California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA630011070	A. BUILDING ______ B. WING ______	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASCO STATE PRISON - CDC	**701 SCOFIELD AVENUE WASCO, CA 93280**

(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) COMPLETE DATE
L 000	Initial Comments The following reflects the findings of the California Department of Public Health during an annual licensing survey. Representing the California Department of Public Health : Elna Ramos, HFEN	L 000		
L 005	T22 DIV5 CH7.1 ART6-75176 Dialysis Facility A dialysis facility means a licensed free-standing specialty clinic which provides less than 24-hour care for the treatment of patients with End-stage Renal Disease, including provision of renal dialysis services or a general acute care hospital having a special permit to provide care and treatment services to patients with End-stage Renal Disease. This Statute is not met as evidenced by: This statute is not met as evidenced by: 1. An initial tour of the dialysis unit was done on 2/7/11 at 3:00 p.m. The following was observed: a. the trash cans by each dialysis chair were full (there were four). b. the floor had several white stains. c. the counter behind the dialysis machine and station was dusty. d. the cart housing the computers were rusty at the bottom area, and caked dirt yellowish brown in color. e. each dialysis machine had chemical stains on the board that contains the jug. 2. On 2/8/11 and 2/9/11, the Janitorial Service did not report to clean the clinic. The Patient Care	L 005		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Technician had to clean the area before the start of treatment. The clinic staff were not aware that the Janitorial Service was responsible to clean the clinic at the end of the day. The clinic staff believed that the cleaning was done by inmate porters.

3. On 2/9/11 at 9 AM during an interview, the clinic staff had stated that an emergency power drill was conducted today at 6 AM, and the generator kicked in successfully. The clinic staff further stated that the computer power was lost for an hour and they could not print the treatment orders for the patients. The staff verbalized that they were not informed of the power outage drill.

4. On 2/8/11, an inspection of the emergency and non-emergency equipment in the clinic revealed the following:

a. The chair scale did not have any information as when was the date of preventive maintenance and calibration was done. The staff were unable to verbalize the information.
b. The AED (Automated External Defibrillator) on the crash cart had a sticker date, that indicated that the last maintenance check was done on 2005.
c. The suction machine on the crash cart had a sticker date, that indicated that the last maintenance check was done on 2005.

5. Inmate-Patient 2 has a physician's order dated 2/3/11, to use Revaclear Max dialyzer. The inmate-patient required a larger dialyzer due to a high Kt/v reading, and weight of over 90 kilograms. As of 2/8/11 the Revaclear Max dialyzer was not available, Inmate-Patient 2 had been using the regular size dialyzer during treatment versus the larger capacity dialyzer.

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The dialysis agency per contract dated 12/21/2010, indicated that staffing, equipments (ie.dialyzer machines, water system) and supplies (i.e., IV fluids, non-reuse dialyzers, gloves, dressings...) will be provided by the contractor.

In an interview at 1:30 PM, with clinic staff, the staff stated that the physician has been made aware of the unavailability of Revaclear Max dialyzer.

Record review of the Inmate-Patient 2's record, indicated no written evidence that the physician has been made aware.

6. On 2/8/11 during end of treatment observation, Inmate-Patients 5 and 6 were not provided with hand gloves to hold the dialysis access sites.

7. On 2/9/11, during clinical record review for Inmate-Patient 1, a Plan of Care documentation under Dialysis Access dated 1/27/11, showed, "PATIENT HAS LEFT ARM ACCESS I JUNE 2010, BUT IS NOT WORKING AND HE WILL SEE THE SURGEON FOR THAT ..."

On 2/8/11 during an interview, Inmate-Patient 2 has stated that he is new to hemodialysis and the central venous catheter is his only access. He stated that he hoped he would get a fistula or graft access soon.

8. On 2/8/11 at 10 AM, during start of treatment, access care observation for Inmate-Patient 1, the RN (registered nurse) applied a mask over the patient's nose and mouth and instructed Inmate-Patient 1 to turn his head away from the insertion site while she prepared the area. Inmate-Patient 1 had a beard about 4-5 inches long and it extended beyond the enclosure of the

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mask. When Inmate-Patient 1 turned his head to the direction of the insertion site, his beard touched the insertion site of the central venous catheter. The RN continued to prepare the port and connected Inmate-Patient 1 to the machine. The RN was not observed to apply a dressing over the insertion site. During the treatment, the RN pulled Inmate-Patient 1's shirt down, leaving the port exposed and the central venous catheter insertion site in contact with Inmate-Patient 1's shirt.

9. On 2/8/11 at 9:30 AM, during treatment, six inmate-patients were having treatment. There were only two staff present; one RN (Registered Nurse) and one PCT (Patient Care Technician). The dialysis agency (De Vita) per contract dated 12/21/2010, states, "One (1) registered nurse and two (2) patient care technician per six (6) patients per shift." The staffing requirement as specified by the contract was not met.

10. On 2/9/11, a clinical record review for Inmate-Patient 2 indicated that on 2/3/11, he had a hypoglycemic episode after the treatment. The documentation described Inmate-Patient 2 as hard to arouse, lethargic, sluggish, opens eye on command but no verbal response.

On the same day in an interview, the clinic RN had stated that a code was activated by the custody officers. Inmate-Patient 2 was administered oral glucose and glucagon. At the time of the incident, the crash cart did not contain a glucometer machine. The glucometer machine had just arrived yesterday (2/8/11). The clinic RN further stated that the clinic staff required an in-service on the use of the new glucometer machine.