPI team and the Governing Body were following and monitoring the progress of the</p>	{V 710}			

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{V 710}	<p>Continued From page 33</p> <p>needed corrections. The Medical Director failed to provide oversight of the facility to ensure compliance with the plan of correction in order to provide quality patient care.</p> <p>* The monitoring of arterial pressures was not done per policy to prevent the possible destruction of red blood cells. Cross reference V715.</p> <p>* The monitoring of infection control regarding hand washing, wearing of gloves, disinfection of dialysis equipment, and wearing of PPE out of the treatment area were not to policy. Audit forms that were to be developed and results presented at the QAPI meetings to ensure infection control policies and procedures were being addressed was not done. Cross reference V113, V115, V116 and V122.</p> <p>* The priming of reused dialyzers to prevent the possible infusion of the germicide into the patients was not being done per policy. All in-services that were to be done had not been completed. The timers attached to the machines to assist with assuring the dialyzers were rotated per policy were not being used. Cross reference V353.</p> <p>* Patient treatments were not being evaluated to determine if the BFRs and DFRs were to physician's orders, blood pressures were not monitored per policy to ensure proper measures were taken, fluid removal and EDWs were not evaluated, and post-treatment assessments were not completed. The oversight and monitoring of these areas was not done. Cross reference V503.</p>	{V 710}			

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{V 710}	Continued From page 34	{V 710}			
{V 715}	<p>* Manual testing of machines for conductivity and pH performed prior to patient treatment was not done per policy. The monitoring and auditing of this procedure was not done. Cross reference V250.</p> <p>The cumulative effect of these systemic failures resulted in the facility's inability to provide quality care in a safe environment.</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL 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, facility policy and record review, the facility failed to ensure the monitoring of patients' arterial pressures during treatment. High arterial pressures could be destructive to the patients' red blood cells. The facility also failed to ensure the dialyzer rinsing procedure was performed per facility policy to remove any possible air and germicide that might remain trapped in portions of the dialyzer and could possibly be infused into the patients. This problem was found for six of 13 dialyzers on the second shift on 2/15/11 (Stations 2, 5, 7, 8, 11 and 19). The same problem was found for two of 11 dialyzers for the third shift on 2/15/11 (Stations 3 and 7), and four of 21 dialyzers for the</p>	{V 715}			

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{V 715}	Continued From page 35 second shift on 2/16/11 (Stations 12, 15, 20 and 23). Findings: 1. This standard was previously cited in the survey completed in October 2010. The facility's Plan of Correction showed the Medical Director understood the oversight role of the Medical Director and staff members would be in-serviced on polices and procedures covering the cited areas. Observation would be done a minimum of five days per week for 30 days to ensure correct procedures were being performed. An audit for infection control practices would be done for 30 days. A random audit of post treatment sheets would be done a minimum of three times per week for 30 days to ensure staff members were appropriately addressing and documenting interventions and resolutions for blood pressure, fluid volume and other patient issues. The Pre & Post Treatment Patient Assessment Audit form supplied to the surveyor showed the audit was only conducted for four days in January, an infection control audit was not provided and in-services had not been completed. Facility Policy 1-03-08A for Treatment Initiation, last revised 6/08, showed an arterial pressure (AP) alarm limit should never be set to exceed a -260 reading if using prepump (before the blood pump) arterial monitoring lines. Pressures exceeding this value were known to be destructive to red blood cells and mechanical hemolysis (breaking of red blood cells) may occur. This P&P was not implemented as follows:	{V 715}			

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{V 715}	<p>Continued From page 36</p> <p>1a. Arterial pressure monitoring was cited on the previous survey of October 2010. Arterial pressures exceeding -260 were observed on the treatment floor and the machines were not alarming in response to readings as low as -280. During staff interviews, they acknowledged arterial pressures exceeding -250 should be addressed to determine the cause. The Medical Director had also acknowledged arterial pressures were checked every 30 minutes and if a pressure was more negative than -250, the blood pump should be stopped and the needle placement checked.</p> <p>1b. Observation of the treatment area on 2/15/11 from 0800 to 1030 hours, showed the following patient arterial pressures:</p> <ul style="list-style-type: none"> * At 0805 hours, the arterial pressure on the dialysis machine at Station 15 was -280, and at 0846 was still at -280. * At 0805 hours, the arterial pressure at Station 12 was -270 * At 1006 and 1020 hours, the arterial pressure at Station 2 was -270. * At 1006 hours, the arterial pressure at Station 19 was -270, at 1020 hours was -290, and at 1119 hours, was -260. * At 1020 hours, the arterial pressure at Station 2 was -270 * At 1021 hours, the arterial pressure at Station 22 was -260 <p>On 2/16/11 at 0730 hours, the arterial pressure on Station 22 was -260</p> <p>There were no audible machine alarms in response to the lower arterial pressure readings.</p>	{V 715}			

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{V 715}	<p>Continued From page 37</p> <p>2. During review of Patient 23's treatment sheets, it showed the patient had arterial pressures of -260 to -280 for eight of 14 treatments. There was no documentation to show the AP had been addressed on the treatment sheets for the following dates: 1/17, 1/19, 1/21, 1/28, 1/31, 2/7, 2/11 and 2/14/11.</p> <p>3. Review of Patient 24's treatments sheets showed the patient had arterial pressures of -260 to -280 for six of 13 treatments from 1/15 to 2/15/11. There was no documentation to show the AP had been addressed.</p> <p>4. On 2/16/11, review of Patient 25's treatment sheet dated 2/9/11, showed the AP was -260 at 1455 hours and 1529 hours and -280 at 1600 hours. There was no documentation to show the AP had been addressed.</p> <p>5. On 2/16/11 at 1420 hours, review of Patient 26's treatment sheet showed the AP was -270 at 1330, 1400 and 1500 hours, -260 at 1430 and 1530 hours. There was no documentation to show the AP had been addressed.</p> <p>On 2/16/11 at 1700 hours, the facility's acting FA stated a representative from the dialysis machine company advised the facility the alarm limits for the arterial pressures could be permanently set to alarm when the arterial pressure exceeded -260, but the facility's nurses had not wanted it done, and the change was not made.</p> <p>During observation of the treatment area, the staff members were not priming patient dialyzers per facility policy to ensure the air and germicide were removed to prevent the possible infusion of</p>	{V 715}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052773	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/16/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER SOUTH DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 14014 MAGNOLIA ST WESTMINSTER, CA 92683		
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{V 715}	Continued From page 38 the germicide into the patients. Cross reference V353.	{V 715}			
V 750	494.180 CFC-GOVERNANCE This CONDITION is not met as evidenced by: Based on observation and record review, the Governing Body failed to demonstrate their responsibility to provide safe patient care as evidenced by: * Failure to ensure correction of infection control issues with regard to the wearing of gloves, hand washing, disinfection of dialysis equipment, removal of supplies from a clean supply cart with contaminated gloves, and the correct use of PPE. Cross reference V113, V115, V116, and V122. * Failure to ensure reused dialyzers were primed per facility policy to prevent possible infusion of germicide to the patients. Cross reference V353. * Failure to ensure physician's orders were followed with regard to BFRs, DFRs and post-treatment assessments were completed. Cross reference V503. * Failure to monitor patients' fluid status, treatment of blood pressures during treatment, and the evaluation of patient EDWs. Cross reference V504. * Failure to ensure the facility's plan of correction for the survey dated October 2010 was implemented, and the deficiencies and plan for improvement were reviewed in QAPI meetings. Cross-reference V625	V 750			

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

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V 750	Continued From page 39 The cumulative effect of these systemic failures resulted in the facility's inability to provide quality care in a safe environment.	V 750			