

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

PRINTED: 09/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052587	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2010
NAME OF PROVIDER OR SUPPLIER BERKELEY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2920 TELEGRAPH AVENUE BERKELEY, CA 94705	
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V 000	INITIAL COMMENTS Surveyor: 05189 The following reflects the findings of the California Department of Public Health during a recertification survey from 7/20/09 to 7/27/09. Representing the Department of Public Health: Dorothy Rice HFEN, Lutgarda Sturms HFEN, and Nikki Kratt HFEN. The census at the start of the survey was 124 (Hemodialysis only) patients. Acronyms and Abbreviations commonly used in this report: AVF arteriovenous fistula AVG arteriovenous graft BP blood pressure ESRD end stage renal disease HD hemodialysis P&P policies and procedures UF ultrafiltration UFR ultrafiltration rate	V 000		
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Surveyor: 05189 Based on direct observation, staff interview, and	V 122		3/25/10

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 122	<p>Continued From page 1</p> <p>record review, the staff failed to implement the infection control procedures related to cleansing/disinfecting the treatment chairs after each patient's usage. This deficient practice increased the risk of the spread of infectious bloodborne conditions for patients utilizing the contaminated chairs.</p> <p>Findings:</p> <p>On 2/23/10 at approximately 11:30 a.m., the evaluator observed Staff W cleaning the treatment chairs at station 15 and 17, after patient treatment. Staff W wiped the chairs with a moistened disinfecting cleaning cloth while the head of the chair was only lowered approximately 30 to 45 degrees, and not fully extended into a near flatten position. When Staff W stated that he had completed cleaning/disinfecting the chairs, the evaluator asked Staff W to lower the head of the chair into an almost flat position. At that time, the evaluator observed a moderate amount of dried reddish-brown, dark-color substance in the deep lower crevices on the side panels and lower, posterior cushions.</p> <p>On 2/23/10 at approximately 11:45 a.m., the evaluator observed Staff U wipe down a treatment chair with moistened disinfecting cleaning cloth without fully extending the head of the chair into a near flatten angle position at station 5. When Staff U stated that he had completed cleaning/disinfecting the chair, the evaluator asked Staff U to lower the head of the chair into an almost flat position. At that time, the evaluator observed a moderate amount of dried, reddish-brown, dark-color substance in the deep lower crevices on the side panels and lower, posterior cushions.</p>	V 122			

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V 122	Continued From page 2 On 2/23/10, review of the "Facility Hygiene" section of the Infection Control For Dialysis Facilities policy and procedure, dated September 2009, showed the following: "Equipment including ...the dialysis chair and side table including opening the chair to reach crevices...will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment." Subsequently, Staff B acknowledged the practice and stated that staff should lower the head of the treatment chairs into a lower reclining position in order to see and clean the blood in the deep crevices.	V 122		
V 126	494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Hepatitis B Vaccination Vaccinate all susceptible patients and staff members against hepatitis B. This STANDARD is not met as evidenced by: Surveyor: 21174 Based on interview and record review, the facility failed to follow their recommended Hepatitis B vaccination schedule for two (2,10) of 13 sampled patients. Patients 2 and 10 did not receive their vaccinations at the manufacturer's specified timed intervals, decreasing the vaccine's efficacy and increasing their susceptibility to Hepatitis B. Findings: 1. Record review on 2/23/10 indicated Patient 2 had been admitted to the facility on 10/10/05 with	V 126		3/25/10

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V 126	<p>Continued From page 3</p> <p>a diagnosis of chronic renal failure. His physician wrote orders documented on 6/22/09 Patient Annual Standing Order that Patient 2 was to have "Hepatitis B and C screening upon admission, then protocol based on status".</p> <p>On 2/23/10 review of the policy "Hepatitis Surveillance, Vaccination and Infection Control Measures", dated December 2008, indicated "If the vaccination series is interrupted after the first dose, the second dose should be administered as soon as possible. The second and third dose should be separated by an interval of at least one month, while making effort to maintain the recommended vaccine specific dosing intervals. If using a four dose series, the fourth dose is to be given six months after the initial dose. If only the fourth dose is delayed, it should be administered when convenient." The policy also instructed, "If hepatitis B surface antibody is < 10 mIU/ml, consider the patient susceptible, revaccinate with an additional full series, and retest for HBsAb one to two months after the last dose of the second series."</p> <p>Review of Patient 2's Hepatitis B status showed he had an HBsAb (Hepatitis B surface antibody) value of 4 and was considered susceptible to infection. According to the facility policy, an HBsAb value of 10 or higher indicated immunity.</p> <p>On 2/25/10 at 12:55 p.m., Staff B confirmed the Adult Dialysis Dependent Hepatitis B Vaccine Dosage Schedules indicated Engerix-B should be administered as a four dose series scheduled at 0, 1, 2, and 6 months. Staff B brought up Patient 2's online Hepatitis vaccination history, indicating he received doses of Engerix on the following dates: 3/14/07; 5/9/07 (two doses 2 months</p>	V 126			

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V 126	<p>Continued From page 4</p> <p>apart); and nearly two years later: 2/9/09; 4/18/09; and 7/24/09 (three doses given in months 0, 2, 5). Staff B stated "He should have had four. Engerix is a four shot series for patients and a three shot series for teammates (dialysis staff). They (meaning the staff) didn't follow the series." Surveyor: 05189</p> <p>2. On 2/23/10 and 2/24/10, the record review showed that Patient 10 was admitted to the facility on 2/22/06. Further interview with Staff X and record review showed that upon admission the physician ordered the staff to implement the facility's Hepatitis B protocol/policy. The "Hepatitis B Vaccine Patient Consent", dated 8/11/06 showed Patient 10 had an HBsAb value < 1.0 indicating the patient was susceptible to infection.</p> <p>The review of the "Hepatitis Surveillance, Vaccination and Infection Control Measures" showed the following:</p> <p>A. "If the vaccination series is interrupted after the first dose, the second dose should be administered as soon as possible. The second and third dose should be separated by an interval of at least one month, while making effort to maintain the recommended vaccine specific dosing intervals. If using a four dose series, the fourth dose is to be given six months after the dose. If only the fourth dose is delayed, it should be administered when convenient."</p> <p>B. "If hepatitis B surface antibody (HBsAb) is <10 mIU/ml, consider the patient susceptible, revaccinate with an additional series, and test for HBsAb on (1) to two (2) after the last dose of the second series."</p> <p>On 2/24/10, Staff B stated that Patient 10 received the four doses Engerix-B series on the following dates: 8/11/06 (first dose), 1/26/07 (the</p>	V 126			

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V 126	Continued From page 5 second dose), 3/14/07 (the third dose), and 5/9/07 (the forth dose). Patient 10's schedule for the hepatitis B vaccination did not follow the vaccine manufacturer's recommendation and facility policy. The second dose was significantly delayed and not administered until 4 months after the first dose. Additionally, since the fourth dose was not the only dose delayed, the fourth dose should have been given six months after the first dose on 2/11/07. Further record review showed that Patient 10 had a 3.0 HBsAb value (< 1.0 indicating susceptibility) on 10/07/09. There was no additional documentation available for review or found after staff researched the patient's record, that indicated Patient 10 was revaccinated with an additional series, and tested for HBsAb on (1) to two (2) after the last dose of the second series. Staff B acknowledged the deficient practice and stated she was not sure why staff did not follow the facility's policy and procedure as written.	V 126			
V 132	494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is not met as evidenced by: Surveyor: 05189 Based on interview and record review, the facility failed to implement its policy and procedure to annually reeducate two of twenty nine staff	V 132		3/25/10	

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V 132	<p>Continued From page 6</p> <p>members regarding infection control practices. (Staff R and Staff S) This failure does not ensure that all existing staff were educated about current infection control practices which increased the risk for transmission of infections.</p> <p>Findings:</p> <p>On 2/22/10 and 2/23/10, the personnel files of twenty-nine staff members were reviewed in the presence of Staff B and Staff D. The following were noted:</p> <p>a. Staff R was hired by the facility on 4/17/95 and received the last updated Infection Control training on 7/21/07. There was no subsequent updated annual Infection Control Training/In-services found for Staff R.</p> <p>b. Staff S was hired by the facility on 7/12/99 and received the last updated Infection Control training on 12/29/08. There was no subsequent annual updated Infection Control Training/In-services information found for Staff S.</p> <p>After additional research (via computer sytem, etc.), Staff B and Staff D acknowledged that there was no annual Infection Control Training documentation found for Staff R and Staff S. Staff D stated she did not know why the two staff did not receive the annual Infection Control material mandated by the the facility's policies and procedures.</p> <p>On 2/24/10, review of the facility's "In-service Progress" guidelines attached to the "Exposure Control Plan Policy" and "Teammate Injury and Illness Prevention" policy and procedure, dated August 2006, showed that the Annual Mandatory</p>	V 132			

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V 132	Continued From page 7 Training in-services for staff included Infection Control Training, and that the "record of training should be in [staff] file."	V 132			
V 142	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P The facility must- (1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and document review, the facility failed to: 1. Implement the "Facility Hygiene" policy and procedure regarding operative fans in the clinical (treatment) area. This failure increased the risk of spreading airborne pathogens which could potentially harm the patients. 2. Implement the policy for "Tuberculosis Monitoring and Follow-Up" for three of twenty nine staff (Staff F, Staff X, Staff Y). This failure increased the potential for transmission of an infectious disease. Findings: 1. During the initial tour of the facility on 2/22/10 at approximately 8:30 a.m., Patient 13 was observed to be fanning himself with a piece of a carton box. When interviewed, Patient 13 stated he was "hot and slightly feverish when I came in this morning". Staff R reviewed Patient 13's treatment record and stated the patient's pre treatment body temperature was 96°F.	V 142		3/25/10	

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V 142	<p>Continued From page 8</p> <p>At around 9:45 a.m., there was an electric fan running on a revolving mode in front of Station 13 where Patient 13 was still sitting.</p> <p>Staff R was interviewed and said, "he is always like that, he complain of feeling hot all the time, that is why we turn on the fan." Record review showed that Patient 13's post dialysis body temperature was 96°F (within normal range).</p> <p>The facility policy and procedure for "Infection Control For Dialysis Facilities", dated September 2009 and reviewed on 2/24/10, under "Facility Hygiene", number 58 stated, "Use of battery operated, electrical or ceiling mounted fans are not allowed in patient treatment area." Surveyor: 05189</p> <p>2. On 2/22/10 and 2/23/10, personnel records for twenty-nine staff members were reviewed with Staff B and Staff D, and the following were noted:</p> <p>a. Staff S was hired by the facility on 7/12/1999 and had a negative PPD (purified protein derivative - tuberculin skin test) result on 12/29/2008. There was no subsequent updated annual tuberculin monitoring documentation available for review.</p> <p>After additional research (via computer sytem, etc.), Staff B and Staff D acknowledged that there was no additional tuberculin monitoring information available for review. Staff D stated that the facility's practice and policy and procedures indicated that staff should be monitored annually in accordance with the facility's policy. For example, staff should either receive the skin test, complete a questionnaire, submit written information from their physician, etc. Subsequently, Staff D stated she was not</p>	V 142			

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V 142	Continued From page 9 sure why there was no additional TB monitoring information in the personnel file of Staff S. On 2/23/10, review of the "Indications for Two-step and Single-step TST [tuberculin skin test]" section of the "Tuberculosis Monitoring and Follow-Up" policy and procedure, dated September 2009, indicated that staff with a Negative TST result will require an annual TST. b. Staff X was hired by the facility on 4/10/06 and had a negative PPD (purified protein derivative - tuberculin skin test) result on 12/29/08. There was no subsequent updated annual tuberculin monitoring documentation available for review. Staff X stated that she was not sure why the test was not done. c. Staff Y was hired on 4/3/00 and had a negative PPD (tuberculin skin test) result on 12/30/08. There was no subsequent updated annual tuberculin monitoring documentation available for review. Staff Y acknowledged the deficient practice and stated that she was not sure why the test was not done.	V 142			
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.	V 147		3/25/10	

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V 147	<p>Continued From page 10</p> <p>II. Surveillance</p> <p>A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Surveyor: 21174 Based on observation, interview, and document review, the facility failed to ensure that staff followed facility policy to maintain aseptic (sterile) technique when accessing central venous (CV) catheter sites for one (Patient 2) of 4 sampled patients with CV catheters from a 12 patients sample. This failure increased the potential for catheter-related infection.</p> <p>Findings:</p> <p>Record review on 2/23/10 indicated Patient 2 was admitted to the facility on 10/10/05 with a diagnosis of chronic renal failure due to hypertension and nephrosclerosis (destruction of the renal tubules from hypertension). He had a</p>	V 147		

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V 147	<p>Continued From page 11</p> <p>CV catheter inserted for dialysis access. On 2/24/10 at 1:35 p.m., Staff L prepared Patient 2 for dialysis. Wearing gloves, gown, and face shield/mask she placed a clean, moisture proof protective barrier under Patient 2's catheter. She removed the old dressing wrapped around the CV catheter's limb leads. Keeping her gloves on, she cleaned the CV catheter limb leads by rubbing the leads with a gauze dressing containing disinfecting agent Alcavis50. After cleaning the limb leads she removed her gloves and washed her hands. After drawing blood from the CV catheter leads, Staff L prepared to clean and change dressings over the CV catheter insertion site (where the CV catheter enters the body). Wearing gloves, Staff L removed his old dressing. Wearing the same gloves, she then cleansed the insertion site with two sterile dressings containing cleansing agent ExSept. After placing new sterile gauze over the insertion site, she covered the dressing with new bandages. She removed her gloves and put on new gloves without first cleansing her hands and connected the catheter leads to the dialysis tubing. Then she removed her gloves and washed her hands.</p> <p>Staff L was interviewed immediately afterward. She was asked what she should do if she is going from dirty to clean. She responded "You have to change gloves." She confirmed that she also needed to cleanse her hands.</p> <p>Review of the facility's policy "Central Venous Catheter (CVC) Cleaning and Dressing Change", dated September 2007, instructed the staff, "With clean, gloved hands remove old dressing and discard. Remove gloves and discard. Wash hands and re-glove." Rationale was to "protect patient and teammate from cross contamination."</p>	V 147			

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V 147	Continued From page 12	V 147			
V 401	<p>During an interview on 2/25/10 at 1:10 p.m., Staff B agreed that Staff L needed to remove her gloves after removing dirty dressings, then cleanse her hands and re-glove prior to performing a "clean" activity like cleansing the insertion site or applying new sterile dressings.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT</p> <p>The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and document review, the facility failed to maintain the floor in the treatment area clean and in good repair, and failed to prevent the accumulation of salts around the concentrate (solution of bicarbonate) delivery systems. This placed the patients, the visitors and the staff at risk for falls.</p> <p>Findings:</p> <p>During the initial tour on 2/22/10 at approximately 8:45 a.m., the following were observed:</p> <p>a. There was a hole in the floor between patient Station 18 and Station 19. The hole was approximately 6 inches by 12 inches and about 2 inches deep by the middle part, exposing the concrete. Staff N acknowledged the hole. The area was a work area for staff to put the patient on and off the machines.</p>	V 401		3/25/10	

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V 401	Continued From page 13	V 401			
V 715	<p>b) In front of patient Station 23, there was an area of broken linoleum, approximately 6 inches by 10 inches and about half inch deep. Facility records and observations during the survey on 2/22, 2/23, and 2/24/10 showed that there were patients coming for treatment that used walkers and wheelchairs and were at risk of tripping on the broken linoleum.</p> <p>c. There was an accumulation of a white crystal like substance in the area of acid concentrate delivery and on the waste receptacles found on the back of the dialysis machines at patient Stations 5,7,8,17,18,19 and 21. These were pointed out to Staff C.</p> <p>Surveyor: 05189</p> <p>d. There was a large pool of clear liquid on the floor beneath the treatment chair and machine at Station 9, observed in the presence of Staff C.</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P</p> <p>The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on observation, staff interview and record review, the facility failed to consistently implement its practice and established policy and procedure</p>	V 715		3/25/10	

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V 715	<p>Continued From page 14</p> <p>for keeping arterial cartridges of the Phoenix dialysis machine filled at least 3/4 filled with blood during treatment for seven of 23 hemodialysis stations Stations 2, 3, 9, 12, 13, 16 and 17). This practice increased the potential of air entering the circuit system and in the patients' bloodstream.</p> <p>Findings:</p> <p>During the facility tour on 2/22/10, the evaluators observed that the facility utilized the Gambro Phoenix machines which contained bloodlines with the arterial and venous cartridges (as opposed to arterial and venous chambers).</p> <p>On 2/23/10 at 8:20 a.m., while walking through the clinical area, the evaluator observed that at Station 16, the arterial cartridge was almost empty (at about 1/8 to 1/4 blood-filled) while the patient was receiving treatment.</p> <p>Further observation between 8:20 a.m. and 8:25 a.m. showed the following:</p> <p>a. At Station 3, the arterial cartridge was approximately 1/4 to 1/2 blood-filled. b. At Stations 2, 9, 12, 13, and 17, the arterial cartridge was only 1/2 filled with blood.</p> <p>On 2/23/10 at approximately 8:40 a.m., Staff D stated that the facility's practice was to keep the the arterial chambers and cartridges at least 3/4 blood-filled during treatment.</p> <p>On 2/23/10, the review of the newly established policy and procedure showed the following: "The arterial and venous drip chamber (cartridge for Gambro Phoenix machine) levels should be observed and adjusted as needed, to keep the</p>	V 715			

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V 715	Continued From page 15	V 715			
V 726	<p>levels 3/4 full at all times."</p> <p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE</p> <p>The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to have complete and accurate records for two of 12 sampled patients (Patient 9 and Patient 12).</p> <p>For Patient 9, the facility failed to have a complete assessment of the oxygen administration, the physician notification of abnormal respiratory condition after treatment, and information regarding the dressing coverage and drainage of the identified wounds for Patient 9. These failures did not give information if the oxygen administration was effective during treatment, if the physician was promptly notified of the continued abnormal lung assessment after treatment, and if the wounds were covered during treatment increasing the risk for cross-contamination.</p> <p>For Patient 12, the facility failed to ensure staff documented the physician notification when the patient's blood pressure reached certain parameters. This failure placed Patient 12 at risk for lack of medical interventions.</p>	V 726		3/25/10	

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V 726	<p>Continued From page 16</p> <p>Findings:</p> <p>1. On 2/24/2010, the record review showed that Patient 9 was admitted with a historic diagnosis of end-stage renal (kidney) disease secondary to hypertensive nephrosclerosis (hardening of the kidney associated with abnormal high blood pressure), and COPD (chronic obstructive pulmonary disease).</p> <p>a. Review of the flowsheet, dated 10/23/2009, showed that Patient 9 had a treatment order for 180 minute (3 hour) duration and that the treatment was initiated at 9:28 a.m. At 9:30 a.m., Patient 9 required administration of oxygen. The staff recorded on the flowsheet, "Oxygen-portable, unit 1". There was no additional documentation to include the oxygen rate of administration, the duration of the oxygen administration, nor the patient's response to the oxygen therapy.</p> <p>On 2/24/2010, Staff X acknowledged the deficient practice and stated that some of the staff included this documentation in the flow sheet records, but some staff did not. Staff X further indicated that although the patient brought in her own oxygen container, its administration duration, rate of flow (liters/minute), and patient response to the oxygen administration should have been documented in the record.</p> <p>b. Review of the treatment flowsheets dated 10/21/2009 and 10/26/2009 showed that Patient 9's pre-hemodialysis treatment assessment found that the patient presented with "Rales" (an abnormal respiratory sound that could be fluid related and heard with a stethoscope). It also showed that the staff documented that the "rales</p>	V 726			

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V 726	<p>Continued From page 17</p> <p>continued to be present post treatment." However, there was no documented evidence that the physician was notified of Patient 9's respiratory condition. On 2/24/2010, Staff X acknowledged the deficient practice and indicated that the physician was probably notified, but staff did not document the notification.</p> <p>c. The "Patient Progress Notes ", dated 10/6/09 showed that Patient 9, "came in with 2 small rounded wounds on left arm..[physician] informed", cultures were ordered, and the "wound dressing changed." Subsequent documentation indicated that the lab confirmed MRSA (Methicillin-Resistant Staphylococcus aureus-drug resistant bacteria). Vancomycin (antibiotic) medication doses were ordered and administered as prescribed from 10/12/09 to 10/23/09.</p> <p>The review of the facility policy for "Infection Control for Bacterial Infections Caused By Drug Resistant Organism", dated September 2008, showed that, "additional infection control precautions should be considered for treatment of patients who might be at risk for transmitting pathogenic bacteria: Such as those patients with an infected wound with drainage that is not contained by dressing..." However, there was no documentation in Patient 9's record that addressed the wound as being or not covered/contained by a dressing during treatment.</p> <p>On 2/2/6/2010 at approximately 2:25 p.m., Staff Z confirmed there was no consistent documentation about Patient 9's wound dressings and precautions taken to prevent spread of infection.</p>	V 726			

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V 726	Continued From page 18 2. Record review on 2/24/2010 showed that Patient 12 was admitted to the facility on 11/24/09 with a diagnosis of End Stage Renal Disease and high blood pressure. The physician was to be notified when the patient's systolic blood pressure was 190 and the diastolic reading was higher than 110. Further review showed that on 2/16/2010, Patient 12's pre-treatment blood pressure was 207/121. There was no documentation that the physician was notified. On 2/18/2010, Patient 12's post-treatment blood pressure was 202/116. (Systolic [top number reading] of 202 or > 190; and Diastolic[lower number reading] BP of 116 or > 110). Again, there was no documentation that the physician was notified.	V 726			
V 729	494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY (1) Current medical records and those of discharged patients must be completed promptly. This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to complete promptly the medical record of one (Patient 9) of two discharged patients reviewed of a 12 patients sample. This failure does not allow for a complete and thorough review of the care provided. Findings: On 2/23/10, administrative assistant staff submitted Patient 9's medical record for review and stated that the patient expired in the acute care hospital.	V 729		3/25/10	

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V 729	<p>Continued From page 19</p> <p>On 2/24/2010, the record review showed that Patient 9 was admitted to the facility on 11/21/2000 with a historic diagnosis of end-stage renal (kidney) disease secondary to hypertensive nephrosclerosis (hardening of the kidney associated with abnormal high blood pressure). Further record review showed that Patient 10 received the last treatment in the facility on 11/6/2009 and developed no complications. Subsequent flow sheet records, dated 11/9/2009 and 11/11/2009 verified Patient 10 did not receive any additional medications (nor treatments) in the facility due to "hospitalization".</p> <p>On 2/24/2010, Staff X verified that Patient 10 received the last treatment in the facility on 11/6/2009, but was not sure of the specific date the patient was admitted to the acute care hospital. Staff X stated that she was not sure of the date when Patient 10 expired, and could not find a discharge summary in the records with the expiration date as well as other pertinent patient information.</p> <p>Staff D also stated that she found no discharge summary in the hard copy record (or the researched electronic computer-generated material) that indicated when Patient 10 expired.</p> <p>On 2/25/2010, after additional and intensive research Staff D submitted an acute care hospital History and Physical (H&P) and a facility computerized-generated History and Physical document. The H&P confirmed an admission date of 11/08/2009, and the facility electronic or computer-generated "Patient Progress Notes" showed that Patient 10 subsequently expired in the acute care hospital on 11/24/2009.</p>	V 729			

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V 729	Continued From page 20 On 2/25/2010, the review of the facility's Medical Record Maintenance policy and procedure showed that "The discharge summary will be documented in the patient's medical record within 30 days after the patient becomes inactive..."	V 729			