

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:  <b>552674</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHRIDGE DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9325 RESEDA BOULEVARD NORTHRIDGE, CA 91324</b>		
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V 000	INITIAL COMMENTS  The following reflects the findings of the Department of Public Health during an Initial Certification survey.  Representing the Department of Public Health:  Sylvia Villaflores, REHS, HFE I Belinda Rarela, RN, Sr. HFEN Shielah Creus, RN, HFEN	V 000			
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 observations and interviews, the facility failed to ensure the staff members wear disposable gloves when caring for the patient or touching the patient's equipment at the patient station, and wash or sanitize hands immediately after removing the gloves.  Findings:  During an observation of a pre-dialysis assessment on March 21, 2011, at 8:56 a.m., Employee A was observed touching Patient 1's lower extremities with bare hands. Without sanitizing or washing her hands, Employee A picked-up a pen and clipboard, proceeded with her charting, placed the clipboard in the dialysis machine basket, and then sanitized her hands.	V 113			

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 113	Continued From page 1	V 113			
V 114	<p>During an interview with Employee A on March 21, 2011, at 4:03 p.m., she stated that after touching the patient, she should have sanitized her hands to prevent spread of infection.</p> <p>According to the Center for Disease Control (CDC), handwashing is the most important measure to prevent contaminant transmission.</p> <p>494.30(a)(1)(i) IC-SINKS AVAILABLE</p> <p>A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure there are sufficient number of sinks designated as hand washing sinks to facilitate hand washing and utility sinks for used or contaminated items.</p> <p>Findings:</p> <p>During an observation of a pre-dialysis assessment on March 21, 2011 at 8:45 a.m., Employee A was observed flushing both the arterial and venous lines of the dialysis catheters into a priming bucket. She had placed the empty 1 liter bag of normal saline (sodium chloride injection) in the same bucket. Employee A continued to empty the contents of the priming bucket (2 empty bags of normal saline and the water flushed through the catheters) into the "Clean Sink" between stations 3 and 4. There was a "Dirty Sink" observed next to station 9.</p>	V 114			

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V 114	Continued From page 2 During an interview with Employee B on March 21, 2011, at 3:30 p.m., he stated that the sink between stations 3 and 4 was supposed to be a clean sink. Employee B stated that the staff were dumping the normal saline bags in the clean sink.	V 114			
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT  Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the multiple use or non-disposable items taken into the dialysis station were cleaned or disinfected before being taken to a common clean area.  Findings:  1. During an observation of a pre-dialysis assessment on March 21, 2011 at 8:42 a.m., Employee A, Registered Nurse (RN), had taken a vial of Renalin Indicator Test strips (a residual	V 116			

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V 116	Continued From page 3 test for peroxides to assure complete rinsing of the chemicals) and set the vial on the armrest of Patient 1's treatment chair, a potentially blood contaminated surface. This vial of Renalin Indicator Test strips was not dedicated to the patient she was assessing, but for use of the whole unit. After the vial and the cover were set on the treatment chair armrest for a few minutes, Employee A then proceeded to recap the vial, and set it on top of the same patient's dialysis machine, also a potentially blood contaminated surface.  During an interview with Employee A on March 21, 2011, at 4:03 p.m., she stated that when she left the vial of Renalin Indicator Test strips on top of the armrest, and put it on the machine, she had violated infection control practice.  2. During an observation of a pre-dialysis assessment on March 21, 2011, at 9 a.m., Employee A was observed setting a glucometer (portable blood sugar monitoring device) on top of the Patient 1's treatment chair armrest, a potentially blood contaminated surface. After use, Employee A brought the glucometer back to the nursing station and placed the glucometer in its storage bag without disinfecting the glucometer.  During an interview with Employee A on March 21, 2011, at 4:03 p.m., she stated the glucometer should be wiped and disinfected with a 1% bleach solution wet towel after use. Employee A stated that she had brought the machine back to the case without wiping it.	V 116			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL	V 122			

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V 122	Continued From page 4  [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that standard infection control precautions were implemented during the cleaning and disinfecting of contaminated surfaces, medical devices and equipment.  Findings:  During an observation of the cleaning of station 4 after dialysis treatment on March 21, 2011, at 11:43 a.m., Employee B was observed wiping the blood pressure cuff with a wet cloth. After discarding the wet cloth, he wound up the blood pressure cuff cable and wrapped the newly cleaned blood pressure cuff around the dirty cable. Afterwards, he took a stack of wipes and used the whole stack to wipe down the patient's chair, arm rests, shelf attached to the arm rest, the footrest, and the chair headrest. Using the same stack of wipes, Employee B proceeded to wipe down the dialysis machine, and the machine's foot base. While wiping the dialysis machine's foot base, Employee B placed the jug of acid on the floor then placed the jug back on top of the cleaned foot base.	V 122			

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V 122	Continued From page 5 During an interview with Employee B on March 21, 2011, at 3:30 p.m., he stated that once the patient is discharged, the patient station is cleaned and all disposable items are thrown. He stated he usually use 5 to 6 "bleach rags" (rags soaked in a bleach solution) - 1% if there was no blood spilled on the station and 10% if there was some blood spill on the station. Employee B stated he first cleans the blood pressure cuff with one bleach rag and the call button with another. He then proceeds to clean the chair with 2 separate bleach rags and then 2 more for the machine. Employee B stated that he realized he had used the same bleach rags on the chair and on the machine, when another staff member brought it to his attention. He stated that he did not clean the blood pressure cable and by wrapping the cable with the clean cuff, " it was as if I did not clean the cuff. " Employee B stated that by placing the acid jug on the floor while cleaning the dialysis machine's foot rest, "it was like I did not clean it (foot rest)."	V 122			
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 failed to ensure the isolation	V 128			

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V 128	<p>Continued From page 6</p> <p>room door was closed during initiation of hemodialysis treatment to prevent contact and transmission by blood spills, splattering or spurting of blood.</p> <p>Findings:</p> <p>On March 21, 2011 at 12:30 p.m., Patient 5, in Station 22 (Isolation Room), was observed sitting in the dialysis treatment chair and Employee C was in the room with him with the door open. Employee C was observed wearing personal protective equipment (PPE) including a face shield, yellow gown, and gloves, cleaned the patient's access site. She cleaned the patient's catheter ports with Betadine swab, wrapped catheter ports with 2 x 2 gauze and applied dressing over the catheter site. At 12:45 p.m., she administered heparin bolus then at 12:48 p.m., with the isolation room door still open, Employee C connected the dialysis blood lines to the arterial and venous catheter ports then started the hemodialysis treatment.</p> <p>A review of the facility's policy titled "Dialyzing Hepatitis B Positive Patients" dated January 2011, revealed closing the door of the isolation room during times when blood spurting or spattering is possible.</p> <p>During an interview on March 21, 2011 at 2:40 p.m., Employee C stated she reviewed the policy and the door to the isolation room must remain open for the alarms to be audible by the staff in the unit.</p> <p>During an interview on March 21, 2011 at 3:15 p.m., Employee D stated the door to the isolation</p>	V 128			

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V 128	Continued From page 7 room should be closed during initiation and termination of treatment. Employee D stated the policy was to be revised during the licensing visit; however when Employee D reviewed the policy, she stated she the policy needed to be revised.	V 128			
V 348	On March 21, 2011 at 4:05 p.m., Employee D handed the revised policy titled "Dialyzing Hepatitis B Positive Patients." The policy indicated "The door to the isolation room should be closed during initiation and termination of treatment. It will be kept open during the treatment so that machine alarms are audible." 494.50(b)(1) VERIFY PT ID-2 PEOPLE  12.2 Verification of patient identification: 2 people Except in the case of home dialysis, two persons should check that the first and last names on the dialyzer and any other appropriate identifying information correspond to the identifying information on the patient's permanent record. If possible, one of the persons checking identification should be the patient. Completion of this step shall be recorded, along with the signature or other unique means of identifying the person verifying patient identification.  NOTE-This step may be done later in the procedure but shall precede initiation of dialysis.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure two persons verified the type of dialyzer and the patient's name label to ensure that both are correct in accordance with the Dialyzer Preparation/Reuse policy and procedure for 2 of 5 patients (Patient 1 and 4).	V 348			

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V 348	Continued From page 8  Findings:  1. On March 21, 2011 at 8:20 a.m., during an observation of the treatment area, Patient 1 was observed in Station 5 during pre-dialysis treatment.  According to the facility patient list Patient 1 was admitted to the facility on January 19, 2011.  A review of the treatment orders dated January 19, 2011, indicated the patient was to undergo hemodialysis treatment 3 days a week, for 3 hours and 30 minutes, on 2 K, 2.5 Ca dialysate bath, blood flow rate of 400 and dialysate flow rate of 800 on Dialyzer model F180 A.  The Hemodialysis Log Sheet dated March 4, 2011, revealed two initials on the dialyzer verification label indicating two individuals verified the Dialyzer.  A review of the Nursing Progress Notes dated March 4, 2011 at 8:33 a.m., indicated the licensed staff "noted patient with incorrect Dialyzer, stopped the treatment and changed to correct Dialyzer." The documentation indicated that the patient checked his Dialyzer when he came in and according the the technician before he primed, he saw the "S" on the Dialyzer and assumed it was Patient 1. (The patient's last name starts with letter "S".)  During an interview on March 21, 2011 at 2:40 p.m., Employee C was asked about the incorrect Dialyzer incident on March 4, 2011, she stated Patient 1 and the patient care technician (PCT)	V 348			

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V 348	<p>Continued From page 9</p> <p>saw letter "S" on the patient's Dialyzer and they assumed it was for Patient 1. Employee C stated the registered nurse (Employee A) signed to indicate she verified without checking if the Dialyzer was for Patient 1. She stated both employees received an inservice on Dialyzer Preparation/Reuse.</p> <p>During an interview on March 21, 2011 at 4:10 p.m., Employee A acknowledged the incorrect Dialyzer incident occurred on March 4, 2011. Employee A stated the PCT handed over the patient's connector told her the dialyzer was clear, and she did not look at the dialyzer. "My mistake, after this, I really go and double check each machine and check the dialyzer and when the patient comes in, I also check it."</p> <p>A review of the Dialyzer Preparation/Reuse policy and procedure indicated to, "Double-check the type of dialyzer and the patient label to verify that both are correct. Two staff members must verify this in writing."</p> <p>2. According to the facility patient list Patient 4 was admitted to the facility on January 19, 2011.</p> <p>A review of the treatment orders dated January 19, 2011, indicated the patient was to undergo hemodialysis treatment 3 days a week, for 3 hours and 30 minutes, on 2 K, 2.5 Ca dialysate bath, blood flow rate of 400, dialysate flow rate of 800 on Dialyzer model F180 A.</p> <p>A review of the Hemodialysis Log Sheet dated February 23, 2011 and March 11, 2011 revealed one initial on the dialyzer verification label.</p>	V 348			

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V 348	Continued From page 10 During an interview on March 21, 2011 at 2:40 p.m., Employee C reviewed the dialyzer verification label and stated there was only one signature, and two signatures are required.	V 348			