

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

PRINTED: 10/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2010
NAME OF PROVIDER OR SUPPLIER ARROWHEAD REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 NORTH PEPPER AVENUE COLTON, CA 92324	
(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 Surveyor: 07599 The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 7/15/10 to 7/20/10. Representing the California Department of Public Health: Frances Bratton, HFEN Octavio Relopez, HFEN Census: 50 Sample Size: 5 Abbreviations and Acronyms: RN - Registered Nurse LVN - Licensed Vocational Nurse IDT - Interdisciplinary Team FA - Facility Administrator CP - Care Plan RD - Registered Dietician MSW - Masters Degree Social Worker	V 000		
V 127	494.30(a)(1)(i) IC-HBV-TEST PTS/STAFF POST LAST DOSE Hepatitis B Screening: Patients and Staff Test all vaccines [patients and staff] for anti-HBs 1-2 months after last primary vaccine dose. -- If anti-HBs is <10 mIU/mL, consider patient or staff member susceptible, revaccinate with an additional three doses, and retest for anti-HBs. -- If anti-HBs are =10 mIU/mL, consider immune, and retest patients annually. -- Give booster dose of vaccine to patients if anti-HBs declines to <10 mIU/mL and continue to	V 127		8/12/10

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 127	<p>Continued From page 1 retest patients annually.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23046 Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure that 1 of 5 sampled patients (Patient 4) who had received hepatitis B (Hep B- a disease of the liver) vaccine was tested for anti-HBs (presence of antibodies produced by the body to fight disease) 1-2 months after the last vaccine dose which had the potential to result in failure to determine the patient's response to the vaccine and continued exposure and susceptibility to hepatitis B virus (HBV) infection. 2. Ensure sufficient information on anti-HB test results for 5 of 5 sampled patients (Patients 1, 2, 3, 4, 5) were provided by reporting test results not in numeric values which had the potential to result in failure to determine the exact level of antibodies and immune or non-immune status of the patient. <p>Findings:</p> <ol style="list-style-type: none"> 1. During review of Patient 4's medical record on 7/16/10, laboratory (lab) test results dated 11/18/09 indicated that Patient 4's anti-HB level had been negative (not immune to hepatitis B). <p>The vaccination record documented that Patient 4 had been administered the HVB vaccine and had received the 4th and last dose on 5/17/10.</p> <p>No documentation was found indicating that</p>	V 127		

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V 127	Continued From page 2 Patient 4 had been re-tested for anti-HB 2 months after the last dose of the vaccine was given to determine the patient's response to the vaccine. The results of the test would indicate whether the patient was immune or non-immune. During an interview with the Nurse Manager on 7/16/10, at 8:50 AM, he reviewed Patient 4's medical record and stated that he did not know why an anti-HB test had not been done. The Nurse Manager further stated that he would request the lab for an anti-HB test for Patient 4. 2. During record review on 7/19/10, the vaccination records and anti-HBs test results for Patients 4, A, B, C, D and E were reviewed. Patient 4's anti-HB test result dated 11/18/09 was documented as negative and Patients A, B, C, D and E's anti-HB test results were documented as positive. During an interview with the Nurse Manager on 7/16/10, he stated that the facility's laboratory send anti-HB test results not in numeric value but in a statement as "positive" when the patient was determined to be immune or "negative" when determined to be non-immune. No further documentation was found in Patients 4, A, B, C, D and E's records to indicate sufficient information on anti-HB test results to determine the exact level of antibodies and immune or non-immune status of the patients.	V 127			
V 402	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to	V 402		8/30/10	

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V 402	Continued From page 3 ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Surveyor: 23046 Based on observation and interview, the facility failed to ensure patient safety by failing to provide a call system in the patients' restroom for patients' use to call for help which had the potential to result in staff's failure to respond and provide emergency care in a timely manner in the event of medical emergencies or accidents. Findings: During the facility tour with the Nurse Manager on 7/16/10, at 9:05 AM, the patients' restroom in the treatment area was observed not equipped with a call system for patients' use as needed to alert staff. The Nurse Manager acknowledged that the patients' restroom did not have a call system and should have been in place for patient safety. The Nurse Manager further stated that they (the facility) were in the process of building a new facility and soon be moving.	V 402			
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;	V 519		8/12/10	

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V 519	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 07599 Based on interview and record review, the facility failed to ensure that a comprehensive assessment for 1 of 5 sampled patients (Patient 1) had been completed annually. This lack of assessment had the potential to result in the (Interdisciplinary Team) IDT's failure to adjust the patient's plan of care. Findings: Patient 1 is a 49 year old patient who was admitted to the facility on 3/28/09 with diagnoses which included: end stage renal disease, anemia, and hypertension. The patient's plan of care was developed and signed by the IDT as completed on 4/21/09. A review of the medical record on 7/16/10 revealed the following hospitalizations: Adm - 4/8/10 Cholecystitis D/C - 4/8/10 4/26/10 Cholecystitis 5/10/10 5/13/10 Pancreatitis 5/21/10 5/27/10 Pneumonia 5/31/10 6/10/10 Bacteremia 6/12/10 Infected catheter 6/29/10 Acute Coronary 7/05/10 Syndrome A further review of the plan of care revealed the care plan was to be updated 90 days after the initial assessment and annually thereafter if the patient was assessed as stable. There was no documented 90 day care plan assessment located in the medical record. In an interview conducted with the Nurse	V 519		

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V 519	Continued From page 5 Manager on 7/16/10 at 2:50 PM, the nurse stated that the was a misinterpretation of the time frame in which the plans were to be updated and was unable to explain the reason the care plan and the assessment had not been updated. The Nurse Manager further stated that Patient 1 was not considered to be unstable until the patient had been hospitalized 3 times in one month or over 8 days per hospitalization. An interview conducted with the Registered Dietician on 7/19/10 at 1:30 PM, revealed Patient 1 had become unstable over the "past few months" as the patient had started to lose weight. According to the dietician, the patient was scheduled for an IDT meeting on 7/21/10. This lack of assessment had the potential to result in the IDT's failure to adjust the patient's plan of care and prevent the patient from becoming unstable.	V 519			
V 546	494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. This STANDARD is not met as evidenced by: Surveyor: 23046 Based on interview and record review, the facility failed to provide necessary care to manage mineral metabolism for one of 5 sampled patients (Patient 5) by failing to administer patient's medication, "Zemplar" (a form of vitamin D used to treat patients with kidney disease), as prescribed by the physician which had the potential to result in failure to manage patient's bone/ mineral metabolism (a process of getting	V 546		8/19/10	

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V 546	<p>Continued From page 6 energy from food) and prevent bone disease.</p> <p>Findings:</p> <p>During record review on 7/19/10, Patient 5's medical record documented that patient was 56 years of age and had diagnosis that included end stage renal disease (ESRD).</p> <p>The physician's order dated 7/7/10 and 7/9/10 documented the following order:</p> <p>7/7/10 - Zemplar 4 micrograms (mcg) intravenous push (IVP) every hemodialysis (q HD) treatment starting next treatment (on 7/9/10). 7/9/10 - Zemplar 3 mcg IVP q HD starting next treatment (on 7/12/10).</p> <p>During review of the dialysis treatment records dated 7/12/10, 7/14/10 and 7/16/10, documentation indicated that Zemplar 4 mcg had been administered to patient instead of the 3 mcg as prescribed during dialysis treatment days on 7/12/10, 7/14/10 and 7/16/10.</p> <p>During an interview with the Nurse Manager on 7/19/10, at 11:45 AM, Patient 5's treatment records were reviewed and the Nurse Manager acknowledged that Patient 5 had not been given the right dose of 3 mcg of Zemplar as prescribed by the physician on 7/12/10, 7/14/10 and 7/16/10.</p>	V 546			