

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

PRINTED: 05/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ONTARIO DIALYSIS CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 WEST 6TH STREET</b> <b>ONTARIO, CA 91764</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 California Department of Public Health during a revisit survey conducted on 4/7/11.  Representing the Department: ID: 28023  Census: 90 Sample Size: 19 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 and interview, the facility failed to ensure that the staff implemented the use of gloves when touching dialysis machines during dialysis treatment. Staff further failed to perform hand hygiene after touching dialysis machines, which created the potential to result in exposure to potentially contaminated medical equipment, infectious substances and transmission of infectious diseases to other patients and staff.  Findings:  An observation on the treatment floor on 4/6/11, at 9:35 AM, PCT 1 was observed to provide direct patient care to patients undergoing hemodialysis	{V 000}			

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.

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

PRINTED: 05/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ONTARIO DIALYSIS CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 WEST 6TH STREET</b> <b>ONTARIO, CA 91764</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 113	Continued From page 1 (HD-the process used to remove waste from the blood) treatment. PCT 1 was observed to write on a paper on top of dialysis machine # 13, and touched the dialysis machine with his bare hands. The same PCT was observed to touch dialysis machine # 14 and dialysis machine # 15, with his bare hands and without performing a proper hand hygiene in between contacts with each of the dialysis machines.  During an interview with PCT 1 on 4/6/11, at 9:40 AM, he was asked if he touched the dialysis machines with his bare hands while patients were undergoing dialysis treatment. PCT 1 stated "I should wear gloves when touching the dialysis machine and wash my hands." PCT 1 also stated that he attended an inservice about infection control last week.  During an interview with the Dialysis Coordinator on 4/6/11 at 2:30 PM, she stated that the dialysis machines were considered dirty and that the staff were supposed to wear gloves when touching the dialysis machine.  A review of the facility policy and procedure for "Infection Control", indicated "Exposure to blood and potentially contaminated items can be routinely anticipated; therefore, gloves are required whenever caring for a patient or touching the patient's equipment."	V 113			
V 637	494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT  The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must-	V 637			

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

PRINTED: 05/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ONTARIO DIALYSIS CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 WEST 6TH STREET</b> <b>ONTARIO, CA 91764</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 637	<p>Continued From page 2</p> <p>(A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the QAPI (Quality Assessment and Performance Improvement) program which included a system to track all patient infections, to review incidents of infection and to develop an action plan to minimize transmission of infection among the ESRD ( End Stage Renal Disease) patients for a universe of 90 patients.</p> <p>Findings:</p> <p>A review conducted on 4/6/11, of the facility's QAPI program for the months of February 2011 to March 2011, revealed no documentation that the facility had tracked patient infections nor that the QAPI members had reviewed and developed an action plan to minimize the transmission of infections among the ESRD patients. The Facility Administrator confirmed the finding and was unable to provide documentation to show that an infection control surveillance program was in place and reviewed by the QAPI members.</p> <p>In an interview conducted with the Director of Nursing on 4/7/11, at 3:30 PM, the DON confirmed that the QAPI program did not include a review of infection control surveillance program.</p>	V 637			

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

PRINTED: 05/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ONTARIO DIALYSIS CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 WEST 6TH STREET</b> <b>ONTARIO, CA 91764</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 637	Continued From page 3 The DON stated that there was no tracking system to monitor the facility infection rate and there was no documentation to show that the facility had analyzed the infection control data. The DON also confirmed that there was no documented action plans to reduce the rate of infection in the monthly QAPI meetings.	V 637			