

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>552507</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/25/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>KIDNEY CENTER OF SHERMAN OAKS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4955 VAN NUYS BLVD, SUITE 111 SHERMAN OAKS, CA 91403</b>		
(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 reflects the findings of the Department of Public Health during a Recertification Survey.  Representing the Department of Public Health:  Rosalinda Ramos, RN, HFEN Sylvia Villaflora, REHS, HFE	V 000			
V 110	494.30 CFC-INFECTION CONTROL  This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Conditions of Participations (COP) for infection control by failing to:  1. Provide a functional and sanitary area for personnel protective equipment (PPE) to minimize the transmission of infectious agents within and between the units ( refer to V111).  2. Provide the patient with gloves when assisting with a procedure such as hold access sites post-treatment, perform hand washing using soap and for duration of 20 seconds and not re-use same gauze twice in cleaning the exit site of a catheter exit site (refer to V113).  3. Ensure that the staff and visitor wore cover garment in the treatment area while patients were receiving hemodialysis treatment (refer to V115).  4. Ensure that multi-dose vial of Tuberculin	V 110		5/19/11	

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 Purified Protein Derivative (PPD) was discarded after a month opened, expired medications were not available for use, multi-dose vials once opened were dated and the medication preparation area was used for preparation and handling of medication and not for storing face shield, clip board and unused equipment (Refer to V117).  5. Ensure that a common cart that containing empty and filled jugs of bicarbonate solution remained in a designated area and not moved between stations to distribute supplies (refer to V119).  6. Close the isolation room door during termination of hemodialysis treatment. (Refer to V128)  7. Demonstrate current aseptic technique when dispensing medication. The licensed nurse wiped the septum of the multidose medication vial with a used alcohol pad prior to inserting a needle to withdraw medication (Refer to V143).  The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 110			
V 111	494.30 IC-SANITARY ENVIRONMENT  The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.  This STANDARD is not met as evidenced by:	V 111		4/13/11	

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V 111	Continued From page 2 Based on observation and interview, the facility staff failed to provide a functional and sanitary area for personnel protective equipment (PPE) to minimize the transmission of infectious agents within and between the units.  Findings:  During the course of the survey from January 19 through 21, 2011, at various times between 7 a.m. to 4 p.m., the personnel protective equipment (PPE) such as face/eye shields and gowns were observed at different areas of the unit. The PPEs were found hanging by a trash bin, on top of the counter with other supplies and equipment, by a chair and/or on top of a computer. The same PPEs were being used by the facility staff when they come back to the treatment area to provide care to the patients.  On January 21, 2010, at 9 a.m., during an interview with Employee D, she stated that the designated area to hang the PPE could not be used because it was broken for sometime. She added the designated area to hang the PPEs would be fixed as soon as possible.	V 111			
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, interview and record	V 113		4/13/11	

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V 113	<p>Continued From page 3</p> <p>review, failed to provide the patient with gloves when assisting with a procedure such as hold access sites post-treatment, perform hand washing using soap and for duration of 20 seconds and not re-use same gauze twice in cleaning the exit site of a catheter exit site.</p> <p>Findings:</p> <p>1. On January 19, 2011, at 1:40 p.m., during observation of the treatment area, a patient in Station 18 (Isolation Room) was observed being taken off the hemodialysis machine. Employee F removed the cannulating needles and applied 4 by 4 gauze that was folded twice over the access sites. The patient applied pressure over the access site without gloves on.</p> <p>During a concurrent interview with Employee F on January 19, 2011 at 1:40 p.m., she stated that the patient could assist in holding the access site during post treatment, however, the patient must wear gloves.</p> <p>A review of the facility policy 05-10 titled "Infection Control" stipulated to provide gloves to patients who assist with procedures with risk of exposure to blood such a holding access sites post treatment.</p> <p>2. On January 19, 2011, at 9:15 a.m., Employee B was observed during hemodialysis catheter dressing change. Patient 1 had a right subclavian catheter. Employee B washed her hands with soap and water for about 5 seconds, dried her hands with towel and donned a pair of gloves, a gown and mask for herself and the patient. Employee B removed the dressing then her</p>	V 113			

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V 113	<p>Continued From page 4</p> <p>gloves after discarding the dressing. Employee B then washed her hands without using soap, donned a new pair of gloves and proceeded to clean the exit site with gauze soaked in Anasept. The same gauze was used twice starting from the center going outward motion over the exit site.</p> <p>During an interview on January 19, 2011 at 9:25 a.m., Employee B stated she was nervous and was not aware that she washed her hands for 5 seconds and failed to use soap. She further stated that she should not use the same gauze to clean the exit site twice.</p> <p>3. On January 19, 2011, at 2 p.m., the clinical nurse manager was observed performing hemodialysis catheter dressing change for Patient 4. The clinical nurse manager used the same gauze soaked in Anasept twice starting from the center going outward motion over the exit site.</p> <p>A review of the facility's policy 12-100 titled "Hemodialysis Catheter Dressing Change" stipulated swab the area gently with saturated sterile(gauze) soaked with ExSept or Anasept, starting at the exit site and circling outward motion.</p> <p>During a concurrent interview with Employee D she stated the policy would be looked at to include the current community standard of not re-using the same gauze to clean an exit site.</p> <p>4. On January 21, 2011, at 9:25 a.m., during tour of the treatment area, Physician A was observed with patients receiving hemodialysis treatment in Stations 10, 12 and 18 ( isolation room). The</p>	V 113			

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V 113	Continued From page 5 physician did not wash his hands in between patient visit. Employee D was made aware of the physician's failure to wash hands in between patients. Employee D reiterated the importance of handwashing in between patient visit during hemodialysis treatment.	V 113			
V 115	A review of the facility's policy 05-110 titled "Aseptic Hand Washing" stipulated all staff is expected to wash hands in between two patients, use of liquid antibacterial soap to hands and CDC recommendation that hand washing incorporates rubbing hands together vigorously for 20 seconds. 494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK  Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff and visitor failed to wear a cover garment in the treatment area while patients were receiving hemodialysis treatment.  Findings:  1. On January 19, 2011, at 1:40 p.m., a patient in station 2 was observed receiving hemodialysis treatment, in the presence of two private sitters	V 115		4/13/11	

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V 115	Continued From page 6 on each side. Both caretakers were not wearing any gown as they remained at the patient's bedside.  During a concurrent interview on January 19, 2011 at 1:40 p.m., Employee D stated that visitors in the treatment area should at least wear gown.  A review of the facility's policy titled "Visitor Policy" stipulated all protective personnel equipment (PPE) precautions would be followed by visitors.  2. On January 21, 2011, at 9:25 a.m., during a tour of the treatment area, Physician A was observed without a cover garment (lab coat or gown) while seeing patients. The physician went to see patients receiving hemodialysis treatment in stations 12 and 10, updated them of their current conditions then went to Station 18 (isolation room) wearing a yellow disposable gown. The physician discarded the yellow gown and proceeded to see patient in station 12, again without wearing any gown. Shortly thereafter, the physician went to the nurses station and documented his findings in the patients' medical records.	V 115			
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	V 117		4/13/11	

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V 117	<p>Continued From page 7</p> <p>that where used equipment or blood samples are 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 and interview, the facility staff member failed to ensure that multi-dose vial of Tuberculin Purified Protein Derivative (PPD) was discarded after a month when it was first opened, expired medications were not available for use, multi-dose vials once opened were dated and the medication preparation area was used for preparation and handling of medication and not for storing face shield, clip board and unused equipment.</p> <p>Findings:</p> <p>On January 19, 2011, at 8:30 a.m., during the medication storage observation with Employee B, the following were noted:</p> <ol style="list-style-type: none"> <li>1. The medication refrigerator had heavy accumulation of ice in the freezer.</li> <li>2. In the medication refrigerator :</li> </ol>	V 117			

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V 117	<p>Continued From page 8</p> <p>a) There was a box of Tempa Dots Thermometer (sterile, single-use Tempa-DOTs thermometers) with expiration date of October 20, 2010.</p> <p>b) There was a bottle of multi-dose vial Cyanocobalamin medication opened and undated.</p> <p>c) There were two (2) vials of Tuberculin Purified Protein Derivative (PPD), one of the vials was labeled as opened on November 23, 2010 and the other vial was opened and undated. According to the Manufacturer's Insert, a vial of Tuberculin PPD which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency.</p> <p>d. There was a vial of Influenza A (H1N1) 2009 (Monovalent Vaccine) open and undated.</p> <p>3. In the medication cabinet, there were three (3) boxes of Triple Antibiotic packets with expiration date of October 2010.</p> <p>4. There were three (3) bottles of hydrogen peroxide opened and undated by the nurses station.</p> <p>During a concurrent interview with Clinical Nurse Manager, she stated that multi-dose vial medications should be dated when initially opened. The facility's policy on Medication Administration stipulated once a multidose vial of medication was opened, the date would be written on the bottle and could be kept for use in the refrigerator.</p>	V 117			

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V 117	Continued From page 9 5. On January 19, 2011, at 8 a.m., during the initial tour of the treatment area, it was noted the designated medication preparation area was by the nurses station. There was face shield lying on top of the table, a suggestion box, a box labeled personal manual pump, an emergency light and a clip board. The medication preparation area was dusty.	V 117			
V 119	During a concurrent interview with Employee B on January 19, 2011 at 8 a.m., she stated that the medication preparation area should not be used to store items not related to medication preparation and handling. 494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS  If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.  Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to ensure that a common supply cart containing empty and filled jugs of bicarbonate solution remained in a designated area and was not moved between stations to distribute supplies.  Findings:  On January 19, 2011, at 3 p.m., during a tour of	V 119		4/13/11	

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V 119	Continued From page 10 the treatment area, Employee E was observed pushing a cart that contained empty and filled jugs of bicarbonate solution around the treatment area. The employee stopped in between hemodialysis stations and picked up jug of bicarbonate solution that needed to be replaced. He then placed the empty jug together with other jugs and moved to the next station.  During an interview on January 19, 2011 at 3:15 p.m., Employee E, stated that it was his duty to check which station needed replacement of bicarbonate solution. He further stated he was not aware that he should not move the cart filled with jugs in between station.	V 119			
V 128	494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY)  Isolation of HBV+ Patients  To isolate HBsAg positive patients, designate a separate room for their treatment.  For existing units in which a separate room is not possible, HBsAg positive patients should be separated from HBsAg susceptible patients in an area removed from the mainstream of activity.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to close the isolation room door during termination of hemodialysis treatment.  Findings:  On January 19, 2011, at 1:40 p.m., during observation of the treatment area, a patient in	V 128		4/13/11	

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V 128	Continued From page 11 Station 18 (Isolation Room) was observed being taken off the hemodialysis machine while the isolation room door remained open.  During a concurrent interview on January 19, 2011 at 1:40 p.m., when made aware that the isolation door was open during termination of treatment, Employee F did not make any comment.  A review of the "Isolation Policy" 05-20 stipulated that during patient's put on and take off from hemodialysis machine isolation room door should be closed.	V 128			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS  [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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to demonstrate current aseptic techniques when dispensing medication. The licensed nurse wiped the septum of the multidose medication vial with a used alcohol pad prior to inserting a needle to withdraw medication.  Finding:  On January 19, 2011, at approximately 9: 55 a.m., during medication preparation observation, Employee B was preparing medication Zemplar in	V 143		4/13/11	

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V 143	Continued From page 12 the designated medication preparation area. The licensed nurse picked up a used alcohol pad and wiped the septum of the multidose vial of Zemplar prior to drawing up medication.	V 143			
V 184	<p>During a concurrent interview with Employee B, she stated she was not aware of what she did because she was nervous. She further stated that alcohol pad should not be re-used to clean the septum of a medication vial.</p> <p>494.40(a) ENVIRONMENT-SECURE &amp; RESTRICTED</p> <p>8 Environment: secure &amp; restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to secure the water treatment room by keeping the door closed.</p> <p>Findings:</p> <p>During an observation of the facility on January 19, 2011, at 7:23 a.m., the door to the water treatment room was kept wide open with a door wedge. The door to the water treatment room is between station 1 and the isolation room.</p> <p>During an interview on January 19, 2011, at 10 a.m., the machine technician stated the door to</p>	V 184		5/19/11	

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V 184	Continued From page 13 the water treatment room should be closed at all times.	V 184			
V 187	<p>494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS</p> <p>8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction.</p> <p>Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow.</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to include in the labels of the major water system components what action to take in the event performance is not within an acceptable range.</p> <p>Findings:</p> <p>During an observation of the water treatment room on January 19, 2011, the labels of the major water system components indicated the function of the component. The labels did not include what action to take in the event performance was not within an acceptable range.</p> <p>During an interview on January 19, 2010, at 10:15</p>	V 187		4/13/11	

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V 187	Continued From page 14 a.m., the technical manager could not give an explanation why the water system component labels did not include what action to take in the event the performance was not within an acceptable range.	V 187			
V 300	494.50 CFC-REUSE OF HEMODIALYZERS & BLOODLINES  This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Conditions of Participations (COP) for reuse of hemodialyses and bloodlines by failing to:  1. Maintain the centralized reprocessing area in a clean and sanitary condition (refer to V 318).  2. Maintain the van used to transport the dirty/reprocessed dialyzers in a sanitary manner (refer to V 331).  The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 300		4/13/11	
V 318	494.50(b)(1) REPROCESSING AREA & VENTILATION  ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1) 8 Physical plant and environmental safety considerations 8.1 Reprocessing area and ventilation The reprocessing area should be designed to suit the operation carried out and maintain acceptable	V 318		4/13/11	

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V 318	<p>Continued From page 15</p> <p>ambient concentrations of harmful substances (see Table 1). The area should be kept clean and sanitary. It may be part of the dialysis treatment area, as long as equipment used is properly designed and vented to meet the requirements for environmental safety (see [AAMI] 8.5).</p> <p>Table 1-OSHA environmental exposure limits (29 CFR 1910, 1 July 1998), except as indicated</p> <table border="1"> <thead> <tr> <th>Substance/material</th> <th>Limits (PEL)a</th> </tr> </thead> <tbody> <tr> <td>Acetic acid</td> <td>10 ppm TWAb</td> </tr> <tr> <td>Chlorine dioxide (syn: chlorine oxide)</td> <td>0.1 ppm TWA</td> </tr> <tr> <td>Citric acid</td> <td>None developed</td> </tr> <tr> <td>Formaldehyde</td> <td>0.75 ppm TWA 2 ppm STELc(15 min)</td> </tr> <tr> <td></td> <td>0.5 ppm action level</td> </tr> <tr> <td>Glutaraldehyde</td> <td>0.2 ppm ceiling NIOSH/OSHA</td> </tr> <tr> <td>Hydrogen peroxide</td> <td>1 ppm TWA</td> </tr> <tr> <td>Peracetic acid</td> <td>None developed</td> </tr> <tr> <td>Phenol</td> <td>5 ppm TWA</td> </tr> </tbody> </table> <p>ppm = parts per million a) PEL (permissible exposure limit) represents the limit of what employees can be exposed to; PELs can be TWAs or STELs. b) TWA (time-weighted average) represents the limit of what an employee can be exposed to in an eight-hour period.</p>	Substance/material	Limits (PEL)a	Acetic acid	10 ppm TWAb	Chlorine dioxide (syn: chlorine oxide)	0.1 ppm TWA	Citric acid	None developed	Formaldehyde	0.75 ppm TWA 2 ppm STELc(15 min)		0.5 ppm action level	Glutaraldehyde	0.2 ppm ceiling NIOSH/OSHA	Hydrogen peroxide	1 ppm TWA	Peracetic acid	None developed	Phenol	5 ppm TWA	V 318		
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V 318	<p>Continued From page 16</p> <p>c) STEL (short-term exposure limit) represents the limit of what an employee can be exposed to in any 15-minute time period.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the centralized reprocessing area in a clean and sanitary and condition.</p> <p>Findings:</p> <p>During a tour of the centralized reprocessing area on January 24, 2011 from 8:30 a.m.- 9:40 a.m., the following was observed:</p> <ol style="list-style-type: none"> <li>1. There was one water stained ceiling tile above the renatron machine.</li> <li>2. The section of the floor under the rubber mats had black stains.</li> </ol> <p>During a telephone interview on January 25, 2011, at 9:45 a.m., the lead reuse technician stated the staff cleaned the floor around the rubber mats at the end of the work day from Tuesday to Sunday. The section of the floor under the rubber mats were cleaned once a week on Mondays.</p> <ol style="list-style-type: none"> <li>3. The two wall vents and the two ceiling vents were dusty.</li> <li>4. There was a dusty electric fan on the floor under the counter.</li> <li>5. There was a dusty radio, two soiled towels</li> </ol>	V 318			

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

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V 318	Continued From page 17 spread out on top of the counter. The section of the counter along the wall where an electrical wire was located was dusty.  During a telephone interview on January 25, 2011, at 9:50 a.m., the lead reuse technician stated the counter was used by the staff to place the labels on the reprocessed dialyzers.  6. Next to the handwashing sink there were two plastic containers piled up upside down used as storage stand for plastic containers with port caps. When the plastic containers were moved, there were approximately 9 port caps on the floor.  7. The base coving was missing throughout the reuse room.  A review of the facility's daily opening-closing log for the reprocessing area from January 16-23, 2011 revealed the closing log was not completed. The following items: towels in the bin, totes sanitized, water test, initial were all left blank.  A review of the reuse technician job description revealed the responsibilities included to keep the storage areas and equipment areas in an orderly and clean manner and to comply with infection control procedures.  At the time of the visit, on Monday, staff were off so there was no observation of the dialyzer reprocessing.	V 318			
V 331	494.50(b)(1) REPROCESSING-TRANSPORTATION & HANDLING  11 Reprocessing	V 331		4/13/11	

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V 331	<p>Continued From page 18</p> <p>11.1 Transportation and handling Persons handling used dialyzers during transportation shall do so in a clean and sanitary manner maintaining Standard Precautions until the dialyzer is disinfected both internally and externally. To inhibit bacterial growth, dialyzers that cannot be reprocessed within 2 hours should be refrigerated and not allowed to freeze. Other transportation and handling issues (such as prolonged delays in reprocessing) not described in this recommended practice shall be validated and documented by the responsible party.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the van used to transport the dirty/reprocessed dialyzers in a sanitary manner.</p> <p>Findings:</p> <p>On January 24, 2011 at 10:05 a.m., during an observation of the van used to transport dirty and reprocessed dialyzers between dialysis units and the centralized reprocessing center, the following were observed:</p> <ol style="list-style-type: none"> <li>1. The back compartment's floor area was dusty.</li> <li>2. A section of the shelf had a support that was loose.</li> <li>3. The door compartment on the driver's side was filled up to the rim with soiled gloves and soiled paper towels.</li> </ol> <p>At the same time, during an interview, the technical area manager stated the van should be</p>	V 331			

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V 331	Continued From page 19 cleaned and the soiled gloves and paper towels should have been discarded.	V 331			
V 400	494.60 CFC-PHYSICAL ENVIRONMENT  A review of the facility's policy and procedure entitled Dialyzer Transport Training revealed the reuse manager was responsible for ensuring a dialyzer transport driver follows the correct policies and procedures. The reuse leader is responsible for providing the dialyzer transport driver adequate education, training and experience. The training curriculum included the location and proper use of gloves.  This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Conditions of Participations (COP) for physical environment by failing to:  1. Maintain a safe and equipped environment for patients, staff and public during hemodialysis treatment ( refer to V 401).  2. Implement and maintain a program to ensure the daily monitoring of the medication refrigerator, blood glucose meters being used in the facility and maintain a current log, an accurate count of the actual medication and check expiration dates of medication in the emergency cart ( refer to V403).  3. Ensure that patient's vascular access sites were visible during hemodialysis treatment ( refer to V 407).	V 400		5/19/11	

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V 400	Continued From page 20 The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 400			
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, interview and record review, the facility staff failed to maintain a safe, equipped and maintained environment for patients, staff and public during hemodialysis treatment.  Findings:  On January 19, 2011, at approximately between 7:20 a.m. through 3 p.m., during the tour of the treatment area, the following was observed :  a. There were thirteen (13) unlabeled and unattended syringes that contained clear, white substance on top of the overbed table by the sink.  During a concurrent interview Employee F stated the syringes should be labeled with the time and date, name and amount of medication drawn and initial of who drew the medication.  A review of the facility's policy 14-00 Medication	V 401		4/13/11	

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V 401	<p>Continued From page 21</p> <p>Administration stipulated all medications once prepared for administration should be labeled with the name of the medication, the dosage, the date and time along with the initials of the person preparing the medication.</p> <p>b. The starter kits consisting of cannulating needles, syringes, gauzes and alcohol pads were placed in an empty armchair in various hemodialysis stations which were accessible to unauthorized people including visitors and other patients who would be in the unit at any given time.</p> <p>c. There was a whole prescription pad with pre-printed information such as the name of the physician, his license number, DEA number, etc left unattended on the top counter by the nurses station. Such prescription pad was at risk for unauthorized access to who passes by the nurses station.</p> <p>During a concurrent interview Employee D stated the prescription pad should be kept in a locked drawer when not in use.</p> <p>d. The Peritoneal Dialysis (PD) Room was observed to be utilized as a storage area for forty (40) boxes of 5 liter compact concentrator, picture frames, empty plastic containers of bleach and specimens cups. There were three (3) boxes of dialysis solutions on the floor. There was a black, empty luggage under the sink. There were no educational materials regarding the PD program, medications and supplies and equipment dedicated for the PD room.</p> <p>During a concurrent interview the PD nurse</p>	V 401			

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V 401	<p>Continued From page 22</p> <p>stated the unit had two (2) PD patients who transferred to the facility on January 1, 2011. However, the PD room was not ready to accommodate the patients at the time of initial tour.</p> <p>e. During the initial tour on January 19, 2011, from 7:10 a.m.-8:24 a.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. The front door was propped open with a trash receptacle.</li> <li>2. There was a damaged section of the wall outside the isolation room area.</li> <li>3. In the treatment area, there were soiled paper towels and a towel around the machine in Station 1.</li> <li>4. There was a gnat observed near station 1.</li> <li>5. The door to the water treatment room located next to station 1 was held wide open with a wedge.</li> <li>6. There was a damaged section of the wall inside the water treatment room near the door.</li> <li>7. There was a dusty electric fan on top of the medication refrigerator in the nurses' station.</li> <li>8. In the treatment area, there was a metal trash receptacle with a rusty cover that was touching the wall next to the sink. The wall behind the trash receptacle was damaged with brown stain.</li> <li>9. The exit door next to station 6 had chipped</li> </ol>	V 401			

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V 401	Continued From page 23 edges.  10. There was a soiled blue clamp on the floor near station 6.  11. In station 7, there was a test strip on top of the wall concentrate panel and a test strip on the floor.  12. In station 8, there was no patient and the blood pressure cuff was on the floor.  13. Under the sink located near the weighing scale, there was a blood pressure apparatus stored next to a plastic container of bleach.  14. In station 12, there were pieces of paper on the floor.  15. In the nurses' station, the cabinet had a nail sticking out that was covered with tape. The cabinet handle was covered with tape.  16. There was a plastic container with 9 reprocessed dialyzers on the floor next to the sink.  At the same time during an interview, the hemodialysis technician stated the reprocessed dialyzers in the plastic container were for the second shift patients.  17. In station 12, there was paper on the floor.  18. The refrigerator used for dirty dialyzers had rusty shelves. The inner surface had an accumulation of brownish black debris in the corners.	V 401			

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V 401	Continued From page 24  At the same time during an interview, the certified technician who accompanied the evaluator during the tour stated the dialyzers were reprocessed in an offsite facility.  19. In station 17, there was no patient and the blood pressure cuff was touching the floor.  20. At 9:15 a.m., there was a gnat in the conference room.  At the same time during an interview, the machine technician stated the facility had pest control service.  21. At 10 a.m., in the machine technician's room, there was a damaged section of the sink counter.  At the same time during an interview, the machine technician stated the damaged sink counter should be replaced.  22. From 1:52-2:08 p.m., in station 11, the blood pressure cuff was on the floor at the side of the treatment chair. Several staff were observed passing the area.  23. At 2:20 p.m., in station 15, the blood pressure cuff was on top of the treatment chair. In station 17, there was no patient, the blood pressure cuff was hanging on the side of the dialysis machine touching the sharps container.  24. On January 21, 2011, at 6:38 a.m., under the sink near the weighing scale, there was a blood pressure apparatus next to a plastic bleach container.	V 401			

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V 401	Continued From page 25  At the same time during an interview, the director of nursing who accompanied the evaluator during the tour, stated nothing should be stored under the sink.  25. At 6:40 a.m., in station 11, the blood pressure cuff was on top of the treatment chair. In station 12, the blood pressure cuff was hanging on the side of the chair.  At the same time during an interview, the director of nursing stated the blood pressure cuff should be placed in the basket located at the side of the dialysis machine when not being used.  26. At 10 a.m., there was a gnat observed in the conference room.  A review of the pest control service dated November 18 and 30, 2010 revealed the target pest was gnats. There was no other documentation of any pest control service after November, 2010.  A review of the pest control service report dated January 21, 2011 revealed target pests included gnats.  27. On January 24, 2011, at 6:50 a.m., the front door was propped open with a trash receptacle.  28. On January 25, 2010, at 6:50 a.m. and at 10:15 a.m., there was a gnat observed in the conference room.	V 401			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU	V 403		4/13/11	

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V 403	<p>Continued From page 26</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to maintain the daily monitoring of the medication refrigerator, blood glucose meters, maintain a current log, an accurate count of actual medications and check expiration dates of medication in the emergency cart.</p> <p>Findings:</p> <p>1. On January 19, 2011, at 8:15 a.m., Employee B was requested to demonstrate how to perform the blood glucose meter quality control on the existing meter in use. The employee readily took out the blood glucose meter, control solution and the strips. However, the glucometer was not working. Employee B changed the battery but the glucometer was still not working. The facility had a back-up glucometer which was available however, the back-up glucometer was not working as well. The control solution for Hi and Lo Level had an expiration date of October 2010.</p> <p>A review of the Glucose Meter Quality Control Log revealed the daily glucometer monitoring was not consistently done. The following documentation revealed the glucometer monitoring was not performed as follows:</p>	V 403			

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V 403	<p>Continued From page 27</p> <p>a. June 1-21 through 23- 30, 2010 (a total of 29 days)</p> <p>b. March 1-17, 19, 21- 22, 24, 26, 28 and 29, 2009 ( a total of 24 days)</p> <p>c. April 2, 4-5, 7-12, 14, 16-19, 21, 23-25, 28 and 29, 2009 ( a total of 18 days)</p> <p>d. May 2-5, 7, 9-12, 14-17, 19-24, 26-31, 2009 ( a total of 25 days)</p> <p>e. June 2-4, 6-7, 9-14, 16-18, 20-24, 27-30, 2009 ( a total of 24 days)</p> <p>f. July 2-5, 7-9, 11-12, 14-16, 18-26, 28-31, 2009 ( a total of 25 days)</p> <p>During a concurrent interview, Employee D was unable to explain why the glucometer daily monitoring was not performed.</p> <p>A review of the Event Log for the month of October 2010 revealed that on October 18, 2010, a patient requested that his blood sugar be checked because he was not feeling well. The blood glucose meter did not work because it needed a new battery.</p> <p>A review of the facility's policy 04-10 "Daily Unit Opening" stipulated verify calibration of glucose-meter units and record results on the log.</p> <p>2. The Daily Temperature Log of the medication refrigerator was reviewed. The log revealed the daily temperature monitoring was not consistently done during the following dates: January 4 and 14, 2011; December 10, 22, 24 and 31, 2010; November 12, 13, 19 and 26, 2010; October 8 and 22, 2010; September 23 and 30, 2010 and July 24 and 29, 2010. The dates mentioned were between Monday to Saturday, when the</p>	V 403			

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V 403	<p>Continued From page 28</p> <p>hemodialysis clinic was opened and patients were receiving hemodialysis treatment.</p> <p>During a concurrent interview Employee C stated the medication refrigerator temperature should be checked daily when patients were receiving hemodialysis treatment at the clinic. Employee D while reviewing the temperature log was unable to find any documentation to indicate why the medication refrigerator temperature was not taken on the above mentioned dates.</p> <p>A review of the facility's policy number 14-00 "Medication Administration" stipulated that a log is maintained of daily temperature check of the refrigerator temperature. "The Registered Nurse (RN) would enter the date, the temperature and his/her signature."</p> <p>3. On January 19, 2011, at 9:45 a.m., during the emergency equipment and drug check with Employee B, the daily crash cart log book was missing.</p> <p>During a concurrent interview the Clinical Nurse Manager stated that she found out on January 18, 2011, during the morning check that the log book was missing.</p> <p>Further observation of the medications in the crash cart revealed the following:</p> <p>a. There were missing medications such as Glucose tablets, Epinephrine 1:1000 1 mg/ml ampule and Phenergan 50 mg/ml.</p> <p>b. The actual medications on hand had a different dosage than what was listed such Atropine 0.4</p>	V 403			

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V 403	Continued From page 29 mg/ml (1 mg/ml) and Phenytoin 100 mg (250 mg/5 ml).  c. There were medications such as Epinephrine Inj. USP 1:10,000 (0.1 mg/ml) with expiration date of January 7, 2011 and 2% of Lidocaine HCL with expiration date of January 8, 2011.  d. There were medications stored in emergency cart which were not listed such as Heparin 1,000 USP units /ml and 30 ml vials.  A review of the facility's policy 07-10 "Crash Cart Checklist" stipulated an RN would check the crash cart each day during day of operation and check expiration dates of medications."	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, interview and record review, the facility staff members failed to ensure that patients' vascular access were visible during hemodialysis treatment.  Findings:  On January 19, 2011, at 7:20 a.m., during tour of the treatment area the vascular access sites of patients in stations 4, 7, 12 and 18 were not visible to the staff members in the unit during hemodialysis treatment. At 9:30 a.m., the vascular access sites of patients receiving	V 407		4/13/11	

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V 407	Continued From page 30 hemodialysis treatment in stations 16 and 18 were not visible. At 10:45 a.m., the vascular access sites of patients in stations 11, 15, 16 and 18 were not visible.  During an observation tour of the treatment area on January 19, 2011, at 7:20 a.m., in station 18, the patient's access site was not visible. At 7:28 a.m., in station 4, the patient's access site was not visible.  During an observation tour of the treatment area on January 21, 2011, at 6:35 a.m., in stations 2,4, 6 and 7, the patients access sites were not visible.  On January 21, 2011, at 7 a.m., during the tour of the treatment area, the patients' vascular access site in stations 4, 6, 16 and 18 were not visible during hemodialysis treatment. During a concurrent interview Employee A, stated patients' access sites should always be visible during treatment. He added that every facility staff members should consistently remind the patients not to cover the access sites during treatment.  On January 25, 2011, at 11:45 a.m., during tour of the treatment area with the Clinical Nurse Manager, the patients' vascular access sites in stations 1 and 8 were not visible while receiving hemodialysis treatment.  A review of the facilities policy number 10-30 "Surveillance for Access Function" stipulated to make sure all access is visible all the time when patient is on dialysis."	V 407			
V 502	494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS	V 502		4/13/11	

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V 502	<p>Continued From page 31</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(1) Evaluation of current health status and medical condition, including co-morbid conditions.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to document monthly foot assessment for diabetic patients and quarterly access function assessment for Patient 6, 7, 9 and 10.</p> <p>Findings:</p> <p>1. A review of the medical record revealed Patient 6 was admitted to the facility on March 29, 2010 with diagnosis that included diabetes.</p> <p>There was no monthly foot assessment and quarterly access function assessment completed.</p> <p>During an interview on January 2, 2011, at 12:20 p.m., the unit manager could not explain why there were no assessments completed.</p> <p>2. A review of the medical record revealed Patient 7 was admitted to the facility on November 11, 2011 with diagnosis that included diabetes.</p> <p>There was no monthly foot assessment and quarterly access function assessment completed.</p> <p>3. A review of the medical record revealed Patient 9 was admitted to the facility on March 22, 2010 with diagnosis that included diabetes.</p>	V 502			

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V 502	Continued From page 32  The monthly foot assessment was done during admission on March 22, 2010. There was no assessment done from April-December, 2010 (9 months).  There was no access function assessment in June, September and /December, 2010 (3 quarters).  4. A review of the medical record revealed Patient 10 was admitted to the facility on September 19, 2005 with diagnosis that included diabetes.  The monthly foot assessment was dated April 27, 2009. There were no other monthly assessments done after April 27, 2009. The quarterly access function assessment was dated April 27, 2009 and there were no quarterly access function assessments done after April 27, 2009.	V 502			
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX  The patient's comprehensive assessment must include, but is not limited to, the following:  (2) Evaluation of the appropriateness of the dialysis prescription,  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to follow physician's order for blood flow rate for Patients 1, 2, 3 and 4, oxygen flow rate for Patient 2, and medication Tylenol dosage for Patient 3.	V 503		4/13/11	

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V 503	<p>Continued From page 33</p> <p>Findings:</p> <p>1. On January 19, 2011, at 9:15 a.m., Patient 1 was observed receiving hemodialysis treatment via right subclavian catheter. The patient was dialyzing on a 2 potassium (K) and 2.5 calcium (Ca) bath. The blood flow rate (BFR) was 350.</p> <p>A review of Patient 1's daily treatment record from January 3 through 17, 2011, revealed BFR was from 238 to 315. A review of the physician's order dated January 3, 2011, indicated the prescribed BFR was 350.</p> <p>2. On January 19, 2011, at 10 a.m., Patient 2 was observed receiving hemodialysis treatment via left lower arm fistula. The patient was dialyzing on 2 K and 2.5 Ca bath. The BFR was 400. The patient was on oxygen at 2 liters via nasal cannula. Upon interview with the patient, he stated he was having shortness of breath and needed oxygen.</p> <p>A review of the daily treatment record for Patient 2 from January 3 through 21, 2011, revealed the BFR was from 362 to 408. A review of the physician's order dated January 3, 2011 indicated the prescribed BFR was 450.</p> <p>Review of the physician order dated January 3, 2011 indicated 6 liters of oxygen per minute via nasal cannula for shortness of breath and notify the physician. Further review of the treatment record dated January 19, 2011 failed to show documentation the patient was administered oxygen for shortness of breath and the physician was notified.</p>	V 503			

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V 503	<p>Continued From page 34</p> <p>3. On January 25, 2011, at 1:45 a.m., Patient 3 was observed receiving hemodialysis treatment via right subclavian catheter. The patient was dialyzing on 1 K and 3.5 Ca bath. The BFR was 350.</p> <p>A review of Patient 3's daily treatment record from January 2 through 22, 2011 revealed the BFR was from 281 to 348 and dialysate bath of 1 K and 3.5 Ca. A review of the physician's order dated May 1, 2010, indicated BFR 350/400, 1 K and 2.5 Ca bath.</p> <p>Further review of the treatment record dated January 18, 2011, at 3:47 p.m., indicated the patient was administered Tylenol 1.95 mg but there was no documented reason why it was administered. A review of the physician order dated May 1, 2010 indicated Acetaminophen (Tylenol) 325 mg orally as needed for general discomfort/headache/temperature greater than 100 degrees Fahrenheit.</p> <p>On January 25, 2011, at 2 p.m., during an interview with the clinical nurse manager while reviewing the medical record, she stated the Tylenol dosage is not the right amount. She agreed there was no documentation of an assessment by the Registered Nurse (RN) of the patient's need for Tylenol medication. She added that if the ordered BFR of the patients was not achieved during dialysis, the patient care technician (PCT) should document in the treatment record the reason and notify the RN.</p> <p>4. On January 19, 2011, at 2 p.m., Patient 4 was observed receiving hemodialysis treatment via right subclavian catheter. The patient was</p>	V 503			

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V 503	Continued From page 35 dialyzing on 2 K and 2.5 Ca bath. The BFR was 300.	V 503			
V 504	<p>A review of Patient 4's daily treatment record from January 3 through 19, 2011 revealed the BFR was from 250 to 361. A review of the physician's order dated May 11, 2010, indicated the prescribed BFR of 300.</p> <p>494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Blood pressure, and fluid management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the licensed nurse failed to reassess Patient 5's blood pressure after the administration of normal saline.</p> <p>Findings:</p> <p>On January 21, 2011, at 7 a.m., Patient 5 was observed receiving hemodialysis treatment via right upper arm fistula. The patient was dialyzing on a 2 K and 2.5 Ca bath.</p> <p>A review of Patient 5's daily treatment record dated January 7, 2011, at 8:17 a.m., indicated the patient's blood pressure (B/P) was 98/47 and noted hypotension. At 8:47 a.m., the B/P was 88/41 and the patient was administered 200 ml of normal saline and the ultrafiltration (water removal from the patient by the artificial kidney)</p>	V 504		4/13/11	

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V 504	Continued From page 36 was off. At 9:16 a.m., the patient's B/P was 89/36. At 9:45 a.m., treatment ended with B/P of 99/50. Further review of the medical record failed to show documentation that the RN assessed the patient during the hypotensive episode.  A review of the physician's order dated March 23, 2009, indicated to maintain B/P at 100/60 by infusion of 200 cc of 0.9% Sodium Chloride per hypotensive episode. May repeat x 1.  On January 21, 2011, at 1:30 p.m., during an interview Employee F stated if and when the same situation happens, she would notify the RN, administer the normal saline and document.	V 504			
V 506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY  The patient's comprehensive assessment must include, but is not limited to, the following:  Immunization history, and medication history.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility staff failed to ensure the patient's comprehensive assessment included immunization history for five sampled patients (Patients 1, 2, 4 and 5).  Findings:  A review of Patient 1's medical record revealed the patient was admitted to the facility on March 11, 2010, with diagnosis of end stage renal disease secondary to type 2 diabetes mellitus. Further review of the clinical record failed to show	V 506		4/13/11	

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V 506	Continued From page 37 documentation of Patient 1's immunization history.  A review of Patient 2's medical record revealed the patient was admitted to the facility on September 14, 2009, with diagnoses that included end stage renal disease, diabetes mellitus type 2 and chronic obstructive pulmonary disease. Further review of the clinical record failed to show documentation of Patient 2's immunization history.  A review of Patient 4's medical record revealed the patient was admitted to the facility on April 17, 2008, with diagnoses that included end stage renal disease, hypertension and hepatitis B. Further review of the clinical record failed to show written documentation of Patient 4's immunization history.  A review of Patient 5's medical record revealed the patient was admitted to the facility on January 5, 2010, with diagnoses that included end stage renal disease, hypertension and respiratory failure. Further review of the clinical record failed to show written documentation of patient 5's immunization history.  On January 25, 2011, at 2 p.m., during an interview the clinical nurse manager while reviewing the clinical records concurred that the immunization history could not be found in the patients' clinical record.	V 506			
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS  The interdisciplinary team as defined at §494.80 must develop and implement a written,	V 541		4/13/11	

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V 541	<p>Continued From page 38</p> <p>individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the interdisciplinary team failed to develop care plan for two sampled patients (Patient 2 and 4). Patient 2 had no coordinated care plan with skilled nursing facility (SNF). Patient 4 had no care plan to address the use of subclavian catheter and ventilator.</p> <p>Findings:</p> <p>1. A review of Patient 2's medical record revealed the patient was admitted to the facility on September 14, 2009, with diagnoses that included end stage renal disease, diabetes mellitus type 2 and chronic obstructive pulmonary disease. The patient is a resident of a skilled nursing facility (SNF). Further review of the medical record failed to show documentation to indicate the interdisciplinary team developed a coordinated care plan with an SNF.</p> <p>2. A review of Patient 4's medical record revealed the patient was admitted to the facility on January 5, 2010 with diagnoses that included end stage</p>	V 541			

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V 541	Continued From page 39 renal disease, hypertension and respiratory failure.  On January 19, 2011, at 2 p.m., Patient 4 was observed receiving hemodialysis via right subclavian catheter. The patient had a tracheostomy tube connected to a mechanical ventilator and resides in a SNF.  Further review of the medical record failed to show written documentation to indicate the interdisciplinary team developed a care plan to address the catheter use, ventilator use and coordinated care plan with the SNF.	V 541			
V 681	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY  All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility	V 681		4/13/11	

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V 681	Continued From page 40 staff failed to ensure that the dialysis staff met the personnel qualifications and demonstrated competencies necessary to meet the comprehensive needs of the patients.  Findings:  On January 25, 2011, at 8 a.m., ten (10) personnel records of the dialysis staff members were reviewed. Eight records were registered nurses (RN), one was an Associated Clinical Social Worker (ACSW) and one was a Registered Dietitian (RD).  A review of the personnel records revealed the following:  1. There were 3 RNs (RN 1, 5 and 6) that did not have written documentation of competencies and orientation in the unit prior to start of work.  2. There were 3 RNs that did not have documentation of an emergency preparedness training in their personnel record (RNs 2, 7 and 8).  3. The 10 personnel files reviewed failed to show documentation of an infection control training/in-services received .  During a concurrent interview Employee D while reviewing the personnel files concurred that there was no documentation to indicate that orientation, competencies and emergency preparedness and infection control were provided.	V 681			
V 727	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL	V 727		4/13/11	

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V 727	<p>Continued From page 41</p> <p>The dialysis facility must-</p> <p>(1)Safeguard patient records against loss, destruction, or unauthorized use; and</p> <p>(2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following:</p> <p>(i) The transfer of the patient to another facility.</p> <p>(ii) Certain exceptions provided for in the law.</p> <p>(iii) Provisions allowed under third party payment contracts.</p> <p>(iv) Approval by the patient.</p> <p>(v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to safeguard patient records against loss, destruction, or unauthorized use.</p> <p>Findings:</p> <p>During a tour of the facility on January 19, 2011, at 10:30 a.m., the storage area for the medical records was an unlocked closet with folding panels as cover in a hallway. The closet was sprinklered and the medical records were stored on the shelves of an open rack.</p> <p>During an interview on January 19, 2011, at 10:42 a.m., the unit manager stated the medical records rack needed a cover. She further stated the facility did not have a policy and procedure on how to retrieve the medical records in case the sprinkler was activated and the medical records got wet.</p>	V 727			

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V 727	Continued From page 42	V 727			
V 750	<p>During a tour of the facility on January 21, 2011, at 6:30 a.m., the medical records closet was unlocked and the medical records were stored on the shelves of an open rack.</p> <p>At 6:45 a.m., the director of nursing was made aware of the unlocked medical records closet.</p> <p>494.180 CFC-GOVERNANCE</p>	V 750		5/19/11	
V 753	<p>This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Conditions of Participations (COP) for governance by failing to:</p> <p>1. Show documentation of the NPDB (National Practitioner's Data Bank) for the 7 physicians on the medical staff as stipulated in the medical staff by-laws ( refer to V 753).</p> <p>2. Implement facility's action plan to resolve a patient reported event regarding a patient equipment (blood glucose meter) necessary for safe patient environment (refer to V755).</p> <p>494.180(a)(1) GOV-ADM RESP FOR STAFF APPOINTMENTS</p> <p>The governing body or designated person responsible must appoint an individual who serves as the dialysis facility's chief executive officer or administrator who exercises responsibility for the management of the facility and the provision of all dialysis services, including, but not limited to-</p> <p>(1) Staff appointments;</p>	V 753		5/19/11	

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V 753	Continued From page 43  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to show documentation of the NPDB (National Practitioner's Data Bank) for the 7 physicians on the medical staff as stipulated in the medical staff by-laws.  Findings:  A review of the 7 physician files revealed no documentation of the NPDB information.  A review of the medical staff by-laws procedure for staff appointment and reappointment revealed the facility shall verify from primary sources including NPDB query.  During an interview on January 25, 2011, at 1:30 p.m., the facility operations manager stated the facility have not done any NPDB query for the medical staff prior to appointment/reappointment.	V 753			
V 765	494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED  The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services.  The grievance process must include- (1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.	V 765		4/13/11	

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V 765	Continued From page 44  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to implement the facility's action plan to resolve a patient reported event regarding a patient equipment necessary for safe patient environment.  Findings:  On January 19, 2011 at 8:15 a.m., Employee B was requested to demonstrate how to perform the blood glucose meter quality control on the existing meter in use. The glucometer was not working and needed replacement battery.  On January 25, 2011, at 9 a.m., during review of Event Log, dated October 18, 2010, a patient was not feeling well that day and requested that a blood glucose test be done. However, the blood glucose meter was not working and needed a replacement battery. Part of the action plan was for the registered nurse to monitor, to check and calibrate the meter daily.  During a concurrent interview with Employee D and review of the daily glucometer quality control log failed to show that it was consistently done. Further review of the Quality Assessment and Performance Improvement (QAPI) minutes for April 26, 2010 and August 10, 2010, failed to show documentation that this concern was addressed in order to resolve the issue of non-functioning glucometer in the facility while patients were receiving hemodialysis treatment.	V 765			