

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: 630012553	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2011
NAME OF PROVIDER OR SUPPLIER VAN BUREN DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3595 VAN BUREN BLVD, SUITE #101 RIVERSIDE, CA 92503		
(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 California Department of Public Health during a initial Certification Survey conducted on February 23, 2011. Representing the Department of Public Health: 18821 22361 Abbreviations used in this document: cc-cubic centimeters htn-hypertension ml-milliliters s/p-status post XXL-extra extra large	V 000			
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: 2. During the initial tour of the facility on February 23, 2011, the following items were stored on the floor: -1 box of laboratory coats (10 bags 50 per case size medium). -1 box of laboratory coats (10 bags 50 per case size XXL). -2 boxes of sharp container (10 each 20 total). -Terumo syringe with needle 10 cc/ml 600 units.	V 401			

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 401	Continued From page 1 In an interview with the water technician he confirmed that the items were stored on the floor. Based on observation and staff interview, the facility failed to store vacutainers that were not expired and failed to properly store supplies off the floor. Findings: During the initial tour on February 23, 2011, at 9:45 a.m., the crash cart was inspected. In the crash cart's second drawer, five vacutainers with expiration date "2010-12" were found. The water technician who was present during the tour, acknowledged that the vacutainers were expired. he stated, "The registered nurse will replace them (vacutainers)."	V 401			
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that they maintained complete, and accurate records for all patients, by the following: -The facility failed to maintain Patient 1's record, by having the patient's name inconsistent throughout the records.	V 726			

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V 726	<p>Continued From page 2</p> <p>-The facility failed to maintain the Patient's name on chest Xray</p> <p>-The facility failed to maintain consistency on Patient 1's medical records on his chart by placing an unsampled Patient's records on Patient 1's medical record.</p> <p>Findings:</p> <p>1. A review of the record for Patient 1 was conducted on February 23, 2011, at 10:30 a.m. Patient 1 was admitted to the facility on December 27, 2010, with the following diagnoses: left below the knee amputation, diabetes, htn, s/p lung resection right, and ESRD.</p> <p>A review of Patient 1's benefits identification identified as (first name, middle initial and last name). On the patient's Medicare card the patient was identified as (first name, middle initial, last name, last name) .</p> <p>In a concurrent interview with the nurse he stated that the Patient was having trouble with his identification. The surveyor asked the nurse how he would ensure proper identification of the patient. The nurse did not respond.</p> <p>2. In an additional review of Patient 1's record there was a chest Xray report on the record, but there was no patient name listed on the Xray report. The nurse was interviewed about how they could identify whose Xray reports belonged to which record as there were no names listed on the documents.</p> <p>The nurse confirmed that no Patient names were listed on the Xray reports and it would be difficult</p>	V 726			

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V 726	Continued From page 3 to decide which reports belonged to whom. 3. A review of the record for Patient 2 was conducted on February 23, 2011, at 12: 30 p.m. Patient 1 was admitted to the facility January 3, 2011, with the following diagnoses; ESRD, diabetes, and htn. A review of Patient 2's record there was a chest Xray report on the record, but there was no patient name listed on the Xray report. The nurse was interviewed about how the facility identified whose Xray reports belonged to which record as there were no identifiable name on the document. The nurse confirmed that no Patient names were listed on the Xray reports and it would be difficult to decide which reports belonged to whom.	V 726			