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	052880	A. BUILDING ______ B. WING ______	03/04/2010

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FMC DIALYSIS SERVICES OF BELLF	10116 ROSECRANS AVENUE BELLFLOWER, CA 90706

(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: 11683 The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: Rosalinda Ramos, RN, HFEN Sylvia Villaflores, REHS, HFE I	V 000		
V 113	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: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to wash hands that included rubbing hands together vigorously for 15 seconds, failed to ensure that the gauze was not used twice when cleaning the exit site of the patient's dialysis access site, and failed to follow the manufacturer's instructions for use of the hand sanitizer. Findings: 1. On March 1, 2010, during a treatment observation, the following was noted: a. At approximately 10:30 a.m., Patient 3's hemodialysis treatment had ended. PCT 4 removed the needles from the dailysis access sites and bleeding was observed. The PCT's	V 113		7/9/10

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 113	Continued From page 1	V 113		

gloves were soiled with blood. The staff removed gloves soiled with blodd and proceeded to wash her hands with soap and water for 10 seconds.

b. At approximately 12 noon, Staff C was observed cleaning the catheter exit site of Patient 8. The patient was then hooked up to the hemodialysis machine and the dialysis treatment was started. Staff C removed her gloves and washed her hands. The staff was observed rubbing her hands with liquid soap and rinsed the hands. The handwashing process lasted for 5 seconds.

c. At approximately 12:55 p.m., Staff B was observed gathering the medications and supplies to the medication preparation area for patients who had just arrived for hemodialysis treatments. The staff washed his hands for 5 minutes and started to draw up medications into the syringes.

Shortly thereafter, in an interview with Staff B, he stated that handwashing, according to the facility's policy, should be at least done for 15 seconds.

d. On March 2, 2010, at approximately 9:15 a.m., Staff E was observed wearing a complete personal protective equipment while providing care to a patient in station 6. Staff E had assembled her clean supplies such as dry gauzes, gauzes soaked in Dynahex antibacterial solution, tape, alcohol swab, and Hemasafe on top of a blue disposable chux by the armchair. The staff removed the wrappings from the ports and cleansed each port with an individual alcohol pad. The staff then removed the dressing on the exit site, applied gel on her hands, and put on a new pair of gloves. She took the soaked gauze

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V 113	Continued From page 2 and cleansed the exit site starting from the center and going twice on the same site with the same gauze. The staff repeated the cleaning of the exit site in an up and down then circular motion twice on the exit site with the same gauze. The staff covered the exit site with a dry dressing. On the same day, at approximately 9:30 a.m., in an interview with Staff E , she acknowledged that she should have not used the same gauze twice in cleaning the exit site of the patient's dialysis access site. Surveyor: 15727 2. During an observation on March 1, 2010, from 9:07 a.m.- 9:14 a.m., several staff members were observed applying the hand sanitizer and rubbing their hands together for approximately 5-10 seconds. A review of the label on the hand sanitizer container revealed the directions for use included: wet hands thoroughly with the product. Rub hands together covering all surfaces until hands are dry, about 30 seconds. During an observation on March 1, 2010, at 3 p.m., in the treatment area, a staff member was observed applying the hand sanitizer and rubbing the hands for approximately 15 seconds.	V 113		
V 115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and	V 115		7/9/10

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V 115	Continued From page 3	V 115		

centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.

This STANDARD is not met as evidenced by:
Surveyor: 11683

Based on observation, interview and record review, the facility staff failed to wear gown, face shields and gloves while providing care to Patient 6, who was on isolation for hepatitis B. Also a facility staff failed to wear the gown properly while providing care to a patient.

Findings:

1. On March 1, 2010, at approximately 9:30 a.m., the transplant motivator was observed wearing a gown opened on the front and the belt was untied which was dragging on the floor as she walked from one hemodialysis station to another and speaking to the patients.

2. On March 2, 2010, at approximately 9:45 a.m., Patient 6 was observed receiving hemodialysis treatment in the designated isolation room. Staff D was observed inside the isolation room not wearing personal protective equipment while attending to Patient 6's care needs. The licensed nurse was noted working on the computer, talking to the patient, adjusting his tubing and administering medication.

In an interview with Staff D, she readily admitted that it was her mistake that she failed to wear personal protective equipment while providing care to the patient.

A review of the facility's policy on Dialyzing

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V 115	Continued From page 4 Patients with Hepatitis B Antigen (HbsAg+) stipulated anyone entering the isolation area/room during patient's treatment must wear a separate fluid resistant gown at all times and clean gloves should be used to work on the keyboards in the isolation area/room.	V 115		
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT 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. -- 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. -- 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. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility staff failed to ensure that the 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. Findings: 1. On March 1, 2010, at approximately 8:30 a.m.,	V 116		7/9/10

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V 116	Continued From page 5 Patient Care Technician (PCT) 2 was observed picking up a jug from station 18 where a patient was currently receiving treatment. The plastic jug was labeled with one (1) potassium (K). PCT 2 took the jug to the backroom and placed with other jugs ready for use without disinfecting the jug. 2. On March 2, 2010, at approximately 8:05 a.m., a bottle of ExSept, First Aid Antiseptic, was left in station 4 and PCT 3 took the bottle back to the common supply cart without disinfecting the bottle. In an interview with PCT 3, she stated that any supplies or equipment brought into the hemodialysis station should be disinfected prior to putting it back to the supply cart.	V 116		
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 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. 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. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they	V 117		7/9/10

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V 117	Continued From page 6 must be cleaned between patients. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to ensure the medication station was dedicated for medication preparation area to prevent cross contamination. Also, the facility staff failed to ensure that the multi-dose vial medication was dated and initialed when first opened, and that the pre-drawn medication syringes that were timed and "put on" kits that contained medication and needles should not be accessible to unauthorized persons in the facility. Findings: 1. On March 1, 2010, at 8:10 a.m., during the tour of the facility, there were twelve (12) "put on" kits that were on top of the cabinet by the bleach area were left unattended and accessible to an unauthorized person. The "put on" kit consists of syringes with heparin, fistula needles, folded under pads, alcohol and Betadine pads and 4 by 4 gauze. During an interview with patient care technician (PCT)1, he stated that after it was prepared it should be placed in a drawer. 2. On March 1, 2010, at 8:45 a.m., during the medication storage observation, the following was noted: a. The medication refrigerator was found to have an accumulation of ice in the freezer. b. A vial of Tubersol, Tuberculin Purified Protein Derivative Mantoux, was opened and undated. According to the Manufacturer's insert stipulated	V 117		

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V 117	Continued From page 7 a vial of Tubersol which had been entered and in use for 30 days should be discarded because oxidation and degradation may have reduce the potency. c. There were eleven (11) syringes of Epogen and three (3) syringes of Zemplar that were pre-drawn by the licensed nurse did not have the time when they were drawn. 3. On March 1, 2010, at 12:55 p.m., Staff B was observed preparing medications in the medication station (designated medication preparation area). There were several folders labeled Daily Water and Safety Log, Registered Nurse Rounding Tool, medication log, a bottle of alcohol, a plastic box, an opened box of disposable ampule opener, tapes, staplers and clipboards found at the medication station. During an interview with the clinical manager, she stated that she was aware the designated medication station should be free of clutter to prevent cross contamination during the medication preparation. 4. On March 1, 2010, at approximately 2:10 p.m., during a review of the Glucometer Monitoring and Quality Control Log revealed that on February 15, 2010 and January 19 and 21, 2010, there was no documented evidence to indicate the reason the daily calibration prior to treatment was not done.	V 117		
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	V 122		7/9/10

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V 122	Continued From page 8 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: 11683 Based on observation and interview, the facility failed to ensure that the cleaning and disinfection of contaminated surfaces, medical devices, and equipment were done in accordance with the standard infection control precautions. Findings: On March 1, 2010, at approximately 1:40 p.m., a patient in station 10 had terminated hemodialysis treatment. Staff B was observed wiping the chair and hemodialysis machine with a cloth soaked in a disinfectant. However, the staff failed to disinfect the blood pressure cuff and call light. Shortly, aonther patient was placed in station 10 and a staff member placed the blood pressure cuff in the patient's arm. In an interview with Staff B, he acknowledged that the blood pressure cuff and call light should have been disinfected prior to placing a patient in the chair.	V 122		
V 185	494.40(a) ENVIRONMENT-ACCESS TO PORTS/METERS 8 Environment: access to ports/meters The layout of the water purification system should provide easy access to all components of the system, including all meters, gauges, and sampling ports used for monitoring system performance.	V 185		7/9/10

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V 185	Continued From page 9 This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to provide easy access to all components of the water purification system. Findings: During an observation in the water treatment area on March 1, 2010, at 9:25 a.m., and on March 2, 2010, at 8:45 a.m., the blending valve was not easily accessible. Two wooden pallets containing bags of powdered sodium bicarbonate and two acid concentrate barrels were blocking the blending valve section of the water treatment system. At the same time during an interview, the chief technician stated the pallets needed to be rearranged for the staff to have easy access to the blending valve.	V 185		
V 187	494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range.	V 187		7/9/10

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V 187	Continued From page 10 This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to provide a schematic diagram of the water system that identified the components, valves and sample ports. Findings: During an observation tour on March 2, 2010, at 8:45 a.m., in the water treatment area, a water treatment and solution delivery system flow diagram was posted on the wall near the bicarbonate mixing systems. A review of the flow diagram revealed the schematic diagram of the water system did not identify the components, valves and sample ports. During an interview on March 4, 2010, at 9 a.m., the clinical manager after reviewing the schematic diagram, stated the diagram did not identify the components, valves and sample ports and needed to be revised.	V 187		
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: 15727 Based on observation and interview, the facility	V 401		7/9/10

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V 401	Continued From page 11	V 401		

failed to and a safe and comfortable treatment environment for patients, staff and the public.

Findings:

During an observation tour of the facility on March 1, 2010, from 7:35 a.m.- 8:38 a.m., the following was observed:
1. In the waiting area, the window blinds were bent and broken.
2. In the conference room, there were three water stained ceiling tiles.
3. In nurses' station 3, the sink faucet had white deposits at the nozzle. The wood flooring of the cabinet under the sink had brownish stains.
4. In nurses' station 2, the alarm panel on the wall for the solution delivery system was blocked by two medical records racks. The call light system panel on the wall for the call buttons in the two patient restrooms, the isolation room and the home hemo room was blocked by two boxes. Both panels were not visible to the staff.
5. In the patient restroom in the treatment area, the sink faucet had an aerator device. The seat cover dispenser was detached from the wall.
6. In the laboratory, the two sink faucets had aerator devices.
7. In nurses' station 1, there were two water stained ceiling tiles. There was peeling wall paint.
8. Outside nurses' station 1, the cabinet under the sink had three plastic containers. The wood flooring had brownish stains.
9. The sink counter top near stations 30, 31, 32, 33 had a faded surface with white stains.
10. In the treatment area, the area where 7 chairs and 3 wheelchairs were stored, the wall had peeling paint approximately 8-10 feet long.
11. In the exit door near stations 34 and 35, the wall had chipped sections.

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V 401	Continued From page 12 12. The concentrate outlets in stations 34 and 35 had an accumulation of brown and white deposits. 13. In the sink near station 36, the counter top was faded with brown and green stains. The counter had a detached side panel. The cabinet under the sink had plastic containers and the wooden flooring was damaged. The automatic sensor was loose. 14. In station 4, the floor had 4 broken tiles measuring approximately 2 inches x 2 inches. 15. The sink outside the isolation room had a faucet with an aerator device. 16. The sink near the weighing scale had no water supply. At the same time during an interview, the licensed nurse stated the sink has not been working for about 2 weeks. 16. In the treatment area, there were three water stained ceiling tiles. 17. The exam room was filled with empty jugs and a rack. There was a sign " Please do not make it a storage room." 18. In the staff lounge, there was one water stained ceiling tile. The sink was clogged up. The sink faucet had an aerator device. 19. In the storage room, the sections of the floor behind the water treatment system and the area behind the acid and bicarbonate systems had an accumulation of dust and debris. There was a section of the cement flooring that was damaged. 20. The wall panels behind the chairs in all the stations had white deposits. At the same time during an interview, the chief technician stated the janitorial service should have cleaned the walls behind the chairs in each	V 401		

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V 401	Continued From page 13 station. During an interview on March 2, 2010, at 9:30 a.m., the chief technician stated there was a leak from the roof which the property management company would fix. He further stated there was a leak from the incoming line so the water was turned off in the sink near the weighing scale. He stated the aerator devices have to be removed.	V 401		
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility staff failed to ensure that the patients' access sites were visible during their hemodialysis treatments. Findings: On March 1, 2010, at approximately 8:10 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 15, 16, 20, 21, 22, 27 and 28. At 11:25 a.m., during an observation, it was noted again that the patients' access sites were not visible in stations 1, 27, 32, 34, 35 and 36. On March 2, 2010, at approximately 8:05 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 15, 24, 25 and 28.	V 407		7/9/10

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V 407	Continued From page 14 During the observation rounds, the facility staff members were passing by the patients without reminding them that their access sites were fully covered and not visible during treatments. On March 2, 2010, at 1:50 p.m., during the observation rounds with the clinical manager, the patients' access sites were not visible in stations 15, 19, 24 and 30. She stated the facility staff should be reminded that the patients' access sites should be visible during the treatments.	V 407		
V 412	494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to have a system in place to identify patients who will need assistance in disconnection and evacuation during an emergency. Findings: During an observation on March 1 and 2, 2010, during various shifts, there was no indication in the respective stations of patients undergoing treatments who needed assistance in case of an emergency. In the nurses' stations, there was no list of patients who needed assistance during an emergency.	V 412		7/9/10

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V 412	Continued From page 15 During an interview on March 4, 2010, at 9 a.m., the clinical manager stated the facility did not have a system in place for staff to identify patients who needed assistance during an emergency.	V 412		
V 413	494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to ensure that the emergency equipment such as suction machine, portable oxygen tank and emergency drugs were functional and readily available for use. Findings: On March 1, 2010, at 8:45 a.m., during the medication storage observation with Clinical Manager, the following were noted: 1. The automatic external defibrillator and suction machine were found on top of the emergency cart. Staff A's responsibility was to check the emergency cart, its contents such as medications, supplies and equipment every first day of the month. The staff attached the tubing and turned on the machine and indicated that's how he check if the suction machine was working. The suction machine's gauge was not working and there was no bacteria/hydrophobic	V 413		7/9/10

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V 413	Continued From page 16 filter at the time of the test. During an interview with Staff A, while reviewing the log revealed the suction gauge had not been working since February 9, 2010 and the chief technician had been notified. 2. When the portable oxygen tank was turned on, the needle on the gauge indicated it was empty. The oxygen tubing was not readily available at the cart. 3. There were two (2) bags of 50% Dextrose missing in the cart. 4. There were two (2) packs of disposable resting ECG electrodes with an expiration date of July 25, 2005. A review of the Medication/Supply/Equipment List dated March 1, 2010, indicated the suction machine, oxygen and medications were all checked. The facility's policy on Emergency Equipment and Supply stipulated the emergency supplies were checked on a monthly basis, expiration dates and proper functioning of all equipment. Also, the policy stipulated that missing and/or depleted stock is to be replaced as soon as possible.	V 413		
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following: (2) Evaluation of the appropriateness of the dialysis prescription,	V 503		7/9/10

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V 503	Continued From page 17 This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility failed to follow the physician's order for dialysis prescription (blood rate, medications, oxygen) for 4 of 18 sampled patients (Patients 2, 5, 9 and 13). Findings: 1. According to the admission facesheet, Patient 2 started dialysis at the facility on June 5, 2007, with diagnoses of end stage renal disease and diabetes with renal manifestations type 2. On January 22, 2009, at 10:30 a.m., Patient 2 was observed receiving hemodialysis treatment via left arm fistula. The blood flow rate was 350 and the dialysate flow rate was 800. A review of the clinical record revealed a physician's order dated July 27, 2007, indicated orders for hemodialysis, 3 times a week, 3 1/2 hours, blood flow rate of 350 and dialysate flow rate of 800. Further review of the clinical record, specifically the treatment data dated January 17, 2009, documented the blood flow rate was 346 -357. On January 8, 2009, the documented blood flow rate was 327- 335. On December 23, 2008, the documented blood flow rate was 325. On December 9, 2008, the physician ordered to restart Zemplar at 6 mcg every treatment if the calcium level was <10.5 and phosphorous level was < 7. The laboratory result dated December 11, 2008, revealed a lab result for calcium level of 6.8 and phosphorous level for 7.5. On December 18, 2008, lab result for calcium level was 7.4 and phosphorous level was 6.3.	V 503		

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V 503	Continued From page 18 A review of the hemodialysis treatment record revealed that on December 13, 20, 22, 23 and 31, 2008, the patient was not administered Zemplar as ordered. 2. According to the admission facesheet, Patient 5 started dialysis at the facility on September 1, 2008, with diagnoses of end stage renal disease and diabetes with renal manifestations type 2. On January 21, 2009, at 10:50 a.m., Patient 5 was observed receiving hemodialysis treatment in an isolation room via left upper arm fistula. The blood flow rate was 450 and the dialysate flow rate was 800. A review of the clinical record revealed a physician's order dated September 15, 2008, indicated orders for 3 times a week treatment for 4 hours, blood flow rate of 450 and dialysate flow rate of 800. Further review of the clinical record specifically the treatment data dated January 19, 2009, documented the blood flow rate was 400-475. On January 16, 2009, the documented blood flow rate was 475-481. On January 14, 2009, the documented blood flow rate was 373-481. 3. According to the admission facesheet, Patient 9 started dialysis at the facility on January 1, 2007, with diagnoses that included end stage renal disease and hypertension. On January 21, 2009, at 12:50 a.m., Patient 9 was observed receiving hemodialysis treatment via left lower arm fistula. The blood flow rate was 450 and the dialysate flow rate was 800. A review of the clinical record revealed a	V 503		

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V 503	Continued From page 19	V 503		

physician's order dated November 1, 2008, indicated order for 3 times a week treatment for 3 hours, blood flow rate of 450 and dialysate flow rate of 800. Further review of the clinical record specifically the treatment data dated December 28, 2008, documented the blood flow rate was 405-443. On January 2, 2009, the documented blood flow rate was 454-462. On January 9, 2009, the documented blood flow rate was 451-456. On January 14, 2009, the documented blood flow rate was 402-459. On January 21, 2009, the documented blood flow rate was 405-456.

On December 26, 2008, the physician ordered Epogen 2,000 units to be administered intravenously every treatment. A review of the hemodialysis treatment record revealed that on December 28 and 30, 2008, and January 2, 5 and 7, 2009, the patient received Epogen 4,000 units.

4. On January 21, 2009, at approximately 1:50 p.m., the licensed nurse was observed preparing Patient 13 for starting the dialysis treatment. The patient was receiving oxygen, 3 liters, via nasal cannula.

A review of the clinical record revealed the patient started the dialysis treatment at the facility on January 21, 2008, with diagnoses that included end stage renal disease, vasculitis and diabetes with renal manifestation type 2. Further review of the clinical record failed to show a physician's order for oxygen administration.

On January 23, 2009, at 10 a.m., during an interview with Employee E, she stated that the patient came with her own oxygen and then switched to the facility's oxygen during the

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V 503	Continued From page 20 treatment.	V 503		
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the facility staff failed to ensure that the patients' comprehensive assessment included blood pressure managment needs for 2 of 18 sampled patients (Patients 1 and 2). Findings: 1. A review of the Hemodialysis Treatment Records of Patient 1 revealed the following documentation: On February 8, 2010, at approximately 8:47 p.m., the patient's blood pressure reading was 95/56. The patient care technician administered 200 milliliters (ml) of normal saline to the patient for complaint of cramping. On February 10, 2010, at approximately 8:52 p.m., the patient's blood pressure reading was 96/49. The patient was administered 200 ml of normal saline by the licensed nurse. On February 17, 2010, at approximately 7:33 p.m., the patient's blood pressure reading was 94/45. The patient was administered 300 ml of	V 504		7/9/10

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normal saline for low blood pressure.

Further review of the Hemodialysis Treatment Records on the above dates failed to show documentation that the patient's episodes of low blood pressure with administration of normal saline was further assessed by the licensed nurse.

A review of the physician order dated November 20, 2009, documented for symptomatic hypotension to administer 0.9% normal saline 100 ml up to 1000 ml IV bolus. Notify the physician if 0.9 NS greater than 1000ml and patient still asymptomatic. For muscle cramps, 0.9% normal saline ml up to 500 ml maximum IV bolus.

On March 4, 2010, at 10 a.m., an interview with Clinical Manager, while reviewing the medical record, she agreed that the physician order was not followed and there was no follow-up assessment by the Registered Nurse (RN) when the patient was having episodes of hypotension.

2. A review of Patient 2's Hemodialysis Treatment Records revealed the following:

On March 1, 2010, at approximately 3:38 p.m., the patient's blood pressure reading was 95/64. At approximately 4:01 p.m., the blood pressure reading was 93/58. At 4:29 p.m., the blood pressure reading was 92/60. The patient was administered 200 ml of normal saline due to complaint of cramping.

On February 26, 2010, at approximately 4:07 p.m., the patient's blood pressure reading was 89/36. The patient was administered 300 ml of normal saline for low blood pressure. At

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V 504	Continued From page 22 approximately 5:06 p.m., the patient's blood pressure reading was 95/56 and the PCT administered extra 200 ml of normal saline for patient's complaint low blood pressure. On February 22, 2010, at approximately 4 p.m., the patient's blood pressure reading was 102/60. The patient was administered 200 ml of normal saline for low blood pressure by the PCT. On February 19, 2010, at approximately 2:05 p.m., the patient's blood pressure reading was 87/43. The patient was administered 200 ml of normal saline by the PCT. At approximately 3:34 p.m., the blood pressure reading was 90/49 and was administered 200 ml of normal saline. At 4:36 p.m., the blood pressure reading was 97/45 and was administered 200 ml of normal saline due to patient complaint of low blood pressure. Further review of the Hemodialysis Treatment Records on the above dates failed to show documentation that the patient's episodes of low blood pressure with administration of normal saline was further assessed by the licensed nurse. A review of the physician order dated November 20, 2009, documented for symptomatic hypotension to administer 0.9% normal saline 100 ml up to 1000 ml IV bolus. Notify the physician if 0.9 NS greater than 1000ml and patient still asymptomatic. For muscle cramps, 0.9% normal saline ml up to 500 ml maximum IV bolus.	V 504		
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written,	V 541		7/9/10

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individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.

This STANDARD is not met as evidenced by:
Surveyor: 11683
Based on record review and interview, the interdisciplinary team failed to develop an individualized care plan that included the patient and the nursing home staff who were responsible for the needs and care of Patients 5 and 7.

Findings:

1. Patient 5 was admitted to the facility on March 13, 2007, with diagnoses that included end stage renal disease, diabetes mellitus type 2 with renal manifestations and anemia in chronic kidney disease. The patient received hemodialysis treatment three times a week for three (3) hours every treatment. The patient's current access site was a left subclavian catheter.
Patient 5 was a resident in a skilled nursing home.

2. Patient 7 was admitted to the facility on February 5, 2010, with diagnoses that included end stage renal disease, diabetes mellitus type 2 with renal manifestations and unspecified acquired hypothyroidism. The patient received

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V 541	Continued From page 24 hemodialysis treatment three (3) times a week for three hours and forty five minutes every treatment. The patient's current access site was antero-venous fistula on the left upper arm. The patient resided in a nursing home. On March 2, 2010, at approximately 11 a.m., in an interview with the clinical manager, while reviewing the clinical records of Patients 5 and 7, failed to show documentation to indicate that an interdisciplinary care plan was developed and coordinated with the skilled nursing homes to address the various needs of the patients such as diet, medications, new orders and transportation needs. A review of the agreement for dialysis services between the the dialysis center (Provider) and the skilled musing homes (Facility) stipulated they should cooperate and work together in exchanging necessary information, including information regarding the condition of Facility residents, which was necessary to develop and implement a care plan enabling the facility residents to receive quality of care in accordance with all federal, state and local regulations.	V 541		
V 681	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to	V 681		7/9/10

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perform the specific duties of their positions.

This STANDARD is not met as evidenced by:
Surveyor: 11683
Based on record review and staff interview, the facility failed to ensure that the dialysis staff met the personnel and health qualifications necessary to meet the comprehensive needs of the patients.

Findings:

On March 3, 2010, at approximately 1:30 p.m., five (5) personnel and health files of dialysis staff members were reviewed and revealed the following:

1. Registered Nurse (RN) 1 was hired on March 9, 2009, as a hemodialysis staff nurse. RN 1 was a regular staff from a sister facility and was being borrowed to work in the facility when short of staff. There was no documentation of an orientation and emergency training procedures in her files.

2. RN 2 was hired on January 22, 2007, as a hemodialysis staff nurse. RN 2 transferred from a sister facility on Janaury 15, 2010. There was no documentation of an orientation and an infection control training prior to starting to work.

3. RN 3 was hired on March 2, 2009,as a hemodialysis staff nurse. RN 3 was transferred from a sister facility on December 2009. There was no documentation of an emergency training procedures, infection control training and tuberculosis evaluation prior to starting to work.

At approximately 11:30 a.m., in an interview with

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V 681	Continued From page 26 Clinical Manager, she stated that tuberculosis testing was a required test for the staff members prior to starting to work. She further stated that all transferred and borrowed staff members were given orientation through a "buddy system" for three days, however there was no documentation available for review.	V 681		