

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

PRINTED: 05/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES CHANNEL ISLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 2679 B SAVIERS RD OXNARD, CA 93033		
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V 000	INITIAL COMMENTS The following represents the findings of the Department of Public Health during a Recertification Survey. The facility census at the time of the survey was 109 patients. The patient sample was 11 hemodialysis patients. Representing the Department of Public Health: Surveyor 26615, HFE-N and Surveyor 27316I, HFE-N	V 000			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation, review of facility policy and procedure, and interview, the facility failed to ensure that staff implemented infection control precautions for glove use and hand hygiene in the dialysis treatment area to prevent transmission of infectious agents. Three staff members (PCT 1, PCT 2, and PCT 3) failed to wash their hands for a sufficient length of time in accordance with CDC recommendations and facility procedure. Additionally, PCT 1 failed to remove her gloves and wash or sanitize her hands and picked up a box of gloves with dirty gloves, and PCT 2 failed to wash/sanitize her hands after removing soiled gloves.	V 113		3/9/11	

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>Findings:</p> <p>The facility's policy and procedure titled, "Hand Hygiene", dated 10/10/08, was reviewed. The purpose of the policy is to promote hand hygiene practices and prevent transmission of pathogenic microorganisms to patients and staff through cross contamination.</p> <p>The facility policy requires staff to wash hands with antimicrobial soap and water when hands are visibly dirty or contaminated with proteinaceous material, blood, or other body fluids, before eating, after using the restroom, before entering and leaving the treatment area and when exposed to anthrax or C-difficile. The policy also requires staff to decontaminate their hands using an alcohol based hand rub or by washing their hands with antimicrobial soap and water before direct contact with patients, after removing gloves, after contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, after contact with equipment, computers, furniture or other items near the patient and before inserting invasive devices.</p> <p>CDC recommendations and the facility's procedure for hand hygiene require vigorously rubbing hands together for 15 seconds when washing the hands, and covering all surfaces of the hands and fingers until hands are dry when using an alcohol based hand rub.</p> <p>1. During an observation on 1/19/11 at 9:15 a.m., Patient Care Technician (PCT) 1, was wearing gloves and touched Patient 12 on an area near the patient's dialysis access. PCT 1 did not</p>	V 113			

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V 113	Continued From page 2 remove her gloves and wash/sanitize her hands, and walked over to a rolling supply cart, picked up a box of gloves, and removed one glove from the box. 2. a. On 1/19/11 at 9:32 a.m., PCT 1 was observed washing her hands at a sink in the treatment area between treatment stations 4 and 5. She washed her hands for 7 seconds, and not 15 seconds in accordance with the facility's procedure and CDC recommendations. b. At 9:48 a.m. on 1/19/11, PCT 2 was observed washing her hands at a sink in the treatment area between stations 4 and 5 and washed her hands for only 8 seconds. c. On 1/19/11 at 10:23 a.m., PCT 3 was observed washing her hands at the sink in the treatment area near station 15, and washed her hands for a total of only 10 seconds 3. During an observation on 1/19/11 at 10:06 a.m., PCT 2 removed her soiled gloves after cleaning equipment used by a patient, but failed to wash or sanitize her hands after removing her gloves. In an interview on 1/19/11 at 4:10 p.m., the Clinic Manager, Clinical Educator, and Director of Operations verified that staff must wash hands for a minimum of 15 seconds, and must either wash or decontaminate their hands using an alcohol based hand sanitizer after removing soiled gloves.	V 113			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and	V 114		3/9/11	

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V 114	<p>Continued From page 3</p> <p>soap should be available to facilitate hand washing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and review of facility policy, the facility failed to ensure that four sinks handwashing sinks in the treatment area were dedicated for handwashing.</p> <p>Findings:</p> <p>The facility policy and procedure titled "Hand Hygiene" dated 10/10/08 was reviewed. The policy includes a section titled "Sink Policy" which states, "Handwashing sinks shall be dedicated only for handwashing purposes and should remain clean... Avoid placing, cleaning or draining used items in handwashing sinks."</p> <p>1. During an observation on 1/19/11 at 11:13 a.m., RN 1 poured the remaining solution from a plastic two liter pitcher into the drain of a sink labeled "Handwashing" near treatment station 15, and rinsed the empty pitcher with tap water.</p> <p>2. On 1/19/11 at 2:15 p.m., accompanied by the Clinical Educator, sinks labeled as "Handwashing" sinks had items stored on the counters by the sinks. The sinks were located between treatment stations 4 and 5, and near treatment stations 11, 15 and 16.</p> <p>The sink between stations 4 and 5 had a two liter plastic pitcher filled with a diluted bleach solution and a rectangular opaque dark blue container which contained clamps. The sinks near stations 15 and 16 had a two liter plastic pitcher filled with</p>	V 114			

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V 114	Continued From page 4 a diluted bleach solution, and the sink near station 11 had a cleaning/disinfection unit for the Phoenix meter (pH and conductivity device), a two liter plastic pitcher filled with a diluted bleach solution, and a rectangular opaque dark blue container which contained clamps.	V 114			
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT 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. -- 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. -- 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. This STANDARD is not met as evidenced by: Based on observation, review of facility policy and procedure, and interview, the facility failed to ensure that a tympanic thermometer and a digital thermometer that were used to measure the temperature of dialysis patients were cleaned and disinfected after use, and before storage in a common area, to prevent cross contamination and transmission of infectious agents. Findings:	V 116		3/9/11	

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V 116	<p>Continued From page 5</p> <p>The facility policy and procedure titled "Dialysis Precautions" dated 10/10/08, was reviewed and states, "Items taken into the dialysis station should be disposed of, dedicated for use only on a single patient, or cleaned and disinfected as appropriate before they are taken into a common area or used on another patient."</p> <p>1. During an observation on 1/19/11 at 9:15 a.m., PCT 1 obtained the temperature of Patient 17 with a tympanic thermometer. PCT 1 did not disinfect the thermometer after taking the patient's temperature and returned the thermometer to a supply cart in front of a desk.</p> <p>The manufacturer's directions for use of the thermometer were reviewed and state, "Use a soft cloth slightly moistened with alcohol to clean the thermometer display and exterior."</p> <p>The Clinical Manager (CM), Clinical Educator (CE), and Director of Operations (DO) were interviewed on 1/19/11 at 4:10 p.m., and confirmed tympanic thermometers require disinfection between patient use and prior to being stored in a common area.</p> <p>2. On 1/25/11 at 3:03 p.m., a digital thermometer was observed in the treatment area in a common supply box. RN 2 was interviewed at the time of the observation and indicated that he purchased the digital thermometer from a local drug store for a patient who did not want the tympanic thermometer used in his ear canal. RN 2 could not explain how the digital thermometer was supposed to be cleaned/disinfected after use.</p> <p>In an interview on 1/25/11 at 4:02 p.m., the CM</p>	V 116			

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V 116	Continued From page 6 and DO stated that facility staff should not be using the digital thermometer, and indicated that other alternatives, such as Tempa Dots (sterile single use disposable oral/axillary thermometers), are available and should be used.	V 116			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on observations, facility policy and procedure review, and interview, the facility failed to implement procedures for cleaning and disinfection of contaminated surfaces, medical devices and equipment in dialysis stations to prevent transmission of infectious agents between patients and staff. Visible dried blood was observed on treatment chairs in two of twenty dialysis stations (Station 10 and 19) that were cleaned/disinfected by staff during patient changeover and identified as ready for patient use. Staff also failed to ensure surfaces, devices and equipment including the blood pressure tubing and cuff, television and television extension arm and the computer monitor and keyboard in one dialysis station (Station 19) were cleaned/disinfected after a treatment.	V 122		3/9/11	

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V 122	<p>Continued From page 7</p> <p>Findings:</p> <p>The facility policy and procedure titled "Cleaning and Disinfection", dated 10/10/08, was reviewed. The policy section titled "General Cleaning" states, "All equipment and work surfaces shall be cleaned and decontaminated after completion of procedures ..." The section titled "Cleaning Non-Disposable Patient Care Supplies" states, "Non-disposable items such as blood pressure cuffs, IV poles, TVs, TV remotes, portable phones etc., as well as clip boards or plastic hemostat clams placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment.</p> <p>The procedure titled "Cleaning the Dialysis Station Between Patient Treatments" dated 10/10/08 was also reviewed and states " Clean and disinfect the dialysis station or treatment area (chair, bed, table, machine, television, IV Pole, B/P cuff, hand sanitizer dispenser and holder, etc.) after each patient treatment with 1:100 bleach solution. Place the chair in Trendelenburg position (flat with foot higher than head) so all surfaces are accessible. Wipe all surfaces and under the arms and side table with the 1:100 bleach solution. Give special attention to cleaning control panel on the dialysis machine and other surfaces that are frequently touched and potentially contaminated with patients' blood and/or body fluids..."</p> <p>The facility policy titled "Dialysis Precautions" dated 10/10/08 also addresses "Computer Use", and states, "The LCD screen should be cleaned with computer screen wipes or a damp cloth with</p>	V 122			

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V 122	<p>Continued From page 8</p> <p>a 1:100 bleach solution if contaminated or soiled. The keyboard should be cleaned with 'damp only' cloth using a 1:100 bleach solution if contaminated..."</p> <p>1. On 1/19/11 at 9:48 a.m., PCT 2 was observed while cleaning/disinfecting treatment station 19 following a dialysis treatment. PCT 2 wiped the treatment chair with bleach solution, then handled the tubing connecting the blood pressure cuff to the dialysis machine. She draped the blood pressure cuff used by the previous patient on the treatment chair without disinfecting the blood pressure cuff and tubing, contaminating the chair. During the cleaning of the dialysis station, PCT 2 did not disinfect the TV screen or TV extension arm and did not disinfect the computer monitor or keyboard located used for charting which was located in the treatment area.</p> <p>The Clinic Manager, Clinical Educator, and Director of Operations were interviewed on 1/19/11 at 4:10 p.m., and acknowledged facility procedures for cleaning and disinfection of the dialysis station between treatments were not implemented.</p> <p>2. During observations on 1/19/11 at 2:17 p.m., facility staff was asked if the treatment chair at station 10 was ready for use, and indicated the treatment chair was clean and ready for the next patient. Upon visual inspection of the chair, however, a dime-sized smear of dried blood was observed on the inner side of the right arm rest.</p> <p>The staff was also asked about the treatment chair in station 19, and verified it was ready for</p>	V 122			

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V 122	Continued From page 9 use by the next patient. Upon inspection, however, a dried blood smear was observed on the left lower side on the metal extension mechanism.	V 122			
V 228	Following the observations staff wiped the area on each of the chairs with bleach solution and removed the dried blood. 494.40(a) MIXING SYSTEMS-LABELING 5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine. Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until the tank has been emptied. Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents. Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure labels on the bicarbonate and acid mixing tanks included the date of	V 228		3/9/11	

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V 228	Continued From page 10 preparation. Findings: During an observation on 1/24/11 at 12:45 p.m., the label on the bicarbonate mixing tank was inspected and did not include the date the bicarbonate solution was mixed. The label on the granuflo (acid) mixing tank was also inspected and did not note the date the acid solution was mixed. The Biomedical Technician (BM) was interviewed at the time of the observation and could not state when the bicarbonate and acid solutions were mixed from the information on the labels.	V 228			
V 229	494.40(a) MIXING SYSTEMS-PERM RECORD/VERIF TEST 5.4.4.1 Mixing systems: perm record/verification testing In addition to container labeling, there should be permanent records of batches produced. These records should include the concentrate formula produced, the volume of the batch, the lot numbers of powdered concentrate packages, the manufacturer of the powdered concentrate, the date and time of mixing, any test results, the person performing the mixing, the person verifying mixing and test results, and the expiration date (if applicable). 6.4.1 Mixing systems Acid and bicarbonate concentrates may be tested by using conductivity or by using a hydrometer. Concentrates should not be used or transferred to holding tanks or distribution systems until all tests are completed. The test results and verification	V 229		3/9/11	

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V 229	<p>Continued From page 11</p> <p>that they meet all applicable criteria should be recorded and signed by the individuals performing the tests.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility records and policies and procedures, the facility failed to ensure that logs of the acid and bicarbonate mixing systems included all required information, and that facility policies and procedures for mixing and testing acid and bicarbonate concentrates specified acceptable ranges for the specific gravity of acid concentrate and for conductivity of bicarbonate concentrate solutions.</p> <p>Findings:</p> <p>1. The facility's acid and bicarbonate solution mixing logs were reviewed on 1/24/11 at 12:45 p.m. The log for the acid concentrate solution did not include the volume mixed, the manufacturer of the dry acid product used in the preparation of the acid solution, and the expiration date of the dry acid product used to prepare the acid solution. The bicarbonate solution mixing log did include the manufacturer of the dry bicarbonate product used in the preparation of the bicarbonate solution, and the expiration date of the dry bicarbonate product used to prepare the bicarbonate solution.</p> <p>In an interview concurrent with the review, the Regional Biomedical Educator (RBME) verified the logs were missing the required information.</p> <p>2. The facility policy and procedure titled "Acid Concentrate Mixing and Handling, Hemodialysis Concentrate Dissolution Unit" dated 7/31/09, was</p>	V 229			

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V 229	Continued From page 12 reviewed and states, "Specific gravity of the acid concentrate solution must be within plus or minus two percent, (+/-2%) of the expected specific gravity." The policy and procedure titled "Concentrate Mixing and Handling, Bicarbonate Concentrate Testing" dated 7/31/09, was also reviewed and states, "Each facility must establish a range of conductivity for bicarbonate concentrate solution prepared in a bicarbonate mixer."	V 229			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on observation, facility document review, and interview, the facility failed to maintain a program that assured equipment used in the facility was safe and functioning properly. The facility failed to ensure the schedule for semi annual and annual maintenance on two of 22 dialysis machines (machines 9 and 20) and preventative maintenance for five of 22 dialysis machines (machines 1, 2, 11, 15, and 16) was performed timely. The facility also failed to ensure that the manufacturer's instructions for daily care	V 403		3/9/11	

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V 403	<p>Continued From page 13</p> <p>of three of 3 Phoenix meters (instrument used to measure pH and conductivity of dialysate) were consistently carried out, that the temperature of a refrigerator utilized to store medications and vaccines was monitored per the facility's policy and procedure, and that one of 20 treatment chairs with torn upholstery was repaired or replaced.</p> <p>Findings:</p> <p>1. In an interview on 1/24/11 at 2:43 p.m., the Biomedical Technician (BM) indicated the facility has a total of 22 dialysis machines and he is responsible for scheduled maintenance of the machines. Per the schedule, dialysis treatment machines are serviced quarterly or every 1000 hours of use (based on what comes first, every six months (semi-annual) or 2000 hours of use, and annually or every 4000 hours of use.</p> <p>The facility's preventative maintenance procedures were reviewed. The "Preventative Maintenance Checklist Annual/4000 Hours", includes a 27 point checklist list to ensure dialysis machines are safe and functioning properly. The "Preventative Maintenance Checklist Six (6) Months", involves a ten point checklist.</p> <p>a. The "Equipment Repair Record" for dialysis machine 9 (5IKOS664D) was reviewed and noted the annual service was performed on 7/7/10. There was no documentation, however, the semi annual service due 1/7/11 had been performed.</p> <p>b. The "Equipment Repair Record" for dialysis machine 20 (5KOS739D) was reviewed and indicated the semi annual service was performed</p>	V 403			

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V 403	<p>Continued From page 14</p> <p>6/10/10. There was no documentation, however, that the annual service, due 12/10/10, had been completed. The last annual service documented was on 12/24/09.</p> <p>At the time of the review, machine 9 was not being utilized on the treatment floor, however, machine 20 was being utilized at station 13. The BM acknowledged that the scheduled maintenance for machines 9 and 20 was past due.</p> <p>c. Further review of "Equipment Repair Records" revealed the following:</p> <ol style="list-style-type: none"> 1. The length of time between the annual and semi annual service for dialysis machine 1 (5KOS295D) and dialysis machine 2 (5KOS306D) was six months and seven days. 2. The length of time between the annual and semi annual service for dialysis machine 11 (5KOS673D), was six months and three days, and exceeding the hours of use by 46 hours. 3. The length of time between the semi annual and annual service for dialysis machine 15 (5KOS691D), was six months and 13 days. 4. The length of time between the semi annual and annual service for dialysis machine 16 (5KOS691D), was six months and two days. <p>2. The manufacturer's directions for the "Tri-Station" (a self-contained preventative maintenance system for dialysis/Phoenix meters), were reviewed. Directions for the steps to be performed daily before use of the Phoenix Meters state:</p> <p>1-RINSE In the morning, expel the NEO-CARE (a solution which removes hard deposits and bacterial film that can cause inaccurate meter</p>	V 403			

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V 403	<p>Continued From page 15</p> <p>readings) into an appropriate receptacle. Rinse 2-3 times with RO (reverse osmosis) water to ensure that all NEO-CARE has been removed.</p> <p>2-DISINFECT Draw bleach solution through the cell completely filling the syringe barrel. Allow the bleach solution to remain in the syringe for 10 minutes (no longer, as it can corrode internal parts).</p> <p>3-RINSE Expel the bleach solution in to an appropriate receptacle. Rinse 2 or 3 times with RO water to ensure that all residual bleach solution has been removed.</p> <p>4-VERIFY Connect the cell to the standard solution bottle. Hold the syringe with the plunger end elevated so that any air bubbles remain in the syringe. Draw solution through the cell and then expel several times through the one-way valve. Observe the reading as the solution flows INTO the cell.</p> <p>5-RINSE At the end of the day, draw NEO-CARE into the syringe 2-3 times. Disconnect the meter from the NEO-CARE solution and draw the syringe halfway back pulling air into the cell and then cap the sample port. Place your meter in the instrument holder rack for overnight storage.</p> <p>The section titled, "Cleaning Your Instrument" (Phoenix Meter), from the manufacturer's Test Instrument User's Guide was reviewed and states, "Draw NEO-CARE solution through the cell and into the syringe. Allow it dwell within the meter and syringe for at least 10 minutes. Rinse thoroughly with RO water. For added convenience and time savings, you may safely store your meter with NEO-CARE in the cell and syringe overnight. Simply expel the NEO-CARE the next morning and rinse thoroughly with RO</p>	V 403			

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V 403	<p>Continued From page 16 water."</p> <p>The facility's "Phoenix Meter Calibration Log Sheets" were reviewed. The log sheets record daily meter verification and monthly calibration, and are also used to document daily rinsing and/or storage of the meter with NEO-CARE each p.m., and daily disinfection of the meter with bleach solution each a.m. prior to use, in accordance with the manufacturer's instructions. The following documentation for daily rinsing/storage and disinfection of the Phoenix meters was missing:</p> <p>June 2010: Meter #1 (P16845)-a.m. bleach 6/5 Meter #2 (P12998)- a.m. bleach 6/4 and 6/5; p.m. NEO-CARE 6/2 and 6/21 Meter #3 (P10118)- a.m. bleach 6/3; p.m. NEO-CARE 6/5 During the month of</p> <p>July 2010: Meter #1-a.m. bleach 7/23 Meter #2-a.m. bleach 7/23; p.m. NEO-CARE 7/30</p> <p>August 2010: Meter #3-a.m. bleach 8/3</p> <p>October 2010: Meter #2-p.m. NEO-CARE 10/24</p> <p>November 2010: Meter #2- p.m. NEO-CARE 11/6 and 11/30</p> <p>3. The refrigerator, located in the treatment area, is used to store medications and vaccines. Both Medications requiring refrigeration and vaccines must be stored within an acceptable temperature</p>	V 403			

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V 403	Continued From page 17 range. Because most vaccines have minimal tolerance to excessive temperatures and may be rendered less effective or ineffective once the manufacturer's established temperature limits are exceeded, the temperature of refrigerators used to store vaccines should be monitored and recorded twice a day. The facility document titled "F* Refrigerator Temperature Log", dated 6/09 was reviewed, and states that the temperature of the refrigerator is to be recorded twice a day (a.m. and p.m.), notes the acceptable temperature range for the refrigerator as 35 to 46 degrees Fahrenheit (F), and provides instructions for the actions to be taken if the temperature is too cold or too warm (above 46 degrees F or below 35 degrees F). Review of the facility's temperature logs from October through December 2010 and January 1-18, 2011 revealed that the p.m. temperatures were not recorded to ensure the refrigerator was functioning properly on 10/12/10, 11/4/10, 12/24/10, 12/31/10 and 1/17/11. 4. During an inspection on 1/19/11 at 2:17 p.m., the treatment chair at station 18 was observed to have a tear in the upholstery (wipeable surface) measuring approximately one half inch in length on the left arm rest portion of the chair. An intact surface is necessary to ensure adequate disinfection between patient use, however, the chair remained available for use.	V 403			
V 470	494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO The dialysis facility must prominently display a copy of the patient's rights in the facility, including	V 470		3/9/11	

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V 470	Continued From page 18 the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the mailing address and telephone complaint number of the State Agency was prominently displayed in the facility. Findings: During an inspection of consumer information posted in the lobby area of the facility on 1/19/11 at 8:02 a.m., information including the mailing address and complaint telephone number of the State Agency was not observed. The facility's Social Worker was interviewed on 1/19/11 at 8:35 a.m. and verified that the contact information for the state survey and certification agency was not posted. Patient 19 was interviewed on 1/27/11 at 8:46 a.m., and indicated that things are fine at the facility. He was not aware, however, where contact information (name, address and telephone number) for the state agency could be found if he had a complaint.	V 470			
V 516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.	V 516		3/9/11	

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V 516	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessment was completed within 30 days or 13 hemodialysis sessions, for two of 11 sampled patients (Patients 6 and 7), to ensure the patients' care needs were met.</p> <p>Findings:</p> <p>1. On 1/24/11 at 8:12 a.m., Patient 6's record was reviewed. Patient 6 was admitted on 12/16/10 with diagnoses including end stage renal disease (ESRD) and hypertension, however, there was no comprehensive assessment and plan of care in the record.</p> <p>In an interview concurrent with the review, the Clinical Manager (CM) verified that the comprehensive assessment and plan of care were not complete and were due by 1/13/10 (30 days or 13 treatments). The CM indicated that care plan meetings are scheduled according to the physician's schedule and not the patient's date of admission, and acknowledged that the patient had received 17 treatments as of the date of the review.</p> <p>2. On 1/24/11 at 9:44 a.m., Patient 7's record was reviewed and indicated he was admitted on 12/10/10 with diagnoses including ESRD, diabetes mellitus and pleural infusion (excess fluid). The comprehensive assessment and plan of care could not be located in the record.</p> <p>In an interview concurrent with the review, the CM</p>	V 516			

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V 516	Continued From page 20 stated that Patient 7 patient had missed five treatments due to a recent hospitalization. She acknowledged that the comprehensive assessment and plan of care were due on 1/19/11 (30 days or 13 treatments), and had not been completed as of the date of the review.	V 516			
V 758	494.180(b)(1) GOV-RN, MSW, & RD AVAIL TO MEET PT NEEDS The governing body or designated person responsible must ensure that- The registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a registered dietician was available a sufficient amount of hours to meet patient clinical needs. Monthly evaluations and progress notes were not completed for 8 of 11 sampled patients in December 2010, and initial comprehensive assessments (which includes nutritional needs) were not completed timely for 2 of 11 sampled patients admitted in December 2010. Findings: On 1/20/11, the records of Patients 1, 2, 3, 4, 5, 6, 9 and 10 were reviewed and monthly progress notes by the Registered Dietician (RD) were missing for the month of December 2010. On 1/24/11, the records of Patients 6 and 7 were reviewed. Patient 6 was admitted on 12/16/10	V 758		3/9/11	

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V 758	Continued From page 21 and Patient 7 was admitted on 12/20/10, however, the comprehensive assessment and plan of care which includes nutritional status had not been completed by the interdisciplinary team and was past due. The RD was interviewed on 1/25/11 at 1:08 p.m., and reported that the facility's RD was on a medical leave and normally works 32 hours per week at the facility. She stated that she was asked to work 20 hours per week at the facility and works 20 hours per week at another facility. She indicated that facility administration was aware of the hours she was working, and verified that she was not current with monthly dietary notes or assessments.	V 758			