

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: 552537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2010
NAME OF PROVIDER OR SUPPLIER DCI - REDDING			STREET ADDRESS, CITY, STATE, ZIP CODE 180 NORTHPOINT DRIVE REDDING, CA 96003	
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 26654 The following represents the findings of the California Department of Public Health during a Recertification Survey from 3/1/10 - 3/4/10.</p> <p>Representing the Department:</p> <p>Glenn Ingo, HFEN Susan McBride, HFEN Steven Gardner, HFEN</p> <p>Census 64 Hemodialysis Patients Sample size 6</p> <p>Abbreviations/Terms used in this document:</p> <p>PCT - Patient Care Technician Admin - Administrative Staff RN - Registered Nurse Tech - Technician Lab Tech - Laboratory technician</p> <p>Dialysis - A procedure that cleans impurities and toxins from the blood of people whose kidneys can no longer perform that function.</p> <p>Access Site - Area, usually on an arm, where needles are placed for the transport of blood to the dialysis machine.</p>	V 000		
V 101	<p>494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS</p> <p>The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.</p>	V 101		3/31/10

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 101	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 26654 Findings:</p> <p>Based on record review and interview the facility failed to ensure:</p> <p>* Three of 6 sampled patients had a dialyzer re-use consent form in the medical record. (Patients 1, 2, and 6)</p> <p>* The facility dialyzer re-use consent form complied with California Code of Regulations, Title 22, §75197, Informed Consent.</p> <p>This failure resulted in patients not consenting to and/or being informed of potential adverse exposure/side effects to the dialyzer cleaning chemical.</p> <p>1. On 3/3/10, records were reviewed for Patients 1, 2, and 6. No consent for dialyzer re-use was found in the records.</p> <p>2. §75197(5) reads: "A list of advantages and disadvantages associated with reuse which shall include, but not be limited to:"</p> <p>§75197(5)(C) reads; "A lower incidence of back pain and chest pain, fever, sweating, blood pressure problems, nausea, and/or vomiting often associated with the initial use of a dialyzer in hypersensitive patients."</p> <p>On 3/4/10 at 2 pm in a concurrent record review and interview, Admin 2 confirmed that the facility dialyzer reuse consent form did not contain the</p>	V 101			

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V 101	Continued From page 2 language specified in 75197(5)(C). Admin 2 further confirmed that Patients 1, 2, and 6 did not have dialyzer re-use consents in the medical record.	V 101			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing. This STANDARD is not met as evidenced by: Surveyor: 25755 Based on observation and interview, the facility failed to ensure patients washed their dialysis access sites prior to treatment. The failure to do this increased the risk of infection at the access site for all patients on hemodialysis. 1. During the initial tour of the facility on 3/1/10 at 10:54 am, two bright yellow signs were observed posted in the patient treatment area, on each side of the scale next to two sinks, that read, "Please wash your access arm." On 3/2/10 at 8:34 am, in the patient treatment room, Admin 3 was observed wheeling Patient 11 into the patient treatment area and onto the floor scale. Patient 11 was then wheeled to Station 7 without having her access site washed. On 3/2/10 at 12:27 pm, Patient 12 entered the patient treatment area in a wheel chair, was weighed, and was wheeled over to Station 9 without washing her access site located in her left forearm. During an observation on 3/2/10 at 12:40 pm, Patient 13 was wheeled into the patient treatment	V 114		4/7/10	

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V 114	<p>Continued From page 3</p> <p>area by Admin 3. He was weighed and taken over to Station 19 in the patient treatment area. His access site was not washed. Staff did not remind Patient 13 to wash his arm.</p> <p>An interview was conducted with Admin 2 on 3/4/10 at 11:30 am. Admin 2 verified that patients' access sites were not being washed prior to their dialysis treatments. Admin 2 stated not all patients wash their access sites.</p> <p>A facility policy and procedure titled, "Pre-Dialysis Skin Prep" date issued 1/04 was reviewed. The policy indicated that "Prior to each treatment, the patients are encouraged to perform a through scrub of their access area. If the patient is unable to perform the scrub, the patient care staff will provide assistance. If the access is in an area that prevents the scrub from being done at a sink, the procedure may be performed at the chair side. The purpose for the policy was to prevent infection by thoroughly cleansing the skin prior to placement of the treatment needles.</p> <p>Surveyor: 27519</p> <p>2. During an interview on 3/2/10 at 4 pm, Patient 9 and Patient 10 both stated they did not wash their access sites with soap and water nor were they asked by any staff member if their sites had been washed before being accessed. Surveyor: 26654</p> <p>3. On 3/2/10 at 8:20 am, a wheelchair patient was observed entering and proceeding to station seven without washing the access site. The PCT did not ask the patient if the site had been washed.</p> <p>On 3/2/10 at 8:24 am, a second wheelchair</p>	V 114		

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V 114	<p>Continued From page 4</p> <p>patient was observed entering and proceeding to station 18 without washing the access site. The PCT did not ask the patient if the site had been washed</p> <p>On 3/2/10 at 8:35 am, an ambulatory patient was observed entering and proceeding to station 19 without washing the access site.</p> <p>On 3/2/10 at 8:37 am, Patient 7, at station 19, stated that he did not wash his access site but the technicians always used "little pads" to clean it before inserting the needles.</p> <p>On 3/2/10 at 8:56 am, PCT 3 was observed using standard site prep prior to inserting Patient 7's needles. PCT 3 did not ask Patient 7 if the site had been washed or wash the site prior to needle prep.</p> <p>On 3/2/10 at 9:25 am, Patient 8 stated that when she started at the clinic she washed her access but then saw no one else was doing it so she stopped.</p> <p>On 3/2/10 at 12:40 pm, an ambulatory patient was observed entering and proceeding to station 17 without washing the access site.</p> <p>On 3/2/10 at 12:56 pm, an ambulatory patient was observed entering and proceeding to station 16 without washing the access site.</p> <p>On 3/2/10 at 4 pm, PCT 4 stated that it is the patient's responsibility to wash their access site. PCT 4 stated she does not ask patients very often if they have washed their site.</p> <p>On 3/2/10 at 4:15 pm, PCT 2 stated that patients</p>	V 114			

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V 114	Continued From page 5	V 114			
V 116	<p>are "encouraged" to wash their access sites but that he "very rarely" asks if they do.</p> <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 26654 Findings:</p> <p>Based on observation and interview, the facility failed to ensure items used or stored in the dialysis stations were cleaned and disinfected between patients. This failure had the potential to result in cross contamination and the transmission of bloodborne pathogens to other patients.</p> <p>1. During observations on the treatment floor on 3/1/10 and 3/2/10, boxes used to store treatment set-up equipment were stored on a shelf behind station 17. Without being cleaned, these boxes</p>	V 116		4/7/10	

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V 116	Continued From page 6 were placed in clean chairs at the end of the treatment day in preparation for the morning.	V 116		
V 122	2. On 3/2/10 at 1 pm, an oxygen concentrator was observed being used in treatment station seven. The concentrator was left in the station between patients but not disinfected. On 3/4/10 at 2 pm, Admin 2 confirmed that the boxes should not be stored behind a station in use. Admin 2 also confirmed that oxygen concentrators should be disinfected between patients. 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: 26654 Findings: Based on observation and interview, equipment used in the treatment stations was not being adequately disinfected. This failure had the potential to result in cross contamination and the transmission of bloodborne pathogens to other patients. 1. On 3/1/10 at 1 pm, PCT 2 was observed	V 122		4/7/10

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V 122	Continued From page 7 cleaning a treatment chair after use. PCT 2 did not clean the crevice between the seat and back of the chair, or between the lower seat and footrest. On 3/1/10 at 1:10 pm, PCT 2 stated that they were told not to "blind sweep" areas they could not see. PCT 2 agreed that by reclining the chair, these areas could be adequately cleaned. 2. During observations on 3/1/10 and 3/2/10, it was noted that staff were not disinfecting the emergency kits located in plastic bags on the side of the dialysis machines between treatments. On 3/2/10 at 2 pm, PCT 1 stated that the emergency kits should be disinfected between treatments.	V 122			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT 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. This STANDARD is not met as evidenced by: Surveyor: 25755 Based on observation, interview, and facility policy review, the facility failed to provide a safe environment when one opened vial of Heparin (a medication that helps prevent clotting of the blood) was not labeled according to facility policy. Findings: On 3/1/10 at 2:57 pm, an opened, unmarked vial	V 401		4/7/10	

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V 401	Continued From page 8 of Heparin was observed in a cupboard located in Pod E of the dialysis patient treatment area. During an interview with RN 1 on 3/1/10 at 3 pm, RN 1 verified that the heparin vial should have been dated when it was opened. A facility policy and procedure titled, "Multi-Dose Medications," dated 9/06, was reviewed. The policy indicated, "All multi-use vials must be dated and initialed when opened for use. Guidelines for length of time for use and labeling needs must be followed."	V 401		
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Surveyor: 25755 Based on observation, interview, and review of manufacturer's maintenance instructions, the facility failed to ensure that: * The facility's eight fire extinguishers were being maintained in accordance with the manufacturer's recommendations. * Eight expired laboratory blood tubes (tubes used when drawing blood specimens) were not available for use. * Drench shower logs (showers used for staff and patients should a chemical spill occur) were completed.	V 403		4/7/10

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V 403	<p>Continued From page 9</p> <p>* Eye wash station logs (a faucet used to rinse the eyes if a chemical splash occurs) were completed.</p> <p>* Maintenance of the Dialysis Machine PM (preventive maintenance) for 3 machines occurred according to manufacturer recommendation timeline.</p> <p>These failures had the potential to result in facility equipment not being maintained in functioning/operational condition.</p> <p>Findings:</p> <p>1. On 3/2/10 at 12:30 pm, a fire extinguisher, located in the back hallway near the employee's break room and employee lockers, was observed. The maintenance tag hanging from the fire extinguisher was blank for February's monthly inspection.</p> <p>During a second observation on 3/2/10 at 12:50 pm, a fire extinguisher located across the hall from the technician's office had no documentation that the fire extinguisher had been inspected in February.</p> <p>During an interview with Tech 1 on 3/3/10 at 11:57 am, Tech 1 stated that none of the eight fire extinguishers were inspected in February, 2010.</p> <p>According to the manufacturer's recommendations, located on the side of the fire extinguishers, the instructions for maintenance were, "Inspect monthly or at more frequent intervals.</p> <p>Surveyor: 27519</p>	V 403			

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V 403	<p>Continued From page 10</p> <p>2. During an observation of the laboratory area on 3/1/10 at 11:50 am, two red top blood tubes that expired on 5/09, two red top blood tubes that expired on 10/09, and four pink top blood tubes that expired on 10/09 were found available for use.</p> <p>During an interview with Lab Tech 1, on 3/1/10 at 12:05 pm, she confirmed that the blood tubes were expired and available for use.</p> <p>3. During a record review on 3/3/10 at 1:55 pm, the drench shower log indicated that the shower was last tested on 10/5/09.</p> <p>4. During a record review on 3/3/10 at 1:55 pm, the logs for the two emergency eyewash stations indicated that the eye wash stations were last tested on 1/7/10.</p> <p>During a concurrent interview, Tech 1 stated that he should have documented the monthly test results of the drench shower and emergency eyewash stations on their logs.</p> <p>5. During a record review on 3/3/10 at 2:30 pm, documentation in the Dialysis Machine PM logbooks for machines number six, eight, and 10 indicated that annual servicing of the machines was not preformed.</p> <p>(a). Dialysis machine number six received annual servicing on 5/5/09, 23 days after the scheduled servicing date.</p> <p>(b). Dialysis machine number eight received annual servicing on 1/27/10, 114 days after the scheduled servicing date</p>	V 403			

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V 403	Continued From page 11 (c). Dialysis machine number 10 received annual servicing on 1/29/10, 100 days after the scheduled servicing date. During a document review on 3/3/10, the manufacture's recommendation for servicing the dialysis machines, dated 7/08, indicated, in Section 12.2.1- Regular Service, "Regular servicing is recommended at intervals of max. (maximum) 12 months." During an interview on 3/3/10 at 2:35 pm, Tech 1 stated that the dialysis machines were supposed to be serviced annually and confirmed that dialysis machines six, eight, and 10 had been serviced late.	V 403			
V 415	494.60(d)(4)(ii) PE-ANNUAL EVAL-EMERGENCY/DISASTER PLANS The facility must- Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary; This STANDARD is not met as evidenced by: Surveyor: 25755 Based on interviews, the facility failed to evaluate the effectiveness of their emergency and disaster plans by not conducting annual mock disaster drills. This failure would impact the facility's ability to evaluate the staff's skills and readiness needed in the event of an actual emergency, and had the potential to affect all patients and staff in the facility. Findings: During an interview with Tech 1 on 3/3/10 at	V 415		4/7/10	

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V 415	Continued From page 12 10:40 am, he stated he does not conduct disaster drills and did not know who did.	V 415		
V 557	On 3/3/10 at 11:17 am, Admin 2 stated she could not find any written documentation that annual disaster drills had taken place. Admin 2 stated for the past year since she has worked for the facility, a disaster drill has not been done. 494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This STANDARD is not met as evidenced by: Surveyor: 25755 Based on interview, clinical record review, and facility policy review, the facility failed to implement the initial plan of care for 1 of 6 sampled patients (Patient 2) within 30 days of admission or 13 dialysis treatments. The failure to implement the initial plan of care had the potential to prevent the facility from meeting the individual needs of the patient. Findings: Patient 2's clinical record was reviewed on 3/3/10. Patient 2's dialysis treatments began on 12/3/09. Patient 2's initial plan of care was dated 1/13/10, exceeding the required time limit by eleven days. On 3/3/10 at 2:40 pm, Admin 2 verified that Patient 2's plan of care was not implemented within the required timeframe.	V 557		4/1/10

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V 557	Continued From page 13	V 557		
V 691	<p>494.140(d) PQ-SW-MSW;GRANDFATHER IF HIRED BEFORE 1976</p> <p>The facility must have a social worker who-</p> <p>(1) Holds a master's degree in social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education; or</p> <p>(2) Has served at least 2 years as a social worker, 1 year of which was in a dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under §494.140 (d)(1).</p> <p>This STANDARD is not met as evidenced by: Surveyor: 26654 Based on interview and record review, the facility failed to ensure that a Licensed Clinical Social Worker (LCSW) provided supervisory oversight for the Masters Social Worker (MSW). This failure has the potential that the psychosocial needs of patients and their families may not be met.</p> <p>Findings:</p> <p>On 3/1/10 at 10:40 am, Admin 1 stated that the facility's LCSW, contracted to supervise the MSW, had resigned "last spring." No specific</p>	V 691		4/30/10

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V 691	<p>Continued From page 14 date could be provided.</p> <p>On 3/2/10, the job description for the facility social worker was reviewed. Among critical skills required are "...advanced assessment and treatment skills including individual, couple, and family therapy..."</p> <p>A direct communication from the Board of Behavioral Sciences, the licensing agency for clinical social workers and family therapists', states:</p> <p>"If an individual is providing psychotherapy and clinical social work, as defined in Business and Professions Code section 4996.9, and does not hold a Licensed Clinical Social Worker (LCSW) license or Associate Clinical Social Worker registration (working under supervision of a LCSW) with this Board, the individual would then be performing unlicensed activity and the Board would have the jurisdiction to take action."</p> <p>The Business and Professions Code reads: "4996.9. The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or</p>	V 691		

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V 691	Continued From page 15 groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work. Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes."	V 691			
V 713	On 3/4/10 at 10 am, Admin 1 stated the facility was actively seeking an LCSW. The only evidence provided for this was a posting on the company website. 494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance. This STANDARD is not met as evidenced by: Surveyor: 25755 Based on interview and facility policy review, the facility failed to develop and implement a policy and procedure to educate and evaluate the staff for emergency and disaster preparedness. This failure could impact the facility's ability to evaluate the staff's skills and readiness needed in the event of an actual emergency, and could affect all staff and patients in the facility. Findings:	V 713		3/24/10	

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V 713	Continued From page 16	V 713		
V 729	<p>On 3/3/10, the facility's Disaster and Emergency Preparedness manual was reviewed. The manual did not contain a policy and procedure for conducting annual drills required to determine staff's readiness in the event of an actual emergency.</p> <p>On 3/4/10 at 2:35 pm, Admin 2 verified the facility did not have a policy and procedure for conducting annual disaster drills.</p> <p>494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY</p> <p>(1) Current medical records and those of discharged patients must be completed promptly.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25755 Based on interview and record review the facility failed to ensure that the treatment flowsheets for 4 of 6 sampled in-center treatment patients (Patients 1, 2, 4, and 6) were complete when the times of pre and post assessments were not documented.</p> <p>Findings:</p> <p>1. On 3/3/10 Patient 2's clinical record was reviewed. Patient 2 began dialysis on 12/3/09. Five of 37 of Patient 2's treatment flowsheets (the document where the dialysis treatment notes are recorded such as; what dialysis treatment the patient receives, the medications given, the patient's vital signs, and the assessments before and after the dialysis treatments) were reviewed. The times for the following assessments were not documented on Patient 2's treatment flowsheet:</p>	V 729		3/31/10

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V 729	<p>Continued From page 17</p> <p>(a). The time of pre-assessment on 2/12/10, was not documented.</p> <p>(b). The time of the post assessment on 2/24/10, was not documented.</p> <p>(c). The time of the pre and post assessments on 12/21/09, 1/15/10, and 2/15/10 were not documented.</p> <p>During a concurrent interview and review of Patient 2's treatment flowsheets on 3/4/10 at 2:35 pm, Admin 2 (Administrative Staff 2) verified that the assessments were not being timed.</p> <p>Surveyor: 26654</p> <p>2. On 3/3/10, during a medical record review of Patients 1 and 6, it was noted that the time of the pre/post treatment assessments portion of the treatment flowsheets were not consistently documented.</p> <p>During an interview on 3/4/10 at 2 pm, RN 2 stated that the times for the pre and post assessments should have been documented, but that they were done sporadically.</p> <p>Surveyor: 27519</p> <p>3. On 3/3/10, during a record review of Patient 4's medical record, seven of nine pre and/or post assessment portions of the treatment flowsheets were not timed on the following dates: 2/8/10, 2/11/10, 2/13/10, 2/15/10, 2/16/10, 2/18/10, 2/20/10.</p> <p>During an interview on 3/4/10 at 8:40 pm, RN 2 stated that the times for the pre and post assessments should have been documented, but that they were done sporadically.</p> <p>During an interview on 3/4/10 at 8:50 pm, RN 3</p>	V 729		

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V 729	Continued From page 18 stated that the times for the pre and post assessments were suppose to be documented on the treatment flowsheet, but it was not always done.	V 729			
V 770	During an interview on 3/4/10 at 9 am, Admin 2 stated that it was her expectation that the time of the pre and post patient assessments be documented on the treatment flowsheet. 494.180(g)(3) GOV-TRANSFER AGREEMENT W/HOSP FOR INPT CARE (3) The dialysis facility must have an agreement with a hospital that can provide inpatient care, routine and emergency dialysis and other hospital services, and emergency medical care which is available 24 hours a day, 7 days a week. The agreement must: (i) Ensure that hospital services are available promptly to the dialysis facility ' s patients when needed. (ii) Include reasonable assurances that patients from the dialysis facility are accepted and treated in emergencies. This STANDARD is not met as evidenced by: Surveyor: 27519 Based on interview and document review, the facility failed to maintain a current transfer agreement with a hospital. This failure had the potential for patients not being accepted or treated by a hospital in an emergency, and had the potential to affect all patients in the facility. Findings: During a document review on 3/2/10 at 10:50 am, documentation in the patient transfer agreement between the facility and the acute care hospital	V 770		3/5/10	

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V 770	Continued From page 19 indicated that the agreement had expired on 2/28/07. In an interview on 3/2/10 at 3:20 pm, Admin 1 confirmed that the transfer agreement between the facility and the acute care hospital had expired.	V 770			