

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>052834</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/25/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAI - EL CAMINO REAL - OCEANSIDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2229C EL CAMINO REAL OCEANSIDE, CA 92054</b>		
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V 000	INITIAL COMMENTS  The following represents the findings of the Department of Public Health during a recertification survey, conducted 2/22/2011 through 2/25/2011. The facility census at the time of the survey was 84 hemodialysis patients, 19 peritoneal dialysis patients and 13 home hemodialysis patients. The sample size was 11 patients.  Representing the Department: Health Facilities Evaluator Nurses 22383, 15932 and 17130.  Glossary of Abbreviations: CCHT Certified Clinical Hemodialysis Technicians CD Center Director CVC Central Venous Catheter ml milliliter P&P Policy and Procedure PD Peritoneal Dialysis PPE Personal protective equipment TB Tuberculosis	V 000			
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS  The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 5 employees, with a past positive tuberculin (TB) skin test, had documentation of chest x-ray results or medical	V 101		3/25/11	

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 101	Continued From page 1 clearance from a physician upon hire.  Findings:  Personnel records were reviewed on 2/25/11 at 2:22 P.M. RN 2 had a TB Symptom Review Questionnaire, dated 9/16/10, in his employee file. According to the TB Symptom Review Questionnaire, the questionnaire was to be completed annually on employees with a documented past positive TB skin test. The TB Symptom Review Questionnaire indicated RN 2 had a negative chest x-ray on 10/07, however a copy of the x-ray results could not be located in the personnel.  The Center Director stated on 2/25/10 at 2:38 P.M., she could not provide documentation of RN 2's negative chest x-ray results or clearance from a physician. She acknowledged that she was aware RN 2 had a previous positive TB skin test.  The facility policy titled TB Screening Of Renal Advantage Employees Initial Screening Protocol, revised on 10/10, stipulated in part, "A. Obtain baseline chest x-ray if the new employee cannot present a written, negative chest x-ray report dated within the past year... C. New employees with skin tests considered positive will not be allowed to work until the center receives written medical clearance from a physician that the employee is not infectious."	V 101			
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	V 113		3/25/11	

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V 113	<p>Continued From page 2</p> <p>wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that RN 1 followed aseptic technique while changing a CVC dressing for 1 non-sampled patient (12) .</p> <p>Findings:</p> <p>During observations on 2/23/11 at 10:25 A.M., RN 1 prepared to change Patient 12's CVC dressing prior to initiating dialysis. RN 1 placed syringes and gauze pads used to change the dressing, on a clean, disposable blue pad located on Patient 12's chairside table. While wearing non-sterile gloves, RN 1 listened to the patient's lung and heart sounds with a stethoscope. RN 1 assessed and palpated Patient 12's ankles for swelling. Wearing the same soiled gloves used to do the physical assessment, RN 1 removed the old CVC dressing, picked up the antiseptic cleansing swab, and began cleansing the catheter site. RN 1 flushed the 2 ports of the catheter with fluid, applied new sterile gauze to the catheter site, and taped the dressing, all without changing gloves.</p> <p>During an interview on 2/23/11 at 10:35 A.M., RN 1 stated she understood that gloves should be changed after completing a physical assessment and before cleansing a catheter site.</p> <p>During a joint interview on 2/23/11 at 10:44 A.M., the Regional Director and CD acknowledged that the nurse should have change gloves after the</p>	V 113			

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V 113	Continued From page 3 physical assessment and prior to changing the CVC dressing, to ensure the dressing change was performed aseptically.	V 113			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL  [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, interview, and record review, the facility failed to ensure that 3 staff members (RN2, CCHT 3, CCHT 4) disinfected the prime buckets (a small bucket attached to the dialysis machine that contained discharged prime fluid) after each patient treatment. The facility P&P failed to accurately reflect regulatory requirements to disinfect the prime buckets. The facility also failed to ensure 1 staff member used proper PPE when touching the dialysis machine.  Findings:	V 122		3/25/11	

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V 122	<p>Continued From page 4</p> <p>1. During observation of change over between patient treatments on 2/23/11 at 9:49 A.M., RN 2 removed the prime bucket from the side of the dialysis machine. RN 2 took the prime bucket to a sink, emptied the contents, and rinsed the bucket with tap water. The RN did not clean or disinfect the prime bucket.</p> <p>During an interview on 2/23/11 at 3:30 P.M., RN 2 stated that he did not disinfect the prime bucket when cleaning Station 2, between treatments for Patient 14 and Patient 12. He said that staff "usually" disinfect the prime bucket with the disinfectant wipes after each treatment.</p> <p>On 2/23/11, the facility provided the P&amp;P titled Cleaning Disinfection of Equipment, Supplies and Treatment Area, which was approved by the governing body on 1/25/11. The policy specified, "Containers used to discard saline prime from dialyzers will be disinfected daily and when visibly contaminated with blood. The container will be filled with bleach/water solution and allowed to dwell for at least 10 minutes; the external surface of the container will also be wiped with a disposable cloth soaked with the bleach/water mixture that is discarded after use." The P&amp;P indicated that disinfecting the prime buckets "daily" was adequate, which was contrary to accepted standards for infection control precautions.</p> <p>2. On 2/23/11 at 1:27 P.M., while observing shift turn over at stations 14 and 15, CCHT 3 and CCHT 4 were both observed when they disinfected the machines between patients. They both wiped the machines and the chairs with a cloth soaked in a bleach solution; neither</p>	V 122			

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V 122	Continued From page 5 removed or wiped the prime bucket.  Both CCHT 3 and CCHT 4 then replaced the dialysis lines and placed the ends of the lines in the prime bucket that still contained the wasted prime from the previous patient. They then primed the new lines.  On 2/23/11 at 2:35 P.M., CCHT 3 stated the prime buckets were to be emptied and cleaned with bleach between patients.  On 2/23/11 at 2:38 P.M., CCHT 4 stated the prime buckets were to be dumped and wiped out between patients. He stated he thought he had done that, but after seeing the fluid still in the prime bucket he acknowledged he had not wiped down the prime bucket during the change over from one patient to the next patient.  On 2/23/11 at 3:34 P.M., the CD stated that prime buckets were to be dumped and cleaned with bleach after each patient.  3. On 2/23/11 at 1:27 P.M., CCHT 4 reset a machine at station 14 by touching the machine buttons with a PPE gown. She then went to station 21 and reset that machine using the same PPE gown. She then returned to station 14 to return the blood and take the patient off the dialysis machine. CCHT 4 continued to use her PPE gown as a barrier when touching the machine.  On 2/23/11 at 2:35 P.M., CCHT 4 stated she thought she could reset the machine using the PPE gown as a barrier instead of using gloves.	V 122			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV	V 143		3/25/11	

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V 143	<p>Continued From page 6</p> <p>MEDS</p> <p>[The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were discarded prior to the expiration date for 2 of 2 nursing stations.</p> <p>Findings:</p> <p>1. On 2/23/11 at 2:16 P.M., during the medication review on Nursing Station 1, a multi-dose vial of Lidocaine 1% was observed inside the refrigerator. RN 2 verified the Lidocaine was opened 12/22/10. The CD stated the Lidocaine should have been discarded 28 days from the date it was opened, yet it was still available for use more than thirty days past the discard date.</p> <p>The facility policy, revised 7/10 and titled Medications: Handling, Administration, Storage, &amp; Disposal was reviewed on 2/23/11. The P&amp;P specified, "Multi-dose medication vials can be used up to 28 days after opening, as long as the vial is handled aseptically and stored per manufacturer instructions, unless manufacturer package insert instructions specify a different time period for use. After 28 days (or the period of time specified by the manufacturer) the vial and any remaining medication in the vial must be</p>	V 143			

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V 143	<p>Continued From page 7 discarded."</p> <p>2. On 2/23/11 at 2:23 P.M., during the medication review on Nursing Station 1, a multi-dose vial of Tuberculin Purified Protein Derivative (PPD used for TB testing) was observed inside the medication refrigerator. RN 2 verified the open date as 12/21/10. The CD stated the PPD should have been discarded 30 days from the date it was opened, yet it was still available for use more than thirty days past the discard date.</p> <p>3. On 2/23/11 at 4:11 P.M., during the medication review on Nursing Station 2, a multi-dose vial of PPD was observed inside the Peritoneal Dialysis (PD) medication refrigerator. The open date written on the PPD vial was 3/2/10. The CD stated that the PPD should have been discarded 30 days from the date it was opened, yet it was still available for use more than 10 months after the discard date.</p> <p>According to the manufactures guidelines, " A vial of 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>4. On 2/23/11 at 4:11 P.M., during the medication review on Nursing Station 2, a multi-dose vial of Influenza Virus Vaccine was observed inside the Peritoneal Dialysis (PD) medication refrigerator. The open date written on the vial of Influenza Virus Vaccine was 11/4/10. The CD stated that the Influenza Virus Vaccine should have been discarded 28 days from the date it was opened, yet it was still available for use more than 3 months after the discard date.</p>	V 143			

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V 143	Continued From page 8 According to the manufactures guidelines, "Once entered, a (Influenza Virus Vaccine ) multi-dose vial, and any residual contents should be discarded after 28 days."  5. On 2/23/11 at 4:11 P.M., during the medication review on Nursing Station 2, a vial of Epogen® 20,000/2 ml was observed inside the PD medication refrigerator. The open date written on the Epogen® vial was 1/10/11. RN 3 stated the Epogen® should have been discarded on 1/31/11, 21 days after it was opened, yet it was still available for use more than 40 days after the discard date.  The manufactures guidelines for Epogen® specify, "Discard 21 days after initial entry."	V 143			
V 196	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY  6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.  Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.  Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine	V 196		3/25/11	

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V 196	<p>Continued From page 9</p> <p>concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L].</p> <p>Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and manufacturer's guidelines, the facility failed to ensure that 1 staff member (CCHT 1) used the appropriate amount of water to test the total chlorine in the water and failed to accurately time the test according to the manufacturer's guidelines.</p> <p>Findings:</p> <p>During observation of the water testing procedure on 2/22/11 at 11:55 A.M., CCHT 1 took a sample of water (20 ml in a medicine cup) from a port located after the first bank of carbon tanks. The carbon tanks remove chlorine from the water used for dialysis. CCHT 1 then immersed the total chlorine test strip into the 20 ml water sample.</p> <p>At 11:56 A.M., CCHT 1 noted that the water temperature was between 72 and 93 degrees. She said that the time for reading the test strip was based on the temperature of the water. CCHT 1 stated that the chlorine test strip should be read after 20 seconds based on the water temperature. CCHT 1 said that she used the</p>	V 196			

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V 196	<p>Continued From page 10</p> <p>clock (with a second hand) on the wall of the water room to time the test. The second hand on the clock was inoperable. When questioned about timing the test without the clock working, CCHT 1 stated that she carried the sample and test strip out to the nurse's station to show the nurse the results. CCHT 1 stated that it took "about 20 seconds" to walk out to the nurse's station. CCHT 1 then walked to the nurse's station and used the clock on the wall in the Patient Care Area to time the strip for another 20 seconds. The total time elapsed after the strip was immersed in the sample was 60 seconds.</p> <p>During an interview on 2/22/11 at 12:00 P.M., CCHT 1 acknowledged that the timing for the test should start when the strip was dipped into the sample. CCHT 1 stated that the clock did not work when she first tested the water for total chlorine in the morning. There was no operable clock (with a second hand) for the initial water testing in the morning and the second testing 4 hours later.</p> <p>During an interview on 2/22/11 at 12:05 P.M., the CD stated that the timing should start when the strip is dipped into the sample, not after walking to the nurse's station.</p> <p>On 2/22/11, the facility provided the manufacturer's guidelines for testing water for total chlorine. The guidelines specified that a water specimen temperature of between 72-93 degrees should be read after 20 seconds. In addition, the guidelines specified that the amount of water used should be 100 ml.</p> <p>During an interview on 2/22/11 at 12:44 P.M., the</p>	V 196			

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V 196	Continued From page 11 Chief Technician stated that he was not aware that the second hand on the clock in the water room did not work. In addition, the Chief Technician expected staff to use 100 ml of water for testing and to read the strip after 20 seconds, according to manufacturer's guidelines.	V 196			
V 519	494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR  In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- (1) At least annually for stable patients;  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to complete a comprehensive reassessment (peritoneal Dialysis Treatment Plan) for 1 of 11 sampled patients (10), according to regulatory requirement and facility P&P.  Findings:  On 2/25/11, electronic record review showed that Patient 10 was admitted to the facility on 12/11/08 for peritoneal dialysis. Patient 10 had a history of anemia, low albumin, and non-insulin dependent diabetes. The annual Peritoneal Dialysis Treatment Plan, dated 7/09/10, showed that the Home Nurse completed the assessment of dialysis adequacy, blood pressure goals, and Peritoneal Dialysis access status. The Social Worker completed the psychosocial assessment.	V 519		3/25/11	

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(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 519	Continued From page 12 The Registered Dietitian failed to complete an assessment of Patient 10's mineral bone disorder status and nutritional status, including albumin levels.  During an interview on 2/25/11 at 9:59 A.M., the Home Nurse stated that Patient 10's Peritoneal Dialysis Treatment Plan should be done yearly, because the patient was considered "stable."  On 2/25/11 at 10:13 A.M., the current Registered Dietitian stated that due to "staffing changes," Patient 10's yearly Peritoneal Dialysis Treatment Plan was missed.  On 2/25/11, the facility provided the P&P titled Treatment Plans. The policy specified that the Interdisciplinary Team should review the Treatment Plan "annually for stable patients." In addition, the policy indicated that the Interdisciplinary Team included the Registered Dietitian.	V 519			
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE  Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 11 sampled residents (10) was administered dialysate at the rate prescribed by the physician.	V 544		3/25/11	

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

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

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V 544	<p>Continued From page 13</p> <p>Findings:</p> <p>The clinical record for Resident 10 was reviewed on 2/24/11 at 4:06 P.M. The dialysate flow rate (DFR) prescribed by the physician on 1/31/11, was 600 ml per minute for 4 hours and 15 minutes.</p> <p>According to the hemodialysis flowsheet dated 2/2/11, Resident 10 started dialysis at 4:11 P.M., with a DFR of 300 ml per minute. The DFR was not increased to the prescribed rate of 600 ml per minute until 6:15 P.M., over two hours after his dialysis treatment began.</p> <p>During an interview with CCHT 2 and CCHT 5 on 2/25/11 at 1:31 P.M., each stated the standard DFR for the facility was 600 ml per minute, and was only decreased between patients to save on bicarbonate and dialysate.</p> <p>The CD stated on 2/25/11 at 1:34 at P.M., that she did not want staff to decrease the DFR to save on bicarbonate and dialysate, even between patients.</p>	V 544			