

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 represents the findings of the Department of Public Health during a Recertification Survey. The facility census was 158 patients. The patient sample was 13. Representing the Department of Public Health: 26615, HFE-N 27316, 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 procedures for hand hygiene, to prevent transmission of infection agents, by failing to wash hands for a sufficient amount of time, and failing to perform hand hygiene after removing gloves and after contact with equipment. Findings: The CDC recommends 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.	V 113		4/14/11	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 113	Continued From page 1 The facility's policy and procedure titled "Hand Hygiene", dated 10/10/08, was reviewed and states, "Follow the procedure outlined below when washing hands with soap and water. 1. If gloves are worn, remove and discard in appropriate waste container. 2. Turn on warm running water. 3. Wet hands with running water. 4. Apply soap to hands using amount recommended by the product manufacturer, frequently three to five milliliters. 5. Rub hands together vigorously for at least 15 seconds. Cover all surfaces of the hands and fingers. 6. Rinse hands with running water and dry thoroughly with a disposable towel. 7. Turn off water faucet using a hands free control or by touching the sink wrist blades with a clean single use paper towel." The policy also indicates that hands should be decontaminated by using an alcohol based hand rub or by washing 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. Before inserting invasive devices (e.g. fistula needles, and IV catheters)." 1. During an observation on 2/8/11 at 3:38 p.m., PCT 1 was observed washing her hands at a sink in the treatment area near treatment station 30, and washed her hands for only 7 seconds. 2. On 2/9/11 at 9:32 a.m., RN 1 was observed washing his hands at the sink near treatment station 10 and washed his hands for only 6	V 113			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 113	Continued From page 2 seconds. 3. During an observation on 2/10/11 starting at 9:45 a.m., PCT 2 cleaned the dialysis machine at station 15, and a container of hand sanitizer in a bracket on the machine. PCT 2 picked up the hand sanitizer without removing the dirty gloves and washing/sanitizing her hands, offered a squirt of hand sanitizer to Patient 14, then placed the container back in the bracket. 4. Each computer monitor in the treatment area had a label which stated, "hand hygiene before and after use." During observations on 2/10/11 at 9:45 a.m., however, PCT 2 and PCT 3 used the computer charting system between stations 14 and 15 without performing hand hygiene. At 10:31 a.m., PCT 3 was again observed using the computer between stations 14 and 15 without performing hand hygiene. The Clinical Manager (CM) was interviewed on 2/11/11 at 3:55 p.m., and confirmed that 15 seconds is the minimum time required for washing hands, and that washing or decontaminating the hands with an alcohol based hand sanitizer is required after removing soiled gloves. She also indicated that labels were placed on the computer monitors, " to remind the staff about cleaning their hands before and after using the computer."	V 113			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.	V 114		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 114	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, facility policy and procedure review, and interview, the facility failed to ensure that warm water was available at two handwashing sinks to facilitate handwashing by patients and staff. The facility also failed to ensure that one sink labeled for "handwashing" was dedicated for handwashing and remained clean. Findings: The facility policy and procedure titled "Hand Hygiene" dated 10/10/08, was reviewed and indicates, "Handwashing sinks shall be dedicated only for handwashing purposes and should remain clean. Avoid placing, cleaning or draining used items in handwashing sinks." 1. During an observation on 2/8/11 at 2:55 p.m., there was no warm water at the handwashing sinks by stations 21 and 22. The water was turned on and ran for more than one minute, but remained cold. The Clinical Educator (CE) was present during the observation and concurred. 2. During a subsequent observation on 2/8/11 at 2:55 p.m., a sink labeled for "Handwashing" located near 30 had a rack holding a Phoenix meter (pH and conductivity meter used to test dialysate), six different cleaning/disinfection solutions, and a tube draining fluid down the sink drain.	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	V 116		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 116	<p>Continued From page 4</p> <p>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, policy and procedure review, and interview the facility failed to ensure that items taken into dialysis stations were disposed of, or cleaned and disinfected before being taken to a common area. Educational materials made of paper which could not be disinfected were left in two dialysis stations and not disposed of, and a medical supply cabinet in the treatment area contained items that were no longer sterile that had not been discarded.</p> <p>Findings:</p> <p>The facility policy and procedure titled "Dialysis Precautions", dated 10/10/08, was reviewed and indicates, "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. On 2/8/11 starting at 2:55 p.m. accompanied</p>	V 116			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 116	Continued From page 5 by RN 2, papers (educational material) titled "Your Heart and Well Being" and "Infection and Inflammation", were observed in the open shelving units behind treatment stations 13 and 17. The papers were non wipeable and could not be disinfected. RN 2 was not able to determine who the papers belonged to or how long they had been at the stations. 2. During a subsequent observation on 2/8/11 starting at 2:55 p.m., two packages of sterile sponges and a syringe were observed in a medical supply cabinet located by treatment station 12. Numbers resembling blood pressure readings were written on the sponge packages and punctured the packaging, rendering the sponges no longer sterile or safe for patient use. The syringe had also been removed from its protective sterile wrapping and was laying in the bottom of the cabinet. PCT 4 was interviewed at the time of the observation and indicated that she was the one who had written on the sponge packages, opened up the syringe and placed it back in the supply cabinet. PCT 4 was not able to state how long the items had been in the supply cabinet.	V 116			
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are	V 117		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 117	<p>Continued From page 6 handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation, policy and procedure review and interview, the facility failed to ensure the room where patient medications are stored and prepared, was maintained as a clean area. A staff member failed to remove a gown worn in the treatment area to protect his clothing from blood and other potentially contaminated substances prior to leaving the treatment area, and hung the gown in the medication room. The medication room is designated as a clean area, and introduction of the dirty item had the potential to result in cross contamination of medications and supplies used in the care of patients.</p> <p>Findings:</p> <p>Review of facility policy and procedure titled "Personal Protective Equipment" dated 10/10/08, indicated "All personal protective equipment shall be removed prior to leaving the treatment area."</p> <p>On 2/16/11 at 3:11 p.m., a gown (personal protective equipment/ PPE) that was worn by RN</p>	V 117			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 117	Continued From page 7 1 on the treatment floor was observed hanging on a hook inside the medication storage/preparation room. In an interview concurrent with the observation, the Director of Operations (DO) indicated that PPE should not be found anywhere outside the treatment area, including the medication room.	V 117			
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 observation and review of facility policy and procedure, the facility failed to implement standard infection control precautions for cleaning and disinfecting contaminated surfaces and equipment in dialysis stations between patient use to prevent potential transmission of blood borne pathogens and other infectious agents . One of 27 treatment chairs was not reclined during patient changeover to ensure cleaning/disinfection of all surfaces. Staff failed to implement appropriate procedures when cleaning/disinfecting equipment at two of 27 stations to prevent recontaminating the treatment chairs. Hand sanitizer dispensers on 27 or 27 treatment machines had paper labels. Paper can harbor infectious agents and cannot be adequately disinfected.	V 122		4/14/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 122	<p>Continued From page 8</p> <p>Findings:</p> <p>The facility policy and procedure titled "Cleaning and Disinfection" dated 10/10/08 was reviewed. For low-level disinfection (no visible blood) the policy states, "Clean and disinfect the dialysis station or treatment area (chair, bed, table, machine, television, IV pole, blood pressure cuff, hand sanitizer dispenser and holder, etc, after each patient treatment with 1:1000 bleach solution. Place the chair in a Trendelenburg position (reclined with head lower than legs) so all surfaces are accessible. Wipe all surfaces and under the arms and side table with 1:1000 bleach solution."</p> <p>1. During an observation on 2/10/11 starting at 9:47 a.m., PCT 3 was observed cleaning/disinfecting station 15 during the patient changeover. PCT 3 cleaned/disinfected the treatment chair in an upright position and did not place the chair in the Trendelenburg position to access the inner surfaces/crevices. After cleaning the chair, she placed the non-disposable blood pressure cuff used on the previous patient onto the seat of the chair, contaminating the chair seat. She wiped the surface of the blood pressure cuff, picked up the cuff, turned it over and placed the cleaned surface back on the seat of the treatment chair.</p> <p>As PCT 3 walked away from the treatment station, PCT 2 asked her if the treatment chair was ready for use by another patient, and PCT 3 replied "Everything at 15 is clean."</p> <p>2. During the next observation, PCT 3 started</p>	V 122			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 122	Continued From page 9 cleaning/disinfecting the treatment chair at station 13. After wiping the treatment chair with a disinfecting solution, she placed the non-disposable blood pressure cuff used by the previous patient onto the right arm of the treatment chair, contaminating the chair arm. She wiped the surface of the blood pressure cuff, picked up the cuff, turned it over and placed the cleaned surface of the cuff back onto the chair arm. 3. During an observation on 2/10/11 starting at 9:50 a.m., each of the 27 treatment machines in the facility had a container of hand sanitizer mounted onto the hemodialysis treatment machine, with a paper label adhered to the container. In an interview with the Clinical Manager(CM) and Director of Operations (DO) on 2/11/11 at 4:04 p.m., the CM indicated the purpose of the labels was to indicate the date the hand sanitizer was placed into service on each machine. Both the CM and DO agreed the paper labels could be adequately disinfected.	V 122			
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.	V 147		4/14/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 147	<p>Continued From page 10</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the mask worn by one unsampled patient (Patient 16) covered the patient's nose as well as the mouth during care of the patient's central venous catheter (CVC), to reduce exposure to airborne contaminants and prevent infection.</p> <p>Findings: The facility's policy and procedure titled, "Initiation of Treatment Using An External Catheter and HemoSafe Patient Connector Clip" dated 7/19/06, was reviewed and states, "Put mask on patient".</p>	V 147			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 147	Continued From page 11 During an observation on 2/10/11 at 11:55 a.m., RN 1 was accessing Patient 16's CVC. RN 1 placed a surgical face mask on the patient, and covered the patient's mouth, but not the nose. As a result, the ports of the CVC were exposed to airborne contaminants from the patient during breathing. In an interview concurrent with the observation, the Education Coordinator confirmed that both the mouth and nose should be covered by the surgical mask when the catheter lumens or exit site are exposed.	V 147			
V 187	494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range. This STANDARD is not met as evidenced by: Based on observation, interview, policy and procedure review, the facility failed to ensure that a schematic diagram was available in the water treatment area that that identified valve location, function and position.	V 187		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 187	Continued From page 12 Findings: During an inspection of the water treatment area with Biomedical Technician (BMT) 1 and BMT 2 on 2/9/11 starting at 10:10 a.m., there was no diagram of the water treatment system, including the valves, observed. BMT 1 and BMT 2 were interviewed at the time of the inspection and indicated that the water treatment area should have a diagram with the valves. The facility policy and procedure titled "Valve Tags and Charts", dated 1/2/95 was reviewed and states, "Valve charts listing the number or letter, function and open or closed position of each valve under normal operating conditions, will be mounted under glass or plastic in a prominent location in the mechanical area. The water treatment system is defined as all piping and equipment used to process water used to prepare dialysis fluid. This includes all valves associated with the following equipment: domestic water booster pump, water heaters used to provide tempered water to R.O. (reverse osmosis) machine, valve boards containing back flow preventers, tempering valve, and bypass valve, multi-media filters, carbon tanks, water softeners, R.O. machines, R.O. water holding tanks and related repressurization pumps and tank, DI (deionized) equipment, micron filters and bacteria filters used in the system."	V 187			
V 229	494.40(a) MIXING SYSTEMS-PERM RECORD/VERIF TEST 5.4.4.1 Mixing systems: perm record/verification testing	V 229		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 229	<p>Continued From page 13</p> <p>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).</p> <p>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 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 interview, document review and review of facility policies and procedures, the facility failed to ensure that records of the batches of acid and bicarbonate concentrates produced in the facility included all required information, and that policies and procedures for the mixing and testing of acid and bicarbonate concentrates included acceptable ranges for specific gravity and conductivity.</p> <p>Findings:</p> <p>1. On 2/16/11 at 3:15 p.m., acid and bicarbonate solution mixing logs were reviewed. Records for the acid concentrate mixed did not contain the volume mixed, the manufacturer of the dry acid</p>	V 229			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 229	Continued From page 14 product used in the preparation of the acid solution, and the expiration date of the dry acid product used to prepare the acid solution. Records for the bicarbonate solution mixing log did not contain 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. In an interview concurrent with the review, the Regional Biomedical Educator (RBME), Biomedical Technician (BMT) 1, BMT 3 agreed the logs were missing the required information. 2. The facility policy and procedure titled "Acid Concentrate Mixing and Handling, Hemodialysis Concentrate Dissolution Unit", dated 7/31/09, was reviewed and indicates, "Specific gravity of the acid concentrate solution must be within plus or minus two percent, (+/-2%) of the expected specific gravity." The facility policy and procedure titled "Concentrate Mixing and Handling, Bicarbonate Concentrate Testing" dated 7/31/09 was also reviewed and indicates, "Each facility must establish a range of conductivity for bicarbonate concentrate solution prepared in a bicarbonate mixer."	V 229			
V 231	494.40(a) ACID CONC MIX SYS-EMPTY ALL/PREV CORROSION 5.4.4.2 Acid concentrate mixing systems: empty completely/prevent corrosion Acid concentrate mixing tanks should be	V 231		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 231	Continued From page 15 designed to allow the inside of the tank to be completely emptied and rinsed according to the manufacturer's instructions when concentrate formulas are changed. Acid concentrate mixing tanks should be emptied completely before mixing another batch of concentrate. Because concentrate solutions are highly corrosive, mixing systems should be designed and maintained to prevent corrosion. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the acid concentrate mixing system in a manner which prevented corrosion. Acid crystal growth was observed on the outside of the Granuflo unit, and on two acid storage tanks. Findings: During the initial tour of the facility on 2/8/11 at 1:18 p.m., the Granuflo unit (acid concentrate mixing system) was observed to have a growth of acid crystals that had formed on the outside of the housing unit of a valve unit due to leakage of the acid solution. Crystal growth was also observed on a red acid storage tank and at a pipe connection leading into a blue acid storage tank. In an interview concurrent with the observation, Biomedical Technician (BMT) 1 and BMT 2 indicated that there should be no crystal growth on the equipment or storage tanks.	V 231			
V 252	494.40(a) MICROB MONITOR-MO H20	V 252		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 252	<p>Continued From page 16 SAMPLES/METHOD</p> <p>7.2 Microbial monitoring methods: monthly water samples/method 7.2.1 General Culture water ...weekly for new systems until a pattern has been established. For established systems, culture monthly unless a greater frequency is dictated by historical data at a given institution.</p> <p>Monitoring can be accomplished by direct plate counts, in conjunction with the measurement of bacterial endotoxin.</p> <p>7.2.2 Sample collection Water samples should be collected directly from outlet taps situated in different parts of the water distribution system. In general, the sample taps should be opened and the water should be allowed to run for at least 60 seconds before a sample is collected in a sterile, endotoxin-free container. A minimum of 50 mL of water, or the volume specified by the laboratory performing the test, should be collected. Sample taps should not be disinfected.</p> <p>This STANDARD is not met as evidenced by: Based on a review of facility policy, documents and interview, the facility failed to ensure that all components of the water distribution system were cultured and the results reviewed monthly. Reports were incomplete and did not include results of bacterial and endotoxin tests for all components for five of 12 months in 2010 (March, April, June, July, and November).</p> <p>Findings:</p>	V 252			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 252	Continued From page 17 The facility policy and procedure titled Microbiological Monitoring of Water Used for Dialysis Purposes, dated 7/31/09 was reviewed and indicates, "Water samples will be collected from the following equipment/locations: Reverse Osmosis (RO) Machine, Distribution Piping, Indirect feed systems (holding tanks) from the first and last points on the distribution loop, samples will be taken of the source water feeding bicarbonate and acid concentrate mixing equipment, Solution Delivery System, and bicarbonate mixers. Once O machine has been successfully validated, a routine schedule of monthly sampling will be followed. The water system or components will be sampled before and after each cleaning and/or disinfection, which must occur at a minimum of monthly or more frequently if required by the manufacturer." Biomedical Technician (BMT) 1 and BMT 3 were interviewed on 2/16/11 at 3:15 p.m., and indicated that bacterial and endotoxin tests are obtained from the following sites: Reverse osmosis, distribution loop 1 (before disinfection), distribution loop 2 (before disinfection), distribution loop 3 (before disinfection), filter 1 (before disinfection), filter 2 (before disinfection), filter 3 (before disinfection), technical station (before disinfection), SDS water 1 (before disinfection), SDS water 2 (before disinfection), treatment station 9 (before disinfection), treatment station 12 (before disinfection), treatment station 21 (before disinfection), Granuflo (before disinfection) bicarb mixer 1 (after disinfection) and bicarb mixer 2 (after disinfection).	V 252			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 252	Continued From page 18 Monthly test results were reviewed, and the facility was not able to locate the results for the following: a. March 2010- culture for SDS and bicarb mixer after disinfection. b. April 2010- endotoxin for SDS 1 and SDS 2. c. June 2010- culture for distribution loop 3. d. July 2010- Granuflo e. November 2010- Technical loop, Granuflo, SDS 1, and SDS 2.	V 252			
V 253	494.40(a) MICROB MONITOR-MO DIALYS SAMPLE/COLLECT/FREQ 7.2 Microbial monitoring methods: 7.2.1 General: Dialysate: monthly dialysate sample/collection/freq Culture ...dialysate fluid weekly for new systems until a pattern has been established. For established systems, culture monthly unless a greater frequency is dictated by historical data at a given institution. Dialysate samples should be collected from at least two machines monthly and from enough machines so that each machine is tested at least once per year. If testing of any dialysis machine reveals a level of contamination above the action level, an investigation should be conducted that includes retesting the offending machine, reviewing compliance with disinfection and sampling procedures, and evaluating microbiological data for the previous 3 months to look for trends. The medical director also should	V 253		4/14/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 253	<p>Continued From page 19</p> <p>be notified. An example of a decision tree for this process is given in Figure 1.</p> <p>7.2.2 Sample collection Dialysate samples should be collected from a dialysate port of the dialyzer ... [or] dialysate sampling ports that can be accessed using a syringe. At least 25 mL of fluid, or the volume specified by the laboratory performing the test, should be collected in sterile endotoxin-free specimen containers.</p> <p>This STANDARD is not met as evidenced by: Based on record review, review of facility policy and procedure, and interview, the facility failed to ensure that 5 of 30 dialysis machines (machines #3, #5, #17, #21 and #30) were cultured at least annually, and that culture results for 8 of the 30 machines (machines # 2, #6, #7, #8, #12, #14, #22 and #27) were reviewed timely, to ensure prompt action to address excessive microbial and endotoxin levels and patient safety.</p> <p>Findings:</p> <p>1. The facility policy and procedure titled "Microbiological Monitoring of Water Used for Dialysis Purposes", dated 7/31/09, was reviewed and indicates, "1/6 of the clinic's machines customarily in use, including backup equipment, will be tested to ensure that all machines are tested every six months."</p> <p>Biomedical Technician (BMT) 1 was interviewed on 2/9/11 at 11:30 a.m., and indicated the facility has a total of 30 dialysis machines with 27 machines in use at any given time. He also indicated that each machine should be cultured at</p>	V 253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 253	<p>Continued From page 20</p> <p>least annually. During a review of culture results, however, no records of annual testing could be located for five dialysis machines.</p> <p>a. Machine #3 (3KOSE845)- last culture documented was on 3/5/09 (1 year, 11 months since last culture).</p> <p>b. Machine #5 (3KOSE640)- last culture documented was on 4/30/09 (1 year, 9 months since last culture).</p> <p>c. Machine #17 (3KOSM486)-last culture documented was on 8/26/09 (1 year, 5 months since last culture).</p> <p>d. Machine #21 (4KOSM243)- last culture documented was on 3/5/09 (1 year, 4 months since last culture).</p> <p>e. Machine #30 (4KOSL854)-last culture documented was on 3/5/09 (1 year, 3 months since last culture)</p> <p>In an interview concurrent with the review, the Director of Operations confirmed that the five machines were being used on the treatment floor.</p> <p>2. Biomedical Technician (BMT) 1 and BMT 3 were interviewed on 2/16/11 at 3:15 p.m. and indicated that cultures and endotoxin tests results should be reviewed approximately 48 hours after submission to the laboratory. BMT 3 indicated he is responsible for reviewing all culture and endotoxin test results relating to machinery and water. The Clinical Manager was also interviewed and indicated that the facility secretary takes the laboratory reports from the printer and places the</p>	V 253			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 253	Continued From page 21 lab results relating to the machines and water in the Biomedical Department file box, and the Biomedical Department is supposed to review the results and take any necessary actions. A review of culture and endotoxin test results for dialysis machines revealed they were not reviewed timely. a. Culture and endotoxin results for dialysis machines #2, #6, #12, and #27, from samples taken on 3/16/10, were not reviewed until 4/27/10. b. The results of samples taken from machines #7, #8 and #22, that were obtained on 5/31/10, were not reviewed until 6/18/10. c. Culture and endotoxin results for machine #14, from samples obtained on 7/28/10, were not reviewed until 8/24/10.	V 253			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the treatment environment for patients was safe. Two medication storage boxes in the treatment area containing medications were unlocked, and the upholstery on the arms of a patient wheelchair stored in the front lobby, was cracked and torn, could not be	V 401		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 401	Continued From page 22 adequately disinfected and posed a potential infection risk. Findings: During observations on 2/8/11 starting at 1:18 p.m., the following was observed. 1. A beige colored metal box labeled "Medication Box 1", was unlocked and on a countertop close to treatment station 5. Inside the box was a 20ml multidose vial of Lidocane 1%. There was also a metal box labeled "Medication Box 3", that was unlocked and on a countertop close to station 18. Inside the box, there was a 30ml multidose vial of heparin. The Clinical Manger was interviewed on 2/9/11 at 3:58 p.m., and stated that medication boxes are supposed to be locked. 2. The upholstery on the arms of a wheel chair stored in the lobby, was cracked and torn, exposing the foam padding.	V 401			
V 402	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the dialysis facility was maintained to ensure the safety of patients and staff. Two water softeners in the water treatment area were not secured to prevent them from	V 402		4/14/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 402	<p>Continued From page 23</p> <p>falling over and causing damage and potential injury. Wet flooring in the bicarbonate mixing area presented a risk for falls and contamination of patient medical supplies that were stored on pallets on the floor. Medical paper tape was used in the treatment area to secure computer cables and repair two pieces of equipment. Eight of 27 stations had cracked floor tiles which had not been replaced preventing adequate cleaning and disinfection. The patient call system did not function properly in the patient bathroom and the home training room placing patients in need of assistance at risk for harm.</p> <p>Findings:</p> <p>1. During an inspection of the water treatment area on 2/8/11 starting at 1:18 p.m., two water softeners were not secured. The cabling used to secure the water softeners was laying on the concrete floor.</p> <p>There was a 4 foot by 8 foot puddle of solution in front of the SDS (solution delivery system) used to mix bicarbonate in the water treatment area, and under the wooden pallets on the floor to the right of the SDS. There were also two areas of dried white residue approximately three feet by six feet in size on each side of the puddle, and a floor squeegee that was propped up against a wooden pallet filled with boxed medical supplies to the left of the SDS.</p> <p>2. During observations on 2/8/11 starting at 2:55 p.m. accompanied by RN 2, the following was observed.</p> <p>a. Medical paper tape was used to secure</p>	V 402			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 402	<p>Continued From page 24</p> <p>computer cabling to an outlet by treatment stations 10, 12, and 14. Paper tape was also observed securing a panel on oxygen concentrator #8, and a panel on the wall mounted paper towel dispenser located by station 10.</p> <p>In an interview concurrent with the observations, RN 2 indicated the tape was being used to hold the computer cabling in place so that the treatment machines and computer system had a good connection. RN 2 also indicated that the panels on the oxygen concentrator and paper towel dispenser should be repaired by the Biomed department and not held together with tape.</p> <p>b. The laminate trim edging on the built in shelving near station 5 was loose and peeling away from the shelving.</p> <p>c. Multiple cracked tiles were observed in the flooring by treatment stations 2, 7, 8, 14, 17, 19, 20, and 27. In an interview on 2/9/11 at 11:00 a.m., the Director of Operations indicated that she was aware of the cracked tiles on the treatment floor and reported that the facility had been working on replacing the cracked tiles.</p> <p>3. During an inspection on 2/16/10 at 3:10 p.m., the call light in the patient bathroom in the treatment area was tested. The surveyor entered the bathroom, closed the door, activated the call light, and waited two minutes, however, staff did not respond. When the door was opened, the light above the door was flashing, however, no audible alarm was heard.</p> <p>The observation was brought to the attention of</p>	V 402			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 402	Continued From page 25 the Director of Operations, who activated the call system and verified that the light above the door was functioning but the alarm did not sound in the treatment area. Upon further investigation, RN 2 reported that someone had been working on the system the day before and forgot to connect all of the wires back together. 4. During an inspection of the home training room on 2/17/11 at 10:38 a.m., RN 3 and RN 4 were asked how they would summon help in the event of a patient emergency. Both nurses indicated that they would activate the call light system. When the surveyor pulled the cord to activate the call system, the light outside the training room was observed to be flashing. Two minutes passed, however, and no staff from the treatment floor responded. The observation was brought to the attention of the Director of Operations, the Clinical Manager, and the Regional Quality Manager, who confirmed the audible portion of the system was not functioning and did not alarm in the treatment area.	V 402			
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, document review, policy	V 403		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	<p>Continued From page 26</p> <p>and procedure review, and interview, the facility failed to ensure dialysis machines and equipment were maintained in accordance with the manufacturer's recommendations to ensure patient safety. Electrical leakage testing, to prevent hazards such as electrical shock to patients and staff, was not performed in accordance with the manufacturer's recommendations for two of 10 dialysis machines audited (machine #4 and #8). Diasafe filters (filters designed to yield ultrapure dialysate/remove endotoxins and microbial products) were not changed timely in accordance with the manufacturer's recommendations for four of 10 dialysis machines audited (machine #3, #4, #8 and #10). The facility also failed to ensure that the manufacturer's directions for care and maintenance of three of three Phoenix meters used to test the pH and conductivity of dialysate were followed.</p> <p>Findings:</p> <p>The facility policy titled "Preventive Maintenance" dated 7/15/94, was reviewed and indicates, "The preventative maintenance program for medical equipment, water treatment equipment and reuse equipment will be in accordance with the equipment manufacturer's printed recommendations. The frequency of performing preventative maintenance on the above types of equipment will be as recommended by the equipment manufacturer's literature."</p> <p>On 2/9/11 at 11:30 a.m., Biomedical Technician (BMT) 1 was interviewed and indicated that the facility has a total of 30 dialysis treatment machines. Twenty seven machines are in use at</p>	V 403			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	<p>Continued From page 27</p> <p>any given time on the treatment floor and there are three back up machines. According to BMT 1, he is responsible for ensuring that the machines are maintained and that maintenance schedules are followed.</p> <p>During the interview, BMT 1 stated that electrical safety checks of dialysis machines are supposed to be performed twice a year (every 6 months). He also indicated that diasafe filters are to be changed every 12 weeks, that the diasafe filters "are the last line of defense" for patients and the dialysate solution, and that "the diasafe filter is in place to make sure the patient receives the purest possible solution."</p> <p>1. The facility policy titled "Electrical Leakage Testing" dated 9/21/01, was reviewed and indicates, "Electrical leakage (risk current) testing is done to ensure that non-therapeutic current that can flow through the patient, medical staff, or bystander will not lead to a hazardous condition. According to the policy and procedure, electrical leakage current measurement must be performed twice a year and after repair or replacement of electro/mechanical components of equipment." The policy and procedure also states "The facility is required to document Electrical Leakage Test results each time the test is performed."</p> <p>a. The "Equipment Repair Record" for dialysis machine #4 (3KOSE722) was reviewed and indicated electrical leakage testing was performed 6/23/10. The next test was not performed until 1/18/11, approximately 7 months later.</p> <p>b. Review of the "Equipment Repair Record" for</p>	V 403			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	<p>Continued From page 28</p> <p>dialysis machine #8(3KOSF403), revealed that electrical leakage tests were performed 3/17/09 and 7/26/10. The next electrical leakage test was due in January 2011, but was not completed. At the time of the review, the machine was being utilized on the treatment floor.</p> <p>2. The facility policy titled, "Diasafe plus dialysis fluid filter" dated 3/10, was reviewed and states, "Period of use/filter exchange: maximum 12 weeks or 100 online plus treatments or if integrity test fails."</p> <p>a. The "Equipment Repair Record" for dialysis machine #3 (3KOSE845) was reviewed and indicated the diasafe filter had been changed 11/17/09. The filter should have been changed by 2/9/10, but was not changed until 3/5/10.</p> <p>b. The "Equipment Repair Record" for dialysis machine #4 (3KOSE722) was reviewed, and noted that the diasafe filter was changed on 10/13/10. The filter should have been changed by 1/5/11, but was not changed until 1/10/11.</p> <p>c. The "Equipment Repair Record" for dialysis machines #8 (3KOSE403) and #10 (3KOSD344) were reviewed, and indicated their diasafe filters were changed on 3/4/10. The filters should have been changed by 5/27/10, but were not changed until 7/26/10.</p> <p>3. The manufacturer's directions for the "Tri-Station" (a self-contained preventative maintenance system for Phoenix meters) were reviewed. Directions for the steps to be performed daily before use of the Phoenix Meters state:</p>	V 403			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	Continued From page 29 1-RINSE In the morning, expel the NEO-CARE (a solution which removes hard deposits and bacterial film that can cause inaccurate meter readings) into an appropriate receptacle. Rinse 2-3 times with RO (reverse osmosis) water to ensure that all NEO-CARE has been removed. 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). 3-RINSE Expel the bleach solution into an appropriate receptacle. Rinse 2 or 3 times with RO water to ensure that all residual bleach solution has been removed. 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. 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. The Manufacturer's test Instrument User's Guide was also reviewed. The section titled, "Cleaning Your Instrument", 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,	V 403			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	<p>Continued From page 30</p> <p>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 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.</p> <p>The following documentation was missing:</p> <p>May 2010- Meter #1 (P12925) disinfection with bleach 5/8/10 and 5/25/10. Meter #2 (P12954) disinfection with bleach 5/8/10, rinsing/storage with NEO-CARE 5/3/10, 5/14/10, and 5/18/10. Meter #3 (P12955), rinsing/storage with NEO-CARE 5/3/10, 5/13/10, and 5/14/10.</p> <p>June 2010-Meter #1 rinsing/storage with NEO-CARE 6/1/10 and disinfection with bleach 6/29/10. Meter #2 rinsing/storage with NEO-CARE 6/3/10. Meter #3 rinsing/storage with NEO-CARE 6/29/10.</p> <p>July 2010-Meter #1 rinsing/storage with NEO-CARE 7/17/10. Meter #2, rinsing/storage with NEO-CARE 7/7/10 and 7/17/10. Meter #3 disinfection with bleach 7/22/10 and 7/27/10 and rinsing/storage with NEO-CARE 7/15/10, 7/22/10 and 7/31/10.</p> <p>August 2010-Meter #1 rinsing/storage with NEO-CARE 8/13/10, 8/14/10, 8/16/10, 8/17/10,</p>	V 403			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	<p>Continued From page 31 and 8/28/10. Meter #3, verification, calibration, disinfection with bleach and rinsing/storage with NEO-CARE not documented on 8/6/10. Rinsing/storage with NEO-CARE 8/12/10, 8/13/10, 8/14/10, and 8/16/10.</p> <p>September 2010-Meter #1 rinsing/storage with NEO-CARE 9/3/10, 9/7/10, 9/9/10 and 9/11/10. A note at the bottom of the sheet stated, "9/9/10 no NEO-CARE solution... Reported to Clinical Manager." Meter #2 rinsing/storage with NEO-CARE 9/1/10, 9/7/10, 9/9/10, 9/10/10, 9/16/10, and 9/28/10. Meter #3 rinsing/storage with NEO-CARE 9/1/10, 9/7/10, 9/9/10, 9/14/10 and 9/18/10. Meter #3 verification, calibration, disinfection with bleach, rinsing/storage with NEO-CARE 9/15/10.</p> <p>October 2010-Meter #2 rinsing/storage with NEO-CARE 10/14/10, 10/16/10 and 10/30/10. No documentation reflecting verification, calibration, disinfection with bleach, or rinsing/storage with NEO-CARE 10/29/10. Meter #3 rinsing/storage with NEO-CARE 10/5/10, 10/16/10, or 10/26/10.</p> <p>November 2010-Meter #2 verification, calibration, disinfection, rinsing/storage with NEO-CARE not documented on 11/13/10 and 11/15/10. Meter #3 verification, calibration, disinfection with bleach, rinsing/storage with NEO-CARE not documented on 11/13/10, 11/15/10, 11/24/10 and 11/26/10.</p> <p>December 2010-Meter #1 verification, calibration, disinfection with bleach, rinsing/storage with NEO-CARE not documented on 12/4/10 and 12/8/10. Rinsing/storage with NEO-CARE 12/27/10. Meter #2 verification, calibration,</p>	V 403			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 403	Continued From page 32 disinfection with bleach, rinsing/storage with NEO-CARE not documented 12/4/10, 12/6/10, 12/8/10 and 12/27/10. Rinsing/storage with NEO-CARE 12/26/10. Meter #3 rinsing/storage with NEO-CARE 12/3/10. Verification, calibration, disinfection with bleach, rinsing/storage with NEO-CARE not documented on 12/4/10, 12/6/10 and 12/27/10. January 2011-Meter #1 rinsing/storage with NEO-CARE 1/6/11. Meter #3 rinsing/storage with NEO-CARE 1/6/11.	V 403			
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the vascular access sites for patients receiving dialysis at eight of 24 stations (stations 4, 5, 7, 10, 18, 24, 28 and 29) were in view of staff. Covering the access site can prevent prompt detection of an adverse event, such as accidental needle dislodgement, and placed patients at risk for significant harm, including hemorrhaging and death. Findings: During treatment observations on 2/8/11 at 1:25 p.m., the access sites of eight patients receiving treatment, at stations 4, 5, 7, 10, 18, 24, 28 and 29, were covered by a blanket or an article of clothing and not visible to staff providing and	V 407		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 407	Continued From page 33 monitoring their care.	V 407			
V 452	<p>On 2/9/11 at 11:30 a.m., the facility Medical Director was interviewed regarding the observation and stated, "I don't disagree with you. That's been a problem we've discussed with the patients and the staff several times. We even put up posters to that effect (keep access sites uncovered)".</p> <p>494.70(a)(1) PR-RESPECT & DIGNITY</p> <p>The patient has the right to-</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to recognize the personal needs of one of 13 patients (Patient 9) and treat the patient with dignity and respect. Patient 9 signed out AMA (against medical advice) and terminated her dialysis treatment 34 minutes early in order to use the bathroom. Patients at the facility are offered the use of bedpans and urinals for toileting but not the use of the bathroom, due the location of the bathroom and the time involved for staff to assist them to the bathroom.</p> <p>Findings:</p> <p>Patient 9's record was reviewed on 2/15/11 and indicated that on 1/14/11, she signed out AMA, 34 minutes before her 3 hour 30 minute hemodialysis treatment was completed, in order to use the bathroom. The patient's pre-dialysis</p>	V 452		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 452	Continued From page 34 assessment noted that she had "mild SOB (shortness of breath) prior to treatment. The post-dialysis assessment noted, "pt still with some edema." Post assessment notes also indicated that Patient 9 left the facility above her estimated dry weight. The Corporate Policy titled "Interruption of Treatment", dated 10/28/08, was reviewed and states, "A patient's treatment may be interrupted to allow the patient to use the restroom for bowel or bladder needs". It also states that "A patient will not forfeit treatment time if he/she has to use the restroom occasionally during dialysis. Time lost during restroom use must be added once the patient resumes treatment to ensure that prescribed treatment time is received." On 2/15/11 at 3:30 p.m., the Clinical Manager (CM) was interviewed, and indicated that the facility does not follow the corporate policy. She pointed to a handwritten comment signed by her on the front of the policy, which stated, "Not approved for this facility due to distance of bathrooms from treatment floor". When asked how the facility accommodates patients who need to use the restroom during dialysis, she stated, "We don't have someone to spend 5 minutes with them when they go to the bathroom, it's a safety issue. They are offered a bedpan, a urinal or sometimes they will sign off AMA."	V 452			
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	V 502		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 35 medical condition, including co-morbid conditions. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessments for 1 of 13 sampled patients and one unsampled patients (Patients 1 and 18) included a current history and physical. Findings: 1. Patient 18's record was reviewed on 2/10/11 and did not contain a current(within 12 months) history and physical. Two history and physicals were located in the chart. One was dated 5/12/03, upon admission, and the other was dated 11/13/08. 2. Patient 1's record was reviewed on 2/11/11 and did not contain a current history and physical. The most recent history and physical was dated 1/26/10. During an interview concurrent with the review, the Director of Operations indicated that the facility has difficulty getting the medical staff to comply and provide a current history and physical for patients.	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;	V 543		4/14/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 36</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that one sampled and one unsampled patient (Patients 3 and 18) were provided with necessary care and services to manage their volume status. Patient 3 consistently failed to achieve his target weight through dialysis treatment without evidence the problem was addressed, placing him at risk for adverse effects related to excess fluid accumulation. Patient 18 experienced abnormally high blood pressures following treatment, without evaluation, physician notification or treatment. Two of three blood pressures taken within a five minute period following treatment on 2/10/11, met parameters established by the physician requiring notification, however, the blood pressures were not documented in the treatment record and the physician was not notified.</p> <p>Findings:</p> <p>1. Observation of post dialysis care provided for Patient 18 at Station 30, on 2/10/11, beginning at 10:05 a.m. revealed that she had a computerized standing blood pressure reading of 199/106 at 10:05 a.m. A repeat standing blood pressure at 10:08 a.m. was 203/106, and a third standing blood pressure at 10:10 a.m. was 215/134 at 10:10 a.m. Staff sat Patient 18 down, her blood pressure was 195/107 at 10:15 a.m., and Patient 18 left Station 30 a couple of minutes later while staff were conferring with each other.</p> <p>The physician's Hemodialysis Standing Orders were reviewed. Orders under "Blood Pressure", stated, "Notify Nephrologist if post treatment</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 37</p> <p>systolic blood pressure is greater than 200 or less than 80, diastolic blood pressure greater than 110 or less than 40."</p> <p>The patient's dialysis record for 2/10/11 was reviewed on 2/11/11. The record indicated that Patient 18 started dialysis at 6:47 a.m. on 2/10/11, with a blood pressure reading of 186/103. Subsequent blood pressures taken at 30 minute intervals between 7:00 a.m. and 9:27 a.m. when treatment was discontinued, ranged from a low of 154/81 to a high of 188/95.</p> <p>Review of blood pressure documentation after treatment ended at 9:27 a.m., listed one blood pressure reading under "Other comments", which stated "pt left with b/p 195/107 no c/o(complaints), thrill present (buzzing sound in access site indicating blood flow), RN aware of b/p." There was no documentation of the hypertensive blood pressure readings taken between 10:05 a.m. and 10:15 a.m., or that the patient's nephrologist was notified, as ordered.</p> <p>2. Patient 3's record was reviewed on 2/11/11, and noted that the patient's estimated dry weight (EDW-patient weight if the kidneys were functioning adequately/weight the patient should leave the facility at after receiving dialysis) had been established at 186 kilograms. A review of twelve treatment records from 1/14/11 through 2/9/11, however, indicated that Patient 3 did not achieve his target weight during any of the twelve treatments and left the facility after each treatment weighing in the high 190 to low 200 kg range.</p> <p>Although the treatment records included nursing</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 38 documentation at discharge noting the patient's weight post dialysis was above the EDW, there was no evidence that his failure to achieve the target weight through dialysis treatment was addressed.	V 543			
V 556	The Clinical Manager and Operations Manager were interviewed at the time of the review and concurred. 494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the plan of care for one of 13 sampled patients (Patient 5) was signed by the patient and the plan of care for one unsampled patient (Patient 13) was signed by the patient within a reasonable time frame. Findings: 1. Patient 5's record was reviewed on 2/14/11. The Patient Plan of Care contained signatures by the physician, nursing, the dietician, and social worker on 1/20/11. The plan of care was not signed by the patient, did not indicate that the patient had refused to sign or indicate the reason	V 556		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 556	Continued From page 39 the patient's signature was not provided. 2. Patient 13's medical record was reviewed on 2/16/11. The Patient Plan of Care was signed by the physician, nursing, the dietician, and the social worker on 8/25/10. Although Patient 13 made his monthly visit to the facility on 9/22/10, he did not sign the plan of care until 10/29/10. The Regional Quality Manager (RQM) was interviewed on 2/15/11 at 3:09 p.m., and indicated that reasonable time frames for obtaining patient signatures following completion of the plan of care is one week for in center patients and at the next monthly visit for home therapy patients.	V 556			
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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; This STANDARD is not met as evidenced by: Based on observation, interview and policy and procedure review, the facility failed to ensure that patient care policies and procedures were implemented for 3 of 13 sampled patients and 1 unsampled patient (Patients 7, 9, 10 and 17). Nursing failed to implement the facility procedure and utilize appropriate technique when cleaning Patient 17's access site to avoid cross contamination and infection. Patient 10 was placed at risk for harm when she developed a	V 715		4/14/11	

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 715	<p>Continued From page 40</p> <p>fever during treatment and procedures to ensure prompt detection and treatment of sepsis were not implemented. For Patients 7 and 9, staff failed to follow physician's orders for oxygen administration. The patients received oxygen during treatment, even though they did not exhibit symptoms indicating a need for supplemental oxygen.</p> <p>Findings:</p> <p>1. Vascular access sites for patients receiving dialysis are routinely cleansed prior to commencing dialysis, in order to reduce the possibility of infection when the dialysis needle is inserted through the skin.</p> <p>During an observation on 2/10/11 at 12:30 p.m. at station 27, RN 6 ws observed preparing Patient 17's access site for initiation of the dialysis treatment. During the observation, RN 6 made 2 swipes over the patient's access with an antiseptic solution using an up and down motion, then made 4 more swipes over the access site in the same manner.</p> <p>The facility procedure titled, "Assessment of Internal access and Preparation", dated 10/01/95, was reviewed and states: "8. Open povidone iodine swab or alcohol prep and wipe in a circular motion from site of insertion out, over a 2-3" area." The procedure rationale states, "Swab is contaminated once used and should not go over an already cleansed area". The procedure also states "9. Repeat step 8 on the second site. Once again, clean away from sites to avoid cross contamination. Do not go over the area already swabbed."</p>	V 715			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 715	<p>Continued From page 41</p> <p>The Clinical Manager (CM) and the Regional Quality Manager (RQM) were interviewed on 2/10/11 at 4:00 p.m. and agreed that the accepted corporate practice is to use a "concentric circle" technique when cleansing the skin, wiping from the center (insertion site) outward in concentric circles, and never returning to the center.</p> <p>2. Patient 10's record was reviewed on 2/15/11, and noted that the patient was admitted to the facility on 5/7/10 with diagnoses including end stage renal disease, hypertension and diabetes mellitus type II. The record also indicated that Patient 10 had a central venous catheter for dialysis access.</p> <p>On 1/17/11, Patient 10 developed a fever during treatment. Her temperature was 96 degrees Fahrenheit (F) when she started treatment and was 100.2 degrees F at the end of treatment. A post dialysis nursing note indicated that the patient's lungs were clear, her heart rate was regular, that the patient was shaky and that her temperature was 100.2.</p> <p>The facility policy titled "Assessment of Fever/Chills Reaction", dated 8/20/98, from the Clinical Services procedure manual was reviewed. The purpose of the policy is to differentiate febrile reactions caused by gram negative sepsis from those caused by endotoxin, which generally abate within a few hours after dialysis has stopped.</p> <p>According to the policy and procedure, the procedures that must be initiated to determine</p>	V 715			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 715	<p>Continued From page 42</p> <p>possible causes of a febrile reaction include, a thorough examination of the patient, blood cultures taken at the time of the reaction, dialysis fluid collected at the time of the reaction for quantitative and qualitative bacteriologic analysis and documentation of symptoms, assessments and patient responses in the treatment record and progress notes.</p> <p>There was no evidence, however, that blood cultures were taken or that dialysis fluid was collected when Patient 10 developed a fever during treatment. A handwritten note in a separate binder at the nurses station dated 1/17/11, indicated, "Increase temperature 100.2 post treatment. Dr [name] notified and ordered to have patient see her primary care physician and vascular surgeon. Patient refuses to see Dr [vascular surgeon] today. Appointment made with Dr [vascular surgeon] tomorrow at 2:15 p.m. Explained to patient in Spanish."</p> <p>A review of Patient 10's treatment record for 1/19/11, noted that her temperature was 102.2 prior to treatment. At 10:55 a.m., nursing noted that the patient arrived at the facility by wheelchair, complained of left hip pain, had a temperature of 102.2 and that the physician was notified. A subsequent note at 11:35 a.m. ,indicated that Patient 10 was transported to the hospital by paramedics for evaluation and management.</p> <p>The hospital history and physical dated 1/19/11, was reviewed and indicated, "Patient had one episode of fever on Monday during dialysis. She went home. She started having some cold sweats, but denied any chills, nausea, vomiting,</p>	V 715			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 715	<p>Continued From page 43</p> <p>abdominal pain, chest pain or urinary symptoms." The hospital discharge summary dated 1/23/11, noted the patient's primary diagnosis as " Line sepsis secondary to Citrobacter (a gram negative bacteria)." It also noted that the patient was sent to the hospital from the dialysis center because she had a temperature of 102 and was hospitalized for five days. At the hospital, blood cultures were obtained, her hemodialysis catheter was removed, the tip culture and blood culture grew Citrobacter, and the patient was treated with antibiotics.</p> <p>In and interview on 2/16/11 at 4:11 p.m., the Clinical Manager (CM), RN 2, Director of Operations (DO), and Regional Quality Manager , acknowledged the procedure was not implemented.</p> <p>3. The facility policy and procedure titled, "Routine Administration of Oxygen" dated 1/6/10, was reviewed and states, "A physician's order is required to administer oxygen routinely to the patient in the dialysis facility.</p> <p>a. Patient 7's record was reviewed on 2/14/11 and included a physician's order for administration of oxygen at 2 liters/minute as needed for respiratory distress or chest pain. A review of the patient's treatment record for 2/7/11 indicated that she began dialysis at 12:00 noon, "without problem". Thirty minute evaluations of the patient between 12:31 p.m. and 3:54 p.m., when her dialysis treatment was completed, however, noted that the patient was receiving oxygen at 2 liters per minute via nasal cannula. There was no documentation the patient experienced chest pain or respiratory distress</p>	V 715			

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: 052656	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2011
NAME OF PROVIDER OR SUPPLIER DIALYSIS CENTERS OF VENTURA COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4567 TELEPHONE RD STE 101 VENTURA, CA 93003		
(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 715	Continued From page 44 during her treatment. b. On 2/10/11 at 9:15 a.m., Patient 9 was observed receiving oxygen at two liters/minute by nasal cannula during dialysis. The physician's orders were reviewed with RN 2 and included an order for "Oxygen @ 2L/min PRN respiratory distress or chest pain." The patient's treatment record was also reviewed, and indicated Patient 9 arrived in the unit without any complaints of SOB (shortness of breath) or chest pain. When questioned regarding the reason for the oxygen, Patient Care Technician 2 reported that Patient 9 requests the oxygen and always receives oxygen during the treatment.	V 715			