

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052792	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OF IMPERIAL COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAKE STREET EL CENTRO, CA 92243
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 22383 The following represents the findings of the Department of Public Health during a recertification visit. The facility census at the time of the visit was 62 hemodialysis patients.</p> <p>Representing the Department were HFEN 15930 and HFEN 22383.</p> <p>Glossary of Abbreviations:</p> <p>CCHT Certified Hemodialysis Technician kg kilogram P&P Policy and Procedure RN Registered Nurse</p>	V 000		
V 113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation and interview, the facility failed to ensure that the medical director used gloves while touching patient equipment and failed to washed his hands between moving from 1 patient station to another, causing cross contamination of 2 shared computer stations and 3 dialysis machines.</p> <p>Findings: On 6/15/10 at 1:00 P.M., while patients were</p>	V 113		7/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 receiving dialysis treatments, the medical director walked from the dialysis machine at station 6 after he touched the control panel, to the shared computer station between stations 5 and 6 where he touched the key board. He then walked to the dialysis machine at station 3, where he touched the control panel and then to the shared computer station between stations 3 and 4 where he used the keyboard. The medical director continued to walk to the dialysis machine at station 4, where he touched the control panel of that dialysis machine. All of the medical director's movements were without gloves, the use of hand sanitizer or washing his hands between "clean" and "dirty" surfaces. This effectively cross contaminated 3 dialysis machines and 2 shared computers. When interviewed on 6/15/10 at 1:05 P.M., the medical director stated, "I have not touched the patients." When his movements were brought to his attention, that he went from a dirty area (the dialysis machine) to a clean area (the shared computers) and had not used gloves, hand sanitizer or washed his hands, he stated, "Oh, I see what you mean."	V 113			
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	V 187		7/9/10	

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V 187	Continued From page 2 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. This STANDARD is not met as evidenced by: Surveyor: 22383 Based on observation and interview the facility failed to ensure the schematic diagram that accurately reflected the water system for the staff to follow. Findings: During the water treatment observation on 6/16/10, the schematic diagram located on the wall in the water room, was 3 pages of components that did not accurately reflect this facility's water room. The diagram did not give a clear picture of how the components interacted with each other. It did instruct a staff member as to how to follow the flow of water through the components. The Chief Tech stated on 6/16/10, that this was the only schematic diagram they had it had. He stated it identified the components but did not accurately reflect the water flow.	V 187			
V 192	494.40(a) CARBON ADSORPTION-TWO TANKS/SAMPLE PORTS 5.2.5 Carbon adsorption: two tanks/sample ports Refer to RD62:2001, 4.3.9 Carbon adsorption media: Carbon adsorption systems shall be adapted specifically to the maximum anticipated water flow rate of the system. Two carbon adsorption beds shall be installed in a series configuration.	V 192		7/9/10	

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V 192	Continued From page 3 5.2.5 Carbon adsorption Two carbon beds shall be installed in series with a sample port following the first bed. A sample port shall also be installed following the second bed for use in the event of free chlorine or chloramine breaking through the first bed. This STANDARD is not met as evidenced by: Surveyor: 22383 Based on observation and interview the facility failed to ensure that both secondary carbon tanks had individual sample ports. Findings: A water treatment observation was conducted on 6/16/10. The facility's 2 sets of carbon tanks were configured in a parallel system. They both had a primary and secondary tank. The secondary tanks had a single chlorine testing sample port after the water from both tanks combined in a single pipe. The Chief Tech stated that he was unaware they did not have a sample port after each tank.	V 192		
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation, interview and record	V 463		7/9/10

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V 463	<p>Continued From page 4</p> <p>review, the facility failed to ensure that 1 of 6 sampled patients (2) received a heparin bolus according to the physician's order. The facility failed to ensure that 1 of 6 sampled patients (4) received the dialysis prescription as ordered by the physician.</p> <p>Findings:</p> <p>1. On 6/17/10 at 12:17 P.M., the facility provided Patient 2's medical record for review. A physician's order dated 3/19/10, indicated that Patient 2 was to receive a heparin bolus of 6000 units per treatment. The dialysis treatment flow sheets from 5/25/10 through 6/15/10, contained documentation that indicated 4000 units of heparin was administered to Patient 2, contrary to the physician's orders of 6000 units.</p> <p>On 6/17/10 at 12:30 P.M., the clinical manager stated that the orders should had been changed in the shared computer system, in order for the staff to know how much heparin to administer.</p> <p>2. On 6/17/10 at 12:17 P.M., the facility provided Patient 4's medical record for review. The dialysis prescription dated 12/29/09, indicated that a 3.0 K bath (K bath is the amount of potassium added to the dialysate) was ordered.</p> <p>On 6/18/10 at 1:30 P.M., Patient 4 reclined in a chair while receiving a dialysis treatment at station 9. CCHT 5 stated that he was responsible for Patient 4's dialysis treatment and further stated that the patient was receiving a 2.0 K bath. The back of the dialysis machine was connected to the direct feed of the facility, which only provided a 2.0 K bath. Patient 4 received 3.5 hours of treatment with the 2.0 K bath, which was</p>	V 463			

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V 463	Continued From page 5 contrary to the physician's order of a 3.0 K bath. On 6/18/10 at 1:35 P.M., RN 6 stated that she normally checked the prescription on the machine before starting the dialysis treatment. RN 6 added, "But, I missed that one." RN 6 stated that the K bath should be verified with another staff member prior to starting the dialysis treatment. On 6/18/10, the facility P&P for "Pre-Treatment Safety Checks", specified that staff review and verify all patient treatment data (prescription) and machine set-up information before the initiation of treatment.	V 463		
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Surveyor: 22383 Based on interview and record review the facility failed to ensure that vital signs were monitored every 30 minutes for 6 of 6 sampled patients (1,2, 3, 4, 5, 6) and failed to achieve the dry weight for 1 of 6 sampled patients (3). Findings: 1. A review of patient 1's treatment sheets for 6/15/10, indicated staff took and recorded vital signs at 9:32 A.M., 10:33 A.M. and 11:30 A.M. each an hour apart. A review of patient 3's treatment sheets for 5/31/10, indicated staff took and recorded vital	V 543		7/9/10

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V 543	<p>Continued From page 6</p> <p>signs at 4:58 P.M. and 5:55 P.M., an hour apart.</p> <p>A review of patient 6's treatment sheets for 6/2/10, indicated staff took and recorded vital signs at 9:33 A.M. and at 10:33 A.M. The treatment sheets for 6/4/10 indicated staff took and recorded vital signs at 8:58 A.M. and 10 A.M. The treatment sheets for 6/11/10 indicated staff took and recorded vital signs at 7:52 A.M. and 8:52 A.M., an hour gap.</p> <p>2. A review of Patient 3's treatment sheets indicated her dry weight was 100.5kg. On 5/26/10 Patient 3's post weight was 103.8kg, on 5/29/10 her post weight was 103.5kg, on 6/7/10 the post weight was 101.7kg, and on 6/16/10 her post weight was 102.5kg. There was no explanation on the treatment sheets to indicate why the patient did not achieve her dry weight. Surveyor: 15930</p> <p>3. On 6/17/10, the facility provided Patient 2's medical record for review. The dialysis treatment flow sheets dated 5/29/10, indicated staff documented vital signs at 8:41 A.M., and 9:53 A.M., more than an hour gap. On 6/5/10, staff documented vital signs taken at 9:32 A.M., and 10:34 A.M., an hour gap.</p> <p>On 6/17/10, the facility provided Patient 4's medical record for review. The dialysis treatment flow sheets dated 5/28/10, indicated staff documented vital signs at 12:35 P.M., and 1:21 P.M. On 6/7/10, staff documented that vital signs taken at 12:39 P.M., and 1:37 P.M. On 6/16/10, staff documented that vital signs taken at 12:15 P.M., and 1:18 P.M., all at an hour or more intervals.</p> <p>On 6/17/10, the facility provided Patient 5's</p>	V 543			

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V 543	Continued From page 7 medical record for review. The dialysis treatment flow sheets dated 5/24/10, indicated staff documented vital signs at 1:36 P.M., 2:30 P.M., and 3:35 P.M. On 5/31/10, staff documented that vital signs taken at 3:34 P.M., and 4:39 P.M. On 6/16/10, staff documented that vital signs taken at 1:27 P.M., and 2:24 P.M., all at an hour or more intervals. The facility's P&P Monitoring during Patient's Treatment indicated vital signs taken at different intervals depending on the patient's condition and ability to communicate. On 6/17/10 at 10: 25 A.M., the Clinical Director stated it was her expectation that vital signs should be taken and recorded every 30 minutes regardless of the patients condition or ability to communicate. She said staff were to have no more than a 30 minute gap in vital signs for all patients.	V 543			
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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; This STANDARD is not met as evidenced by: Surveyor: 22383 Based on interview and record review the facility failed to ensure that 6 of 6 sampled patients (1, 2, 3, 4, 5, 6) were assessed pre and post dialysis treatment by a registered nurse as per the facility	V 715		7/9/10	

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V 715	<p>Continued From page 8 policy and procedure.</p> <p>Findings:</p> <p>On 6/16/10, the facility provided a copy of their pre and post dialysis policy and procedure. The Pre- Dialysis P&P included instructions to determine if a patient was experiencing any respiratory distress, edema in the extremities, neck veins or face. The Pre-Dialysis P&P also included instructions to document the patient's pulse and respiratory rate noting the rhythm and quality.</p> <p>The Post-Dialysis P&P included instructions to document the patient's pulse and respiratory rate noting the rhythm and quality to compare to the pre-dialysis rates.</p> <p>The treatment sheets were reviewed for all 6 sampled patients, there was only one RN assessment documented within the first hour of each patient's treatment.</p> <p>The charge nurse stated on 6/16/10 at 2:00 P.M., that a post assessment was not done. She said, "Only 1 assessment was done by the RN during the treatment. It was not necessarily done pre treatment." There was no place on the treatment sheet to document pre and post assessments.</p> <p>On 6/16/10 at 2:54 P.M., both the charge nurse and the medication nurse stated they did an initial assessment of the patients. They described the details of the assessment including assessing breath sounds and edema. They stated the assessment was done at the start of the treatment not before the treatment started. They said they only reassess patients if a CHT notified</p>	V 715			

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V 715	Continued From page 9 them of a problem. They did not reassess breath sounds or edema after treatment unless it was brought to their attention by a CHT. The clinical manager stated on 6/17/10 at 10:26 A.M., that she expected the RN to assess all the patients for blood pressure, weight, breath sounds, and edema. She expected patients to be assessed both pre and post treatment.	V 715			