

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 California Department of Public Health during the investigation of a complaint. Complaint Number: CA00255390 Representing the Department of Public Health: Octavio Relopez, HFEN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Four (4) deficiencies were written as a result of complaint number CA00255390.	V 000			
V 502	494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co-morbid conditions. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the comprehensive assessment conducted for Patient A included an evaluation of current health status and medical condition as evidenced by staff's failure to evaluate the patient's health, medical condition and clinical needs immediately after the patient had a fall. This resulted in failure of the staff to take the appropriate steps after the fall and to provide the appropriate care needed which	V 502			

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.

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 502	<p>Continued From page 1 resulted in the patient's death.</p> <p>Findings:</p> <p>On 2/9/11, a review of Patient A's medical record was conducted. The patient was 64 years of age, admitted to the facility on 8/18/06 for in-center hemodialysis (The use of a machine to clean the blood) treatment. The patient had diagnoses that included end stage renal disease (ESRD- a kidney disease), hypertension (high blood pressure) and anemia (a low blood count that can make a person get tired and short of breath).</p> <p>A review of the facility's discharge summary report for the patient dated 12/29/10, indicated that after starting hemodialysis (HD) treatment (Tx), the patient requested to go to restroom and the patient fell while in the restroom. The discharge report further indicated that the reason for discharge was that the patient expired on 12/8/10, while in the acute care hospital.</p> <p>A review of the facility's Risk Management investigation conducted by the Quality Improvement (QI) consultant on 12/10/10, the "summary of the investigation" included the following:</p> <p>"Patient A fell at dialysis unit while in the bathroom 12/7/10. Patient A also on Coumadin (medication used to make the blood thinner to prevent clotting), INR (International Normalized Ratio- a test to measure the clotting tendency of blood) level at 6.9 (Normal INR range is 0.8 to 1.2 according to Guidelines and Protocols on Anti-coagulation Therapy Management in adults, dated October 1, 2010). Unknown if he was seen</p>	V 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 502	<p>Continued From page 2</p> <p>by a physician at the facility after the incident. Patient was sent home. Patient became more lethargic (drowsy) at home; EMS (Emergency Medical Services) was called and transported patient to hospital. Patient unresponsive by the ambulance arrived around 8 PM. Neurologist evaluated patient and found subdural hemorrhage (bleeding inside the brain) and brain stem (area at the base of the brain) injury. Patient removed from life support and died on 12/8/10."</p> <p>During a review of the patient's HD treatment record dated 12/7/10, no documented evidence in the intradialytic (during the course of treatment) and the RN (RN 1) post assessment notes was found which indicated that the patient's fall was noted and an evaluation of the patient's health, medical condition and clinical needs was immediately conducted after the fall. The intradialytic notes and the RN post assessment notes were noted as follows:</p> <p>"9:15 AM- BP 102/52;... initiated treatment... Noted by PCT 1.</p> <p>10:09 AM- BP 98/54; ... Ultra Filtration rate (UFR- amount of fluid removed during dialysis treatment) off. Noted by PCT 1.</p> <p>10:44 AM- BP 107/57; ... Off for bathroom use. Noted by RN 2.</p> <p>11:06 AM- BP 108/60; ... Patient back from restroom. Noted by PCT 1.</p> <p>11:58 AM- BP 94/61; ... UFR still off, BP still low. Noted by PCT 1.</p>	V 502			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 502	<p>Continued From page 3</p> <p>12:21 PM- BP 104/57; ... Noted by PCT 2</p> <p>1:00 PM- BP N/A; ... terminated treatment with normal saline. Noted by PCT 2.</p> <p>(According to the American Heart Association publication dated 2003, "the normal blood pressure for normal adults ranges 90- 119/ 60- 79"). Medications given during the HD treatment included Heparin Pork bolus 1100 units by intravenous push (IVP). Discharge Status: Discharged to home (Routine Discharge)."</p> <p>There was no written evidence found in the patient's medical record which indicated that the RN had documented the patient's fall and assessed the patient immediately after the fall. The RN assessment documentation of the patient's fall was dated 12/10/10, 3 days after the patient's fall and was a modified nurse's progress notes written by RN 1. Furthermore, there was no written evidence found to indicate that the attending physician and the family or responsible party was notified promptly after the patient's fall.</p> <p>There was no documented evidence found in the Post Treatment assessment conducted by RN 1 at 1:28 PM, which indicated that the patient had a fall during the treatment and that the patient was immediately assessed after the fall.</p> <p>During review of a modified progress note written by RN 1 on 12/10/10, three days after the patient's fall, the progress note included the following:</p> <p>"Patient went to the restroom at 10:44 AM. Standing up blood pressure (BP) 107/57 ... At 11</p>	V 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 502	<p>Continued From page 4</p> <p>AM, patient called for help, found on a sitting position. Assisted back to the wheel chair. Assessed patient denies pain. Patient stated 'I fell on my butt.' Blood pressure after the fall was 108/60, PR 66. The physician notified ordered to resume treatment. Patient awake, alert, oriented to place person and time. Patient offered to go to emergency room (ER) for further evaluation, patient refused. Heparin held before and during the treatment. Charge nurse aware of the situation. Patient's wife notified. Modified by RN 1 on 12/10/10, at 1436 (2:36 PM)."</p> <p>During an interview with RN 1 on 2/9/11, at 11:10 AM, RN 1 was asked why the documentation regarding the patient's fall was completed three days after the fall. RN 1 did not have an answer. When further asked if the physician and the patient's family had been notified immediately after the fall, RN 1 stated that he did not notify the family because the RN Charge nurse had informed him that she (RN Charge nurse) had already called the family.</p> <p>RN 1 acknowledged that he had written the modified progress notes on 12/10/10, three days after the patient's incident of fall and that the post HD treatment assessment notes on 12/7/10 did not include evaluation of the patient's health status after the fall.</p> <p>A review of the modified progress notes written by the RN Charge nurse on 2/4/11, 60 days after the fall, showed that the patient's family called and talked to the charge nurse on 12/7/10 requesting to use a bandage wrap for the patient's access site instead of a tape for the next HD treatment. The progress notes further</p>	V 502			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 502	Continued From page 5 indicated that the RN Charge nurse had informed the family about the patient's fall after the family called the facility and talked to the RN Charge nurse. There was no written evidence found in the HD treatment record and nurse's progress notes which indicated that the Charge nurse had assessed Patient A immediately after the fall and had taken the appropriate steps to provide the care needed for the patient after the fall. A request was made to interview the RN Charge nurse and the Charge nurse was not available. A review of the facility's Policy and procedure titled, "Fall Prevention Procedure" dated September 2008, showed that if a fall occurred, the RN Charge Nurse would be notified to examine (evaluate the patient's current health status) the patient.	V 502			
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement the plan of care to manage the volume status for Patient A by failing to consistently implement the physician's orders in managing the patients' low blood pressure (hypotension) during hemodialysis (HD- the use of a machine to remove waste in the blood) treatment, which had the potential to result in falls and injuries, and other serious medical	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 543	<p>Continued From page 6 condition.</p> <p>Findings:</p> <p>On 2/9/11, Patient A's medical record was reviewed. Patient A had diagnoses that included end stage renal disease (ESRD), hypertension (high blood pressure) and anemia (a low blood count that could make a patient get tired and short of breath).</p> <p>A review of the patient's Hemodialysis Standing Orders dated 2/1/07 for hypotension included, "Normal saline (a salt solution) 200 ml for hypotension. May repeat up to five times. Place (patient) in Trendelenberg position (the lower extremities elevated and head lowered)...."</p> <p>During a review of the patient's HD treatment record dated 12/4/10 and 12/7/10, it was noted that the patient's blood pressure before, during and after HD treatment were abnormally low. (According to the American Heart Association publication dated 2003, "the normal blood pressure for normal adults ranges 90- 119/ 60- 79.") The patient assessment and the patient's blood pressure were documented as follows:</p> <p>1. 12/4/10: Pre-treatment Assessment (by RN 1) - Low BP (90/50), patient verbalized took BP medications before coming in.</p> <p>8:30 AM- BP 85/44; initiate treatment with 200 milliliters (ml) normal saline, BP low, ultra filtration rate (UFR- amount of fluid removed during dialysis treatment) off.... Noted by PCT 3.</p> <p>9:00 AM- BP 92/51; ... eyes closed resting</p>	V 543			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 543	Continued From page 7 comfortably. Noted by PCT 3 9:30 AM- BP 90/53; ... Noted by PCT 3 10:02 AM- BP 94/47; ... Noted by PCT 3 10:30 AM- BP 90/49; ... Noted by PCT 2 11:00 AM- BP 97/54; ... Noted by PCT 4 11:26 AM- BP 95/51; ... Noted by PCT 4 11:55 AM- BP 95/49; ... Noted by PCT 2 12:37 PM- BP 100/53; ... terminated treatment with normal saline. Noted by PCT 3 2. 12/7/10: Pre-treatment Assessment (by RN 1) - Low BP, sodium (Na) variation on profile number 2 (prescribed order during dialysis treatment for a patient with low BP). 09:15 AM- BP 102/52; initiated treatment... Noted by PCT 1. 10:09 AM- BP 98/54; ... Noted by PCT 1. 10:44 AM- BP 107/57; Off for bathroom use. Noted by RN 2. 11:06 AM- BP 108/60; Patient back from restroom. Noted by PCT 1. 12:21 PM- BP 104/57; Noted by PCT 2 1:00 PM- BP N/A; pulse N/A... Terminated treatment with normal saline. Noted by PCT 2.	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 543	Continued From page 8 There was no written evidence found in the treatment records to indicate that RN 1 had reassessed the patient's persistent and excessively low blood pressure during HD treatment and took action to address the problem. The patient's HD treatment records indicated that facility staff had failed to implement the prescribed standing orders for hypotension when the patient showed signs of persistently low blood pressure during the HD treatment. There was no documented evidence found in the treatment records to indicate that the patient was placed in a Trendelenberg position, administered normal saline as ordered when the patient's blood pressure was not restored and remained persistently low, and the physician notified. During an interview with RN 1 on 2/9/11 at 11:10 AM, RN 1 acknowledged that the patient's blood pressure was persistently low before, during and after the HD treatment. RN 1 acknowledged that there was no written evidence in the patient's HD treatment record to indicate that the patient's persistent low blood pressure during dialysis treatment was reassessed and action taken to address the problem.	V 543			
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by:	V 634			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 634	Continued From page 9 Based on interview and record review, the facility failed to ensure that the quality assessment and performance improvement (QAPI) included medical injuries as evidenced by the unavailability of QAPI information on patient fall reports during and/or after HD treatment. This had the potential to result in the facility's failure to review and trend falls and injuries to identify the prevalence and causes of falls, and to develop action plans to prevent further falls. Findings: On 2/9/10, a review of facility's adverse occurrence report (AOR) for the past six months, dated from 6/1/10 to 12/21/10, was conducted. The AOR report showed six (6) fall occurrences, including Patient A's two falls which occurred on 12/7/10 and 7/24/10. During an interview with the facility administrator (FA) on 2/9/11 at 8:45 AM, the facility's QAPI report on patient's injuries including falls was requested for review. At about 10:15 AM, the FA and the clinical care specialist (CCS) stated that the requested QAPI report was still unavailable and that they would continue to look for the report. During the exit conference on 2/8/11 at 11:45 AM, with the FA and the CCS, the requested QAPI report on patient medical injuries and falls was not provided to the surveyor.	V 634			
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE	V 638			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 638	<p>Continued From page 10</p> <p>The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that its performance in prevention of falls, actions taken to improve performance, and tracking performance were continuously monitored as evidenced by the unavailability of QAPI information that included trending patient falls, analysis of root causes of falls, development of improvement plans to prevent further falls, implementation of those plans, evaluation of the success of the plan, and revision of the plan as indicated. This failure resulted in an inadequate Patient Fall Protocol, inaccurate fall assessment conducted for Patient A, and an inadequate patient care plan for fall which further resulted in the death of the patient as a result of fall.</p> <p>Findings:</p> <p>On 2/9/10, a review of Patient A's medical record and the facility's adverse occurrence report (AOR) dated from 6/1/10 to 12/21/10 was conducted. The AOR report included six (6) fall occurrences including Patient A's two falls on 12/7/10 and 7/24/10.</p> <p>Patient A was 64 years of age, admitted to the facility on 8/18/06 for in-center hemodialysis (The use of a machine to clean the blood) treatment and discharged on 12/8/10. The patient had diagnoses that included end stage renal disease (ESRD- a kidney disease), hypertension (high</p>	V 638			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 638	<p>Continued From page 11</p> <p>blood pressure) and anemia (a low blood count that can make a person get tired and short of breath).</p> <p>The discharge summary report dated 12/29/10, indicated that after starting hemodialysis (HD) treatment (Tx) on 12/7/10, the patient requested to go to the restroom and the patient fell while in the restroom. The discharge report further showed that the reason for discharge was that the patient expired on 12/8/10 while in the acute care hospital.</p> <p>During an interview with the facility administrator (FA) on 2/9/11 at 8:45 AM, the facility's QAPI tracking and trending report including the development and evaluation of action plans for falls was requested.</p> <p>At about 10:15 AM, the FA and the clinical care specialist (CCS) stated that the requested QAPI report was still unavailable and that they would continue to look for the report.</p> <p>Further review of the patient's medical record on 2/9/11, showed that the patient's fall risk assessment dated 10/21/10 was inaccurate. The fall risk assessment showed that the patient had a total score of three (3) due to the patient's use of a walker to ambulate (walk). However, the assessment did not include the patient's past history of fall (a score of 6 on the fall risk assessment tool) on 7/24/10, which would have a total fall risk score of nine (9).</p> <p>According to the facility's Fall Prevention policy and procedure dated September 2008, the fall risk assessment guidelines included as follows:</p>	V 638			

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

PRINTED: 05/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/09/2011
NAME OF PROVIDER OR SUPPLIER UPLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 600 N 13TH AVENUE UPLAND, CA 91786		
(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 638	<p>Continued From page 12</p> <p>"Any patient who scores 6 or greater on the Fall Risk Assessment will have 'Critical Fall Risk' precautions implemented and will have a safety component as part of their plan of care. These precautions can be found on the Safety portion of the Patient Care Plan."</p> <p>The patient's Fall and Safety Plan of Care dated 10/21/10, did not include critical risk precautions as part of the care plan.</p> <p>During the exit conference on 2/8/11 at 11:45 AM, with the FA and the CCS, the requested QAPI tracking and trending report, which included the development and evaluation of action plans for falls, was not provided to the surveyor. The FA acknowledged that the patient's fall risk assessment score of 3 was inaccurate and that the care plan would have included critical fall risk precautions.</p>	V 638			