

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: 053520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2011
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 999 W TAYLOR STREET SAN JOSE, CA 95126		
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V 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted 3/2/11 to 3/9/11. Representing the Department were 10918, Health Facilities Evaluator Nurse; and 14549, Health Facilities Evaluator Nurse.	V 000			
V 113	The census of the facility on 3/2/11 was 110. 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, interview and record review, the facility failed to ensure staff performed hand hygiene in accordance with facility policy and Center for Disease Control (CDC) recommendations during patient care when one patient care technician (PCT) 1 failed to perform hand hygiene while caring for one of 11 sampled patients (6) and one random patient. One PCT (2) failed to wear gloves when silencing an alarm on a dialysis machine. This failure created the risk for cross-contamination (transfer of an infection from one person/source to another). Findings: 1. During patient care observation on 3/7/11 at 3:00 p.m., PCT 1 was observed walking to Station 2 to cancel a dialysis machine alarm. PCT	V 113		3/31/11	

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 113	<p>Continued From page 1</p> <p>1 cancelled the alarm using her gloved hand. Without removing her gloves and performing hand hygiene, at 3:10 p.m. PCT 1 proceeded to initiate dialysis for Patient 6 at Station 3. PCT 1 placed a Chux (underpad) under Patient 6's right arm, used two povidone-iodine swabs to wipe the access site and within five seconds wiped the site with an alcohol swab. She inserted two needles into the access and secured the sites with tape. At 3:17 p.m. after starting dialysis, she removed her gloves and without performing hand hygiene began documenting patient information on a keyboard.</p> <p>According to the CDC, handwashing is the most important measure to prevent contaminant transmission. The CDC's "Guideline for Hand Hygiene in Healthcare Settings" (2002) indicates, "Hand hygiene is required regardless of whether gloves are used or changed. Failure to remove gloves after patient contact or between "dirty" and "clean" body-site care on the same patient must be regarded as nonadherence to hand-hygiene recommendations." "Hand hygiene" includes either washing hands with soap and water (when hands are visibly soiled), or using a waterless alcohol-based antiseptic rub, and should be done by rubbing hands together "vigorously" for 15 seconds. The CDC recommends hand hygiene be performed immediately after gloves are removed, because even with glove use, hand hygiene is necessary as hands could be contaminated through small defects in the gloves and from the outer part of the gloves during removal.</p> <p>In an interview on 3/9/10 at 2:30 p.m., the quality assurance (QA) nurse stated, "I saw it too," the</p>	V 113			

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V 113	<p>Continued From page 2</p> <p>staff member did not wash her hands between patients.</p> <p>2. On 3/8/11 at 3:10 p.m., during an observation of the treatment area, a patient care technician (PCT 1) was observed applying a blood pressure cuff to Patient 12 prior to the start of his dialysis PCT 1 was wearing gloves at this time. While waiting for the blood pressure reading, PCT 1 walked to the supply cart and proceeded to prepare the supplies needed to cannulate the patient (insertion of the needle portion of the dialysis lines into the access). During this time, while still wearing the same gloves, PCT 1 removed supplies from the cart drawers.</p> <p>At 3:20 p.m., after removing the blood pressure cuff from the patient's arm, PCT 1 returned to the cart and obtained a roll of tape while still wearing the same gloves.</p> <p>During the next 15 minutes, while preparing the access site and cannulating the patient, PCT 1 changed her gloves five times without washing her hands after removing each pair of gloves.</p> <p>At 4:50 p.m. during an interview with PCT 1 regarding handwashing after removal of gloves, she stated she removed her gloves if she was working with a patient and went to another location or patient, but she did not wash her hands. When PCT 1 was informed of the recent observations and reminded of the facility's policy and procedure regarding infection control she stated, "If I had to wash my hands every time I removed my gloves, I wouldn't get my work done!"</p>	V 113			

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V 113	Continued From page 3 3. During observation of the treatment area on 3/7/11 at 5:25 p.m., PCT 2 was observed wrapping part of his gown over his right index finger and touching the screen of a dialysis machine in order to silence an alarm. After doing this, he uncovered his hand and resumed taking care of another patient. During an interview with PCT 2 the same day at 5:45 p.m., regarding answering the alarm without first donning a glove, PCT 2 stated, "I shouldn't have done that." During a review of the dialysis facility's policy and procedure for infection control, dialysis specific, the following was noted: "Hand cleansing is the single most important thing that can be done to prevent the spread of infection. 1. Staff must cleanse/wash hands between patients and after removing gloves. 2. Hand cleansing will be done: a. Before and after giving patient care or having contact with a patient. b. After removing gloves or personal protective equipment (gown, mask, face shield, and goggles). Outcome: to prevent the transmission of infection from patient to patient, staff to patient, and patient to staff."	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	V 117		3/31/11	

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V 117	<p>Continued From page 4</p> <p>areas where used supplies and equipment are handled. Do not handle and store medications or 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 dialysis facility failed to ensure all designated clean areas in the treatment area were not contaminated by used supplies and equipment, when a pair of protective glasses were noted on top of a supply cart. This failure increased the potential for cross-contamination of a clean work area.</p> <p>Findings:</p> <p>During an observation of the treatment area on 3/8/11 at 3:15 p.m., a pair of protective glasses were noted inside a folded disposable barrier towel, sitting on top of a clean supply cart. The cart contained all the clean and sterile supplies used during dialysis, and the top of the cart was where the staff assembled the packs used to cannulate an access (the insertion of the needle portion of the dialysis lines) or prepare a catheter for dialysis and do the dressing change.</p>	V 117			

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V 117	Continued From page 5	V 117			
V 407	<p>When the clinical manager (CM) was shown the glasses on the cart, he did not say anything at first. When asked what he thought about their location, the CM still did not respond. When asked if he thought it was appropriate, considering the packs were assembled there, the CM stated, "Probably not."</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS</p> <p>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the staff failed to follow the facility policy to ensure every patient's vascular access site was visible at all times during their hemodialysis treatment, when one sampled patient (5) and 5 random patients (13, 14, 15, 16 and 17) were observed with their accesses covered. This failure increased the potential for accidents to occur unnoticed and thus affect patient safety. Findings:</p> <p>During an observation of the treatment area from 3:55 p.m. to 4:50 p.m. on 3/4/11, Patients 5, 13, 14, 15, 16 and 17 were noted to have their access site covered either with their clothes or a blanket. During this time, assigned staff were observed making visits to these stations in order to talk to the patients or enter information in the chair-side computer. However, at no time were any of the staff observed assessing the access sites.</p>	V 407		3/31/11	

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V 407	Continued From page 6 During an interview with one of the registered nurses (RN 1), when informed of the observation, she stated, "We talk to the patients and remind them of the importance of not covering their access, but they say they are cold and do it anyway."	V 407			
V 506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. This STANDARD is not met as evidenced by: Based on interview and record review, the dialysis facility failed to demonstrate it followed the standard infection control precautions specific to screening for tuberculosis (TB) when the medical records for seven of eleven sampled patients (1, 2, 3, 4, 6, 8, and 10) did not contain a report of the pre-admission chest X-ray to rule-out TB. This failure increased the risk for patient-to-patient and/or patient-to-staff transmission of a major disease. Findings: During review of the medical records, from 3/3/11 through 3/7/11, seven of the records were noted to be lacking a report of the required pre-admission chest X-ray ordered to rule-out TB (a chronic bacterial infection transmitted by inhalation or ingestion of infected droplets, usually affecting the lungs, although infection of multiple organ systems also occurs). During an interview on 3/7/11 at 8:10 a.m. with	V 506		3/31/11	

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V 506	Continued From page 7 the Quality Assurance/Staff Development Nurse (QA) regarding the facility's TB screening, she stated, "The hospital did away with the skin test...a chest X-ray is always done. If we don't get a report, we assume it is negative. Not all the charts have the initial report specifically for ruling-out TB." When asked how the facility monitored the patients, QA stated, "We don't monitor annually." On 3/7/11 at 10:15 a.m., a review of the policy and procedure "Admission of New, Transfer Patients, or Readmission" indicated a chest X-ray was to be done within 3 months prior to the start of dialysis in the outpatient facility. During a telephone interview with a nurse from the County Department of Public Health, Communicable Diseases (PHN) on 3/11/11, she stated a chest X-ray would only test for TB in the lungs. "TB could be elsewhere in the body and not be detected. That's why a skin test is necessary." PHN also stated annual screening was very important. "Since blood tests are routinely being done in dialysis, they could include the test for Quanti-FERON along with the annual labs." (Quanti-FERON is a blood test that tests for the presence of tuberculosis anywhere in the body, not just the lungs.)	V 506			
V 517	494.80(b)(2) PA-F/U REASSESSMENT-WITHIN 3 MO OF INITIAL A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.	V 517		3/31/11	

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V 517	Continued From page 8 This STANDARD is not met as evidenced by: Based on interview and record review, the dialysis facility failed to conduct a complete reassessment within three months after admission for one of 11 sampled patients (10). The failure resulted in the lack of evaluation determining if the patient was receiving and/or following his treatment plan and lacked indication if the continuity of patient medical, psychosocial, and nutritional care/needs were being met. Findings: Patient 10 was admitted to the facility for in-center hemodialysis with diagnoses including chronic kidney disease, insulin dependent diabetes, anemia, and hypertension. Hemodialysis is a medical procedure using special machines to filter waste and excess water from the body. Record review on 3/7/11 indicated the three months treatment care plan dated 6/14/10 was incomplete. The care plan for "indicators" of volume status and access (site that leads to a patient's bloodstream to allow dialysis to occur) lacked notation to show assessments, treatment plans, target dates to meet goals and persons assigned. The diabetic status indicator contained an assessment indicating Patient 10 had complications from diabetes but there was no treatment plan for the problem with a target date to evaluate if goals were met. In an interview on 3/8/11 at 2:45 p.m., the quality assurance (QA) nurse stated she did not know why the care plan was not completed.	V 517			
V 556	494.90(b)(1) POC-COMPLETED/SIGNED BY	V 556		3/31/11	

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V 556	Continued From page 9 IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided. This STANDARD is not met as evidenced by: Based on interview and record review, the dialysis facility failed to ensure a treatment plan was either signed by the patient or had a reason for the lack of patient signature for one of 11 sampled patients (9). The failure resulted in lack of supporting documentation indicating patient involvement in her dialysis care planning and treatment. Findings: Patient 9 was admitted to the facility for in-center hemodialysis. Hemodialysis is a medical procedure using special machines to filter waste and excess water from the blood. Record review on 3/7/11 indicated Patient 9 had a three months care conference on 2/23/11. The Additional Comments/Treatment Interventions form indicating participation in the care conference dated 2/23/11 lacked a signature or explanation for the lack of a patient signature. In an interview on 3/7/11 at 5:40 p.m., quality assurance (QA) nurse stated she did not know why the patient signature was missing.	V 556			
V 560	494.90(b)(4) POC-PTS SEEN BY MED STAFF 1X/MO	V 560		3/31/11	

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V 560	Continued From page 10 The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the dialysis facility failed to ensure each patient was seen by their physician at least monthly and periodically during the patient's hemodialysis treatment when the clinical records of eight of eleven sampled patients (1, 3, 5, 6, 8, 9,10 and 11) did not contain a monthly progress note and/or documentation of the physician's visit. This failure had the potential to interfere with the continuity of care for each patient when the facility was not kept informed of the patient's current health status, and deny the physician the opportunity to assess the patient's response to treatment and observe the care provided by the staff. Findings: Between 3/3/11 and 3/7/11, review of the eight patients' records revealed the following: a. Proof of monthly physician's office visits were lacking in the records of Patients 5 and 6. b. Proof of at least quarterly visits during dialysis were lacking in the records of Patients 1, 3, 5, 6, 8, 9,10 and 11. Throughout the survey, no physicians were	V 560			

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V 560	Continued From page 11 observed in the facility. Interviews with these patients confirmed their physicians did not visit them before, during or after their dialysis.	V 560			
V 562	On 3/8/11 at 2:30 p.m. during an interview with the Quality Assurance/Staff Development Nurse (Q.A.), she stated she spoke to the medical director and he stated, "The regulations say the documented information regarding dialysis unit visits has to be in a central location, but doesn't specify where." 494.90(d) POC-PT/FAMILY EDUCATION & TRAINING The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the dialysis facility failed to ensure staff had provided adequate patient education in washing their access sites for 2 of 10 sampled patients (6 and 10). Although documentation showed health education was provided, two patients interviewed stated they were not instructed to wash their access sites before dialysis (6 and 10). An access is a site that leads to a patient's bloodstream or abdominal cavity to allow dialysis to occur. The failure resulted in an increased risk for infection. Findings: 1. Patient 6 was admitted to the facility for	V 562	3/31/11		

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V 562	<p>Continued From page 12</p> <p>in-center hemodialysis with a left lower arm fistula as an access site. Hemodialysis is a medical procedure using special machines to remove waste and excess water from the body. A fistula is a connection of vein and artery, usually in the forearm to allow hemodialysis.</p> <p>In an observation on 3/7/11 at 2:40 p.m., after entering the dialysis treatment room Patient 6 weighed herself on a weight scale, walked to Station 3, took out pillows and a blanket from her bag and sat on a dialysis chair without washing her access site. At 3:10 p.m., PCT 1 started dialysis without asking Patient 6 if she had washed her access site.</p> <p>In an interview on 3/8/11 at 8 a.m., the quality assurance (QA) nurse stated there was no policy for patient education to wash their access sites before dialysis. Instead, education was provided to patients and documented in the Health Education - RN form to include washing the access as part of orientation and during the annual care care conference review.</p> <p>In an interview on 3/7/11 at 3:40 p.m., the clinical director stated patients were to wash their access sites (fistula and grafts) before dialysis. A graft is a synthetic tube implant placed under the skin to serve as an access for dialysis. In a separate interview at 3:45 p.m., registered nurse (RN 1) said patients needed to wash their access with soap and water before treatment.</p> <p>Record review on 3/9/10 indicated Patients 6 and 10 received health education in 2010 to "wash access."</p>	V 562			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 053520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2011
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 999 W TAYLOR STREET SAN JOSE, CA 95126		
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V 562	Continued From page 13 On 3/7/11 at 3:17 p.m., Patient 6 stated "We don't wash (access sites) here". In a separate interview at 3:45 p.m., Patient 10 stated he was not informed about washing his access before treatment.	V 562			