

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

PRINTED: 05/31/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052677</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAN JOAQUIN VALLEY DIALYSIS CE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3636 NORTH FIRST STREET, SUITE 144 FRESNO, CA 93726</b>	
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V 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health-Licensing and Certification during a RECERTIFICATION survey.</p> <p>Representing the California Department of Public Health: Beverly Griffin HFEN, Kim Cooper HFEN, and Kelley Newby HFEN.</p> <p>Capacity:           22 Stations Census:             164 Sample:             12</p> <p>Abbreviations/Acronyms:</p> <p>AED                 Automated External Defibrillator BMT                 BioMed Technician CM                  Clinical Manager CNS                 Clinical Nurse Specialist CE                  Clinical Educator LN                  Licensed Nurse MD                 Medical Doctor ml                  milliliter PCT                 Patient Care Technician RN                  Registered Nurse RO                  Regional Officer WC                 Ward Clerk</p>	V 000		
V 143	<p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS</p> <p>[The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p>	V 143		3/24/11

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 143	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation, staff interview, and administrative document review, the facility failed to implement a process to ensure that expired medications were not available for use to patients when 18 syringes containing 4 per cent Sodium Citrate had labels with expired dates. This failure had the potential to place patients at risk of harm or injury from the dispensing of expired medications.  Findings:  1. On 2/23/11 at 3:45 p.m., during an observation at Station 3, the locked medication cupboard was opened by the Clinic Manager (CM) and contained eighteen 2 ml syringes of 4% Sodium Citrate (a medication placed in the dialysis catheter at the end of dialysis to prevent blood clots from obstructing the catheter tube). The eighteen syringes (instrument for injecting fluids) each had a label with the expiration date of 2/11/11.  On 2/23/11 at 3:47 p.m., during a interview, the CM stated, "those medications should not be in there, they are expired."  On 2/23/11 at 4:00 p.m., during review of an Administrative Policy and Procedure titled, "FMS Clinical, " dated 1/12/11, the policy indicated, "Expired Medication...Expired dates for all stored medications are to be monitored on a monthly basis."  Review of ASHP Technical Assistance Bulletin on	V 143			

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V 143	Continued From page 2 Hospital Drug Distribution and Control American Journal of Hospital Pharmacist 1980 page 61 under " Drug Storage and Inventory Control ... A method to detect and properly dispose of outdated, deteriorated, recalled, or obsolete drugs and supplies should be established."	V 143			
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, staff interview, administrative document and manufacturer's manual review, the facility failed to implement and maintain a preventative maintenance program for the AED (a portable electronic device used in emergencies to correct life threatening rapid heart rates) located on the emergency cart. This failure had the potential to increase patient risk to preventable serious injury in the event of emergency and the need to use the AED.  Findings:  On 2/24/11 at 1:20 p.m., during a concurrent interview and record review, the BMT arrived in the CM's office with the facility maintenance log. The BMT stated, " I don't see the Automated External Defibrillator (AED), in the preventive maintenance log in the book."	V 403		3/24/11	

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V 403	Continued From page 3 On 2/24/11 at 1:35 p.m., in the CM's office, the BMT returned and stated, "we don't have a maintenance log for that (AED)...we used to send it out, but we don't any more...the nurses just check it and see that the green light comes on for the battery...that means the battery is at least up to 25% of it's capacity."  On 2/24/11 at 5:30 p.m., during a review of the AED manufacture's manual indicated the following recommendations for maintenance on page 23 "3. Using the simulator (a special computer that is attached to the medical equipment and imitates various heart activity)...verify that the AED proceeds through the indicated steps, "...verify that the charge tone, "ready" is heard and that the shock button illuminates...NOTE this test checks the device's ability to defibrillate, (to give the heart an electrical shock at predetermined level)...does not verify the correct defibrillation energy was delivered...a defibrillator analyzer should be used...to test the accuracy of the delivered energy..."	V 403			
V 415	494.60(d)(4)(ii) PE-ANNUAL EVAL-EMERGENCY/DISASTER PLANS  The facility must- Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary;  This STANDARD is not met as evidenced by: Based on staff interview and administrative document review, the facility failed to effectively evaluate their emergency plan when:	V 415		3/24/11	

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V 415	<p>Continued From page 4</p> <p>1. Areas of improvement were identified on mock drills and no plan was put into place to show improvement.</p> <p>2. No evidence was provided that showed the facility had a disaster plan in place.</p> <p>These failures had the potential to increase patient and staff risk to injury in the event of emergency.</p> <p>Findings:</p> <p>1. On 2/24/11 at 10 a.m., during a concurrent interview and administrative document review, the facility's "Disaster Drill Plan Observation" form dated 9/28/10 indicated under the type of disaster was "fire" and the narrative review of performance indicated 100% of staff members were unable to verbalize or demonstrate how to turn off the facilities utilities (for example, water, gas and electrical). The CM stated that no follow-up drill was scheduled to re-evaluate performance. The CM stated no in-service was scheduled to re-educate staff.</p> <p>2. On 2/24/11 at 9:05 a.m., during an interview, the CM stated that fire drills were done quarterly, but the Emergency Disaster drills had not been practiced. The CM indicated that no collaboration with community or state emergency agencies for disaster preparedness had been done.</p> <p>On 2/24/11 at 10:40 a.m., during an interview, the CM stated, "we really need a disaster plan; it is important."</p> <p>On 2/24/11 at 11 a.m., during an interview, the WC stated that no disaster drills had been</p>	V 415			

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V 415	Continued From page 5 conducted for the past three and one-half years she had been there.  On 2/24/11 at 2:55 p.m., during an interview, the CE stated was asked to provide evidence for disaster training and competencies. The CE was unable to provide evidence for any training or competencies regarding disaster preparedness.  On 2/24/11, during record review, the "Continuous Quality Measures Committee" minutes dated January 2011 had no entry for focus or narrative for the heading "Disaster Drill".	V 415			
V 639	494.110(c) QAPI-PRIORITIZING IMPROVEMENT ACTIVITIES  The dialysis facility must set priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes or patient safety.  This STANDARD is not met as evidenced by: Based on staff interview, and administrative document review, the facility failed to utilize collected data and identified problems to prioritize improvement activities when emergency preparedness was not addressed in quality improvement minutes after identifying areas to improve. This failure had the potential to place patients and staff at risk of preventable injury in the event of an emergency.  Findings:  On 2/23/11, the administrative document titled "2010 Facility Quality Assessment and Performance Improvement (QAI) Hemodialysis	V 639		3/24/11	

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V 639	<p>Continued From page 6</p> <p>and Home Therapy Monthly Meeting" dated 1/27/11 was reviewed and indicated it contained data/information reviewed for the month of December 2010. The meeting minutes contained documentation of patient care quality indicators. Quality indicators under "Section IV Emergency Preparedness" were not addressed.</p> <p>On 2/23/11, the "Fire/Emergency Drill Observations" report for 2011 was reviewed with the CM Under "Disaster Drill" and there were zeros and no documentation of the type of disaster drill. The evaluation narrative documented staff did not meet standards of performance.</p> <p>On 2/24/11 at 9:05 a.m., during an interview in the CM's office, the CM indicated fire drills were done quarterly, and the Emergency Disaster Plan drills had not been done.</p> <p>On 2/24/11 at 10:10 a.m., during administrative document review of the facility's "Disaster Drill Observation," dated 9/28/10, the document indicated that 100 % of facility staff were unable to: locate or verbalize the disaster plan for any type of utility failure; the staff were unable to turn off water, gas, and electrical supplies in a disaster.</p> <p>On 2/24/11 at 10:40 a.m., during an interview, the CM while in her office stated, "we really need a disaster plan...it is important...I will try and contact someone for the disaster plan."</p> <p>On 2/24/11 at 2:15 p.m., the clinical educator provided an undated document titled, "Annual Direct Patient Care Skills Checklist" of Clinical</p>	V 639			

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V 639	Continued From page 7 Competencies. On page 4 of the document, a section titled, "Emergency Preparedness" had the following entries: ..."Locates emergency disaster box..." The CM was unable to provide competency forms that had been completed, or documentation of annual educational requirements, such as medical or emergency disaster preparedness for facility personnel.  On 2/24/11 at 2:27 p.m., during an interview in her office, the CE stated, "...there were two preceptors at the facility, the CM and a clinical staff member...they assist with education and sign off staff competencies." The CE was unable to provide any annual training documentation for Disasters.  On 2/24/11 at 4:15 p.m., MD A and Regional Officer (RO) acknowledged the facility did not consider the area of disaster preparedness for prioritization in the QAI minutes and did not prioritize the disaster plan as an area affecting patient safety and that the disaster plan had not been implemented, monitored, or evaluated.	V 639			
V 676	494.130 LAB-CLIA LABS/MEET NEEDS OF PTS  The dialysis facility must provide or make available, laboratory services (other than tissue pathology and histocompatibility) to meet the needs of the ESRD patient. Any laboratory services, including tissue pathology and histocompatibility must be furnished by or obtained from, a facility that meets the requirements for laboratory services specified in part 493 of this chapter.  This STANDARD is not met as evidenced by: Based on observation, staff interview and	V 676		3/24/11	

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V 676	<p>Continued From page 8</p> <p>administrative document review, the facility failed to provide laboratory services to meet the needs of the ESRD patient when:</p> <ol style="list-style-type: none"> <li>1. Wound culture swabs were used after the expiration date.</li> <li>2. Three of twelve patients' (Patients 9, 10, and 11) blood specimen tubes were identified with a label containing only the last name of the patient; one of twelve (Patient 12) were identified with last name and first initial.</li> </ol> <p>These failures had the potential to increase patient risk to negative health outcomes associated with inaccurate laboratory results.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 2/22/11 at 3:25 p.m., during an observation in the laboratory room, a plastic cart contained 17 of 50 wound culture swabs with expiration dates of 2/11/11.</li> </ol> <p>On 2/22/11 at 3:30 p.m., during an interview, the CM indicated that the swabs were expired and should not be in the cart.</p> <p>On 2/22/11 at 3:55 p.m., the facility's current reference document, from the contracted lab was reviewed. The document, dated 5/2004, titled "Collecting and Preparing Specimens," indicated, "Which tubes to Use for Blood Specimens...prior to using any blood specimen collection tubes, check the expiration date. The tubes will expire on the last date of the month. "</p> <ol style="list-style-type: none"> <li>2. On 2/22/11 at 2:20 p.m., during an initial tour at</li> </ol>	V 676			

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V 676	<p>Continued From page 9</p> <p>Station 2, four blood sample tubes identified with last name only were placed in the specimen refrigerator. These blood sample tubes were reportedly for Patient 9 (2 tubes), Patient 10 and Patient 11. On the counter above the specimen refrigerator was another blood tube identified by a label with last name and first initial. This blood tube was reportedly for Patient 12. No other identifying information was labeled on the blood sample tubes.</p> <p>On 2/22/11 at 2:25 p.m., during a interview at Station 2's laboratory specimen area, the Clinical Manager (CM) stated, "The tech will label the blood specimens at the end of the day, before they are packaged and sent to the lab."</p> <p>On 2/24/11, during review of the facility's contracted "Laboratory Reference Guide", Section 5, page 5.2, indicated, "Collecting Blood Specimens", Subsection titled, "Evacuated Tube Venipuncture Method," "2. Have collection tubes ready for use. Check to be sure patient's name, draw date and time of draw are written legibly."</p>	V 676			