

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>052870</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/19/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>SATELLITE DIALYSIS OF SUNNYVALE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>155 NORTH WOLFE ROAD</b> <b>SUNNYVALE, CA 94086</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 represents the findings of the California Department of Public Health during the investigation of a complaint.  Complaint number: CA00245946.  Representing the Department: Lutgarda F. Sturms, HFEN.  The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	V 000			
V 113	Four deficiencies were issued for the complaint. <b>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</b>  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, interview, and record review, the facility failed to ensure three staff (PCT-patient care technician) 1, PCT 3, and RN-registered nurse 2) followed the policy and procedure on hand hygiene and wearing gloves when providing care to five patients observed (Patients at Stations 14, 15, and 16, and Patients 2 and 4). This failure placed patient at risk for cross contaminations and spread of blood borne infections.  Findings:	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  1. During an unannounced facility visit on 1/19/11 at approximately 8: 15 a.m., observation showed PCT 1 touched the screen of the machine at Station 15 without wearing gloves, then went to Station 14 to lay down the patient head by pushing the head of the chair lower, then went back to Station 15 to care for that patient, without wearing gloves or performing hand hygiene between tasks.  Further observation at approximately 8:35 a.m., showed PCT 1 was wearing gloves while caring for the patient at Station 14. PCT 1 took off his gloves and without using hand sanitizer or washing his hands, done new pair of gloves and went to care for the patient at Station 16. Then, PCT 1 took off his gloves, and again without performing hand hygiene, picked up the clipboard at Station 16 to write something. RN 1 said that PCT 1 should have used hand sanitizer or washed his hands in between wearing gloves.  At 10:45 a.m., RN 2 was changing the dressing on Patient 2's catheter, at Station 8. Wearing gloves, RN 2 took off the patient's old catheter dressing, then changed gloves without hand hygiene, and proceeded to use the antiseptic solution to prepare the site/catheter for a new dressing. Again, RN 2 changed gloves without performing hand hygiene and applied the dressing.  PCT 3 was observed at around 1 p.m. transferring Patient 4 from the wheelchair to the Hoyer lift weighing scale. He was wearing gloves. PCT 3 was then observed manipulating the Hoyer lift, transferring Patient 4 back to the	V 113			

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V 113	Continued From page 2 chair and helping the patient to a comfortable position. He took off his gloves and put on another pair of gloves without washing hands or using hand sanitizer.  The facility policy and procedure entitled "Hand Hygiene", dated 8/15/10, was reviewed with the Clinical Manager on 1/19/11. The policy stated, "Staff should disinfect their hands either by washing them with a disinfectant hand soap or by disinfecting them with an alcohol based hand rub: after performing procedures with potential for exposure, between treatments of different patients and anytime after removing gloves." The facility policy for "Universal Precautions", dated 6/26/08, instructed staff to, "Wear gloves when touching patients or medical equipment."  "According to Center for Disease Control (CDC), handwashing is the most important measure to prevent contaminant transmission. Hand hygiene includes either washing hands with soap and water, or using a waterless alcohol based antiseptic hand rub with 60-90% alcohol content. According to CDC, even with glove use, hand hygiene is necessary after glove removal because hands become contaminated through small defects in gloves and from the outer surface of gloves during glove removal."	V 113			
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS  Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or	V 117			

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V 117	<p>Continued From page 3</p> <p>clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a designated clean area when staff allowed patients to place personal belongings next to clean nursing supplies. This failure increased the potential risk for crosscontamination and spread of infections.</p> <p>Findings:</p> <p>During a facility tour on 1/19/11 at approximately 10 a.m., there were clean nursing supplies, such as packets of gauze, tapes, boxes of clean gloves, catheter dressing kits, on a counter by the weighing scale. It was observed that one patient came in the treatment room, took off his jacket, and placed it on the counter next to the weighing scale, touching the nursing supplies. The patient proceeded to weigh himself. Shortly after, another patient came in, took his cell phone and wallet from his pockets, and put them on the same counter. Immediately after, a patient who had</p>	V 117			

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V 117	Continued From page 4 already finished her treatment walked to the weighing scale, placed her purse and another bag on the same counter, and weighed herself. All these incidents were also witnessed by RN 1 who did not intervene.	V 117			
V 120	494.30(a)(1)(i) IC-TRANSDUCER PROTECTORS-NOT WETTED/CHANGED  Use external venous and arterial pressure transducer filters/protectors for each patient treatment to prevent blood contamination of the dialysis machines' pressure monitors.  If the external transducer protector becomes wet, replace immediately and inspect the protector. If fluid is visible on the side of the transducer protector that faces the machine, have qualified personnel open the machine after the treatment is completed and check for contamination. This includes inspection for possible blood contamination of the internal pressure tubing set and pressure sensing port. If contamination has occurred, the machine must be taken out of service and disinfected using either 1:100 dilution of bleach (300-600 mg/L free chlorine) or a commercially available, EPA-registered tuberculocidal germicide before reuse.  Change filters/protectors between each patient treatment, and do not reuse them. Internal transducer filters do not need to be changed routinely between patients.  This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility staff failed to maintain the transducer protector clean and dry during dialysis	V 120			

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V 120	Continued From page 5 treatments for one of one dialysis machines observed. This failure increased the potential for cross-contamination or inaccurate venous and /or arterial pressures.  Findings:  On 1/19/11 at approximately 9 am, it was noted that the venous transducer pertaining to machine number 22 at Station 19 was wet. This was pointed out to RN (registered nurse) 1 who asked a PCT (patient care technician) to change the transducer.  According to Center for Disease Control, the external transducer protector, (which provides a protective barrier between dialysis bloodlines and the dialysis machine) should not be reused. Wet, (meaning wet with blood or other fluids) external transducer protectors "must be changed immediately and the side of the external transducer protector that faces the machine should be inspected for visible fluid....."	V 120			
V 146	494.30(c)(2) IC-CATHETERS:GENERAL  (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as	V 146			

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V 146	<p>Continued From page 6</p> <p>the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html</a></p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure staff followed the policy and procedure for the initiation of dialysis treatment with a catheter for one (Patient 1) of one patients reviewed. This failure increased the risk of infections .</p> <p>Findings:</p> <p>On 1/19/11 at approximately 1 p.m., RN 2 was observed initiating Patient 2's treatment at Station 8. RN 2 and the patient were wearing a mask. RN 2 was talking to the patient whose face was not turned the other direction from where the catheter exit site was.</p> <p>The policy and procedure for "Initiation of Dialysis with a Catheter", dated 4/28/10, instructed staff to " have the patient wear a mask and turn his/her head away from the site, for all catheter procedures that remove the catheter caps and access the patient's blood stream."</p>	V 146			