

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: 052536	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2011
NAME OF PROVIDER OR SUPPLIER SAN DIEGO DIALYSIS SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 303 WEST 26TH STREET NATIONAL CITY, CA 91950		
(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 conducted 3/8/11 to 3/11/11. The facility census at the time of the survey was 120 hemodialysis patients. The sample size was 12 patients. Representing the Department were, HFEN 22383 and HFEN 15932 and HFEN 17130. Glossary CCHT Certified Clinical Hemodialysis Technician CN Charge Nurse CM Clinic Manager Hep B Hepatitis B LN Licensed Nurse O2 Oxygen P&P Policy And Procedure SW Social Worker	V 000			
V 110	494.30 CFC-INFECTON CONTROL This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff who cared for hepatitis B positive patients did not simultaneously care for patients who were susceptible (non-immune) to hepatitis B (refer to V 131). In addition, the facility failed to ensure that 1 staff member disinfected a clipboard after placing it on the chairside table during a patient's dialysis treatment and prior to taking the clipboard to the nurse's station (refer to V122). The facility	V 110		4/29/11	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 110	Continued From page 1 also failed to ensure staff disinfected prime buckets, acid and bicarb jugs between patients (refer to V122).	V 110			
V 122	<p>The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 staff member (Social Worker) disinfected a clipboard after placing it on the chairside table during Patient 14's dialysis treatment and prior to taking the clipboard to the nurse's station. The facility also failed to ensure 3 of 3 staff disinfected prime buckets, acid jugs, and bicarbonate jugs between patients.</p> <p>Findings:</p> <p>1. On 3/9/11 at 9:42 A.M., the facility Social Worker (SW) was observed sitting on a stool and speaking with Patient 14 during the dialysis treatment. The SW placed a clipboard containing</p>	V 122		4/29/11	

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V 122	<p>Continued From page 2</p> <p>several sheets of paper on the collapsible chairside table attached to Patient 14's dialysis chair. At the conclusion of the conversation, the SW picked up the clipboard and walked to the nurse's station. The SW did not disinfect the clipboard after placing it on the Patient 14's chairside table.</p> <p>During an interview on 3/9/11 at 9:50 A.M., the SW stated that she understood the clipboard was contaminated by being placed on the chairside table while a patient was on dialysis.</p> <p>During an interview on 3/9/11 at 11:42 A.M., the facility Area Manager confirmed that the clipboard was contaminated by being on the chairside table while the patient was on dialysis.</p> <p>On 3/9/11 at 11:49 A.M., the facility provided the policy for Clean Versus Contaminated Areas, which was approved by the governing body on 3/26/10. The policy specified, "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 to a common area or used on another patient."</p> <p>2. On 3/9/11 between 11:40 A.M. and 12:00 P.M., 3 staff were observed during turnover. Patients were removed from the dialysis machines and the stations were cleaned before the next group of patients were placed on the dialysis machines. The following was observed:</p> <p>a. At 11:41 A.M., the CCHT assigned to station 1 began disinfecting the machine between patients.</p>	V 122			

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V 122	Continued From page 3 She moved the acid jug to the shelf in back of the machine, without disinfecting the jug. She also failed to disinfect the bicarb jug. b. At 11:53 A.M., CCHT 1 did not disinfect the prime bucket or bicarb jug between patients. c. At 11:54 A.M., LN 2 did not disinfect the prime bucket when disinfecting the machine between patients. LN 2 was asked when the prime bucket was to be cleaned and he stated it was to be disinfected between patients.	V 122			
V 131	494.30(a)(1)(i) IC-HBV-ISOLATION-STAFFING Isolation of HBV+ Patients Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during the period when dialysis is terminated on one patient and initiated on another. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff who cared for 10 of 55 patients (H1, H2, H3, H4, H5, H7, H11, H12, H13, H14) that were susceptible (non-immune) to hepatitis B simultaneously provided care for patients who were hepatitis B positive. Findings: On 3/8/11 at 11:00 A.M., the facilities Hepatitis Vaccine Record, the patient schedules, and the patient seating charts were reviewed. The seating chart identified the isolation room and patient's that were hepatitis B positive. The patient	V 131		4/29/11	

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V 131	<p>Continued From page 4</p> <p>schedules indicated that patients in the pods that contained the hepatitis B positive patients also contained 10 patients that were susceptible (non-immune) to hepatitis B.</p> <p>On 3/8/11 at 1:58 P.M., a meeting was conducted with the regional manager, the area manager, and the clinical manager to discuss the identified teams concerns related to the staff caring for the hepatitis B positive patients simultaneously while providing care to susceptible (non-immune) patients. They stated the facility routine was to have the CN assigned to provide care to the hepatitis B positive patients and during the dialysis treatments, the CN was the only one that cared for the hepatitis B positive patients.</p> <p>On 3/8/11 at 2:23 P.M., the CN stated she was assigned to care for the hepatitis B positive patients. She stated she tried to be the only one to care for those patients, but the other nurses and the float CCHT would help with whatever was needed. The other staff may initiate a treatment, discontinue the treatment and do the monitoring (every 30 minute vital sign and machine parameter checks) for the hepatitis B positive patients. In addition, other staff may assist with cleaning the machine ir chair and set up for the next patient. She said, "They all work as a team."</p> <p>When asked about the patients seating schedule, she stated it was made years ago, and was updated as needed. She stated when making changes to the schedule, she did not take the patient's hepatitis status into account.</p> <p>On 3/8/11 at 3:40 P.M., the records of the hepatitis B positive patient's were reviewed. The</p>	V 131			

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V 131	<p>Continued From page 5</p> <p>treatment sheets for all the hepatitis B positive patient's indicated that multiple staff members cared for them during their treatments.</p> <p>Patient H8's treatment sheets were reviewed. The treatment sheets for 2/24/11, 3/1/11, 3/3/11, and 3/5/11 indicated the CN initiated the treatment and another staff member discontinued the treatment.</p> <p>Patient H9's treatment sheets were reviewed. The treatment sheets for 2/19/11 indicated a CCHT initiated the treatment and the CN discontinued the treatment. The treatment sheet for 2/15/11 indicated that a CCHT cared for the patient throughout the treatment.</p> <p>Patient H10's treatment sheets were reviewed. The treatment sheets for 2/23/11, 2/28/11 and 3/7/11 indicated the CN initiated the treatment and another staff member discontinued the treatment.</p> <p>Patient H6 stated on 3/9/11 at 10:05 A.M., "The nurse in blue and her partner" provide care for him during his dialysis. Patient H6 stated, "One puts me on and one will take me off" the dialysis machine. He further stated that sometimes, "Many different people" would help with his dialysis treatment.</p> <p>Patient H8 stated on 3/10/11 at 9:28 A.M. that during his dialysis treatment, "All different nurses take care of me."</p> <p>An Immediate Jeopardy (IJ) was called at 3/8/11 at 3:40 P.M. the regional manager, the area manager, and the clinical manager were present.</p>	V 131			

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V 131	Continued From page 6 They were informed an immediate Plan of Correction (POC) would need to be submitted to the survey team to abate the IJ.	V 131			
V 413	On 3/8/11 at 5:34 P.M., the IJ was abated after the facility presented the survey team with an acceptable POC. 494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to secure 3 emergency oxygen tanks located in the storage room. Findings: During a tour of the facility storage on 3/8/11 at 8:22 A.M., three "E" (660 liter) oxygen tanks were observed unsecured along the wall next to the secured "H" (6900 liter) oxygen tanks. On 3/8/11 at 9:30 A.M., the Technical Area Manager stated, "It doesn't appear staff has a place for them." According to the National Council on Patient Safety, oxygen tanks that are not stored in an upright, secure setting where there is no risk of tipping or crashing to the ground, can become dangerous projectile objects.	V 413		4/29/11	