

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: 052797	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2011
NAME OF PROVIDER OR SUPPLIER BIO MEDICAL APPLICATIONS ARDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 37478 CEDAR BLVD UNIT A NEWARK, CA 94560		
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V 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during the investigation of one complaint and one entity reported incident. Complaint number: CA00262257 Entity Reported Incident: CA00262261. Representing the Department: 05819, HFEN The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Complaint CA00262257 and Entity Reported Incident CA00262261 (same issues) were substantiated and two deficiencies were issued.	V 000			
V 452	494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to consistently ensure one patient's right to respect, dignity, and recognition of her sensitivity to her psychological needs. (Patient 1) 1. The facility failed follow the patient's request to bring the insurance card into the facility "On Saturday". 2. The facility failed to provide the patient with an explanation to the delay of treatments "three weeks ago" and document the explanation in the	V 452			

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 452	<p>Continued From page 1 record.</p> <p>3. The facility failed to inform and document the son and physician's decision to change the patient's treatment station location prior to the patient returning to the facility (as noted previously where the daughter indicated that "she would explain" the transfer to her mother".)</p> <p>These failure increased the risk of invoking and escalating disruptive behaviors especially when the patient had a historical assessment of a paranoia condition (a disorder characterized by an elaborate overly suspicious system of thinking, with delusions of persecution).</p> <p>Findings:</p> <p>1. On 3/30/11 and 4/11/11, the review of the "Multidisciplinary Progress Notes", dated 9/30/10 [Thursdays] showed that staff spoke with the Patient 1 about giving a copy of her insurance card to the facility. The notes showed the patient said "her son is the only one home and he can't hear...and will bring insurance card on Saturday..." The notes also showed that staff further requested the patient's daughter to ask the person who picks up the patient, to bring in the insurance card. Subsequently, the notes showed that the "son came and brought the insurance card/patient's purse to the unit" and "pt [patient] started becoming upset and agitated, using profane words..."</p> <p>2. On 3/30/11 and 4/11/11, the review of the "Multidisciplinary Progress Notes", dated 11/9/10 showed Patient 1 was upset, yelling profanity stating that three weeks ago staff started her treatments 30 minutes late.</p>	V 452			

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V 452	Continued From page 2 The review of the patient schedule dated, 10/19/11 (three weeks prior to 11/9/10) showed that Patient 1 was scheduled for three hour treatment duration to start at 5:45 am. The review of the treatment flowsheets dated, 10/19/11 showed that treatment was not started until 6:10 am; on 10/23/10 at 6:14 am; and on 10/30/10 at 6:09 am. There was no indication that any reason for the delay in the start of treatment was provided to the patient, nor any rationale documented in the record for the delay in the start of treatment. Subsequently, the Clinical Administrator acknowledged the deficient practice.	V 452			
V 767	494.180(f)(4) GOV-INVOL DISCHARGE PROCESS REQUIREMENTS The medical director ensures that no patient is discharged or transferred from the facility unless - (4) The facility has reassessed the patient and determined that the patient's behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient's interdisciplinary team- (i) Documents the reassessments, ongoing problems(s), and efforts made to resolve the	V 767			

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V 767	<p>Continued From page 3</p> <p>problem(s), and enters this documentation into the patient's medical record;</p> <p>(ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge;</p> <p>(iii) Obtains a written physician's order that must be signed by both the medical director and the patient's attending physician concurring with the patient's discharge or transfer from the facility;</p> <p>(iv) Contacts another facility, attempts to place the patient there, and documents that effort; and</p> <p>(v) Notifies the State survey agency of the involuntary transfer or discharge.</p> <p>(5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all staff follow the facility's involuntary discharge policies and procedures to completely document their attempted reassessment and efforts made to resolve the ongoing disruptive behavioral problems in the record for one patient. (Patient 1) This failure did not ensure that the facility effectively managed the disruptive behavior resulting in the patient's involuntary discharge from the facility.</p> <p>Findings:</p> <p>During two visits to the facility on 3/30/11 and 4/1/11, the Facility Administrator stated the facility utilized the policy, dated 11/16/05, entitled " Management of Patient/Provider Conflict (138-030-170); Disruptive Patient Policy</p>	V 767			

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V 767	<p>Continued From page 4</p> <p>(138-030-170-1); Involuntary Discharge Policy 9138-030-170-2) " , to manage patients with disruptive behavior. The policy instructed, "Any attempt to calm a person who is verbally acting out in the facility should be approached with care and caution...Inform the patient that no further treatment can be provided..until a meeting has occurred...The team should schedule a meeting immediately following the incident... Questions for team to consider included "what condition must the patient agree to in order to continue to receive treatment in the facility [agreement to condition of a behavior contract..., anger management?]" The "Behavior Contracts" section of the policy showed that, "Behavior contracts are ...a tool that defines behavior that is disruptive to a dialysis facility's operation which must be stopped or controlled by the patient." This section of the policy further showed that " a behavior contract, as an intervention tool, has a better chance of success if it used when a problem is first identified " and that " most problem behaviors ...can be defused, corrected and/or managed to prevent involuntary discharge, if addressed early on. " The facility policy further instructed the staff to schedule a meeting with the patient and to involve the pateint in the development of an action plan. "If the patient agrees to all conditions, schedule the next dialysis treatment and and begin efforts to work with staff to cooperate with the agreed plan", the policy further instructed.</p> <p>Record review on 3/20/11 showed Patient 1, a 78 year-old female, was admitted for treatments on 8/26/10. The transfer records from the acute care hospital indicated Patient 1 had a long history of mental illness and "had innumerable episodes of outrageously angry, violent behavior that have</p>	V 767			

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V 767	<p>Continued From page 5</p> <p>required her to be psychiatrically hospitalized ." The "Mental Neurological Status" section of the Initial Comprehensive Interdisciplinary Assessment, dated 8/30/10, included Patient 1's mental health history, however the "Psychosocial Status" section of the Initial Care Plan, dated 9/23/10, did not address the patient's needs related to her mental health issues.</p> <p>Further record review showed Patient 1 became very upset and used profanities when staff requested that her insurance card be brought in by teh pateitn's son on 9/30/10 and not the next treatment day. A "Multidisciplinary Progress Notes", dated 10/05/10 at 9:00 a.m. showed that during treatment, Patient 1 complained of cramping, yelled, and was verbally abusive to staff.</p> <p>Record review showed no evidence that a meeting was held with Patient 1 after she exhibited behavioral problems. Patient 1's plan of care was not updated to reflect her behavior and to address teh nursing interventoins planned to manage the behaviors.</p> <p>Review of the "Multidisciplinary Progress Notes", dated 11/9/10, showed Patient 1 "was very rude, yelling & verbalizing bad words loudly...stating all sort of bad words. Apparently pt. has been verbally abusive to staff members taking care of her, threatening staff that she will hurt someone if this continues..." On 11/9/10, Patient 1's physician increased the dose of Seroquel (mood stabilizer). There was no update to Patient 1's plan of care to reflect the escalating disruptive behavior.</p>	V 767			

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V 767	<p>Continued From page 6</p> <p>The review of the "Multidisciplinary Progress Notes" dated, 11/23/10 showed, "Upon taking off the patient, she started yelling at one of the PCT [patient care technician]. She almost hit her while she was helping me. I tried to talk to patient to be calm but kept saying bad words, "Bull Shit & She's a bitch."</p> <p>On 11/23/10, a multidisciplinary meeting was held with staff, patient and patient's daughter. In summary, the review of the the multidisciplinary team meeting document, dated 11/23/10 showed a tentative plan which:</p> <ul style="list-style-type: none"> a. Identified the patient's disruptive behavior (to the clinic and patients as well as an allegation that patient almost hit a staff) b. Offered (and patient accepted) a different shift (per daughter's request on 4 th shift) c. Granted the patient's daughter's wish for a private room (Station 12) d. Patient agreed to comply with the facility's unwanted behavior (to include taking her Seroquel medication and having routine blood pressure checks done). e. Patient was given 30 days to improve; and f. A follow-up meeting scheduled on December 27, 2010. <p>The review of the Social Worker Note, dated 11/23/10 showed that staff found an opening for the patient on the Monday, Wednesday, Friday schedule in a Private Room (Station 12).</p> <p>On 3/30/11 at approximately 11:30 am, the Charge Nurse stated that the designated Private Quiet Room (with less external stimuli) utilized as station 12 was assigned for Patient 1.</p>	V 767			

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V 767	<p>Continued From page 7</p> <p>The review of the Updated Care Plan, dated 11/23/10 showed:</p> <p>a. The intervention to the "Behavior Issue" problem included a patient and family member meeting "to discuss behavioral issues and how pt. [patient] can deal with it."</p> <p>b. The expected outcome/timetable where the "pt will take the prescribed medication to control behavior prior to HD[hemodialysis], and will adhere to treatment modifications as discussed with her within 1 month."</p> <p>The review of the "Multidisciplinary Progress Notes" dated, 11/26/10 showed, "Pt came in upset, cursing me..."</p> <p>The review of the "Multidisciplinary Progress Notes" dated, 11/29/10 showed that when staff attempted to do the patient's pre-assessment, the patient reuse, "started yelling, stating 'You are a liar! Called me all sorts of names including a 'Bitch'...and walked out."</p> <p>The review of the "Multidisciplinary Progress Notes" dated, 3/9/11 showed, "During treatment today, pt machine was alarming, PCT were trying to fix the problem, but pt. kept on cursing and yelling at them...causing other pts anxiety."</p> <p>The review of the "Multidisciplinary Progress Notes" dated, 3/11/11 showed, "...She started yelling at me, calling me a 'Bitch'."</p> <p>There was no 30 day follow-up meeting as planned on December 27, 2010 (nor January, 2011 or February, 2011) to possibly consider the condition the patient would agree to in order to continue to receive treatment in the facility. i.e., agreement to a formalized behavior contract? Additionally, there was no updated plan of care</p>	V 767			

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V 767	<p>Continued From page 8</p> <p>addressing the continuing and escalating disruptive behavior with additional/changed interventions, timetables, etc.</p> <p>On 3/30/11 at approximately 11:30 and during an interview, the Charge Nurse stated that during the interim, Patient 1 was intermittently transferred from a free standing station (Stations 8) to a Quiet Private Room station (Station 12 with lower external stimuli), and back to the free standing station (Station 8). The Charge Nurse stated that the changes were done through patient/family requests and patient availability seating schedule arrangements. The Charge Nurse stated that during an interval when the patient's behavior was disruptive the weekend prior to the assaultive adverse incident occurrence on 3/14/10, the physician and son agreed to the patient transfer from the free standing station back to the Quiet Private Room (Station 12). The Charge Nurse further stated that she was informed of the change, the schedule was adjusted to accommodate the change, but did not inform the patient as indicated in the above policy. For example, the "Introduction " section of the policy showed that one example of a situation in the dialysis facility that might result in a patient becoming verbally inappropriate or abusive was: "Not being informed in advance of changes in the facility that directly impact patients." (Cross reference to V 452)</p> <p>The review of "Multidisciplinary Progress Notes" dated, 3/14/11 (Monday) at 9:30 am showed, "Pt came in for her regular treatment. Certified Hemodialysis Technician [CHT] 1, informed her that she is assigned at Chair # 12 [Quiet Room/Station 12], she [Patient 1] started talking</p>	V 767			

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V 767	Continued From page 9 in a loud voice & refusing to go to her assigned chair. CHT called me [Charge Nurse] to explain to her about chair assignments. While I was explaining to her, she started yelling at me, calling me names & said 'I will sit wherever I want.' ...and then she suddenly slapped me with the paper pad she was holding." Subsequently the police was called and patient was involuntarily discharged from the facility.	V 767		