

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA080001614	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2011
NAME OF PROVIDER OR SUPPLIER EL CENTRO DESERT VALLEY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH FIFTH STREET EL CENTRO, CA 92243		
(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) COMPLETE DATE	
L 000	<p>Initial Comments</p> <p>FOR INFORMATION ONLY</p> <p>The following represents the findings of the California Department of Public Health during a licensing visit on 3/29/11.</p> <p>Representing the Department of Public Health: Health Facility Evaluator Supervisor 14719 and Health Facility Evaluator Nurse 22383</p> <p>No deficiencies were issued related to the licensing visit.</p> <p>The facility submitted correspondence, dated 2/17/11, indicating the facility would be changing over their entire water system i.e. RO machine, storage tank, and delivery loop. A follow-up telephone conversation was conducted with the Director of Operations on 3/11/11 to discuss the new system. At that time, he reported he was still trying to allocate funds for the project, contact the city for permits, and contact OSHPD for approval. The Director of Operations was notified that he would need to present a plan to the Department regarding displacement of the centers 80 patients during the change over to the new system. He would need to collect cultures and wait at least 72 hours until culture reports were back, and the cultures were negative, prior to the return of the patients to the center. He planned to investigate alternatives at other locations, to ensure the patients had a safe environment and continued to receive their scheduled dialysis treatments.</p> <p>On 3/29/11, the Department received an e-mail indicating, "The patients were doing fine." Culture reports were included with the e-mail. Cultures were positive for growth of unidentified</p>	L 000			

Licensing and Certification Division

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 000	<p>Continued From page 1</p> <p>organisms.</p> <p>On 3/29/11 at 11:44 A.M. to 2:48 P.M., a licensing visit was conducted. Ten patients were receiving dialysis treatments at the time of the visit. Two patients were in isolation rooms. The Biomed Tech said that a new bicarb mixer had been installed, but was not being used. In addition, a PSDS system was added 6 months prior. This system was a central feed for acid and bicarb. The acid was automatically fed to individual patient stations for treatments, but the bicarb was not connected. The staff were filling jugs of bicarb and taking them to the individual dialysis stations. He said the bicarb was plumbed, but would not be used until the cultures were negative for 3-4 weeks.</p> <p>The Clinic Manager reviewed the e-mails the Department received from the Director of Operations. She said that the e-mails were not accurate. The facility had not yet submitted all of the paper work necessary to replace the entire water system. The facility planned to move patient's to a sister facility for 3-4 days during the installation of the new system and to await 72 hour culture results. She said the current positive culture reports started after an earthquake in the area, and had nothing to do with installation of the new system. She said the facility had positive cultures since August 2010. The facility collected cultures and if the cultures were positive, the system was disinfected with bleach and cultures were redrawn. At first, the cultures would be negative on the redraw and then a week later the cultures would be positive again. The situation seemed to be improving and then in December it became worse. At that time, cultures were positive at all collection sites. However, they were not testing at individual patient treatment</p>	L 000			

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L 000	Continued From page 2 stations. The facility disinfected the system. The facility implemented a plan to have only one person test the system. The sample kits were discarded and new ones obtained. The Techs collection methods were verified by the Biomed Supervisor. The Medical Director was informed and assisted with the investigation to determine why the cultures were positive. They were unable to determine the source. However, the facility did not ask the laboratory to identify the specific organisms present in the cultures. Infection control logs were reviewed from July 2010 to February 2011. Blood cultures were drawn on anyone that developed fever and/or chills or were symptomatic. The following results were available: July 2010, permcath infected with enterobacter cloacae (1 patient) August 2010, permcath infected with MRSA (1 patient) September 2010, no infections October 2010, blood cultures positive pseudomonas aerog (1 patient) and wound infected with staph (1 patient) November 2010, no infections December 2010, no infections January 2011, blood cultures positive for MRSA (1 patient) February 2011, wound infected with morganelli gangrene (1 patient) Hospitalizations were reviewed from July 2010 to February 2011. Four patients were hospitalized with clotted grafts; 2 patients were hospitalized for falls outside the facility; 1 patient had a cardiac arrest and expired; 1 patient was hospitalized for hypoglycemia; and 1 patient was hospitalized for an infected toe.	L 000		

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L 000	Continued From page 3 Mortality logs were reviewed for July 2010 to February 2011, as follows: July 2010, 1 "really sick" elderly patient expired August 2010, 2 patients expired with cancer of liver/renal and pneumonia/sepsis September 2010, no deaths October 2010, 1 patient expired from pneumonia November 2010, no deaths December 2010, 1 patient expired from CVA January 2011, 1 patient expired from pneumonia February 2011, 1 patient expired from aspiration of bloody vomit The patients that expired were 60 - 83 years old. The deaths were not unexpected. The Clinic Manager described all of these patients as "really sick" prior to their demise. The Clinic Manager said the Medical Director has picked out the new RO system. The facility has received 2 bids for construction. They still need to obtain permits from the city, have OSHPD approval, and submit a letter to the Department for a licensing visit. The installation and cultures should take 3-4 days. The plan is to have the patient receive treatments at a sister facility until negative cultures are obtained. They will continue to culture weekly for 4 weeks after the installation of the new system. The anticipated time of completion is 2 months. The Clinic Manager, Biomed Supervisor, and Director of Operations all acknowledged the above plan. The facility will not install the new system until the current cultures are negative.	L 000			