

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: 052846	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2010
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OF INGLEWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 336 EAST HILLCREST AVENUE, SUITE 100 INGLEWOOD, CA 90301	
(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: 15727 The following reflects the findings of the Department of Public Health during a recertification visit. Representing the Department Public Health: Rosalinda Ramos, RN, HFEN Sylvia Villaflores, REHS, HFE I	V 000		
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to provide a sanitary environment to minimize the transmission of infectious agents. Findings: 1. During an observation on February 1, 2010, at 9:15 a.m., a certified hemodialysis technician (CHT) was observed removing the bloodlines and dialyzer after a treatment. The CHT disposed the bloodlines and dialyzer into the biohazard container. He removed his gloves and washed his hands. The handwashing lasted approximately 5 seconds. At 9:30 a.m., in the treatment area, another staff member removed her gloves and washed her hands for approximately 8 seconds.	V 111		

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 111	<p>Continued From page 1</p> <p>During an observation on February 2, 2010, at 8:30 a.m., in the treatment area, a staff member was washing her hands for approximately 5 seconds.</p> <p>A review of the facility's policy and procedure on Hand Hygiene revealed to rub hands together vigorously for at least 15 seconds. Cover all surfaces of the hands and fingers. Friction helps to remove skin surface contaminants. 15 seconds is approximately the time to sing "Happy Birthday" once.</p> <p>2. During an observation on February 2, 2010, at 12:35 p.m., the hand sanitizer dispensers next to the patient access sink and the dispenser by the exit door were dispensing a minimal amount of the solution.</p> <p>At the same time during an interview, the staff in the treatment area stated there were times when the amount dispensed was minimal and they had to make a bigger cut at the dispensing nozzle of the bag in order for more solution to be dispensed.</p> <p>At the same time, during an interview, the chief technician stated housekeeping was in charge of putting the sanitizer bags in the dispenser.</p> <p>3. During an observation on February 3, 2010, at 7:25 a.m., a staff member in the treatment area was dispensing the hand sanitizer to her hands. She proceeded to rub her hands for approximately 20 seconds.</p> <p>A review of the manufacturer's Guide for Hand Hygiene revealed to apply the instant hand sanitizer into cupped dry hands. The procedure</p>	V 111			

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V 111	Continued From page 2 included 6 steps. For each step, spend 6 seconds while rubbing your hands. Make sure hands remain moist throughout the process- a full 30 seconds.	V 111			
V 116	Surveyor: 11683 4. On February 1 and February 2, 2010, at different times of day, the employees' protective personal equipment such as gowns and face shields were observed hanging on the side wall by a sink. The bottom of the gowns were noted to be touching the opening of the trash bin. The gowns were observed being re-used by staff members whenever they returned to the treatment area after their breaks. 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, interview, and record	V 116			

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V 116	<p>Continued From page 3</p> <p>review, the facility staff failed to ensure that the items taken into the dialysis station used for a patient were not returned to the common storage area.</p> <p>Findings:</p> <p>On February 1, 2010, at approximately 9:20 a.m., during the tour of the treatment area, the following was observed:</p> <ol style="list-style-type: none"> 1. Employee C took a bottle of Tums from the medication storage cabinet. Employee C took the bottle of Tums and showed it to the patient in station 13 to see if this was the medication that he needed to take at that time. The bottle of Tums was later taken back to the medication cabinet and placed it with the other medications in the cabinet without disinfecting the bottle. 2. At approximately 11:20 a.m., Employee C was observed to take a box of gloves and a roll of tape and brought them to station 2. The employee used the supplies to clean Patient 8's catheter site on the left chest. The employee used the the same soaked gauze to clean the catheter site twice in a circular motion. Afterwards, the patient was hooked up on the dialysis machine, and the employee took the box of glove and roll of tape back to the supply cart located by the medication cabinet. <p>A review of the facility's policy on Changing Central Venous Dressing stipulated to do not wipe over a cleaned area with the same gauze to prevent potential cross contamination.</p> <p>On the same day, at a later time, during an interview, the employee stated that she was not</p>	V 116			

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V 116	Continued From page 4 aware not to take back the bottle of medications and other supplies to the supply cart with other clean supplies.	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 must be cleaned between patients. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview, and record review, the facility failed to ensure the multi-dose	V 117			

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V 117	<p>Continued From page 5</p> <p>vial medications were dated and initialed when first opened, single dose medication residual discarded after initial use, and the medications were not accessible to unauthorized persons.</p> <p>Findings:</p> <p>1. On February 1, 2010, at approximately 9:10 a.m., during the tour of the treatment area, the following was observed:</p> <p>a. The medication refrigerator was observed with heavy accumulation of ice in the freezer. There was a multi-dose vial of Epogen opened and undated. A single dose vial of Vancomycin opened on January 31, 2010, was together with current medications in use.</p> <p>b. In the emergency cart, the suction tubing was observed exposed to the elements. The suction canister did not fit into the mold of the suction machine. When Employee B was requested to test the suction machine, the supplies were not readily available and needed to be taken from the supply room.</p> <p>A review of the Daily Emergency Cart Checklist indicated a portable oxygen tank which was full. There was no portable oxygen near the emergency cart. The staff found out later that the portable oxygen was located in the supply room.</p> <p>The Crash Cart had no Calcium Chloride, manual blood pressure cuff, and different sizes of syringes. The crash cart had extra eight (8) vials of epinephrine 1:10,000, one (1) 50% dextrose and missing one (1) Solu-Cortef 100mg/vial.</p> <p>2. On February 2, 2010, at approximately 8 a.m.,</p>	V 117			

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V 117	Continued From page 6 and February 3, 2010, at approximately 2 p.m., a bottle of Lidocaine HCL, Heparin and 0.9% Sodium Chloride were left unattended on the medication preparation area.	V 117			
V 122	On February 1, 2010, at approximately 11 a.m., in an interview with Employee B, she stated that the suction tubing should be stored in a plastic bag when not in use. She added the medications should not be left unattended at all times. 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: 11683 Based on observation, interview record review, the facility staff failed to ensure that the contaminated surface, equipment, and supplies were cleaned and disinfected after patient use. Findings: On February 1, 2010, at approximately 1:30 p.m., it was noted that a wet napkin was placed on top of the sharps container beside the hemodialysis machine in Station 4. There was a patient still seated in the chair although his dialysis treatment had ended. Employee H used the wet napkin by the sharps container to clean the hemodialysis	V 122			

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V 122	Continued From page 7 machine. She then took a tubing from the top of the hemodialysis machine and set it up for the next treatment. As soon as the patient left the station, the employee took the wet napkin on top of the sharps container and started wiping the chair.	V 122		
V 226	494.40(a) MIX SYS-DFU/MONITOR/PM/LOG/SANITIZE 5.4.4.1 Mixing systems: follow DFU/monitor/PM/log/sanitization If a concentrate mixing system is used, the preparer should follow the manufacturer's instructions for mixing the powder with the correct amount of water. If a concentrate mixing system is used, the number of bags or the weight of powder added should be determined and recorded. Manufacturer's recommendations should be followed regarding any preventive maintenance and sanitization procedures. Records should be maintained indicating the date, time, person performing the procedure, and results (if applicable). 6.4.1 Mixing systems: Systems for preparing either bicarbonate or acid concentrate from powder should be monitored according to the manufacturer's instructions. This STANDARD is not met as evidenced by:	V 226		

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V 226	<p>Continued From page 8</p> <p>Surveyor: 15727</p> <p>Based on observation, interview and record review, the facility failed to follow the manufacturer's directions for use for preparing the bicarbonate from powder.</p> <p>Findings:</p> <p>During an observation on February 1, 2010, at 2 p.m., a certified hemodialysis technician (CHT) was observed pouring a bag of the bicarbonate powder into the water inside the mixing tank. The product used was Naturalyte 4000 Rx-12 Dry Pack bicarbonate Powder. At 2:08 p.m., 8 minutes after the mixing tank was started, he stopped the mixing tank.</p> <p>At the same time during an interview, the CHT stated he set the mixing pump for 10 minutes.</p> <p>A review of the label of the bicarbonate powder used revealed the directions for use to empty the entire dry pack into 90 liters of water and to mix for 1 minute. Add water for a total volume of 96 liters and to mix again for 10 minutes. This was not done by the staff member.</p> <p>During an interview on February 3, 2010, at 9:55 a.m., the CHT stated he did not run the bicarbonate mix for 10 minutes. He stated he stopped it 2 minutes early.</p> <p>A review of the facility's policy and procedure on Concentrate Mixing and Handling: Solution Delivery System revealed a timer must be used to avoid over-mixing of the bicarbonate solution and to refer to the manufacturer's instructions for use for appropriate mixing times. The instructions included to add 90 liters of water to a mix tank.</p>	V 226		

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V 226	Continued From page 9	V 226		
V 401	<p>Gradually add the entire contents of the bag while gently mixing the solution and continue mixing for 1 minute after the powder has been added. This is done to dissolve the powder. Add additional water to raise the fluid level to the 96 liter mark on the mix tank and continue mixing for approximately 10 minutes.</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: 15727 Based on observation, interview and record review, the facility failed to maintain the the building to ensure a safe, functional and comfortable environment.</p> <p>Findings:</p> <p>During an observation tour of the facility on February 1, 2010, from 8:15 a.m.- 9 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. The front door had one panel that did not close completely leaving approximately a 2-3 inches gap. 2. In the treatment area, there were two water stained ceiling tiles above stations 9 and 10. 3. The blinds covering the glass of the emergency exit door were bent and damaged. 4. In the laboratory area, the sink faucet was loose. The freezer section of the refrigeration unit had ice build-up. 	V 401		

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V 401	<p>Continued From page 10</p> <p>5. In the storage room, there were 5 water stained ceiling tiles.</p> <p>6. In the water treatment room, there were 2 water stained ceiling tiles. The floor had chipped sections creating an uneven surface. There were openings around the pipes which was a possible entry point for rodents and other insects.</p> <p>At the same time, during an interview, the chief technician stated there was a leak from the rain water pooling in the parking lot above the facility.</p> <p>7. The biohazard room had a damaged section of the wall.</p> <p>8. In the trash bin area, the floor had an accumulation of dust and debris. There were approximately 15-20 soiled gloves and approximately 20 cigarette butts on the floor. The trash bin lids were open. The trash was at the level of the rim.</p> <p>At the same time during an interview, the chief technician who accompanied the evaluator during the tour stated the trash bin area had to be cleaned.</p> <p>9. During an observation tour of the facility on February 2, 2010, at 12:30 p.m., the patient restroom in the waiting area had a call light system that provided a light above the door when activated. However, there was no audible alarm when activated. The staff in the treatment area was not aware that the call light was activated.</p> <p>At the same time, during an interview, the chief technician stated the alarm should be installed in the treatment area in order for the staff to respond.</p>	V 401			

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V 401	Continued From page 11	V 401		
V 403	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain a program to ensure that all dialysis machines were maintained.</p> <p>Findings:</p> <p>During an observation on February 1, 2010, at 8:34 a.m., in the technical area, there were 4 dialysis machines (# 18, 8, 11 and 12). Dialysis machine # 18 was ready for use. The other three machines were not ready for use.</p> <p>During an observation on February 1, 2010, at 1:59 p.m., Patient 10 was ready to leave after treatment. She stated she had stayed for 8 hours.</p> <p>A review of the treatment record dated February</p>	V 403		

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V 403	Continued From page 12 1, 2010, revealed Patient 10's treatment started at 6:45 a.m. At 8:20 a.m., treatment was interrupted due to machine blood pump problem. The machine had to be changed. Treatment was resumed at 9:34 a.m.(approximately 1 hour and 14 minutes) At 11:47 a.m., treatment was interrupted again. The machine alarm sounded due to low flow error. All the blood was returned. Treatment was resumed at 12:19 p.m. (approximately 32 minutes later). Treatment completed at 1:35 p.m. During an interview on February 3, 2010, at 7:55 a.m., Staff A (a certified hemodialysis technician) stated she was on duty on February 1, 2010. She stated the reason the treatment of Patient 10 took over an hour to be resumed was because the machine to be used was not rinsed by the equipment technician and was not ready for use. The second time the machine was rinsed and ready for use. During a tour of the biomed area on February 2, 2010, at 7:45 a.m., machines # 16, 19 and 11 were not ready for use. There was no back-up machine ready. At the same time, during an interview, the chief technician stated he would get a machine ready. During an interview on February 2, 2010, at 10:25 a.m., the biomed technician stated he always had only one machine ready each time. During an interview on February 3, 2010, at 1:30 p.m., the chief technician stated two back-up dialysis machines should be ready at all times.	V 403			
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS	V 407			

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V 407	Continued From page 13 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, interview and record review, the facility staff failed to ensure the patient's access sites were visible during hemodialysis treatments. Findings: On February 1, 2010, at approximately 8 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 2, 10 and 18. At 11:45 a.m., during an observation round, the patients' access sites were not visible in stations 3, 4, 8, 13, 15, 17 and 20. On February 2, 2010, at approximately 7:30 a.m., the patients' access sites were not visible in stations 5, 8, 15, 16, 17 and 20. At 2:30 p.m., during an observation round with Employees D and E, it was noted that patients' access sites were not visible in stations 6 and 11. In an interview with both staff members, they stated that the access sites should be visible while the patient was receiving treatment. Facility staff members were observed around and passing by the patients and failing to remind the patients that their access sites were covered and should be visible.	V 407			
V 415	494.60(d)(4)(ii) PE-ANNUAL EVAL-EMERGENCY/DISASTER PLANS	V 415			

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V 415	Continued From page 14 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: 15727 Based on interview and record review, the facility failed to evaluate the effectiveness of the emergency and disaster plans and update them as necessary. Findings: A review of the disaster manual revealed there was no documentation of any fire/disaster drills that were conducted. During an interview on February 2, 2010, at 11 a.m., the facility secretary stated they had no documentation of any fire/disaster drills that were conducted.	V 415			
V 416	494.60(d)(4)(iii) PE-CONTACT LOCAL EOC ANNUALLY The facility must- (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on interview and record review, the facility failed to provide documentation that the local disaster management agency was contacted	V 416			

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V 416	Continued From page 15 annually. Findings: A review of the disaster manual revealed there was no documentation that the local disaster management agency was contacted annually. At the same time during an interview, the facility secretary stated they had no documentation that the local disaster management agency was contacted annually.	V 416			
V 454	494.70(a)(3) PR-PRIVACY & CONFIDENTIALITY-TREATMENT The patient has the right to- (3) Privacy and confidentiality in all aspects of treatment; This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility failed to provide privacy for one of 12 sampled patients (Patient 1). Findings: During observation on February 1, 2010, at approximately 9:10 a.m., Patient 1 was observed seating on a chair by station 17. The certified hemodialysis technician (CHT) prepared the patient's tubing and access site to start the treatment. The CHT failed to provide privacy curtain while he started to cleanse and cannulate on the patient's access site which was located on her left upper thigh. During the treatment observation, the patient's access site was not	V 454			

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V 454	Continued From page 16 visible as the patient was fully covered with a blanket from the waist down. At the termination of hemodialysis treatment, the CHT again failed to provide privacy curtain when the patient was being taken off from hemodialysis treatment.	V 454		
V 502	494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co-morbid conditions. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview, and record review, the facility failed to assess the patient's current health status and co-morbid conditions for 2 of 12 sampled patients (Patient 8 and 10) and 1 randomly selected patient (Patient 13) who were observed receiving oxygen therapy. Findings: 1. During a treatment observation on February 1, 2010, at 12 p.m., Patient 10 was receiving oxygen at 2 liters/minute.	V 502		

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V 502	Continued From page 17 A review of the treatment record dated February 1, 2010, revealed no documentation of shortness of breath or that oxygen was administered. A review of the physician's order revealed there was no order for the use of oxygen. 2. During a treatment observation on February 1, 2010, at 2:15 p.m., Patient 8 was receiving oxygen at 1.5 liters per minute by nasal cannula. A review of the treatment record dated February 1, 2010, revealed at 11:40 a.m., oxygen was started at 3 liters by nasal cannula due to patient had difficulty of breathing. A review of the physician's standing dialysis orders revealed oxygen at 3 liters per minute via nasal cannula PRN for shortness of breath, chest pain, and low blood pressure, and to notify the physician within 30 minutes of administering oxygen. There was no documentation that the physician was notified. During an interview on February 2, 2010, at 10:40 a.m., the licensed nurse stated there should be a physician's order for oxygen and followed as ordered. Surveyor: 11683 3. During a treatment observation on February 1, 2010, at approximately 11:30 a.m., Patient 13 was observed receiving oxygen at 2 liters/minute via nasal cannula. A review of the treatment record dated February	V 502			

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V 502	Continued From page 18 1, 2010, documented the patient was on oxygen via nasal cannula. A review of the physician's order dated November 24, 2009, indicated oxygen 3 liters/minute via nasal cannula as needed for shortness of breath, chest pain and low blood pressure and notify physician within 30 minutes of administering oxygen.	V 502		
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, This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview, and record review, the facility staff failed to follow physician's orders for the blood flow rate (BFR) and dialysate flow rate (DFR) for Patients 2, 3, 4, 5 and 6. Findings: 1. On February 2, 2010, at approximately 7:30 a.m., Patient 2 was observed receiving hemodialysis treatment via a right subclavian catheter. The patient was dialyzing on a 2 Potassium (K) and 2.5 Calcium (Ca) bath. The blood flow rate (BFR) was 205 and dialysate flow rate (DFR) was 800. The hemodialysis order dated February 11, 2009, indicated a dialysate flow rate (DFR) of A1.5 and blood flow rate (BFR) of 400. (A 1.5 is auto flow option automatically adjusts the dialysate flow at	V 503		

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V 503	<p>Continued From page 19</p> <p>either 1.5 times the blood flow (QB) or 2.0 times the blood flow (QB) depending on the selection). Review of the daily treatment record dated January 12 through 30, 2010, documented BFR ranged between 198 and 350. The DFR was 500.</p> <p>2. On February 1, 2010, at approximately 12:45 p.m., Patient 3 was observed receiving hemodialysis treatment via an AV graft on the left arm. The patient was dialyzing on a 2 K and 2.5 Ca bath. The BFR was 500 and DFR was 800.</p> <p>The hemodialysis order dated December 26, 2009, indicated a DFR of Auto 1.5 and BFR of 500. Review of the daily treatment record dated January 15 to 22, 2010, documented BFR was between 325 to 483 and DFR was between 500 to 700.</p> <p>3. According to the clinical record, Patient 4 was admitted to the facility on March 23, 2007, with diagnoses that included end stage renal disease and polycystic kidneys.</p> <p>The hemodialysis order dated December 8, 2009, indicated a DFR of A1.5 and BFR of 400. Review of the daily treatment record dated January 21 through 30, 2010, documented BFR between 346 to 350 and DFR of 600.</p> <p>4. According to the clinical record, Patient 5 was admitted to the facility on June 1, 2006, with diagnosis of End Stage Renal Disease and Diabetes Mellitus Type II with renal manifestation.</p> <p>The hemodialysis order dated November 23, 2009, indicated a DFR of A1.5 and BFR of 500.</p>	V 503			

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V 503	Continued From page 20 Review of the daily treatment record dated January 21 through 28, 2010, documented BFR between 445 to 524 and DFR between 500 to 800. 5. On February 2, 2010, at approximately 8 a.m., Patient 6 was observed receiving hemodialysis via a fistula on the left lower arm. The patient was dialyzing on a 2 K and 2.5 Ca bath. The DFR was 600 and BFR was 400. A review of the clinical record revealed a physician's order dated December 3, 2009, for BFR of 500 and DFR of A1.5. Review of the daily treatment record dated December 15, 2009 to January 19, 2010, documented a BFR between 320 to 511 and DFR between 500 to 800. On February 3, 2010, at approximately 10 a.m., in an interview with Employee F, she stated that if the ordered BFR was not achieved, the facility staff should have documented the reason why it was not achieved.	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: 15727 Based on interview and record review, the facility staff failed to assess the blood pressure and fluid management needs for 3 of 12 sampled patients	V 504			

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V 504	<p>Continued From page 21 (Patients 4, 5 and 10).</p> <p>Findings:</p> <p>1. A review of the treatment record dated February 1, 2010 revealed that at the end of treatment, Patient 10's blood pressure was 114/56. There was documentation that 200 ml of normal saline was given. There was no documentation that the blood pressure was rechecked or if more normal saline was administered.</p> <p>A review of the standing orders for hypotension/cramping revealed to give 100-250 cc normal saline bolus as needed and to call the physician if more than 500 cc was needed.</p> <p>During an interview on February 2, 2010, at 10:50 a.m., the licensed nurse stated the blood pressure should be re-checked every 15 minutes after the normal saline was given for low blood pressure. After reviewing the medical record, the licensed nurse stated there was no documentation that this was done by staff.</p> <p>Surveyor: 11683</p> <p>2. A review of the treatment record dated January 21, 2010, at 4:09 p.m., indicated that during treatment Patient 4's blood pressure reading was 237/150. It was documented the patient care technician (PCT) notified the registered nurse (RN) of the patient's high blood pressure reading. At 4:27 p.m., the RN administered 3 tablets of 10 mg Clonidine HCL. A review of the physician's order dated December 8, 2009, indicated Clonidine 0.1 mg orally for</p>	V 504		

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V 504	<p>Continued From page 22</p> <p>systolic blood pressure (SBP) > 180, diastolic blood pressure (DBP) >110, and call the doctor if no relief in 30 minutes.</p> <p>A review of the treatment record dated January 22, 2010, revealed at the end of treatment the patient's BP was 183/119 and was discharged home. Further review of the clinical record failed to show documentation that the RN had assessed the patient prior to discharge.</p> <p>3. A review of the treatment record dated January 23, 2010, revealed that during treatment, Patient 5's blood pressure reading was 106/69. It was documented that 150 cubic centimeters (cc) of normal saline was administered to the patient. The patient's blood pressure was re-checked after 30 minutes.</p> <p>On January 26, 2010, it was documented in the treatment record the patient's blood pressure reading was 126/44. The patient was administered 150 cc of normal saline and the blood pressure was re-checked after 30 minutes.</p> <p>A review of the physician's order dated November 23, 2009, indicated for hypotension administer normal saline 0.95%, 300 cc IVP and 3 Liters of oxygen via nasal cannula and to notify physician if not responding to normal saline and oxygen for further orders.</p> <p>On February 2, 2010, at approximately 10:30 a.m., during an interview with Employee B, while reviewing the clinical record, revealed no documentation that the patient's episodes of low blood pressure with administration of normal saline was comprehensively assessed by the licensed nurse.</p>	V 504			

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V 513	<p>494.80(a)(10) PA-TRANSPLANTATION REFERRAL</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on interview and record review, the facility staff failed to ensure the evaluation of suitability for a transplantation referral, based on the criteria developed by the prospective transplantation center and its surgeons, was documented in the medical record for 1 of 12 sampled patients (Patient 2).</p> <p>Findings:</p> <p>Patient 2 was admitted to the facility on February 17, 2009, with diagnoses that included diabetes mellitus type II with renal manifestation and obstructive sleep apnea.</p> <p>The Life Plan (Long Term Program) dated January 14, 2007, indicated the patient would like to be evaluated for transplant and/or/referred to transplant center.</p> <p>The Comprehensive Interdisciplinary Assessment dated March 12, 2009, indicated the patient was</p>	V 513		

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V 513	Continued From page 24 interested, suitable and referred for transplantation. However, further review of the clinical record failed to show documentation that the patient had been referred for an evaluation for transplantation.	V 513			
V 541	An interview with the Employee G on February 2, 2010, at 11:40 a.m., as well as a review of the entire clinical record, disclosed no documented evidence that an evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation, had been done. 494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, 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 involved the patient as well as the nursing home staff who were responsible for the care and needs of Patients 3 and 5.	V 541			

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V 541	<p>Continued From page 25</p> <p>Findings:</p> <p>1. Patient 3 was admitted to the facility on June 1, 2006, with diagnoses that include end stage renal disease, diabetes mellitus type 2 with renal manifestations and anemia in chronic kidney disease. The patient received hemodialysis three (3) times a week for three (3) hours every treatment. The patient's hemodialysis access was a graft on the left arm. Patient 3 is a resident in a skilled nursing facility.</p> <p>2. Patient 5 was admitted to the facility on June 1, 2006, with diagnoses that included end stage renal disease and diabetes mellitus type type II with renal manifestations. The patient received hemodialysis treatment three (3) times a week for three and half (3.5) hours every treatment. The patient's hemodialysis access was a graft on the left upper arm. Patient 5 is a resident in a skilled nursing facility.</p> <p>On February 1, 2010, at 2 p.m., during an interview with Employee E, while reviewing the clinical records failed to show documentation to indicate that an interdisciplinary care plan was developed and coordinated with the skilled nursing facilities to address the various needs of Patients 3 and 5. Also there was no other written evidence or communication to indicate that the skilled nursing facilities were involved in the care needs of the patients such as his diet, medications, new orders and transportation.</p> <p>A review of the written contract between the dialysis facility and the skilled nursing facility (SNF) stipulated the development and implementation of patient's plan of care would be</p>	V 541			

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: 052846	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/03/2010
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OF INGLEWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 336 EAST HILLCREST AVENUE, SUITE 100 INGLEWOOD, CA 90301		
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V 541	Continued From page 26 done by the SNF in coordination with the dialysis facility. Also it stipulated a communication between the contracting parties to communicate issues and/or concern regarding care of the resident so as to provide continuity of care.	V 541			
V 599	494.100(c)(2) H-RECORDKEEPING SYSTEM (2) The dialysis facility must maintain a recordkeeping system that ensures continuity of care and patient privacy. This includes items and services furnished by durable medical equipment (DME) suppliers referred to in §414.330(a)(2) of this chapter. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the facility failed to ensure that the staff maintained a record keeping system that would ensure continuity of care for the home dialysis Patient 12. Findings: According to the clinical record, Patient 12 was admitted to the facility on June 26, 2006, with diagnosis of end stage renal disease. On November 4, 2009, the patient was started on continuous ambulatory peritoneal dialysis (CAPD). On November 11, 2009, the patient changed to continuous cycler peritoneal dialysis (CCPD). On December 11, 2009, the physician ordered five (5) exchanges per day with 1 hour and fifty (50) minutes dwell time, 2.00 liters of fill volume and 1.50 (2.5/4.25)% of Dextrose in 5.00 liter bag.	V 599			

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V 599	Continued From page 27 Further review of the clinical record revealed there were no home records from November 10 to 30, 2009, December 1 to 31, 2009 and January 1 to 18, 2010. The available home records in the clinical record failed to have documentation of blood pressure and pulse readings. On February 2, 2010, at approximately 8:20 a.m., during an interview with Peritoneal Nurse (PD), while reviewing the the monthly clinic visit notes dated December 11, 2009, revealed there was no documented evidence to indicate that the PD nurse had discussed with the patient regarding the home record not available for review. A review of the facility's policy on Patient Home Record Keeping stipulated the patient must bring Home Treatment log to each monthly clinic visit and would be reviewed by Home Program nursing staff during the patient monthly clinic visits to identify trends and omissions.	V 599			
V 727	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts. (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of	V 727			

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V 727	<p>Continued From page 28 the dialysis program.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to safeguard patient records against loss, destruction or unauthorized use.</p> <p>Findings:</p> <p>During an observation tour of the facility on February 1, 2010, at 8:30 a.m., the medical records room was wide open. The medical records room did not have a sprinkler system. There were medical records in an open rack. The medical records room was situated next to station 20.</p> <p>During an interview on February 3, 2010, at 7:45 a.m., the licensed nurse stated the medical records were placed in the open racks in the medical records room. She further stated if the medical records were destroyed in case of a fire, several sections of the medical record could not be retrieved, like the care plan and multidisciplinary assessments. The sections of the medical records that could be retrieved from the computer would be the treatment records and the physician orders.</p> <p>The facility was not able to provide the survey team with a policy and procedure on how to safeguard patient records against loss, destruction or unauthorized use.</p>	V 727			