

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 the investigation of a complaint. Complaint Number: CA00256141 Representing the Department: Octavio Relopez, HFEN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three (3) deficiencies were written as a result of complaint number CA00256141.	V 000			
V 510	494.80(a)(7) PA-MSW-PSYCHOSOCIAL NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: (7) Evaluation of psychosocial needs by a social worker. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that the psychological needs of Patient 1 was evaluated by the social worker as evidenced by the failure of the social worker to assess and address the patient's non-compliance to prescribed hemodialysis (HD- the use of a machine to clean the blood) treatment and medication. This resulted in the failure of the interdisciplinary team (IDT) to develop and implement a plan of care that addressed the	V 510			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 510	<p>Continued From page 1</p> <p>patient's problem. Furthermore, this failure resulted in multiple unmet health need goals and hospitalization .</p> <p>Findings:</p> <p>On 3/7/11, the medical record of Patient 1 was reviewed. Patient 1 was 25 years of age, had diagnoses that included end stage renal disease (ESRD- a kidney disease), hypertension (high blood pressure) and anemia. Patient 1 was receiving hemodialysis (HD) treatment in the facility.</p> <p>A review of the nurses' progress notes report dated from February 2010 to February 2011, indicated that Patient 1 was noncompliant with dialysis treatments, prescribed medications and physician's orders and instructions during dialysis treatment. The progress notes report showed the following:</p> <p>1. Patient 1 had requested to terminate dialysis treatment before its completion time thereby shortening the prescribed hemodialysis treatment. The patient's HD treatment was terminated against medical advice (AMA) 16 times (on 2/10, 5/3, 7/12, 7/14, 7/26, 8/6, 8/9, 9/5, 9/17, 9/24, 9/27, 11/3, 11/26/10, 1/14/11, 1/21, 2/9/11) with 25 minutes to one and one half (1 ½) hours left prior to HD treatment completion. When staff explained to the patient the risk associated with shortening the prescribed dialysis treatment time on 2/10/10, the patient responded, "I would rather die happy."</p> <p>2. Patient 1 had refused to take the prescribed BP medication (clonidine) offered to him six (6)</p>	V 510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 510	<p>Continued From page 2</p> <p>times (on 5/17/10, 8/13, 9/10, 9/18, 9/24/10, 1/19/11) when his blood pressure was elevated to an abnormally high level at a range of 161/118 to 210/145 (According to the American Heart Association publication dated 2003, normal adult BP range is at 90-119/ 60-79). When staff explained that the patient's BP was abnormally high and offered the medication, the patient refused and stated that "the clonidine does not work ...; he is going to take his medication when he gets in the car ...; as soon as he gets home ...; he has his own medicine and that he was okay."</p> <p>3. Patient 1 had refused to be taken to an acute care hospital/ ER as instructed and ordered by the attending physician five (5) times (on 6/21/10, 6/25, 7/14, 8/11, 11/26/10) when he had shown significant signs of change in condition which included abnormally high BP, headache, nausea and vomiting, and pain and swelling of the upper arm and buttocks. When the staff advised the patient to go to the ER as ordered by the physician, the patient refused and stated that "he will not have anyone to pick him up and take him home, ... hospital staff are only going to tell him to take his blood pressure medication and send him home, and ...not sure yet."</p> <p>4. Patient 1 had refused to see the physician on 8/24/10 (scheduled appointment with a physician) and to follow a treatment order by refusing to have the registered nurse (RN) clean his central venous catheter (CVC- dialysis access site) on 2/18/11.</p> <p>During a review of the IDT 90 day Comprehensive Patient Assessment (CPA) dated 4/21/10, the assessment did not include the</p>	V 510			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 510	<p>Continued From page 3</p> <p>patient's non-compliance to physician's orders and to prescribed hemodialysis treatment and medication. The social worker's Psychosocial Assessment section indicated that the patient did not have difficulty completing the prescribed and full dialysis treatment time, taking medications as prescribed, and that the patient had adjusted and cooperative.</p> <p>There was no documentation found in the patient's medical record to indicate that a psychosocial reassessment had been conducted to evaluate the patient's persistent non-compliance to prescribed treatment and medication. There was documentation found in the patient's care plan dated 4/30/10 which indicated that a plan of care had been developed to address the patient's persistent non-compliance to prescribed medication and treatment.</p> <p>During an interview with the Social Worker on 3/7/11 at 2:30 PM, the Social Worker reviewed the patient's medical record and acknowledged that the patient's psychosocial assessment of the CPA was inaccurate and did not include the patient's non-compliance to prescribed treatment and medication. The Social Worker acknowledged that there was no plan of care developed to address the patient's persistent non-compliance.</p> <p>The IDT's failure to assess the patient's non-compliance, conduct a follow up reassessment to evaluate the patient's persistent non-compliance to the prescribed treatment and medication resulted in failure to develop a plan of care that addressed the patient's non-compliance</p>	V 510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 510	<p>Continued From page 4</p> <p>to care which further resulted in unmet care plan goals and multiple hospitalization as follows:</p> <p>a. On 2/17/10, the patient's Hgb level received by the staff was abnormally low at 5.3 g/dL. On 3/17/10, the patient's Hgb (Hgb- a blood component)level remained low at 7.5 and was sent to an acute care hospital ER for blood transfusion. The patient care plan for anemia (a low blood count that can make a person get tired and short of breath) dated 4/30/10, indicated that the patient's goal to have a hemoglobin level of 10 g/dL to 12 g/dL had not been met consistently. The comprehensive patient assessment dated 4/21/10 showed that the patient's Hgb levels remained low at 9.3 on 4/5/10, 8.6 on 4/12/10 and 9.5 on 4/19/10.</p> <p>b. On 7/21/10, while undergoing dialysis treatment, Patient 1 became lethargic (drowsy) and had an abnormally high blood pressure of 210/145. The staff called 911, terminated the dialysis treatment and sent patient to an acute hospital ER. The patient care plan for the management of Blood Pressure/Volume Status dated 4/30/10, indicated that the patient's goal to have a pre-HD treatment systolic blood pressure (SBP- the top blood pressure number which represents the pressure of blood on the arteries when the heart contracts and pushes the blood out) of 140 and below, and a post-treatment SBP of 130 and below, had not been met consistently. The comprehensive patient assessment dated 4/21/10 showed that the patient's pre-treatment SBP from 3/31/10 to 4/19/10 was at 150- 175, and the post-treatment SBP from 156- 189.</p> <p>c. On 5/28/10, while undergoing dialysis</p>	V 510			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 510	Continued From page 5 treatment, the patient showed an "altered level of consciousness" (slow to respond and hard to arouse) and with a rapid pulse rate of 121 - 142 beats per minute (according to the American Heart Association, 2003 publication on Resting Heart Rate, an adult normal pulse rate range is at 60 - 80 beats per minute). The physician was notified and the patient was sent to an acute care hospital for further evaluation and treatment.	V 510			
V 552	d. On 3/5/10, while undergoing dialysis treatment, Patient 1 became unresponsive with no pulse. Staff performed cardiopulmonary resuscitation (CPR) and administered an automated external defibrillator (AED- a machine used to re-start heartbeat). Patient 1 was sent to an acute care hospital for further evaluation and treatment. 494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that the IDT had provided necessary monitoring and interventions to assist Patient 1 in achieving and sustaining an appropriate psychosocial status as evidenced by the IDT's failure to develop a plan of care that	V 552			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 552	<p>Continued From page 6</p> <p>addressed the patient's persistent non-compliance to care, to prescribed hemodialysis (HD- the use of a machine to clean the blood) treatment and medication. This resulted in unmet health and care plan goals and multiple hospitalizations.</p> <p>Findings:</p> <p>On 3/7/11, the medical record of Patient 1 was reviewed. Patient 1 was 25 years of age, had diagnoses that included end stage renal disease (ESRD- a kidney disease), hypertension (high blood pressure) and anemia. Patient 1 was receiving hemodialysis (HD) treatment in the facility.</p> <p>A review of the nurses' progress notes report dated from February 2010 to February 2011, indicated that Patient 1 was noncompliant with dialysis treatments, prescribed medications and physician's orders and instructions during dialysis treatment. The progress notes report showed the following:</p> <p>1. Patient 1 had requested to terminate dialysis treatment before its completion time thereby shortening the prescribed hemodialysis treatment. The patient's HD treatment was terminated against medical advice (AMA) 16 times (on 2/10, 5/3, 7/12, 7/14, 7/26, 8/6, 8/9, 9/5, 9/17, 9/24, 9/27, 11/3, 11/26/10, 1/14/11, 1/21, 2/9/11) with 25 minutes to one and one half (1 ½) hours left prior to HD treatment completion. When staff explained to the patient the risk associated with shortening the prescribed dialysis treatment time on 2/10/10, the patient responded, "I would rather die happy."</p>	V 552			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 552	Continued From page 7 2. Patient 1 had refused to take the prescribed BP medication (clonidine) offered to him six (6) times (on 5/17/10, 8/13, 9/10, 9/18, 9/24/10, 1/19/11) when his blood pressure was elevated to an abnormally high level at a range of 161/118 to 210/145 (According to the American Heart Association publication dated 2003, normal adult BP range is at 90-119/ 60-79). When staff explained that the patient's BP was abnormally high and offered the medication, the patient refused and stated that "the clonidine does not work ...; he is going to take his medication when he gets in the car ...; as soon as he gets home ...; he has his own medicine and that he was okay." 3. Patient 1 had refused to be taken to an acute care hospital/ ER as instructed and ordered by the attending physician five (5) times (on 6/21/10, 6/25, 7/14, 8/11, 11/26/10) when he had shown significant signs of change in condition which included abnormally high BP, headache, nausea and vomiting, and pain and swelling of the upper arm and buttocks. When the staff advised the patient to go to the ER as ordered by the physician, the patient refused and stated that "he will not have anyone to pick him up and take him home, ... hospital staff are only going to tell him to take his blood pressure medication and send him home, and ...not sure yet." 4. Patient 1 had refused to see the physician on 8/24/10 (scheduled appointment with a physician) and to follow a treatment order by refusing to have the registered nurse (RN) clean his central venous catheter (CVC- dialysis access site) on 2/18/11.	V 552			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 552	<p>Continued From page 8</p> <p>During review of Patient 1's comprehensive care plan dated 4/30/10, there was no written evidence found to indicate that the IDT had developed a plan of care that addressed the patient's non-compliance to care, prescribed hemodialysis treatment and medication, and to physician's orders.</p> <p>There was no documentation found in the patient's medical record to indicate that the patient's psychosocial plan of care was revised and/or updated to address the patient's persistent non-compliance to prescribed medication and treatment.</p> <p>During an interview with the Social Worker on 3/7/11 at 2:30 PM, the Social Worker reviewed the patient's medical record and confirmed that there was no written evidence to indicate that the IDT had developed, updated and/or revised the plan of care to address the patient's non-compliance to prescribed treatments and medication. The Social Worker acknowledged that there was no plan of care developed to address the patient's persistent non-compliance.</p> <p>The IDT's failure to develop a plan of care that addressed the patient's non-compliance to care resulted in unmet care plan goals and multiple hospitalization as follows:</p> <p>a. On 2/17/10, the patient's Hgb level received by the staff was abnormally low at 5.3 g/dL. On 3/17/10, the patient's Hgb (Hgb- a blood component level remained low at 7.5 and was sent to an acute care hospital ER for blood transfusion. The patient care plan for anemia (a low blood count that can make a person get tired</p>	V 552			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 552	<p>Continued From page 9</p> <p>and short of breath) dated 4/30/10, indicated that the patient's goal to have a hemoglobin level of 10 g/dL to 12 g/dL had not been met consistently. The comprehensive patient assessment dated 4/21/10 showed that the patient's Hgb levels remained low at 9.3 on 4/5/10, 8.6 on 4/12/10 and 9.5 on 4/19/10.</p> <p>b. On 7/21/10, while undergoing dialysis treatment, Patient 1 became lethargic (drowsy) and had an abnormally high blood pressure of 210/145. The staff called 911, terminated the dialysis treatment and sent patient to an acute hospital ER. The patient care plan for the management of Blood Pressure/Volume Status dated 4/30/10, indicated that the patient's goal to have a pre-HD treatment systolic blood pressure (SBP- the top blood pressure number which represents the pressure of blood on the arteries when the heart contracts and pushes the blood out) of 140 and below, and a post-treatment SBP of 130 and below, had not been met consistently. The comprehensive patient assessment dated 4/21/10 showed that the patient's pre-treatment SBP from 3/31/10 to 4/19/10 was at 150- 175, and the post-treatment SBP from 156- 189.</p> <p>c. On 5/28/10, while undergoing dialysis treatment, the patient showed an "altered level of consciousness" (slow to respond and hard to arouse) and with a rapid pulse rate of 121 - 142 beats per minute (according to the American Heart Association, 2003 publication on Resting Heart Rate, an adult normal pulse rate range is at 60 - 80 beats per minute). The physician was notified and the patient was sent to an acute care hospital for further evaluation and treatment.</p>	V 552			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 552	Continued From page 10 d. On 3/5/10, while undergoing dialysis treatment, Patient 1 became unresponsive with no pulse. Staff performed cardiopulmonary resuscitation (CPR) and administered an automated external defibrillator (AED- a machine used to re-start heartbeat). Patient 1 was sent to an acute care hospital for further evaluation and treatment.	V 552			
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that its performance in the prevention of dialyzer failures, adverse events, water and dialysate (a solution concentrate used during dialysis treatment) quality, taking actions to improve performance, and tracking performance were continuously monitored as evidenced by the unavailability and lack of quality assessment and performance improvement (QAPI) information that included trending data, analyzing root causes of failure, development of improvement plans, evaluation of the plans and revision of the plans as indicated. This resulted in the facility ' s failure to have a mechanism to ensure that improvement was sustained and conditions that could pose a threat to the health and safety of dialysis patients were identified and corrected immediately. Findings:	V 638			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 638	<p>Continued From page 11</p> <p>During an interview with the nurse manager (NM) on 3/7/11 at 11:20 AM, the QAPI reports and the adverse occurrence report (AOR) tracking log were requested. The NM provided one (1) QAPI report dated 7/7/10 and four (4) individual adverse event reports dated 3/16, 8/14, 11/23/10 and 2/24/11. When asked if the facility had a mechanism in place to continuously monitor, trend and analyze AOR and QAPI data, the NM stated, " I don't keep a surveillance log for adverse events. I just started (as a nurse manager) last July (of 2010) and this is what I inherited. I am also behind with QAPI reports and this is all I have. "</p> <p>A review of the QAPI report dated 7/7/10, the Medical Injuries/ Error section showed that the number of dialyzer failures due to maximum number of use for the past three months (April, May, and June 2010) had consistently gone up. The numbers of failed dialyzers were as follows:</p> <p>April - Nine (9) dialyzers failed</p> <p>May - 12 dialyzers failed</p> <p>June - 17 dialyzers failed</p> <p>According to the QAPI guidelines documented in the report dated 7/7/10, an action plan would be required if there was a sustained increase in the number of failures for any reason over the 3 month period being reviewed.</p> <p>There was no written evidence found in the QAPI report which indicated that an action plan was developed to improve dialyzer performance and/ or decrease dialyzer failure.</p>	V 638			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 638	<p>Continued From page 12</p> <p>On the Water and Dialysate Quality section, the percentage (%) of water (pure water) samples at action level (when the amount of bacteria in the water reached a certain level, measures would be taken to reduce to an acceptable level) for bacteria had a sharp increase from 4.35 % on April to 13.0 % on May.</p> <p>According to the QAPI guidelines documented in the report, an action plan would be required if a large increase in the number or percentage of water samples at action level for any reason in any given month.</p> <p>There was no written evidence found in the QAPI report which indicated that an action plan was developed to improve the quality of the water that would be used during the dialysis treatment of the patients.</p> <p>During an interview with the Nurse Manager on 3/7/11 at 2:25 PM, the Nurse Manager reviewed the QAPI report and confirmed that there was a sustained increase in the number of failed dialyzers over the 3 month period of April, May and June. The Nurse Manager acknowledged that there was no written evidence which indicated that an action plan was developed to improve dialyzer performance and/ or decrease dialyzer failure.</p> <p>The Nurse Manager further confirmed that the percentage of water samples at action for bacteria had a sharp increase from 4.35 % on April to 13.0 % on May. The NM acknowledged that there was no written evidence found which indicated that an action plan was developed to</p>	V 638			

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: 052575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2011
NAME OF PROVIDER OR SUPPLIER RAI - NORTH WATERMAN - SAN BERNARDINO			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH WATERMAN AVENUE SAN BERNARDINO, CA 92404		
(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 638	Continued From page 13 improve the quality of the water that would be used during the dialysis treatment of the patients.	V 638			