

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: 052855	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2010
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NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES RANCHO C	STREET ADDRESS, CITY, STATE, ZIP CODE 10532 ACACIA STREET, SUITE B-2 RANCHO CUCAMONGA, CA 91730
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25868 The following reflects the findings of the California Department of Public Health during a Recertification Survey conducted on 3/26/2010.</p> <p>Representing the California Department of Public Health: Lourdes Singh, RN, HFEN Octavio Relopez, RN, HFEN Patricia Chisholm, RN, HFEN</p> <p>Census: 114 In-Center Hemodialysis Patients 1 Home Hemodialysis Patient</p> <p>Sampled Patients: 10 In-Center Hemodialysis Patients 1 Home Hemodialysis Patient</p> <p>Acronyms and Abbreviations: MD Medical Director OM Operations Manager FA Facility Administrator Group FA Group Facility Administrator CSS Clinical Service Specialist CNM Clinical Nurse Manager RN Registered Nurse PCT Patient Care Provider MSW Masters Social Worker RD Registered Dietitian Pt Patient IJ Immediate Jeopardy tx treatment K+ Potassium Na+ Sodium B/P Blood Pressure</p>	V 000		
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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 000	Continued From page 1 HD Hemodialysis HHD Home Hemodialysis ESRD End Stage Renal Disease Hct Hematocrit Hgb Hemoglobin Rx Prescription Wt Weight DFU Directions for Use PoC Plan of Correction CP Care Plan IDT Inter-Disciplinary Team QAPI Quality Assurance Program Improvement P&P Policy and Procedure AOR Adverse Occurrence Report HTN High blood pressure DM Diabetes Mellitus CDC Centers for Disease Control	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: 25868 Based on observation and interview, the facility failed to provide and monitor a sanitary environment to minimize the transmission of infectious agents by failing to dispose of expired, open, and dirty supplies and by failing to maintain clean supply carts in a clean and sanitary manner. These failures resulted in the potential for the transmission of infectious agents to patients receiving dialysis treatments for a universe of 114 patients. Findings:	V 111		

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V 111	Continued From page 2 During initial tour of the facility's treatment floor, conducted on 3/22/10, between 9:15 AM and 10:30 AM, the following was noted: Multiple suture removal packages were observed to be open and stored in the clean supply carts. Dust and slimy matter observed on all the clean supply carts. A vial containing Lidocaine (anesthetic used on patients prior to cannulation of access sites) observed to be expired. Multiple bottles of DYNA-HEX antiseptic were noted to be open but were not labeled with the opening date. A biohazard bucket was observed next to the clean supply cart #5. About 85 pink Vacutainers with expiration date of 2/2010 were observed in the Kaiser lab supplies drawer at the nurses station. During an interview with the CNM, on 3/22/10, accompanying this surveyor at the time of the observations, confirmed that above findings were true and accurate and stated that the open and expired items would be disposed of immediately.	V 111			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing. This STANDARD is not met as evidenced by:	V 114			

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V 114	Continued From page 3 Surveyor: 25868 Based on observation and interview, the facility failed to ensure that warm water was dispensed from all the sinks in the treatment floor to facilitate hand washing for staff and patients, This failure had the potential to result in the transmission of infectious organisms between staff and patients for an universe of 114 patients. Findings: During initial tour of the facility on 3/22/10, between 9:15 AM and 10:30 AM, the sinks in the treatment floor were noted to dispense only cold water. During an interview with unsampled Patient A, on 3/22/10, at 9:45 AM, in the treatment floor, Patient A stated that the water from the patients' sink was cold all the time. During an interview with the CNM, on 3/22/10, at 9:50 AM, in the treatment floor, the CNM confirmed that the water from all the sinks in the treatment floor was cold to touch. During an interview with the OM, on 3/22/10, at 10:25 AM, in the treatment floor, stated that the facility's water heater was malfunctioning and that repairs would be done as soon as possible.	V 114			
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	V 116			

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V 116	<p>Continued From page 4</p> <p>and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868 Based on observation, interview, and record review, the facility failed to ensure that items taken into the dialysis stations would 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. This failure had the potential to result in the transmission of infectious organisms from patient to patient for an universe of 114 patients.</p> <p>Findings:</p> <p>1. Observation of PCT 3 cleaning patient station 8, on 3/23/10, at 9:00 AM, in the treatment floor, immediately after the previous patient left the station, PCT 3 was observed removing a roll of tape from dialysis station 8's chair table and placed it in her pocket. PCT 3 was further observed removing 2 blue clamps from the previous patient's blood lines at the same station and proceeded to hang them on the hemodialysis machine's IV pole without cleaning.</p> <p>During an interview with PCT 3, on 3/23/10, at 9:01 AM, PCT 3 retrieved the roll of tape out of</p>	V 116			

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V 116	<p>Continued From page 5</p> <p>her pocket and stated that it should had been trashed instead of placed in her pocket. PCT 3 further stated that the blue clamps should have been placed in a bleach bucket for cleaning, but failed to do so.</p> <p>Record review conducted on 3/23/10 of the facility's policy titled " Cleaning and Disinfection" with an effective date of 10/10/08, page 4 of 7, indicated that non-disposable items such as plastic clamps placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment. Also, the same policy indicated that non-disposable items that cannot be cleaned and disinfected (example: adhesive tape) should be dedicated for use only on a single hemodialysis patient or kept in a clean area. Any disposable items taken into the patient station that is not used for that patient must be discarded.</p> <p>2. Observation of patient care on 3/23/10, at 10:28 AM, in the treatment floor, RN 2 was observed removing a roll of tape from the chair table at the dialysis station 16 and observed to place the roll of tape back in the clean supply cart across from station 16.</p> <p>During an interview with RN 2, on 3/23/10, at 10:29 AM, in the treatment floor, RN 2 stated that the roll of tape should had been discarded in the trash can, but instead, he placed it back on the clean supplies cart.</p> <p>Record review conducted on 3/23/10 of the facility's policy titled " Cleaning and Disinfection" with an effective date of 10/10/08, page 4 of 7, indicated that non-disposable items that cannot be cleaned and disinfected (example: adhesive</p>	V 116			

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V 116	Continued From page 6 tape) should be dedicated for use only on a single hemodialysis patient or kept in a clean area. Any disposable items taken into the patient station that is not used for that patient must be discarded.	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: 25868 Based on observation and interview, the facility failed to ensure that clean areas were clearly designated as medication preparation areas at the nursing station. This failure had the potential to result in the contamination and the transmission of infectious agents to all patients in a universe of 114.	V 117			

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V 117	Continued From page 7	V 117		
V 119	<p>Findings:</p> <p>During initial tour of the facility's treatment floor, on 3/22/10, between 9:15 AM and 10:30 AM, RN 2 was observed preparing medications for a patient. There was no evidence of a clear designation at or around the medication preparation area that this was a clean area specifically designated for medication preparation.</p> <p>During an interview with the CNM, on 3/22/10, at 10:25 AM, at the nurses station, the CNM confirmed that the medication preparation was not clearly designated as such.</p> <p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868 Based on observation, interview, and record review, the facility failed to ensure that facility staff did not carry supplies in their pockets to be used on multiple patients. This failure had the potential to result in the transmission of infectious organisms in a universe of 114 patients.</p> <p>Findings:</p>	V 119		

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V 119	Continued From page 8 Observation of PCT 3 cleaning patient station 8, on 3/23/10, at 9:00 AM, in the treatment floor, immediately after the previous patient left the station, PCT 3 was observed removing a roll of tape from the chair table at dialysis station 8 and placed it in her pocket. During an interview with PCT 3, on 3/23/10, at 9:01 AM, on the treatment floor, PCT 3 retrieved the roll of tape out of her pocket and stated that it should had been discarded in the trash can instead of putting it in her pocket. Record review conducted on 3/23/10 of the facility's policy titled " Cleaning and Disinfection" with an effective date of 10/10/08, page 4 of 7, indicated that non-disposable items that cannot be cleaned and disinfected (example: adhesive tape) should be dedicated for use only on a single hemodialysis patient or kept in a clean area. Any disposable items taken into the patient station that is not used for that patient must be discarded.	V 119		
V 124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results.	V 124		

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V 124	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868</p> <p>Based on interview and record review, the facility failed to ensure that all patients were managed appropriately based on their Hepatitis B (Hep B) testing results by failing to administer the Hep B immunization series to non-immune patients in a timely manner for 1 of 11 sampled patients (Patient 3). This failure resulted in the potential to result in the transmission of Hep B infection to the non-immune patients.</p> <p>Findings:</p> <p>Review of sampled Patient 3's medical record conducted on 3/25/10, at 1:00 PM indicated the following:</p> <p>The admission record indicated that sampled Patient 3 was a 50 year old female, admitted to the facility on 12/22/99, with diagnoses that included ESRD.</p> <p>The laboratory results for the month of 12/09 indicated that sampled Patient 3 was Hep B non-immune.</p> <p>There was no documented evidence in sampled Patient 3's medical record that the Hep B immunization series was administered or that the immunization was offered, accepted or declined by the patient.</p> <p>Interview with the CNM on 3/25/10, at 3:00 PM, in the conference room, the CNM confirmed that the Hep B immunization was not administered and/or offered to the patient. The CNM stated that the facility was in the process of implementing a vaccination program for all the patients in the</p>	V 124			

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V 124	Continued From page 10 facility.	V 124			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Surveyor: 23046 Based on observation and interview, the facility failed to ensure that supplies used for water and dialysate cultures were maintained in accordance with the manufacturers recommendation by failing to dispose of expired culture swabs stored in the water treatment storage area. Findings: During a physical environment tour with the machine technician (MT) on 3/22/10, at 8:48 AM, 5 culture swabs with expiration dates of 2/2010 (February 2010) were found stored in the water treatment lab (laboratory) room. The MT confirmed that the culture swabs had expiration dates of 2/2010 and stated that the culture swabs continued to be used to obtain water culture specimen. The MT removed the expired culture swabs from the storage and disposed them.	V 403			
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes	V 408			

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V 408	<p>Continued From page 11</p> <p>and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23046 Based on observation and interview, the facility failed to ensure that the contents of the emergency evacuation supply box were periodically checked for expiration dates and completeness which had the potential to result in the inability of staff to manage and provide necessary care to dialysis patients in the event of a disaster in a universe of 114 patients</p> <p>Findings:</p> <p>During the environmental tour on 3/22/10, at 10:45 AM, the CNM opened the emergency evacuation supply box to be inspected. There was no documentation found inside or outside the emergency supply box indicating that the contents were being checked and monitored periodically for its completeness and for expiration dates.</p> <p>The CNM confirmed that that there was no documentation indicating that staff were checking and monitoring the contents of the emergency supply box for expiration dates and completeness.</p> <p>During an interview with the CNM on 3/22/10, at 10:45 AM, she stated that the emergency</p>	V 408			

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V 408	Continued From page 12	V 408		
V 409	<p>evacuation supply box contents were to be checked and monitored every month for expiration dates and for its completeness.</p> <p>494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS</p> <p>The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following:</p> <p>(i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of-</p> <p>(A) What to do;</p> <p>(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;</p> <p>(C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and</p> <p>(D) How to disconnect themselves from the dialysis machine if an emergency occurs.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868 Based on interview and record review, the facility failed to provide appropriate training and orientation in emergency preparedness to all staff working for the facility. This failure had the potential to result in the implementation of inappropriate procedures if an emergency situation should occur in an universe of 114</p>	V 409		

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V 409	Continued From page 13 patients. Findings: Review of the facility's personnel files conducted on 3/24/10 revealed that about 40% of staff working for the facility did not have current emergency preparedness training. The last documented emergency preparedness training and education was for the year of 2008. Interview with the CNM conducted on 3/24/10, confirmed that about 40% of the staff working for the facility did not have the mandatory emergency preparedness training. The CNM stated all teammates are to have annual training and education for emergency preparedness.	V 409		
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: 25868 Based on observation and interview, the facility failed to ensure that emergency equipment be clean, accessible, and ready to use at all times by failing to have suction tubing immediately available in the crash cart or on the facility's premises and by failing to replace expired and/or open supplies in a timely manner. This failures resulted in the potential for serious harm to a patient should a emergency crisis would arise for an universe of 114 patients.	V 413		

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V 413	Continued From page 14 Findings: 1. During initial tour of the facility's treatment floor, on 3/22/10, between 9:15 AM and 10:30 AM, suction tubing was noted to be missing from the crash cart. The request was made by this surveyor for suction tubing to be replaced in the crash cart immediately, but the facility was not able to find any suction tubing in the facility. During an interview with the CNM and the Chief Technician, accompanying this surveyor at the time of the observation, confirmed that no suction tubing was found in the crash cart and was not available anywhere in the facility at the time. 2. During initial tour of the facility's treatment floor, on 3/22/10, between 9:15 AM and 10:30 AM, while doing observation in the emergency cart, the following was noted: 2 AV fistula needle sets were noted to have an expiration date of 8/2006 and 6/2008 respectively. 1 open package containing a non-sterile pharyngeal suction tip. 1 open package containing an oxygen mask. 2 tri-flo suction catheter with an expiration date of 01/95. During an interview with the CNM and the Chief Technician, accompanying this surveyor at the time of the observation, confirmed that the above findings were true and accurate. The CNM stated that the expired and open supplies should have been replaced as soon as they became open or expired.	V 413			
V 452	494.70(a)(1) PR-RESPECT & DIGNITY	V 452			

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V 452	<p>Continued From page 15</p> <p>The patient has the right to-</p> <p>(1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23046 Based on observation and interview, the facility failed to ensure respect and dignity for 1 of 11 sampled patients (Patient 8) as evidenced by the staff's failure to cover Patient 8's exposed lower body part during dialysis treatment which had the potential to result in decline of emotional state, self-esteem and self-worth.</p> <p>Findings:</p> <p>Observation on 3/24/10, at 9:00 AM, Patient 8 was lying on a treatment chair with eyes closed and having dialysis treatment. Her upper body part including the lower part of the hips were covered with a blanket while her right leg was bent and crossed over her left leg exposing the upper thighs.</p> <p>Patient 8's exposed body part was with in full view as multiple staff passed by including 5 staff who were standing close to Patient 8's chair side. Staff did not attempt to talk to Patient 8 and to cover her exposed body part until the surveyor intervened.</p> <p>During an interview with the CNM who was standing near Patient 8 on 3/24/10, at about 9:05 AM, she confirmed that Patient 8's upper thighs were exposed and no attempt were made by staff</p>	V 452			

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V 452	Continued From page 16 to talk to patient and to cover the exposed body part.	V 452		
V 504	The CNM further stated, "I will talk to the social worker, I know she is a heavy sleeper and moves around when sleeping and could exposed sensitive parts." 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: 23046 Based on observation, interview and record review, facility nursing staff failed to perform pre and post treatment assessments in a consistent manner for 10 of 11 sampled patients (Patients 2 and 11) and failed to provide 30 minutes monitoring for 1 of 11 sampled patients (Patient 10) in a universe of 114 patients. These failures resulted in the potential for delayed identification and treatment of abnormal signs and symptoms including serious health problems related to hemodialysis treatment. Findings: 1. Observation of Patient 9's care on 3/23/10, at 9:35 AM, revealed Patient 9 had experienced signs and symptoms of hypotension after dialysis treatment. PCT 2 who had been attending to Patient 9's care stated that her blood pressure level was low at 80/35 (normal adult BP range at	V 504		

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V 504	<p>Continued From page 17</p> <p>120/80) and had administered intravenous (into the bloodstream) normal saline solution (a type of salt solution). After administering the normal saline solution, further observation revealed PCT 2 stated Patient 9's BP was 90/30, PCT 2 then instructed Patient 9 to remain seated for a few minutes then discharged the patient home.</p> <p>Observation revealed PCT 2 did not notify the RN regarding Patient 9's low blood pressure and a post treatment assessment was not performed prior to Patient 9's discharge home.</p> <p>During an interview with RN 1 on 3/23/10, at about 9:45 AM, she acknowledged that PCT 2 should have notified her and a post treatment assessment should have been performed after Patient 9 experienced signs and symptoms of hypotension and before the patient was sent home.</p> <p>Record review conducted on 3/24/10, revealed documentation that Patient 9 was 55 years of age and had diagnosis that included end stage renal (kidney) disease and diabetes (a person with high blood sugar level). Hemodialysis treatment records dated 3/2/10 to 3/23/10 documented that Patient 9 had been experiencing intradialytic signs and symptoms of hypotension which included complaints of dizziness, cramping and "not feeling well." The treatment record on 3/23/10 further documented Patient 9's blood pressure during and after treatment had been low and 200 ml of saline had been administered. No documentation was found indicating that a post assessment had been performed by the RN prior to discharging Patient 9 to home.</p>	V 504			

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V 504	<p>Continued From page 18</p> <p>Interview with Patient 9 on 3/25/10, at 8:45 AM, she stated that "sometimes" the nurses would examine her before and not after dialysis treatment. Patient 9 further stated that she had experienced frequent dizziness and cramping of her legs during dialysis treatment.</p> <p>During an interview with the CNM on 3/24/10, at 11:20 AM, she reviewed Patient 9's clinical record and failed to find documentation indicating that the RN had performed a post treatment assessment after the patient had experienced signs and symptoms of hypotension and prior to discharging the patient to home.</p> <p>2. Record review on 3/24/10, revealed Patient 6 was 54 years of age and had diagnosis that included end stage kidney disease and hypertension.</p> <p>Dialysis treatment records dated from 3/12/10 to 3/22/10 revealed documentation that Patient 6 had been experiencing adverse intradialytic symptoms of hypotension which included complaints of being nauseated (a feeling of an urge to vomit) and severe leg and abdominal cramps. No documentation was found indicating that post dialysis treatment assessment had been conducted by the RN prior to discharging the patient to home.</p> <p>During an interview with Patient 6 on 3/24/10, at 8:45 AM, she stated that she had experienced severe cramps on her abdomen and legs during and after dialysis treatment because staff "pull too much water" (water or fluid removed from the blood during dialysis).</p> <p>During an interview with the CNM on 3/24/10, at</p>	V 504			

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V 504	<p>Continued From page 19</p> <p>11:20 AM, she reviewed Patient 6's clinical record and failed to find documentation indicating that the RN had performed post assessment after patient had experienced signs and symptoms of hypotension and prior to discharging patient to home.</p> <p>Surveyor: 25868</p> <p>3. Review of the medical records for sampled Patients 2, 3, 4, 5, 7, 8, 10, and 11 conducted between 3/23/10 and 3/26/10, documentation could not be located that indicated that nursing staff performed pre and post treatment assessments in a consistent manner.</p> <p>During an interview with sampled Patient 10, conducted on 3/23/10, at 9:30 AM, in the treatment floor, sampled Patient 10 stated after each dialysis treatment she felt dizzy and tired and that it would take a few hours for her to recover from this. Patient 10 also stated that nursing staff did not always perform a post treatment assessment on her.</p> <p>During an interview with sampled Patient 3, conducted on 3/24/10, at 11:20 AM, in the treatment floor, sampled Patient 3 stated that post treatment assessments were not conducted on her by the nursing staff.</p> <p>During an interview with RN 3, conducted on 3/24/10, at 2:50 PM, in the treatment floor, RN 3 stated that patient assessments were done pre and post treatments for all patients to identify areas of concern. The patient assessment would include the auscultation of the lung sounds and the heart rate and rhythm, the observation of the patient to identify if edema was present and to what degree, and the identification of any areas of concern from the results of the patient</p>	V 504			

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V 504	Continued From page 20 assessment. The findings of the assessment were to be documented in the patient's record. During an interview with the CNM and the Regional Education Coordinator (REC), conducted on 3/24/10, the REC stated the pre and post nursing assessments were conducted if the PCT's would notify the nursing staff that the patient was experiencing an unusual sign/symptom that needed to be addressed by the nurse. 4. Review of sampled Patient 10's medical record, conducted on 3/24/10, indicated that Patient 10 was a 63 year old female, admitted to the facility on 2/12/09, with diagnoses that included ESRD. Review of Patient 10's treatment sheet dated 3/16/10 indicated that the dialysis treatment started at 5:40 AM and ended at 9:45 AM. There was no documented evidence in the treatment sheet that the patient safety checks were performed by the facility staff from 7:13 AM to 9:45 AM. Review of the facility's policy # 132-020-425, titled "Monitoring During Patient's Treatment," dated 2/15/99, indicated that half hourly safety checks were indicated when the patient's vital signs were stable on dialysis. During an interview with the CNM, conducted on 3/25/10, at 8:45 AM, in the conference room, the CNM stated that, "all patient checks are done every 30 minutes."	V 504		
V 506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY	V 506		

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V 506	<p>Continued From page 21</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Immunization history, and medication history.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868 Based on record review and interview, the facility failed to ensure that all patients were tested at least once for a baseline tuberculin skin test (TST), failed to ensure that chest x-rays were used for individuals for whom the TST was not an option, and failed to offer pneumococcal vaccines and have pneumococcal immunization histories for 11 of 11 sampled patients (Patients 1 to 11). This failure had the potential to result in the transmission of infection which could result in the further decline of the compromised health of these patients.</p> <p>Findings:</p> <p>1. The medical records for sampled Patients 1 to 11 were reviewed between 3/23/10 and 3/26/10, no documented evidence could be located in the medical records that any of the patients had been tested for a baseline TST, but instead, used the results of the patient's chest x-rays as an indicator of absence of tuberculosis (TB) in the patients.</p> <p>Interview with the CNM, conducted on 3/25/10, at 9:50 AM, in the conference room, the CNM stated that it was not the facility's practice to perform baseline TST, but instead, the facility obtained a chest x-ray on all patients and used the negative</p>	V 506		

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V 506	Continued From page 22 results as being negative for TB. 2. The medical records for sampled Patients 1 to 11 were reviewed between 3/23/10 and 3/26/10, no documented evidence was located in the patients medical records to show that the facility offered pneumococcal vaccines or that the facility had pneumococcal immunization histories on all patients. Interview with the CNM, conducted on 3/25/10, at 9:50 AM, in the conference room, the CNM stated that it was not the facility's practice to offer pneumococcal vaccines or to track them, but instead the patients were referred to their primary care physician to be vaccinated. The CNM also stated that the facility administration was aware that this practice did not meet the federal regulations, but were working to catch up with the regulations.	V 506			
V 541	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:	V 541			

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V 541	Continued From page 23 Surveyor: 25868 Based on record review and interview, the facility failed to ensure that the patients plan of care consistently included measurable goals/outcomes and estimated timetables and reassessment dates to achieve these goals for 11 of 11 sampled patients (Patients 1 to 11). This failure resulted in the potential to result in the delayed identification and implementation of appropriate interventions to achieve the goals and the possible decline of the already compromised patient's health. Findings: The medical records for sampled Patients 1 to 11 were reviewed between 3/23/10 and 3/26/10, in the conference room. Documentation in the medical record revealed the patients care plans did not consistently include measurable goals/outcomes and estimated timetables and reassessment dates to achieve these goals. During an interview with the SW, conducted on 3/25/10, at 1:35 PM, in her office, the SW stated facility staff were having difficulty understanding the whole care planning process, but the facility staff were working together to develop the patients plans of care. Interview with the CNM, conducted on 3/26/10, at 10:00 AM, in the conference room, the CNM confirmed that the patients' care plans did not consistently include measurable goals/outcomes and reassessment dates.	V 541			
V 542	494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient.	V 542			

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V 542	<p>Continued From page 24</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23046</p> <p>Based on interview and record review, the facility failed to develop a plan of care (POC) for health problems identified by the comprehensive assessment for 2 of 11 sampled patients (Patients 6 and 7).</p> <p>For Patient 6, the facility failed to develop a care plan for abnormally high potassium level which may have resulted in patient's continued abnormally high potassium level (hyperkalemia- an abnormally high concentration of potassium in the blood), and had the potential to result in symptoms which would include heart palpitations, weakness, nausea and vomiting, abdominal pain or even sudden death.</p> <p>For Patient 7, the facility failed to develop a plan of care for chronic (long standing) pain of the left big toe and right shoulder, frequent hospitalization due to respiratory problems and infections, and high risk for fall.</p> <p>Findings:</p> <p>1. Record review conducted on 3/24/10, Patient 6's clinical record noted that the patient was 54 years of age and had diagnosis that included end stage kidney disease and hypertension.</p> <p>Review of Patient 6's lab reports noted that the patient's potassium levels had been abnormally high (hyperkalemia - an abnormally high concentration of potassium in the blood) and increasingly going up from 5.2 on 2/8/10 to 6.4 (normal K level range from 3.5 - 5.0) on 3/8/10.</p> <p>Dialysis treatment records dated 3/12/10 to</p>	V 542			

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V 542	<p>Continued From page 25</p> <p>3/22/10 documented that Patient 6's had been experiencing adverse intradialytic symptoms of hypotension which included complaints of being nauseated (a feeling of an urge to vomit), weakness and severe abdominal cramps.</p> <p>Review of Patient 6's plan of care dated 9/14/09, no documentation was found indicating that the IDT had addressed patient's abnormally high and increasing potassium level of 5.2 on 2/8/10 to 6.4 on 3/8/10, and developed a plan of care.</p> <p>Interview with the CNM on 3/24/10, at 11:20 AM, she reviewed Patient 6's clinical record and confirmed that the interdisciplinary team (IDT) had failed to address patient's abnormally high and increasing potassium level of 5.2 on 2/8/10 to 6.4 on 3/8/10, and failed to develop a plan of care.</p> <p>2. During record review on 3/26/10, Patient 7's clinical records indicated that she was 85 years of age and had diagnosis that included end stage renal (kidney) disease, hypertension (high blood pressure), congestive heart failure (a medical condition in which the heart cannot pump enough blood to the organs) and diabetes mellitus (a condition characterized by high blood sugar level).</p> <p>Review of the comprehensive IDT assessment dated March 2010 noted that Patient 7 had been having chronic pain of the right shoulder and the left foot due to arthritis and gangrenous ulcer on left big toe. Patient 7 had been using a wheelchair to move around and her fall risk score was at level 4 indicating high risk for fall.</p> <p>The comprehensive IDT assessment further</p>	V 542			

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V 542	Continued From page 26 documented that Patient 7 had been hospitalized twice in the past 3 months, on 1/30/10 and on 2/4/10 due to pleural effusion (a medical condition in which fluid seeps/flows into the lung wall). Patient 7's respiratory status was documented that her lungs had decreased breath sounds (an indication of an obstructive lung disease) and had a + 1 pitting edema (a mild swelling from accumulation of watery fluid) in lower extremities. Review of the Physician's progress notes dated 2/18/10 documented that Patient 7's had recently been hospitalized twice and were due to congestive heart failure and pneumonia (inflammation of the lung tissue). Review of the POC dated March 2009 and 2010, no documentation was found indicating that a plan of care had been developed to address Patient 7's chronic pain problem, high risk for fall to prevent potential injuries and potential recurrence and further decline of respiratory problem. Interview with the CNM on 3/26/10, at 9:50 AM, she reviewed Patient 7's clinical record and confirmed that a plan of care had not been developed to address the problems identified by the comprehensive assessment which included chronic pain, high risk for fall and potential further decline of respiratory status.	V 542			
V 545	494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional	V 545			

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V 545	<p>Continued From page 27</p> <p>evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 23046 Based on interview and record review, the facility failed to provide the necessary care to achieve the appropriate potassium level for 1 of 11 sampled patients (Patient 6) by failing to implement a physician's dialysis treatment order to change the potassium (K+) bath (a solution concentrate containing potassium) which may have resulted in patient's continued abnormally high potassium level (an abnormally high concentration of potassium in the blood), and had the potential to result in symptoms which would include heart palpitations, weakness, nausea and vomiting, abdominal pain or even sudden death.</p> <p>Findings:</p> <p>Record review conducted on 3/24/10, Patient 6's clinical record noted that the patient was 54 years of age and had diagnosis that included end stage kidney disease and hypertension.</p> <p>Review of the physician's order sheet dated 3/12/10, at 7:50 AM, noted that the physician had written an order which included to "Change bath to 1K , rest of treatment today."</p> <p>The dialysis treatment records dated 3/12/10 documented that Patient 6 had started dialysis treatment at 6 AM and ended at 9:35 AM for a total of 3 1/2 hours. The treatment record further indicated that the K bath used for the entire duration of treatment was at a higher</p>	V 545			

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V 545	Continued From page 28 concentration of 3K and had not been changed to a lower concentration of 1K as ordered by the physician. Review of Patient 6's lab reports noted that patient's potassium levels had been abnormally going up from 5.2 on 2/8/10 to 6.4 (normal K level range from 3.5 - 5.0) on 3/8/10. The treatment records further documented that Patient 6 had been experiencing adverse intradialytic symptoms which included weakness, abdominal cramps and complaints of being nauseated (a feeling of an urge to vomit). Interview with the CNM on 3/24/10, at 11:20 AM, she reviewed Patient 6's clinical record and confirmed that the physician's order to change the bath to 1K on 3/12/10 had not been implemented by staff. She further acknowledged that the RN should have followed up the physician's order and implemented the order in a timely manner.	V 545			
V 559	494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must- (i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section. This STANDARD is not met as evidenced by:	V 559			

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V 559	<p>Continued From page 29</p> <p>Surveyor: 23046</p> <p>Based on observation, interview and record review, the facility failed to ensure that blood pressure and fluid management needs of 2 of 11 sampled patients (Patients 6 and 9) were evaluated, reassessed and the plan of care adjusted when patients experienced signs and symptoms of hypotension (low blood pressure) during hemodialysis (removal of waste from the blood) treatment which had the potential to result in delayed identification and treatment of abnormal signs and symptoms including low blood pressure (BP), irregular heart rate, dizziness, etc., related to hemodialysis treatment.</p> <p>Findings:</p> <p>1. Observation of patient care on 3/23/10, at 9:35 AM in the treatment floor, Patient 9 had experienced signs and symptoms of hypotension after dialysis treatment. PCT 2 who had been attending to Patient 9's care stated that her blood pressure level was low at 80/35 (normal adult BP range at 120/80) and had administered intravenous (given into the bloodstream) normal saline solution.</p> <p>During record review on 3/24/10, Patient 9's clinical record noted that patient was 55 years of age and had diagnosis that included end stage renal (kidney) disease and diabetes (a person with high blood sugar level). The hemodialysis treatment record dated from 3/2 to 3/23/10 documented that Patient 9 had been experiencing intradialytic signs and symptoms of hypotension which included complaints of dizziness, cramping and "not feeling well."</p> <p>During review of the plan of care for blood</p>	V 559			

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V 559	<p>Continued From page 30</p> <p>pressure and fluid management dated 11/30/09, documentation indicated that the care plan goal and expected dry weight (EDW) had not been met due to cramping. No further documentation was found indicating that the interdisciplinary team (IDT) had reassessed and revised the plan of care.</p> <p>During an interview with Patient 9 on 3/25/10, at 8:45 AM, she stated that she had experienced frequent dizziness and cramping of her legs during dialysis treatment.</p> <p>During an interview with the CNM on 3/24/10, at 11:20 AM, she reviewed Patient 9's clinical record and confirmed that the plan of care for blood pressure and fluid management had not been reassessed and revised when the goal had not been met. She further acknowledged that the IDT should have reassessed and revised the plan of care.</p> <p>2. During record review on 3/24/10, Patient 6's clinical record noted that patient was 54 years of age and had diagnosis that included end stage kidney disease and hypertension.</p> <p>The dialysis treatment records dated from 3/12 to 3/22/10 documented that Patient 6's pre-dialysis BP level were at high range from 173/90 to 201/70, had facial edema (swelling) and intradialytic and post dialysis BP were at low range from 79/36 to 87/46. Patient 6's post dialysis weight goal or EDW had not been being met.</p> <p>The treatment records further documented that Patient 6's had been experiencing adverse intradialytic symptoms of hypotension which</p>	V 559			

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V 559	<p>Continued From page 31</p> <p>included complaints of being nauseated (a feeling of an urge to vomit) and severe leg and abdominal cramps.</p> <p>During review of the plan of care for blood pressure and fluid management dated 9/14/09, documentation indicated that the care plan goal and EDW had not been met due to cramping. No documentation was found indicating that the IDT had reassessed and revised the plan of care.</p> <p>During an interview with Patient 6 on 3/24/10, at 8:45 AM, she stated that she had been experiencing severe cramps on her abdomen and legs during and after dialysis treatment because staff "pull too much water" (water or fluid removed from the blood during dialysis).</p> <p>During an interview with the CNM on 3/24/10, at 11:20 AM, she reviewed Patient 6's clinical record and confirmed that the plan of care for blood pressure and fluid management had not been reassessed and revised when the goal had not been met. She further acknowledged that the IDT should have reassessed and revised the plan of care.</p>	V 559			