

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: 052861	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
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NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES SOUTH ORANGE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 EAST FIRST STREET, SUITE 110 SANTA ANA, CA 92705
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 22781 The following represents the findings of the California Department of Public Health during a RECERTIFICATION SURVEY.</p> <p>The facility census at the time of the survey was 152 in-center hemodialysis patients. The patient sample consisted of 15 hemodialysis patients.</p> <p>The Clinical Manager was the facility coordinator for this survey.</p> <p>Representing the Department of Public Health: Raul Reyes, HFEN; Phyllis Weaver, HFEN.</p> <p>GLOSSARY:</p> <p>BFR - Blood Flow Rate BP - Blood Pressure DFR - Dialysis Flow Rate EDW - Estimated Dry Weight ESRD - End Stage Renal Disease HD - Hemodialysis Hypotension - Low blood pressure Hypovolemia - Low blood volume Kg - Kilogram (1 Kg equals 2.2 pounds) Mg - Milligrams mL - Milliliters NS - Normal Saline Mortality - Death P&P - Policy and Procedure PCT - Patient Care Technician PPE - Personal Protective Equipment QAPI - Quality Assurance and Performance Improvement RN - Registered Nurse UF - Ultrafiltration Rate (fluid removal rate)</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 116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on observation and record review, a nondisposable item (paper tape) that could not be cleaned or disinfected was taken to a patient's dialysis station, used on the patient, and returned to the clean supply cart after use. This resulted in the potential spread of blood borne infection.</p> <p>Findings:</p> <p>On 2/11/10 at 1330 hours, review of the facility policy FMS-CS-1C-11-155-070A for Dialysis Precautions, issued 10/10/08, showed that items taken into the dialysis station should be disposed of, dedicated for use only on a single patient, or cleaned and disinfected as appropriate before they were taken to a common area or used on another patient.</p>	V 116		4/30/09

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V 116	Continued From page 2	V 116		
V 122	<p>During observation of the treatment area on 2/11/10 at 1250 hours, Employee 8 was observed completing a patient's treatment. Employee 8 was observed removing the clamps placed over the patient's access site to promote clotting of the needle site. One of the needle sites started to bleed during removal of the clamps. After cleaning the blood from the patient's arm Employee 8, still wearing the same gloves, picked up a roll of paper tape that had been sitting on the patient's chairside table. The employee tore off strips of the paper tape to be used later. Employee 8, still wearing the same gloves, returned the roll of tape back to the common supply cart containing clean supplies.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on observation, interview and record review, the facility failed to ensure four dialysis machines and all items in the dialysis station were being disinfected by three employees (Employees 12, 16 and 17) between patient treatments per facility policy. This created the potential for the spread of blood borne infection.</p>	V 122		4/30/10

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V 122	<p>Continued From page 3</p> <p>Findings:</p> <p>1. On 2/11/10 at 1330 hours, review of the facility policy FMS-CS-1C-11-155-090A for Hand Hygiene, effective 10/10/08, showed that hand sanitizer dispensers were to be mounted on the side of the dialysis machine with the blood pressure cuff mounting. The dispenser and the bracket were to be cleaned between patients with a 1:100 parts bleach solution.</p> <p>The facility policy FMS-CS-1C-11-155-110A for Cleaning and Disinfection, effective 10/10/08, showed the dialysis station (chairs bed, table, machine, IV pole, TVs, TV remote control, hand sanitizer dispenser and holder, etc.) should be cleaned after each patient treatment, and before the next patient, with a 1:100 bleach solution. Also, non-disposable items such as blood pressure cuffs, IV poles, TVs, TV remotes, portable phones, etc., as well as clip boards or plastic hemostat clamps placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment.</p> <p>On 2/10/10 at 0710 hours, an interview was done with Employee 12. The employee stated that after a patient treatment, the machine was to be disinfected from the top to the bottom, including the hand sanitizer container, the prime bucket, the IV pole and any clamps on the IV poles should be removed and placed in a bleach solution to soak. The chairside computer was also to be disinfected. The employee was asked if the acid containers that were used for the patients also needed to be wiped down when the machine was being disinfected. The employee stated they only needed to be cleaned if there</p>	V 122			

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V 122	<p>Continued From page 4</p> <p>was visible blood on the container.</p> <p>2. On 2/11/10 at 0745 hours, the dialysis machine at Station 5 was observed being disinfected by Employee 12 after completion of a patient treatment. Sitting on top of the machine was a white plastic rack used to hold laboratory tubes. The employee picked up the rack and wiped the top of the machine and replaced the rack without disinfecting it. The hand sanitizer container and bracket on the side of the machine was not disinfected. The prime bucket and the IV pole were not disinfected. The acid container sitting on the front ledge of the machine, still attached to the machine, was moved and the ledge where the container was sitting was disinfected. The acid container was then moved back into place, but was not disinfected. The employee then started placing clean lines and a dialyzer on the machine for the next patient.</p> <p>3. At 0800 hours on 2/11/10, the dialysis machine at Station 9 was observed being disinfected by Employee 12 after a patient treatment. The IV pole, the clamps hanging from the IV pole, and the hand sanitizer container were not disinfected.</p> <p>4. At 0817 hours on 2/11/10, the disinfection of the machine by Employee 16 at Station 1 was observed. The white plastic lab tube rack sitting on top of the machine was picked up and the top of the machine was disinfected, but the rack was replaced on top of the machine without being disinfected. The hand sanitizer container and the IV pole were not disinfected. The acid container on the front machine ledge was moved to the side, and the machine ledge was disinfected. The acid container, which was still attached to the machine, was then moved back to its original</p>	V 122			

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V 122	Continued From page 5 place on the ledge. The acid container was not disinfected. The machine was then prepared for the next patient.	V 122			
V 132	5. On 2/11/10 at 0822 hours, observation of the disinfection of Station 15 by Employee 17 was done. The IV pole on the machine and the clamps on the pole were not disinfected, nor were the clamps removed and replaced with clean clamps . The acid container on the machine ledge was moved so the machine ledge could be disinfected and then the same container was put back on the ledge of the machine without being disinfected. 494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is not met as evidenced by: Surveyor: 21262 Based on observation,record review and staff interview, the facility failed to educate all staff members at risk for exposure to blood about infection control practices appropriate to their responsibilities. In addition, the facility failed to train staff members on proper handling and preparation of parenteral medications. This resulted in a potential for contamination of medications and the clean treatment area. Findings:	V 132	4/30/10		

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V 132	<p>Continued From page 6</p> <p>1. At the entrance of the hallway leading to the staff lounge, administrative offices and restrooms, a sign that stated, "NO PPE Beyond This Point" was observed.</p> <p>On 2/10/10 at 1230 hours, the facility's housekeeper was observed cleaning the staff restrooms wearing personal protective equipment (PPE) beyond the point where PPE was allowed. The housekeeper was then observed leaving the restrooms and going into the treatment area to collect more trash wearing the same PPE.</p> <p>On 2/10/10 at 1240 hours, the Education Coordinator was asked if the infection control training included the housekeepers. She stated that housekeepers were not included in the facility's infection control training because they were contracted employees. The Education Coordinator assumed these contracted employees were trained in infection control before being able to work in the dialysis facility.</p> <p>On 2/10/10 at 1245 hours, a PCT was asked to interpret for the surveyor with the housekeeper. When the housekeeper was asked whether she attended an infection control training class, she stated that the company who hired her did not think it was necessary because her responsibilities were just to clean the restrooms and pick up the trash.</p> <p>2. On 2/9/10 at 1010 hours, during the initial tour of the facility conducted with Employee 6, the locked medicine cupboards were inspected. A prepared syringe of Zemplar (Vitamin D medication for long-term dialysis patients) had a label indicating the name of the patient but without the initial of the staff who prepared the</p>	V 132			

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V 132	Continued From page 7 medication. The dose had only the number 2 written on it. There was no indication whether the dose was measured in milligrams or in milliliters and whether it was to be given intramuscularly versus intravenously. Employee 6 acknowledged the incomplete medication label by disposing of the syringe. The employee was unable to determine the dose, the route and who prepared the syringe. She added that the last name written on the label could belong to one of the doctors instead of the patient. On 2/10/10 at 1100 hours, per review of the facility's medication policy (138-020-130) on Preparation and Administration of Medications, dated 1/12/05, Item 6 showed that, "Medications other than Epogen/Zemplar may be pre-drawn up to one hour prior to administration and stored for later use. The medication must be labeled with the following: patient name, medication, dosage, route of administration, date, time and preparer's initials."	V 132			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Surveyor: 21262 Based on observation, record review and staff	V 143		4/30/10	

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V 143	Continued From page 8 interview, the facility failed to dispose of an expired bag of intravenous solution and follow their P&P for expired intravenous medications and opened multidose vials, ensuring that potentially ineffective and/or contaminated solutions biologicals were not available for use. Findings: 1. On 2/9/10 at 1010 hours, during the initial tour of the facility conducted with Employee 6, the locked medication cupboards were inspected. In an emergency kit, contained in a red box, a bag of 150 ml NS was found with an expiration date of October 2009. 2. The locked medication refrigerator contained a multidose vial of seasonal flu vaccine which was dated as opened on 10/26/09 at 1600 hours. The rubber cap of the vial appeared old and dirty with brown spots. When Employee 6 was queried regarding the length of time the multi-dose vial was opened, she stated that the manufacturer's label suggested that the facility may keep the opened multidose vial until its expiration date. The facility's medication policy (138-020-130), dated 1/12/05, stated that, "Multi-dose vials of medications with preservative may be kept and used for 30 days once the vial has been entered. The vial should be dated on the first date of use and discarded 30 days from this initial date."	V 143			
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety,	V 407		4/30/10	

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V 407	<p>Continued From page 9 (video surveillance will not meet this requirement).</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure the safety of three non-sampled patients (Patients I, J and K) during treatment by not reminding the patients their vascular access sites, bloodline connections and face were to be visible during the dialysis treatment. This created the potential for a rapid blood loss if the access site and tubing became disconnected.</p> <p>Findings:</p> <p>The facility policy for Monitoring During Patient's Treatment #132-020-425 dated 2/15/99, reviewed on 2/11/10 at 1330 hours, showed that to facilitate monitoring, the patient should be instructed to leave their access site uncovered so they are readily visible. On Page 3, under Safety Checks, it showed in Step 1, to assure that all patient connections were secure and visible. At the bottom of Page 3 it showed: the patient's access, needle/catheter insertion sites, and bloodline connections must be visible at all times.</p> <p>During observation of the treatment floor on 2/10/10 at 0650 hours, Patients I, J and K were observed with their dialysis access sites covered. Patient I was completely covered with a blanket so both their head and access site were not visible.</p> <p>At 0700 hours on 2/10/10, an interview was conducted with Employee 5. When asked about</p>	V 407			

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V 407	Continued From page 10 patients covering their access site, the employee stated the staff needed to remind the patients not to cover their access sites, and it should be documented in the computer on the patient treatment sheet when they were reminded. On 2/10/10 at 0705 hours, an interview was conducted with Employee 11. When asked about Patient I having their access site and head covered with a blanket, the employee stated that Patient I was a special patient, and did not follow the rules. Review of the clinical record and treatment sheets for Patient I showed no documentation the patient had been reminded regarding not covering of their vascular access site, nor any documentation the patient had been uncooperative. There was no documentation to show if this had been discussed during IDT meetings or with the physician. On 2/10/10 at 0813 hours, an interview was done with Employee 3 regarding Patient I's compliance with the facility policies. Employee 3 stated the patient's non-compliance was never reported to them and that was why they had not documented anything about the issue in the patient's clinical record. On 2/10/10 at 1300 hours, an interview was conducted with Employee 1. The employee stated the informed consents for treatment signed by the patients contained information about the access sites being visible during treatment. There was no other documentation in the clinical record to show Patient I had been counseled about covering their access site and head during treatment.	V 407			
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES	V 408		4/30/10	

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V 408	<p>Continued From page 11</p> <p>The dialysis facility must implement processes 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: 21262</p> <p>Based on observation, staff interview and record review, two clinical staff members interviewed were unable to determine the location of the main water shut-off valve. In addition, one of nine fire extinguishers was missing. This was in the water treatment area. This created a potential for delayed response to fire and/or disaster emergencies.</p> <p>Findings:</p> <p>On 2/11/10 at 1200 hours, personnel file review revealed that all staff members went through an annual emergency preparedness skills test.</p> <p>1. On 2/11/10 at 1300 hours, a male PCT was asked where would he turn off the main water supply during a natural disaster such as an earthquake. The PCT went to the water treatment room but after going through the water treatment area admitted he did not know which control to operate.</p> <p>The PCT referred the surveyor to Employee 6.</p>	V 408			

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V 408	Continued From page 12 Employee 6 went around the treatment room to the water treatment room and around the building but was unable to determine the location of the main water shut-off valve.	V 408			
V 501	2. On 2/11/10 at 1330 hours, review of the facility's emergency plan and diagram stated that there were 9 fire extinguishers throughout the facility. When the fire extinguishers were counted with Employee 6, there were 9 fire extinguisher signs but only 8 actual fire extinguishers. One was missing in the water treatment area. 494.80 PA-IDT MEMBERS/RESPONSIBILITIES The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. This STANDARD is not met as evidenced by: Surveyor: 22781 Based on observation, record review and staff interview, the facility failed to ensure the non-compliance for one non-sampled patient (Patient I) was addressed during the IDT (interdisciplinary team) meetings in order to develop a plan of care to address the visualization of the patient's face and access site during treatment. This resulted in a potential for Patient I	V 501		4/30/10	

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V 501	<p>Continued From page 13</p> <p>to experience excessive bleeding if the access site and bloodline tubing became disconnected and staff were not immediately aware of the disconnection..</p> <p>Findings:</p> <p>The facility policy for Monitoring During Patient's Treatment #132-020-425 dated 2/15/99, reviewed on 2/11/10 at 1330 hours, showed that to facilitate monitoring, the patient should be instructed to leave their access site uncovered so it is readily visible. On Page 3, under Safety Checks, it showed in Step 1 to assure that all patient connections were secure and visible. At the bottom of Page 3, it showed: the patient's access, needle/catheter insertion sites, and bloodline connections must be visible at all times.</p> <p>During observation of the treatment floor on 2/10/10 at 0650 hours, Patient I was observed completely covered with a blanket so both their head and access site were not visible.</p> <p>At 0700 hours on 2/10/10, an interview was conducted with Employee 5. When asked about patients covering their access site, the employee stated the staff needed to remind the patients not to cover their access sites and it should be documented in the computer on the patients' treatment sheets when they were reminded.</p> <p>On 2/10/10 at 0705 hours, an interview was conducted with Employee 11. When asked about Patient I having their access site and head covered with a blanket, the employee stated the patient was a special patient, and did not follow the rules. Review of the clinical record and treatment sheets for Patient I showed no</p>	V 501			

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V 501	Continued From page 14 documentation the patient had been reminded regarding not covering their vascular access site, nor any documentation the patient had been uncooperative with the facility policies. There was no documentation to show if the patient's behavior had been discussed during IDT meetings or with the physician. On 2/10/10 at 0813 hours, an interview was done with Employee 3 regarding the non-compliance of Patient I with the facility policies. Employee 3 stated the patient's non-compliance had not been reported to them and that was why there was no documentation in the patient's clinical record regarding their lack of cooperation with the facility policies. They also stated the nurses had been told they needed to address the patients about non-compliance with keeping their access sites visible. On 2/10/10 at 1130 hours this information was reviewed with Employees 1 and 10.	V 501			
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: 22781 Based on clinical record review and staff interview, the facility failed to evaluate the current dialysis prescriptions for nine of 15 sampled	V 503		4/30/10	

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V 503	<p>Continued From page 15</p> <p>patients (Patients 1, 2, 4, 5, 7, 8, 10, 11, and 12) to ensure the patients' dialysis needs were being met. This resulted in the potential for ineffective blood clearance for Patients 1, 2 and 10, potential vascular access clotting for Patient 7, low blood pressure for Patients 2, 4, 5, 7, 8, 11 and 12, and potential impaired fluid balance for Patients 8 and 12.</p> <p>Findings:</p> <p>1. Review of the clinical record for Patient 2 was initiated on 2/10/10.</p> <p>Patient 2's treatment sheet dated 1/25/10, showed the patient had a scheduled dialysis time of three hours and 30 minutes. In the treatment record notes area, the RN had documented the patient's physician had ordered the treatment time to be increased by 15 minutes the prior week as the patient's treatment adequacy was not meeting the minimum standard of 1.2. The patient's measured adequacy on 1/29/10, was at 1.08. The patient stated he would think about it. The nurse also documented that today (1/25/10), the patient stated he was willing to increase the treatment time, and the nurse added they would inform the physician and the Charge RN.</p> <p>Review of Patient 2's clinical record and treatment sheets from 1/29/10 until 2/8/10, showed the patient's scheduled treatment time was still three hours and 30 minutes. There was no physician's order to increase the patient's time to three hours and 45 minutes or documentation to show the nurse had contacted the physician or the charge nurse regarding increasing the patient's treatment time.</p>	V 503			

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V 503	<p>Continued From page 16</p> <p>The Comprehensive Interdisciplinary Assessment dated 2/1/10, showed in the physician assessment area the patient's adequacy level remained low (below 1.2) even after increasing the patient's time to three hours and 45 minutes.</p> <p>During review of the patient's clinical record with Employees 1 and 10, a physician's order to increase Patient 2's scheduled time to three hours and 45 minutes could not be located.</p> <p>The IDT failed to ensure Patient 2's treatment time was increased as suggested by the physician, that a physician's order was in place for the increased time, and the physician and Charge Nurse were informed of the patient's agreement for the increased time. Cross reference V715.</p> <p>2. Review of the clinical record for Patient 7 was initiated on 2/10/10.</p> <p>2a. Patient 7's first dialysis treatment at the facility was on 1/14/10. The initial orders for Patient 7 showed for the first treatment the patient was to receive no heparin for the first treatment. Beginning with the next treatment, the patient was to receive a 2000 unit heparin bolus before each dialysis treatment.</p> <p>Review of Patient 7's treatment sheet dated 2/9/10, showed the patient's heparin regimen was "free" (patient was not receiving any heparin). The physician's order dated 1/14/10, for 2000 units of heparin bolus before every dialysis treatment had not been initiated.</p> <p>Review of Patient 7's clinical record showed no documentation of an assessment by the IDT as to</p>	V 503			

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V 503	<p>Continued From page 17</p> <p>why the order for the 2000 units of heparin before treatment had not been initiated or why the patient was not receiving any heparin. Also, there was no physician's order in the clinical record for "free" heparin.</p> <p>2b. The treatment sheet dated 2/9/10, showed Patient 7 had an EDW of 93.0 Kg. The patient's pre-treatment weight on 2/9/10, was 95.0 Kg. The patient was only 2.0 Kg above their EDW, but the fluid removal goal set for this treatment was 4.0 Kg. The patient's BP had decreased from 122/68 at 1352 hours, to 89/55 at 1433 hours. The comments showed the patient was alert, their BP was low, and the patient was given 200 mL of NS. The fluid removal goal was then decreased from 4.0 Kg. to 3.5 Kg. The intervention for the low BP was done at 1433 hours. However, no further BPs were recorded. The patient's treatment was completed at 1515 hours, and no BP was documented at this time.</p> <p>No documentation was found during review of Patient 7's clinical record that the patient's treatment sheets had been reviewed by the IDT to evaluate the treatment deviations from the physician ordered prescription. Cross reference V715.</p> <p>3. Review of Patient 12's treatment sheets and clinical record was initiated on 2/10/10.</p> <p>3a. A physician's order dated 11/24/09, increased Patient 12's EDW to 75.5 Kg from 74.0 Kg. A Physicians Progress Note dated 12/22/09, showed to continue to challenge the patient's EDW.</p> <p>Review of the 17 treatment sheets for Patient 12</p>	V 503			

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V 503	<p>Continued From page 18</p> <p>from 1/2/10 to 2/9/10, showed the patient never achieved the ordered EDW of 75.5 Kg. The lowest post-dialysis weight achieved in this timeframe was 75.8 Kg. on 1/30/09. The patient's other post-dialysis weights in this timeframe ranged from 76.2 Kg. to 78.0 Kg.</p> <p>On 2/9/10, Patient 12's pre-dialysis weight was 79.2 Kg, and the patient had 3.7 Kg of available fluid to be removed. The treatment record showed that 2.2 Kg of fluid were removed, leaving the patient 1.5 Kg over their dry weight. Of the 17 treatment sheets reviewed, the available fluid for removal goal was not met for 16 treatments.</p> <p>3b. Further review of the treatment sheets for Patient 12 showed:</p> <ul style="list-style-type: none"> * On 1/3/10 at 1230 hours, the UF was turned off and the patient was complaining of cramping. The fluid goal was reduced to 2.5 Kg. * On 1/7/10 at 1110 hours, the patient's BP was 121/57, and trended downward. At 1201 hours, the BP had decreased to 106/50, and the treatment sheet showed the fluid goal was reduced to 2.8 Kg. because of low BP. * On 1/12/10, Patient 12's BP decreased from 111/48 at 1101 hours to 95/52 at 1222 hours, and the UF was turned off. The patient was given 200 mL of NS as the patient was complaining of cramping. The UF was left off until the completion of the treatment at 1241 hours. * On 1/16//10, Patient 12's BP decreased from 135/66 at 1136 hours to 117/61 at 1205 hours. The comments showed the patient denied complaints, patient OK, UF turned off and the patient complained of cramping. * On 1/19/10, the patient's BP decreased from 115/62 at 1208 hours to 101/52 at 1230 hours. The UF was turned off and the patient was 	V 503			

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V 503	<p>Continued From page 19</p> <p>complaining of cramping in their leg.</p> <p>* On 1/23/10, at termination of treatment, it was documented the patient was given an extra 100 mL of NS because of cramping.</p> <p>There was no documentation to show the patient's fluid retention, BP decreases and cramping had been assessed by the IDT to determine if the patient's treatment prescription was appropriate. Cross reference V715.</p> <p>4. Review of the treatment sheets for Patient 1 was initiated on 2/10/10. The treatment sheets showed the patient had an ordered blood flow rate (BFR) of 350. The following BFR deviations were noted:</p> <p>* On 1/12/10, the average BFR achieved for the treatment was 240.</p> <p>* On 1/14/10, the average BFR for the treatment was 300.</p> <p>* On 1/12/10, the average BFR for the treatment was 240.</p> <p>* On 2/2/10, the ordered BFR had been increased to 400.</p> <p>* On 2/4/10, the average BFR achieved for the treatment was 300.</p> <p>There was no documentation on the treatment records to show why the BFRs did not meet the physician ordered rate, or documentation to show if the BFR deviations had been identified and assessed by the IDT.</p> <p>5. Review of the treatment sheets for Patient 11 was initiated on 2/10/10.</p> <p>5a. The treatment sheet dated 1/20/10, showed the patient had an EDW of 97.0 Kg. The patient's pre-treatment weight was 98.80 Kg. The fluid</p>	V 503			

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V 503	<p>Continued From page 20</p> <p>removal goal for the treatment was 2.4 Kg. The patient's starting BP was 133/68, and decreased during treatment to a BP of 80/37. The treatment sheet showed the amount of fluid removed from the patient during treatment was 2.665 Kg, (0.265 Kg above the patient's fluid removal goal). The patient's post weight was 0.10 Kg. below their dry weight.</p> <p>5b. Patient 11's treatment sheet dated 1/25/10, showed the patient's EDW had been increased to 97.5 Kg. The patient's pre-treatment weight was 99.0 Kg, and a target fluid removal for the patient had been figured at 2.0 Kg. The treatment was initiated at 0509 hours, and the patient had a BP of 158/72. During treatment the patient's BP trended downward, and at 0735 hours, the BP was 86/48. The total fluid removed from the patient was 2.429 Kg, (0.429 Kg over the patient's fluid goal). The patient's post-treatment weight was 0.70 Kg. below their dry weight.</p> <p>There was no documentation to show an IDT evaluation of the treatments were done to address why the fluid removed from the patient was greater than the goals set, or the decreased BPs continued with the increased EDW. Cross reference V715.</p> <p>6. The treatment sheet review for Patient 10 was initiated on 2/11/10.</p> <p>6a. The treatment sheet dated 2/2/10, showed Patient 10 had an ordered BFR of 400, and for the treatment, the patient had an average BFR of 350 with no documentation to show why the BFR had been decreased.</p> <p>6b. Review of Patient 10's treatment sheets</p>	V 503			

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V 503	<p>Continued From page 21</p> <p>dated 1/26 to 1/9/10, showed the patient had an ordered BFR of 350. The following was found:</p> <ul style="list-style-type: none"> * On 1/26/10, showed an average BFR of 300 for the treatment. * On 1/23/10, showed an average BFR of 260 for the treatment. * On 1/19/10, showed an average BFR of 220 for the treatment. * On 1/16/10, showed an average BFR of 270 for the treatment. * On 1/14/10, showed an average BFR of 300 for the treatment. * On 1/12/10, showed an average BFR of 300 for the treatment. * On 1/9/10, showed an average BFR of 210 for the treatment <p>There was no documentation on the treatment sheets to show why the physician ordered BFR was not met. There was no documentation in the patient's clinical record to show if the BFR deviations had been assessed by the IDT to determine the possible cause for the decreased BFRs.</p> <p>7. Review of the clinical record for Patient 8 showed a physician's order dated 1/15/10, to increase the patient's hemodialysis treatments to three times a week. Patient 8 had an EDW of 53.5. The patient's treatment sheets dated 1/19/10, 2/2/10, 2/4/10, and 2/9/10, showed the patient's pre-treatment weights had decreased from 53.40 Kg on 1/19 to 51.8 Kg. on 2/9/10 (below the patients EDW of 53.5 Kg). The patient's post-treatment weights had decreased from 51.50 Kg. on 1/19/10 to 49.6 Kg. on 2/9/10 (below the patient's EDW), The post dialysis notes showed the patient had been discharged to home at their EDW.</p>	V 503			

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V 503	<p>Continued From page 22</p> <p>There was no documentation in the patient's clinical record to show the patient's EDW had been reassessed by the IDT related to the decreased pre and post weights.</p> <p>8. Patient 4's record review was initiated on 2/11/10.</p> <p>Review of the treatment sheet dated 1/6/10, showed the treatment started at 1049 hours and the initial BP was 107/53. At 1202 hours, the BP was down to 80/48. The PCT comment stated, "Ultrafiltration rate was off; patient BP low; alert and resting comfortably." There was no NS infused and no BP taken the next 5-15 minutes but after 30 minutes the BP was up to 92/56. At 1317 hours, the BP was down to 87/53. The comment stated "UF off; BP low; NS given, however, no amount of fluid was documented as administered.</p> <p>On 1/11/10, the treatment started at 1045 hours with the BP at 112/74. At 1302 hours, the BP was down to 81/55 with the patient feeling dizzy per the PCT's documented comment. Another BP was taken which came up to be 93/47. The ultrafiltration rate was turned off and 200 mL NS was infused, however, no follow-up BP was taken until after 30 minutes.</p> <p>During the treatment on 1/15/10, the BP decreased to 86/59 at 1203 hours. The low BP was recognized and was treated by turning off the UF and administering 200 mL NS. At 1206 hours, the BP was up to 100/65 yet another 100 mL of NS was infused with the PCT comment that the BP remained low. On treatment completion at 1308 hours, there was no documented 400 mL</p>	V 503			

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V 503	<p>Continued From page 23</p> <p>NS rinse back to return the patient's remaining blood.</p> <p>Further review of the treatment sheets dated 1/25/10, 1/29/10, 2/3/10, 2/5/10, revealed that Patient 4's BP had been dropping significantly down to 76/44 with no follow-up BP check, inconsistent documentation of the amount of NS administered and inconsistent documentation of the amount of rinse back to be able to return the patient's remaining blood.</p> <p>On 2/11/10 at 1130 hours, the findings on the treatment sheets were discussed with Employees 1 and 10, who both stated that they had not identified BP problems and had not conducted IDT conferences to assess the patient for a need to change the plans of care.</p> <p>9. Review of the treatment sheets for Patient 5 was initiated on 2/10/10.</p> <p>9a. On 2/3/10, Patient 5's treatment was initiated at 0551 hours, with a BP of 157/82 and pulse rate of 59. By 0616 hours, the BP had decreased to 134/73 with a pulse rate of 62. The BP trended downward and at 0805 hours, the BP was 109/65 and pulse rate of 77. At 0826 hours, 200 mL of NS was given to the patient. The comment section showed the UF had been turned off , and the patient had a BP of 86/51. At 0827 hours, Patient 5's BP decreased further to 62/38. The treatment sheet showed no additional NS was given to the patient after the BP had decreased further, nor had another BP been taken.</p> <p>The last BP recorded on the treatment area was the BP of 62/38 taken at 0827 hours. The patient's treatment was completed at 0848 hours.</p>	V 503			

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V 503	Continued From page 24 A BP was not taken at this time. There was no normal saline documented as administered at the completion of the treatment at 0848 hours. The treatment sheet showed the total fluids administered to the patient for the treatment was 400 mL, the 200 mL given at the initiation of treatment and the 200 mL given to the patient at 0826 hours. The post dialysis section showed after new complaints or observations which developed during dialysis was "no". 9b. On 2/1/10, Patient 5's treatment was initiated at 0527 hours with a BP of 161/87 and a pulse rate of 69. At 0702 hours the BP was 133/75 with a pulse rate of 76, and at 0802 hours, the BP dropped to 112/70 with a pulse rate of 92. At 0821 hours, treatment was completed, and the BP recorded was 75/45 with a pulse rate of 90. The patient was given 400 mL of NS and placed on oxygen at 2 liters per minute. There was no other BP recorded on the treatment area after the BP taken at 0821 hours. The comments recorded at 0821 hours showed treatment was discontinued without problem, the patient's BP dropped, treatment finished and oxygen at two liters per minute was given by nasal cannula. There was no further documentation regarding the patient's status. The post dialysis notes at 0834 hours, showed the patient's BP had dropped, the treatment finished four minutes early, and the patient felt better after blood was returned, but no BP documented to show if the intervention worked. Cross Reference V715.	V 503			
V 540	494.90 CFC-PATIENT PLAN OF CARE	V 540		4/30/10	

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V 540	Continued From page 25 This CONDITION is not met as evidenced by: Surveyor: 22781 Based on observation, record review and staff interview, the facility failed to demonstrate identification of patient care issues and address the goals and plans set for 12 of 15 sampled patients and one unsampled patient. (Patients 1, 2, 4, 5, 7, 8, 9, 10, 11, 12, 15 and I). Findings: The facility failed to identify/monitor decreased BPs, changes in pre and post treatment weights, fluid removal goals or deviations in BFRs. Cross Reference V503, V715. Care plan interventions were not developed for patients to comply with the access site and face being uncovered during treatment, preventative treatment of hypotensive episodes during treatment. Cross Reference V501, V503, V541. There was failure to monitor patient treatment data for adherence to physician orders, to confirm physician orders were in place, to prevent hypotensive episodes and treatment of low BPs per facility policy, and to monitor patient fluid volumes. Cross Reference V503, V541, V715. Treatment orders were not initiated timely, P&Ps regarding hypotensive episodes, post-dialysis weights under or above patient EDWs were not implemented, and cramping and deviations from ordered BFRs were not addressed. Cross Reference V503, V541, V543, V715.	V 540			

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V 540	Continued From page 26	V 540			
V 541	<p>The cumulative effect of these systemic problems resulted in the failure to ensure the provision of quality care in a safe environment</p> <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on clinical record review and staff interview, the facility failed to assess BPs for nine sampled patients (Patients 2, 4, 5, 7, 8, 9, 11,12 and 15) during treatment in order to allow development of an individualized care plan for treatment interventions and goals for BP management during treatment.</p> <p>Findings:</p> <p>1a. Review of the treatment sheets for Patient 5 dated 2/1/10 and 2/3/10, showed the patient had an EDW of 54.0 Kg, and the patient had experienced decreased BP toward the end of the treatment. The treatment sheet dated 2/1/10,</p>	V 541		5/27/10	

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V 541	<p>Continued From page 27</p> <p>showed the patient had a BP of 161/87 at the start of their treatment at 0527 hours. The patient's BP trended downward, and at 0802 hours had decreased to 112/70. At 0821 hours, the BP had decreased to 75/45. The comments on the treatment sheet showed the patient's BP had dropped and the patient was receiving oxygen at 2 liters per minute by nasal cannula.</p> <p>1b. On 2/3/10, the treatment sheet showed the patient's pre-treatment sitting BP was 157/82 and the DW was 54.0 Kg. The patient's BP trended downward during the treatment, and at 0805 hours had decreased to 109/65. At 0827 hours, the BP had further decreased to 62/38.</p> <p>The Comprehensive Interdisciplinary Assessment for Patient 5 dated 2/5/10, showed the patient's average pre and post-treatment BPs had been recorded in the area for blood pressure and volume status. The area, "BP stable during treatment" and the area for Adverse Intradialytic Symptoms, "yes" or "no" were left blank.</p> <p>The Physician Assessment area notes dated 2/8/10, showed the patient's dry weight had been increased to 54.5 Kg. due to the decreased BP at the end of dialysis.</p> <p>The Plan of Care, should include all the treatment interventions the Interdisciplinary Team determines should be put in place to meet patient needs and should reflect the comprehensive assessments made by all members of the Interdisciplinary Team.</p> <p>2a. The treatment sheet for Patient 11 dated 1/25/10, showed the patient had a pre-treatment sitting BP of 159/78. During treatment the</p>	V 541			

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V 541	<p>Continued From page 28</p> <p>patient's BP trended downward, and at 30 minutes prior to the completion of the treatment, the BP had decreased to 86/48. The treatment sheet showed the patient's fluid removal was stopped, and the discharge notes showed the patient had been discharged to home below their estimated dry weight.</p> <p>2b. The treatment sheet dated 1/20/10, showed Patient 11 had a pre-treatment sitting BP of 125/60 and the BP had trended downward during treatment. At one hour and 15 minutes into the treatment the BP had decreased to 96/49, and 30 minutes later was 80/37. The fluid removal was stopped. The discharge notes showed the patient was discharged from the facility below their estimated dry weight.</p> <p>Review of the patient's clinical record showed the decreased BPs during treatment, and the patient being discharged below their EDW had been not been assessed in order to complete or revise the plan of care.</p> <p>3. Patient 4's record review was initiated on 2/11/10.</p> <p>Review of the treatment sheet dated 1/6/10, showed the treatment started at 1049 hours and the initial BP was 107/53. At 1202 hours, the BP was down to 80/48. The PCT comment stated, "Ultrafiltration rate was off; patient BP low; alert and resting comfortably." after 30 minutes the BP was up to 92/56. At 1317 hours, the BP was down to 87/53. The comment stated "UF off; BP low; NS given". There was no documentation to show the amount of NS given.</p> <p>On 1/11/10, the treatment started at 1045 hours</p>	V 541			

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V 541	<p>Continued From page 29</p> <p>with the BP at 112/74. At 1302 hours, the BP was down to 81/55 with the patient feeling dizzy per the PCT's documented comment. Another BP was taken which came up to be 93/47. The ultrafiltration rate was turned off and 200 mL NS was infused.</p> <p>During the treatment on 1/15/10, the BP was down to 86/59 at 1203 hours. The low BP was recognized and was treated by turning off the UF and administering 200 mL NS. At 1206 hours, the BP was up to 100/65 yet another 100 mL of NS was infused with the PCT comment that the BP remained low.</p> <p>Further review of the treatment sheets dated 1/25/10, 1/29/10, 2/3/10, 2/5/10, revealed that Patient 4's BP had been dropping significantly down to 76/44 with no follow-up BP check, inconsistent documentation of the amount of NS administered and inconsistent documentation of the amount of rinse back to be able to return the patient's remaining blood.</p> <p>On 2/10/10 at 1130 hours, the findings on the treatment sheets were discussed with Employees 1 and 10, who both stated they had not identified such problems or made changes in the plan of care.</p> <p>4. Review of the treatment sheets for Patient 8 was initiated on 2/11/10.</p> <p>The treatment sheet dated 2/9/10, showed the patient's pre-treatment standing BP was 132/51 and the sitting BP was 150/47. Patient 8's treatment was initiated at 0520 hours, with a BP of 150/47. The patient's EDW was 53.5 Kg, and the patient had a pre-treatment weight of 51.8 Kg.</p>	V 541			

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V 541	<p>Continued From page 30</p> <p>Patient 8 was 1.7 Kg below their EDW. The treatment record showed that 2.20 Kg was removed from the patient during the treatment. At 0733 hours, the patient's BP was 130/60 and at 0750 hours, when the treatment was discontinued, the patient's BP had decreased to 95/56, a drop of 35 mmHg in the systolic BP. The treatment comments showed that at 0750 hours, treatment was discontinued without problem. No follow up BP was done except for the discharge BP which showed Patient 8's sitting BP was 112/68 and their standing BP was 101/60. Post dialysis comments showed the patient was discharged to home at their estimated dry weight, and no new complaints or observations developed during dialysis.</p> <p>The changes in the patient's dry weight had not been assessed in order to assure the patient's Plan of Care reflected the patient's current status.</p> <p>5. Review of the treatment sheets for Patient 12 was initiated on 2/11/10.</p> <p>The treatment sheet dated 1/26/10, showed the patient's treatment was initiated at 0934 hours, with a BP of 136/66. At 1104 hours, the BP was 126/58 with comments the patient was resting comfortably. At 1133 hours, the BP was 111/55 with comments the patient was resting comfortably. At 1202 hours the BP had decreased to 92/49 with no comments documented. At 1230 hours the BP was down to 89/40. The treatment comments at 1230 hours, showed the patient was passing out, had low blood pressure and 800 mL of NS were given.</p> <p>The patient's low blood pressures during treatment were not assessed to ensure the</p>	V 541			

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V 541	<p>Continued From page 31</p> <p>patient's Plan of Care contained interventions to address the low blood pressures.</p> <p>6. Review of Patient 7's treatment sheets was initiated on 2/11/10.</p> <p>The treatment sheet dated 2/9/10, showed Patient 7's treatment was initiated at 1200 hours with a BP of 146/83. At 1352 hours, the patient's BP was 122/68, and at 1433 hours, the BP had decreased to 89/55, a change of 33 mmHg. The comments on the treatment sheet showed the patient was given 200 mL of NS and the fluid removal goal was decreased from 4.0 Kg. to 3.5 Kg. At 1515 hours the treatment was discontinued.</p> <p>7. The review of the treatment sheets for Patient 9 was initiated on 2/11/10</p> <p>7a. The treatment sheet dated 1/23/10, showed the patient's treatment was initiated at 0520 hours, with a BP of 202/128. The patient had a downward trend in their BP during treatment. At 0912 hours, the BP decreased to 82/41 from 135/60 at 0835 hours, a decrease of 53 mmHg. The comment section showed the patient's UF had been turned off. At 0920 hours, the patient's treatment was completed and the BP was 76/34. The comments were that the treatment had ended, the patient's BP was low and extra NS was given. The patient received 800 mL of NS.</p> <p>The multidisciplinary notes showed that at 0916 hours the patient had complained of a headache and was given 650 milligrams of acetaminophen, the patient had a low BP and the UF was at minimum. At 0943 hours, the notes showed the patient had a post dialysis standing BP of 95/45</p>	V 541			

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V 541	<p>Continued From page 32 and refused to stay in the unit for observation, stating he was okay.</p> <p>7b. Patient 9's treatment sheet for 1/16/10 showed at 0805 hours, the BP was 139/75. At 0833 hours the BP had decreased to 111/66 and at 0903 hours, the BP had decreased to 87/39, a decrease of 24 mmHg. The comments at 0903 hours, showed the UF had been decreased to minimum because the patient had a low BP. At 0920 hours, the BP had decreased to 80/44 and the patient's treatment was completed early at the patient's request as the patient had to use the restroom. The patient was given 500 mL of NS.</p> <p>7c. The treatment sheet dated 1/12/10 showed that Patient 9's treatment was initiated at 0525 hours, and the initial BP was 134/76. The BP trended down during treatment to 105/69 at 0733 hours. At 0842 hours, the BP had decreased to 88/55 with comments the patient was alert. At 0905 hours, the BP was 92/50 and the comments showed the patient was alert, UF had been turned off and the patient's BP was low. Another BP was not done until 0928 hours, and the BP had decreased to 76/42. The comments showed the patient denied complaints, was alert and treatment was discontinued without problem. The patient was given 500 mL of NS at end of treatment</p> <p>7d. The treatment sheet dated 1/5/10, showed Patient 9's treatment was initiated at 0537 hours, with an initial BP of 161/90. At 0737 hours, the BP was 147/76 and decreased to 88/52 at 0903 hours. The patient's pulse rate was 78 at initiation of treatment and had increased to 101 at 0903 hours. The comments showed the patient was alert and treatment was interrupted, UF was</p>	V 541			

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V 541	<p>Continued From page 33</p> <p>off. Patient 9 had requested to use the rest room. The patient's blood was returned and the patient was given 200 mL of NS.</p> <p>7e. The 1/3/10, treatment sheet showed Patient 9's treatment was initiated at 0538 hours with a BP of 158/92. The BP decreased during the treatment. At 0932 hours, the BP was 85/43. The comments showed the patient denied complaints, was alert and resting comfortably. No interventions were documented. At 0939 hours, the patient's treatment was completed. The patient was given 600 mL of NS, and the BP taken at 0939 hours, was 85/43.</p> <p>The decreased blood pressures during treatment were not assessed in order to revise the patient's Plan of Care to ensure interventions were planned to prevent the continued decreased blood pressure during treatment.</p> <p>8. Review of the treatment sheets for Patient 2 was initiated on 2/10/10.</p> <p>The treatment sheet dated 2/1/10, showed the patient's treatment was initiated at 1230 hours, with a BP of 88/45. At 1403 hours, the patient's BP was 78/40 and the comments showed the patient was resting comfortably and the UF had been turned off because of the low BP. The next BP documented was at 1443 hours.</p> <p>9. Review of the treatment sheets for Patient 15 was initiated on 2/11/10.</p> <p>9a. The treatment sheet dated 1/5/10, showed that at 1204 hours, Patient 15's BP was 130/71, and at 1238 hours, had decreased to 89/46, a drop of 41 mmHg. The patient's treatment was</p>	V 541			

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V 541	<p>Continued From page 34</p> <p>discontinued at 1238 hours. The patient was given 400 mL of NS to rinse back their blood.</p> <p>9b. The treatment sheet dated 1/19/10, showed on initiation of treatment at 0935 hours, the patient had a BP of 149/72 and a pulse rate of 69. The patient had an EDW of 70.5 Kg. The pre-treatment weight was 72.9 Kg, with an available fluid removal amount of 2.40 Kg. At 1209 hours, the patient's BP was 132/63 with a pulse rate of 81. At 1239 hours, the patient's BP had decreased to 59/38, a decline of 73 mmHg, with a pulse rate of 55. The treatment sheet comments at 1239 hours, showed the patient denied complaints, was alert and resting comfortably.</p> <p>On 2/11/10 at 0720 hours, Employee 6 was interviewed. The employee stated that all low BPs should be reported to the physician. The employee stated for a BP of 65/40, the patient should be placed in a Trendelenburg position, oxygen administered, and NS given.</p> <p>On 2/11/10 at 1120 hours, an interview was conducted with Employee 2. When asked about decreased BPs during treatment, the employee stated there were no parameters for reporting to the physicians. The employee did agree that there was not enough documentation showing what interventions were done for the patients with decreased BPs during treatment. Employee 2 added the physicians reviewed patient treatments to make a determination of the patients' dialysis orders, and the nurses also advised regarding the patient's status and any problems. The employee did agree the BPs they were shown by the surveyor were low.</p>	V 541			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052861	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES SOUTH ORANGE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 EAST FIRST STREET, SUITE 110 SANTA ANA, CA 92705	
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V 541	Continued From page 35 On 2/11/10 at 1130 hours, the findings on the treatment sheets were discussed with Employees 1 and 10, who both stated that they had not identified BP problems and had not conducted IDT conferences to assess the patient for a need to change the plans of care.	V 541		
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: 22781 Based on clinical record review, the facility failed to ensure management of the volume status for nine of 15 sampled patients, (Patients 2, 4, 5, 7, 8, 9, 11, 12 and 15). This resulted in low BPs, the need for fluid replacement and oxygen for Patient 5, Patient 8 being consistently discharged below the EDW, Patient 11 being below the EDW and having low BPs, and Patient 12 not meeting the EDW and developing cramping during dialysis. Findings: 1a. Review of the treatment sheets for Patient 5 dated 2/3/10 and 2/1/10, showed the patient had an EDW of 54.0 Kg, and on 2/1/10 and 2/3/10, the patient had experienced decreased BP toward the end of the treatments. The treatment sheet dated 2/1/10, showed Patient 5 had a BP of 161/87 at the start of their treatment at 0527 hours. The patient's BP trended downward, and at 0802 hours, the BP had decreased to 112/70,	V 543		4/30/10

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V 543	<p>Continued From page 36</p> <p>and again decreased to 75/45 at 0821 hours. The comments showed the patient's BP had dropped and the patient was receiving oxygen at 2 liters per minute by nasal cannula.</p> <p>1b. On 2/3/10, the treatment sheet showed the patient's pre-treatment sitting BP as 157/82. The patient's BP trended downward during the treatment, and at 0805 hours had decreased to 109/65. At 0827 hours, the BP had further decreased to 62/38.</p> <p>The Comprehensive Interdisciplinary Assessment for Patient 5 dated 2/5/10, showed in the area for blood pressure and volume status the patient's average pre-treatment and post-treatment BPs had been recorded. The area was "BP stable during treatment?" had not been answered. The area for Adverse Intradialytic Symptoms, "yes" or "no" had not been answered.</p> <p>The Physician Assessment area notes dated 2/8/10, showed the patient's dry weight had been increased to 54.5 Kg. due to the decreased BP at the end of dialysis.</p> <p>The Comprehensive Interdisciplinaty Assessment did not reflect the patient's accurate blood pressure status so an individualized plan of care regarding the patient's BP could not be developed.</p> <p>2. Review of Patient 12's treatment sheets and clinical record was initiated on 2/10/10.</p> <p>2a. A physician's order dated 11/24/09, increased Patient 12's dry weight to 75.5 Kg from 74.0 Kg. A Physicians Progress Note dated 12/22/09, showed to continue to challenge the patient's</p>	V 543			

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V 543	<p>Continued From page 37 EDW.</p> <p>Review of the 17 treatment sheets for Patient 12 from 1/2/10 to 2/9/10, showed the patient never achieved the ordered EDW of 75.5 Kg. The lowest post-dialysis weight achieved in this timeframe was 75.8 Kg. on 1/30/09. The patient's other post-dialysis weights in this timeframe ranged from 76.2 Kg. to 78.0 Kg.</p> <p>On 2/9/10, Patient 12's pre-dialysis weight was 79.2 Kg, and had 3.7 Kg of available fluid to be removed. The treatment record showed that 2.2 Kg. of fluid was removed leaving the patient 1.5 Kg over their dry weight. Of the 17 treatment sheets reviewed, the available fluid for removal goal was not met for 16 treatments.</p> <p>2b. Further review of the treatment sheets for Patient 12 showed:</p> <ul style="list-style-type: none"> * On 1/3/10 at 1230 hours, the UF was turned off and the patient was complaining of cramping. The fluid goal was reduced to 2.5 Kg. * On 1/7/10 at 1110 hours, the patient's BP was 121/57, and trended downward. At 1201 hours, the BP had decreased to 106/50, and the treatment sheet showed the fluid goal was reduced to 2.8 Kg. because of low BP. * On 1/12/10, Patient 12's BP decreased from 111/48 at 1101 hours to 95/52 at 1222 hours, and the UF was turned off. The patient was given 200 mL (milliliters) of NS as the patient was complaining of cramping. The UF was left off until the completion of the treatment at 1241 hours. * On 1/16/10, Patient 12's BP decreased from 135/66 at 1136 hours to 117/61 at 1205 hours. The comments showed the patient denied complaints, patient OK, UF turned off and the 	V 543			

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V 543	<p>Continued From page 38</p> <p>patient complained of cramping.</p> <p>* On 1/19/10, the patient's BP decreased from 115/62 at 1208 hours to 101/52 at 1230 hours. The UF was turned off and the patient was complaining of cramping in their leg.</p> <p>* On 1/23/10, at termination of treatment, it was documented the patient was given an extra 100 mL of NS because of cramping.</p> <p>* On 1/26/10, Patient 12's treatment was initiated at 0934 hours, with a BP of 136/66. At 1133 hours, the BP was 111/55 with comments the patient was resting comfortably. At 1202 hours the BP had decreased to 92/49 with no comments documented. At 1230 hours the BP was down to 89/40. The treatment comments at 1230 hours, showed the patient was passing out, had low blood pressure and 800 mL of NS were given. The patient became alert and verbally responsive at this time. The treatment sheet showed the UF was not turned down. There was no documentation to show if the physician had been advised of this occurrence.</p> <p>There was no documentation to show the patient's BP decreases and cramping had been assessed to determine if the patient's plan of care needed to be changed.</p> <p>3. Review of the treatment sheets for Patient 11 was initiated on 2/10/10.</p> <p>3a. The treatment sheet dated 1/20/10, showed the patient had an EDW of 97.0 Kg. The patient's pre-treatment weight was 98.80 Kg. The fluid removal goal for the treatment was 2.4 Kg. The patient's starting BP was 133/68, and decreased during treatment to a BP of 80/37. The treatment sheet showed the amount of fluid removed from the patient during treatment was 2.665 Kg, (0.265</p>	V 543			

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V 543	<p>Continued From page 39</p> <p>Kg above the patient's fluid removal goal). The patient's post weight was .010 Kg. below their EDW.</p> <p>3b. Patient 11's treatment sheet dated 1/25/10, showed the patient's EDW had been increased to 97.5 Kg. The patient's pre-treatment weight was 99.0 Kg, and a target fluid removal for the patient had been figured at 2.0 Kg. The treatment was initiated at 0509 hours, and the patient had a BP of 158/72. During treatment the patient's BP trended downward, and at 0735 hours, the BP was 86/48. The total fluid removed from the patient was 2.429 Kg, (0.429 Kg over the fluid goal). The patient's post-treatment weight was 0.70 Kg. below their dry weight.</p> <p>There was no evidence the plan of care was reviewed by the IDT to determine if it was appropriate to meet the patient's needs.</p> <p>4. Review of the clinical record for Patient 8 showed a physician's order dated 1/15/10, to increase the patient's hemodialysis treatments to three times a week. The patient had an EDW of 53.5 Kg.</p> <p>The patient's treatment sheets dated 1/19/10, 2/2/10, 2/4/10, and 2/9/10, showed the patient's pre-treatment weights had decreased from 53.40 Kg on 1/19 to 51.8 Kg. on 2/9/10. The patient's post-treatment weights had decreased from 51.50 Kg. on 1/19/10 to 49.6 Kg. on 2/9/10.</p> <p>There was no evidence the Patient 8's plan of care was reviewed by the IDT to determine if it met the patient's needs.</p> <p>5. Patient 4's record review was initiated on</p>	V 543			

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V 543	<p>Continued From page 40 2/11/10.</p> <p>Review of the treatment sheet dated 1/6/10, showed the treatment started at 1049 hours and the initial BP was 107/53. At 1202 hours, the BP was down to 80/48. The PCT comment stated, "Ultrafiltration rate was off; patient BP low; alert and resting comfortably." after 30 minutes the BP was up to 92/56. At 1317 hours, the BP was down to 87/53. The comment stated "UF off; BP low; NS given", however, no amount of fluid was documented as administered.</p> <p>On 1/11/10, the treatment started at 1045 hours with the BP at 112/74. At 1302 hours, the BP was down to 81/55 with the patient feeling dizzy per the PCT's documented comment. Another BP was taken which came up to be 93/47. The ultrafiltration rate was turned off and 200 mL NS was infused.</p> <p>During the treatment on 1/15/10, the BP was down to 86/59 at 1203 hours. The low BP was recognized and was treated by turning off the UF and administering 200 mL NS. At 1206 hours, the BP was up to 100/65 yet another 100 mL of NS was infused with the PCT comment that the BP remained low.</p> <p>Further review of the treatment sheets dated 1/25/10, 1/29/10, 2/3/10, 2/5/10, revealed that Patient 4's BP had been dropping significantly down to 76/44 with no follow-up BP check, inconsistent documentation of the amount of NS administered and inconsistent documentation of the amount of rinse back to be able to return the patient's remaining blood.</p> <p>On 2/10/10 at 1130 hours, the findings on the</p>	V 543			

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V 543	<p>Continued From page 41</p> <p>treatment sheets were discussed with Employees 1 and 10, who both stated they had not identified such problems or made changes in the plan of care.</p> <p>6. Review of Patient 7's treatment sheets was initiated on 2/11/10.</p> <p>The treatment sheet dated 2/9/10, showed Patient 7's treatment was initiated at 1200 hours with a BP of 146/83. At 1352 hours, the patient's BP was 122/68, and at 1433 hours, the BP had decreased to 89/55, a change of 33 mmHg. The comments on the treatment sheet showed the patient was given 200 mL of NS and the fluid removal goal was decreased from 4.0 Kg. to 3.5 Kg. At 1515 hours the treatment was discontinued.</p> <p>7. The review of the treatment sheets for Patient 9 was initiated on 2/11/10</p> <p>7a. The treatment sheet dated 1/23/10, showed the patient's treatment was initiated at 0520 hours, with a BP of 202/128. The patient had a downward trend in their BP during treatment. At 0912 hours, the BP decreased to 82/41 from 135/60 at 0835 hours, a decrease of 53 mmHg. The comment section showed the patient's UF had been turned off. At 0920 hours, the patient's treatment was completed and the BP was 76/34. The comments were that the treatment had ended, the patient's BP was low and extra NS was given. The patient received 800 mL of NS.</p> <p>The multidisciplinary notes showed that at 0916 hours the patient had complained of a headache and was given 650 milligrams of acetaminophen, the patient had a low BP and the UF was at</p>	V 543		

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V 543	<p>Continued From page 42</p> <p>minimum. At 0943 hours, the notes showed the patient had a post dialysis standing BP of 95/45 and refused to stay in the unit for observation, stating he was okay.</p> <p>7b. Patient 9's treatment sheet for 1/16/10 showed at 0805 hours, the BP was 139/75. At 0833 hours the BP had decreased to 111/66 and at 0903 hours, the BP had decreased to 87/39, a decrease of 24 mmHg. The comments at 0903 hours, showed the UF had been decreased to minimum because the patient had a low BP. At 0920 hours, the BP had decreased to 80/44 and the patient's treatment was completed early at the patient's request as the patient had to use the restroom. The patient was given 500 mL of NS.</p> <p>7c. The treatment sheet dated 1/12/10 showed that Patient 9's treatment was initiated at 0525 hours, and the initial BP was 134/76. The BP trended down during treatment to 105/69 at 0733 hours. At 0842 hours, the BP had decreased to 88/55 with comments the patient was alert. At 0905 hours, the BP was 92/50 and the comments showed the patient was alert, UF had been turned off and the patient's BP was low. Another BP was not done until 0928 hours, and the BP had decreased to 76/42. The comments showed the patient denied complaints, was alert and treatment was discontinued without problem. The patient was given 500 mL of NS at end of treatment</p> <p>7d. The treatment sheet dated 1/5/10, showed Patient 9's treatment was initiated at 0537 hours, with an initial BP of 161/90. At 0737 hours, the BP was 147/76 and decreased to 88/52 at 0903 hours. The patient's pulse rate was 78 at initiation of treatment and had increased to 101 at</p>	V 543			

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V 543	<p>Continued From page 43</p> <p>0903 hours. The comments showed the patient was alert and treatment was interrupted, UF was off. Patient 9 had requested to use the rest room. The patient's blood was returned and the patient was given 200 mL of NS.</p> <p>7e. The 1/3/10, treatment sheet showed Patient 9's treatment was initiated at 0538 hours with a BP of 158/92. The BP decreased during the treatment. At 0932 hours, the BP was 85/43. The comments showed the patient denied complaints, was alert and resting comfortably. No interventions were documented. At 0939 hours, the patient's treatment was completed. The patient was given 600 mL of NS, and the BP taken at 0939 hours, was 85/43.</p> <p>8. Review of the treatment sheets for Patient 2 was initiated on 2/10/10.</p> <p>The treatment sheet dated 2/1/10, showed the patient's treatment was initiated at 1230 hours, with a BP of 88/45. At 1403 hours, the patient's BP was 78/40 and the comments showed the patient was resting comfortably and the UF had been turned off because of the low BP.</p> <p>9. Review of the treatment sheets for Patient 15 was initiated on 2/11/10.</p> <p>9a. The treatment sheet dated 1/5/10, showed that at 1204 hours, Patient 15's BP was 130/71, and at 1238 hours, had decreased to 89/46, a drop of 41 mmHg. The patient's treatment was discontinued at 1238 hours. The patient was given 400 mL of NS to rinse back their blood.</p> <p>9b. The treatment sheet dated 1/19/10, showed on initiation of treatment at 0935 hours, the</p>	V 543			

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V 543	Continued From page 44 patient had a BP of 149/72 and a pulse rate of 69. The patient had an EDW of 70.5 Kg. The pre-treatment weight was 72.9 Kg, with an available fluid removal amount of 2.40 Kg. At 1209 hours, the patient's BP was 132/63 with a pulse rate of 81. At 1239 hours, the patient's BP had decreased to 59/38, a decline of 73 mmHg, with a pulse rate of 55. The treatment sheet comments at 1239 hours, showed the patient denied complaints, was alert and resting comfortably.	V 543			
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Surveyor: 21262 Based on observation, staff interview and record review, the facility failed to have an effective QAPI program as evidenced by: Findings: The facility failed to identify/monitor hypovolemia (decreased fluid volume) as a possible source of hypotension (decreased blood pressure) where 70% of the last year's adverse events could be attributed. Cross Reference V634, V638. The facility failed to develop root-cause analysis of adverse events presented by dialysis patients such as headache, clotted dialyzers, weakness, hypotension, chest pain, patient falls while in the treatment area, and a patient collapsing in the parking lot. Cross Reference V634. The facility failed to analyze trends of adverse events to recognize and prioritize major problems that threatened the health and safety of patients;	V 625		4/30/10	

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V 625	Continued From page 45 and identify opportunities to improve performance by taking actions to reduce and prevent the same events from recurring. Cross Reference to V503 and V541. The facility failed to adhere to their P&P with regard to preventing and treating hypotension leading to increased hospitalization and possible mortality. Cross Reference to V715. The facility failed to collect data on QAPI monitor indicators for adverse events from June 2009 to November 2009. Cross Reference V634. The cumulative effect of these systemic problems resulted in the failure to ensure quality care in a safe environment.	V 625			
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Surveyor: 21262 Based on staff interview and record review, the facility failed to identify, track and trend the causes of prevailing adverse events as having the same common cause and effect. The development of necessary actions to prevent such events from recurring was not evident. This resulted in repeat hypotensive episodes for nine of 15 sampled patients (Patients 2, 4, 5, 7, 8, 9, 11, 12 and 15) and 7 non-sampled patients (Patient A, B, C, D, E, F and H) and patient falls.	V 634		4/30/10	

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V 634	<p>Continued From page 46</p> <p>Findings:</p> <p>On 2/10/10, per review of the facility's Training Manual on "Sequelae of Hypotension," page 6 showed that intravascular volume depletion accounts for the majority of hypotensive episodes during chronic hemodialysis.</p> <p>The consequences of hypotension ranged from mild to severe. The mild consequences could be diaphoresis, nausea/vomitting, decreased mental status and post-dialysis malaise (feeling unwell) and fatigue leading to decreased ability to perform daily activities.</p> <p>The more severe results were loss of consciousness, seizures and cerebral infarction, decreased blood to the heart resulting in chest pain and/or heart attack, aspiration pneumonia, shock and death.</p> <p>The note on page 7 showed that, "Since prolonged hypotension could cause sudden death, the ultimate goal of nursing care was to prevent hypotensive episodes rather than merely treat them."</p> <p>The note on page 8 after Hypotension After Dialysis showed that, "Recurrent episodes of hypotension warrant physician notification, team conferences and evaluation of the patient at patient care conferences. Hypotension should never be allowed to occur on a recurrent basis without assessment and intervention."</p> <p>On 2/10/10 at 0930 hours, review of the facility's adverse events for the year 2009, revealed that from 1/27/09 to 5/19/09, 7 non-sampled patients</p>	V 634			

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V 634	<p>Continued From page 47</p> <p>(Patient A, B, C, D, E, F and H) and one sampled patient (Patient 14) were reported to have adverse events categorized in "Other Patient Event" (involving severe headache and nausea, weakness and hypotension) to Cardiac cases (involving chest pain with fast heart rate), and Patient Falls.</p> <p>Per review of the Variance Reports for further investigation on 2/10/10 at 1100 hours, the following were revealed:</p> <p>a. Non-sampled Patient A complained of severe headache necessitating hospitalization.</p> <p>b. Non-sampled Patient B was found on the ground in the parking lot while trying to transfer from his wheelchair to the car after dialysis treatment. Due to weakness and hypotension, non-sampled Patient B was taken to the hospital for further evaluation.</p> <p>c. Non-sampled Patient D complained of chest pain with tachycardia (fast heart rate) while having his dialysis treatment. 911 was called and the patient was taken to the hospital.</p> <p>d. Non-sampled Patient F lost consciousness in the treatment area on her way to the restroom. The patient was later taken to the hospital for further evaluation.</p> <p>e. Sampled Patient 14 was waiting for his ride after dialysis treatment when the patient developed chest pain. The patient was examined by a dialysis physician. 911 was called to take the patient to the hospital.</p> <p>f. Non-sampled Patient H fell while standing for a BP check and suffered a laceration on the back of the head and was sent to the hospital for further evaluation.</p> <p>Further review of the adverse events analysis</p>	V 634			

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V 634	Continued From page 48 showed that these events were not marked as an identified trend. The events were submitted for review by the QAI team, however, follow-up actions failed to reveal that actions were implemented to prevent further recurrence of the same events. There was no further action recommended after affected patients were taken to the hospital. On 2/11/10 at 1100 hours, record review of nine of 15 randomly sampled patients (Patients 2, 4, 5, 7, 8, 9, 11, 12 and 15), revealed frequent episodes of hypotension on an ongoing basis. Cross Reference V715. On 2/11/10 at 1600 hours, the ongoing decreased BPs and the subsequent adverse events were discussed with Employees 1, 10 and 14. They agreed that monitoring and root-cause analysis and follow-up needed improvement.	V 634			
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Surveyor: 21262 Based on record review and staff interview, the facility failed to monitor its performance from 6/09 to 11/09 and take actions that resulted in improved performance. Findings:	V 638		4/30/10	

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V 638	Continued From page 49 1. On 2/11/10, review of the Adverse Events Analysis showed only the adverse events that occurred from 1/09 to 5/09 ranging from cases of clotted dialysis lines, chest pain and patient falls were tracked. The latest adverse event recorded was on 12/23/09 regarding a medication error. There was no adverse event that was reported and reviewed by QAPI from 6/09 to 11/09. However, further review of the Wasted Dialyzer Tracking Log displayed in the treatment area revealed that from 11/11/09 to 1/13/10, there were three cases of clotted lines that were not reported for QAPI review unlike the clotted lines that were reported before for the months of January to February 2009. On 2/11/10 at 1100 hours, when Employee 6 was asked for the past copies of the Wasted Dialyzer Tracking Log, she stated that Employee 13 was keeping the records. Employee 13 stated the tracking sheets were shredded because he had no use for them. When Employee 1 was asked how the facility was to track and trend adverse events without the collected data, she made no comment. In addition, the Wasted Dialyzer Tracking Log showed 8 occurrences of "no show" from 11/11/09 to 2/10/10. Some patients were identified but other cases were unknown. On 2/11/10 at 1330 hours, when Employee 1 was asked regarding analysis and evaluations of the "no show" cases and follow-up actions, no comment was made.	V 638		
V 710	494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR	V 710		4/30/10

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V 710	Continued From page 50 This CONDITION is not met as evidenced by: Surveyor: 21262 Based on observation, staff interview and record review, the Medical Director failed to ensure that quality patient care was being provided by using the patients' clinical outcomes to identify deficient practices. Findings: The Medical Director failed to ensure QAPI program data was collected from June to September 2009 and addressed adverse outcomes such as hypotension. Cross Reference V634, V638. The Medical Director failed to demonstrate oversight of patient assessment and the IDT plan of care. Cross Reference V501, V541. The Medical Director failed to ensure staff followed the facility's P&P. Cross Reference V501, V503, V715, V726. The cumulative effect of these systemic problems resulted in the facility's failure to ensure quality care in a safe environment.	V 710			
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;	V 715		4/30/10	

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V 715	<p>Continued From page 51</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on treatment record reviews and staff interview, the Medical Director failed to ensure facility policies and procedures regarding the care and treatment of the patients were adhered to with regard to the treatment and documentation of hypotensive (low blood pressure) episodes, and the monitoring of patients during the dialysis treatment for nine of 15 sampled patients (Patients 2, 4, 5, 7, 8, 9, 11, 12 and 15). This resulted in the potential for patients to experience dizziness, falls and other complications of low blood pressure after they returned home from dialysis. In addition, failure to follow the P&Ps for labelling of prefilled medication syringes and storage of heparin resulted in the potential for medication errors.</p> <p>Findings:</p> <p>Review of the facility policies was initiated on 2/11/10 at 1330 hours.</p> <p>The facility's policy for Treatment of Hypotension #132-030-130, showed that common symptoms of hypotension include gradual or precipitous decrease in blood pressure, nausea, vomiting, dizziness, restlessness, fatigue, yawning, feeling hot, cold clammy skin, shortness of breath, blurred vision, decreased responsiveness and seizures. Monitoring of BP assured correct treatment was provided. The patient was to be placed in Trendelenburg (head down) position to facilitate blood flow to the vital organs, particularly to the brain. The UF was to be reduced to</p>	V 715			

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V 715	<p>Continued From page 52</p> <p>minimum to prevent further removal of fluid and normal saline was to be given in 100 mL boluses as needed to raise the BP. The total amount of saline infused was to be determined by the Charge Nurse and physician order. The staff were to monitor and record the BP at least every five minutes until symptoms related to hypotension had been relieved. The policy also showed the event was to be accurately documented on the treatment sheet and to review the patient medical record for weight and BP trends over the past treatments.</p> <p>The facility policy for Monitoring During Patient's Treatment #132-020-425, showed the patient's current BP was to be compared with previous measurements to assess changes in the patient's status. Appropriate interventions should be made in response to changes in vital signs, i.e., fluid replacement or machine adjustments, and to follow up on all interventions to assure desired response. Additional interventions might be required and all interventions were to be documented on the hemodialysis treatment sheets and should include the patient response to the intervention.</p> <p>The facility's policy for Medical Records - Hemodialysis Treatment Sheet #132-060-125, showed that since the record was a legal document, all information recorded on the treatment sheet must be legible and reflect an accurate and precise representation of the care and treatment provided to the patient. Also that RNs and Patient Care Technicians (PCTs) would review and complete daily hemodialysis treatment sheets during each patient's treatment, recording the date and time of the treatment, observations and any problems or unusual occurrences that</p>	V 715			

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V 715	<p>Continued From page 53 arose.</p> <p>Review of the FMC Dialysis Training Manual for employees, for Complications/Treatments/Charting, showed that intravascular volume depletion accounted for the majority of hypotensive episodes during chronic hemodialysis, and the goal of the immediate treatment for hypotension was to expand the intravascular volume. Later goals were to determine the specific cause of the blood pressure drop and initiate measures to maintain volume status while removing the required amount of fluid during the treatment.</p> <p>Per the Core Curriculum for Nephrology Nursing, Fifth Edition, 2008, by impairing tissue perfusion, low blood pressure can compromise dialysis adequacy, contribute to loss of residual kidney function and predispose patients to lack of blood to the heart and brain. A post dialysis systolic BP of less than 100 correlates with a 2.5 times increased risk of death. Two or more hypotensive episodes per week increases the mortality rate to 70%.</p> <p>1. Review of the treatment sheets for Patient 15 was initiated on 2/11/10.</p> <p>1a. The treatment sheet dated 1/5/10, showed that at 1204 hours the Patient 15's BP was 130/71, and at 1238 hours, had decreased to 89/46, a drop of 41 mmHg. The patient's treatment was discontinued at 1238 hours. The patient was given 400 mL of NS to rinse back their blood. There was no follow up BP done to recheck the patient's BP after administration of the saline.</p>	V 715			

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V 715	<p>Continued From page 54</p> <p>1b. The treatment sheet dated 1/19/10, showed on initiation of treatment at 0935 hours, the patient had a BP of 149/72 and a pulse rate of 69. The patient had an EDW of 70.5 Kg. The pre-treatment weight was 72.9 Kg, with an available fluid removal amount of 2.40 Kg. At 1209 hours, the patient's BP was 132/63 with a pulse rate of 81. At 1239 hours, the patient's BP had decreased to 59/38, a decline of 73 mmHg, with a pulse rate of 55. The treatment sheet comments at 1239 hours, showed the patient denied complaints, was alert and resting comfortably. No interventions for the hypotension were initiated, no NS was given and the UF was not decreased. The patient's BP was not taken again until 1251 hours, when the patient's treatment ended, and the patient was given 400 mL of NS. A follow-up BP was not done after the NS was administered.</p> <p>2. Review of the treatment sheets for Patient 5 was initiated on 2/10/10.</p> <p>2a. On 2/3/10, Patient 5's treatment was initiated at 0551 hours, with a BP of 157/82 and pulse rate of 59. By 0616 hours, the BP had decreased to 134/73 with a pulse rate of 62. The BP trended downward and at 0805 hours, the BP was 109/65 and pulse rate of 77. At 0826 hours, 200 mL of NS was given to the patient. The comment section showed the UF had been turned off , and the patient had a BP of 86/51. At 0827 hours, Patient 5's BP decreased further to 62/38. The treatment sheet showed no additional NS was given to the patient after the BP had decreased further, nor had another BP been taken.</p> <p>The last BP recorded on the treatment area was the BP of 62/38 taken at 0827 hours. The</p>	V 715			

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V 715	<p>Continued From page 55</p> <p>patient's treatment was completed at 0848 hours. A BP was not taken at this time. There was no normal saline documented as administered at the completion of the treatment at 0848 hours. The treatment sheet showed the total fluids administered to the patient for the treatment was 400 mL, the 200 mL given at the initiation of treatment and the 200 mL given to the patient at 0826 hours. The post dialysis section showed after new complaints or observations which developed during dialysis was "no".</p> <p>2b. On 2/1/10, Patient 5's treatment was initiated at 0527 hours with a BP of 161/87 and a pulse rate of 69. At 0702 hours the BP was 133/75 with a pulse rate of 76, and at 0802 hours, the BP dropped to 112/70 with a pulse rate of 92. At 0821 hours, treatment was completed, and the BP recorded was 75/45 with a pulse rate of 90. The patient was given 400 mL of NS and placed on oxygen at 2 liters per minute.</p> <p>There was no other BP recorded on the treatment area after the BP taken at 0821 hours. The comments recorded at 0821 hours showed treatment was discontinued without problem, the patient's BP dropped, treatment finished and oxygen at two liters per minute was given by nasal cannula. There was no further documentation regarding the patient's status.</p> <p>The post dialysis notes at 0834 hours, showed the patient's BP had dropped, the treatment finished four minutes early, and the patient felt better after blood was returned, but no BP documented to show if the intervention worked.</p> <p>3. Review of the treatment sheets for Patient 8 was initiated on 2/11/10.</p>	V 715			

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V 715	<p>Continued From page 56</p> <p>The treatment sheet dated 2/9/10, showed the patient's pre-treatment standing BP was 132/51 and the sitting BP was 150/47. Patient 8's treatment was initiated at 0520 hours, with a BP of 150/47. The patient's EDW was 53.5 Kg, and the patient had a pre-treatment weight of 51.8 Kg. Patient 8 was 1.7 Kg below their EDW. The treatment record showed that 2.20 Kg was removed from the patient during the treatment. At 0733 hours, the patient's BP was 130/60 and at 0750 hours, when the treatment was discontinued, the patient's BP had decreased to 95/56, a drop of 35 mmHg in the systolic BP. The treatment comments showed that at 0750 hours, treatment was discontinued without problem. No follow up BP was done except for the discharge BP which showed Patient 8's sitting BP was 112/68 and their standing BP was 101/60. Post dialysis comments showed the patient was discharged to home at their estimated dry weight, and no new complaints or observations developed during dialysis.</p> <p>4. Review of the treatment sheets for Patient 12 was initiated on 2/11/10.</p> <p>The treatment sheet dated 1/26/10, showed the patient's treatment was initiated at 0934 hours, with a BP of 136/66. At 1104 hours, the BP was 126/58 with comments the patient was resting comfortably. At 1133 hours, the BP was 111/55 with comments the patient was resting comfortably. At 1202 hours the BP had decreased to 92/49 with no comments documented. At 1230 hours the BP was down to 89/40. The treatment comments at 1230 hours, showed the patient was passing out, had low blood pressure and 800 mL of NS were given.</p>	V 715			

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V 715	<p>Continued From page 57</p> <p>The patient became alert and verbally responsive at this time. Another BP was not taken until 1250 hours when treatment was completed.</p> <p>The treatment sheet showed the UF was not turned down, the BP was not monitored per policy and there was no documentation to show if the patient was placed in Trendelenburg position per facility policy. There was no documentation to show if the physician had been advised of this occurrence. The post dialysis notes showed the complaints or observations which developed during dialysis as "none".</p> <p>5. Review of Patient 7's treatment sheets was initiated on 2/11/10.</p> <p>The treatment sheet dated 2/9/10, showed Patient 7's treatment was initiated at 1200 hours with a BP of 146/83. At 1352 hours, the patient's BP was 122/68, and at 1433 hours, the BP had decreased to 89/55, a change of 33 mmHg. The comments on the treatment sheet showed the patient was given 200 mL of NS and the fluid removal goal was decreased from 4.0 Kg. to 3.5 Kg. At 1515 hours the treatment was discontinued. The last BP recorded on the treatment sheet was at 1433 hours.</p> <p>6. The review of the treatment sheets for Patient 9 was initiated on 2/11/10</p> <p>6a. The treatment sheet dated 1/23/10, showed the patient's treatment was initiated at 0520 hours, with a BP of 202/128. The patient had a downward trend in their BP during treatment. At 0912 hours, the BP decreased to 82/41 from 135/60 at 0835 hours, a decrease of 53 mmHg. The comment section showed the patient's UF</p>	V 715		

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V 715	<p>Continued From page 58</p> <p>had been turned off. At 0920 hours, the patient's treatment was completed and the BP was 76/34. The comments were that the treatment had ended, the patient's BP was low and extra NS was given. The patient received 800 mL of NS. Another BP was not taken until 0943 hours.</p> <p>The multidisciplinary notes showed that at 0916 hours the patient had complained of a headache and was given 650 milligrams of acetaminophen, the patient had a low BP and the UF was at minimum. At 0943 hours, the notes showed the patient had a post dialysis standing BP of 95/45 and refused to stay in the unit for observation, stating he was okay.</p> <p>6b. Patient 9's treatment sheet for 1/16/10 showed at 0805 hours, the BP was 139/75. At 0833 hours the BP had decreased to 111/66 and at 0903 hours, the BP had decreased to 87/39, a decrease of 24 mmHg. The comments at 0903 hours, showed the UF had been decreased to minimum because the patient had a low BP. At 0920 hours, the BP had decreased to 80/44 and the patient's treatment was completed early at the patient's request as the patient had to use the restroom. The patient was given 500 mL of NS. There were no BPs recorded in the treatment sheet after the BP done at 0920 hours. The post dialysis vital signs recorded on the treatment sheet showed they were done at 0918 hours, prior to the completion of the patient's treatment.</p> <p>6c. The treatment sheet dated 1/12/10 showed that Patient 9's treatment was initiated at 0525 hours, and the initial BP was 134/76. The BP trended down during treatment to 105/69 at 0733 hours. At 0842 hours, the BP had decreased to 88/55 with comments the patient was alert. At</p>	V 715			

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V 715	<p>Continued From page 59</p> <p>0905 hours, the BP was 92/50 and the comments showed the patient was alert, UF had been turned off and the patient's BP was low. Another BP was not done until 0928 hours, and the BP had decreased to 76/42. The comments showed the patient denied complaints, was alert and treatment was discontinued without problem. The patient was given 500 mL of NS at end of treatment. No follow-up blood pressure was done after the NS was administered.</p> <p>6d. The treatment sheet dated 1/5/10, showed Patient 9's treatment was initiated at 0537 hours, with an initial BP of 161/90. At 0737 hours, the BP was 147/76 and decreased to 88/52 at 0903 hours. The patient's pulse rate was 78 at initiation of treatment and had increased to 101 at 0903 hours. The comments showed the patient was alert and treatment was interrupted, UF was off. Patient 9 had requested to use the rest room. The patient's blood was returned and the patient was given 200 mL of NS. At 0910 hours, the comments showed the patient denied complaints and was alert. Treatment was resumed as the patient was back from the restroom. No BP was taken at 0910 hours. The next BP done was at 0931 hours.</p> <p>6e. The 1/3/10, treatment sheet showed Patient 9's treatment was initiated at 0538 hours with a BP of 158/92. The BP decreased during the treatment. At 0932 hours, the BP was 85/43. The comments showed the patient denied complaints, was alert and resting comfortably. No interventions were documented. At 0939 hours, the patient's treatment was completed. The patient was given 600 mL of NS, and the BP taken at 0939 hours, was 85/43. The post vitals recorded at 0944 hours, showed the patient had a</p>	V 715			

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V 715	<p>Continued From page 60</p> <p>sitting BP of 110/71 and a comment the patient refused to have their standing BP taken and stated they were okay and did not feel dizzy. It was documented the Patient looked upset.</p> <p>7. The treatment records for Patient 11 were reviewed on 2/11/10.</p> <p>7a. Patient 11's treatment sheet dated 1/25/10, showed the patient's treatment had been initiated at 0509 hours with a BP of 158/72. The BP decreased during treatment, and at 0735 hours the BP was 86/46. The comments showed the UF had been turned off because of low BP. Another BP was not taken until 0803 hours. The post dialysis notes showed the patient's post weight was below their EDW.</p> <p>7b. The treatment sheet dated 1/20/10, showed the treatment was initiated at 0515 hours, and at 0531 hours, the patient's BP was 135/73. At 0603 hours, the BP was 107/54, a decrease of 28 mmHg. At 0831 hours, the BP was at 96/49 and the comments showed the patient was resting comfortably. At 0701 hours, the BP had decreased to 80/37 and the comments showed the patient denied complaints and the UF had been turned down. The next BP was not done until 0730 hours and was 83/41. The UF was left off because of the low BP. The post dialysis notes showed the patient's post weight was below their EDW.</p> <p>8. Review of the treatment sheets for Patient 2 was initiated on 2/10/10.</p> <p>The treatment sheet dated 2/1/10, showed the patient's treatment was initiated at 1230 hours, with a BP of 88/45. At 1403 hours, the patient's</p>	V 715			

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V 715	<p>Continued From page 61</p> <p>BP was 78/40 and the comments showed the patient was resting comfortably and the UF had been turned off because of the low BP. The next BP documented was at 1443 hours.</p> <p>On 2/11/10 at 0720 hours, Employee 6 was interviewed. The employee stated that all low BPs should be reported to the physician. The employee stated for a BP of 65/40, the patient should be placed in a Trendelenburg position, oxygen administered, and NS given.</p> <p>9. Patient 4's record review was initiated on 2/11/10.</p> <p>Review of the treatment sheet dated 1/6/10, showed the treatment started at 1049 hours and the initial BP was 107/53. At 1202 hours, the BP was down to 80/48. The PCT comment stated, "Ultrafiltration rate was off; patient BP low; alert and resting comfortably." There was no NS infused and no BP taken the next 5-15 minutes but after 30 minutes the BP was up to 92/56. At 1317 hours, the BP was down to 87/53. The comment stated "UF off; BP low; NS given, however, no amount of fluid was documented as administered.</p> <p>On 1/11/10, the treatment started at 1045 hours with the BP at 112/74. At 1302 hours, the BP was down to 81/55 with the patient feeling dizzy per the PCT's documented comment. Another BP was taken which came up to be 93/47. The ultrafiltration rate was turned off and 200 mL NS was infused, however, no follow-up BP was taken until after 30 minutes.</p> <p>During the treatment on 1/15/10, the BP decreased to 86/59 at 1203 hours. The low BP</p>	V 715			

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V 715	<p>Continued From page 62</p> <p>was recognized and was treated by turning off the UF and administering 200 mL NS. At 1206 hours, the BP was up to 100/65 yet another 100 mL of NS was infused with the PCT comment that the BP remained low. On treatment completion at 1308 hours, there was no documented 400 mL NS rinse back to return the patient's remaining blood.</p> <p>Further review of the treatment sheets dated 1/25/10, 1/29/10, 2/3/10, 2/5/10, revealed that Patient 4's BP had been dropping significantly down to 76/44 with no follow-up BP check, inconsistent documentation of the amount of NS administered and inconsistent documentation of the amount of rinse back to be able to return the patient's remaining blood.</p> <p>On 2/11/10 at 0720 hours, Employee 6 was interviewed. The employee stated that all low BPs should be reported to the physician. The employee stated for a BP of 65/40, the patient should be placed in a Trendelenburg position, oxygen administered, and NS given.</p> <p>On 2/11/10 at 1120 hours, an interview was conducted with Employee 2. When asked about decreased BPs during treatment, the employee stated there were no parameters for reporting to the physicians. The employee did agree that there was not enough documentation showing what interventions were done for the patients with decreased BPs during treatment. Employee 2 added the physicians reviewed patient treatments to make a determination of the patients' dialysis orders, and the nurses also advised regarding the patient's status and any problems. The employee did agree the BPs they were shown by the surveyor were low.</p>	V 715			

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V 715	<p>Continued From page 63</p> <p>On 2/11/10 at 1130 hours, the findings on the treatment sheets were discussed with Employees 1 and 10, who both stated that they had not identified BP problems and had not conducted IDT conferences to assess the patient for a need to change the plans of care.</p> <p>10. Review of the facility's Medication Policy #138-020-130 dated 1/12/05, showed under storage of medications that all medications were to be kept in a locked cabinet except:</p> <ul style="list-style-type: none"> * Heparin (1:1000) * Hypertonic saline * Local anesthetics. <p>The policy also showed that medications other than Epogen/Zemplar may be predrawn up to one hour prior to administration and stored for later use. The medication must be labeled with the following information:</p> <ul style="list-style-type: none"> * Patient's name. * Medication. * Dosage. * Route of Administration. * Date. * Time. * Preparer's initials. <p>10a. On 2/9/10 at 1115 hours, two filled syringes were found in the top drawer of a supply cart near Station 10. The syringes were filled with a clear liquid and were labeled with the dosage and the initials of the preparer. However, there were no patient names, medication name, date or time on the label. An interview was done with Employee 8. The employee stated the syringes contained heparin, had been prepared around 1030 hours, and were for the third shift patients.</p>	V 715			

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V 715	Continued From page 64	V 715			
V 726	<p>10b. On 2/10/10 at 0645 hours, three vials of heparin 1:5000 were found on the unlocked supply carts (one vial on the cart at Station 1 and two vials at Station 2) on the treatment floor. During an interview with Employee 4, the employee stated the carts were where the PCTs drew up their 1:1000 heparin and anesthetics used to initiate patient treatments. The 1:5000 heparin was used by the nurses for catheters, and the PCTs knew they were not to use the 1:5000 heparin. The surveyor requested a copy of the medication policy. The policy for storage of medications was reviewed with Employees 4 and 9. The employees stated they were not aware the medication policy directed that the 1:5000 heparin had to be kept in a locked cabinet. They stated the 1:5000 heparin had always been kept on the supply carts so it would be available when it was needed.</p> <p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE</p> <p>The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22781</p> <p>Based on clinical record review and staff interview, the facility failed to ensure patient medical records were complete and accurate for five of 15 sampled patients (Patients 2, 4, 10, 11 and 12). There was no documentation to show</p>	V 726		5/27/10	

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V 726	<p>Continued From page 65</p> <p>the total amount of NS that had been administered to Patients 12, 10 and 4 during their treatment. No physician orders for increased BFRs for Patients 2 and 11, and no documentation to show when Patient 2 had signed their treatment consent. This resulted in the potential for information to not be available to staff for adequate treatment and care planning.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The clinical record for Patient 2 was initiated on 2/10/10 and showed the patient's Informed Consent for Hemodialysis Treatment (nonreuse) had been signed by the patient, but the date signed area had not been completed. 1b. Review of the treatment sheets showed that on 2/3 and 1/29/10, Patient 2 was dialyzed at a BFR of 450. The patient's ordered BFR was 400. Review of the clinical record showed no physician orders for those dates to increase the BFR to 450. 2. Review of the treatment sheet for Patient 11 dated 1/25/10, showed the patient had an ordered BFR of 400. The patient was dialyzed with the BFR averaging 453 for the treatment. Review of the clinical record showed no physician order for the increased BFR. 3. Patient 12's treatment sheet dated 1/16/10, showed the amount of NS given during the termination of treatment had not been documented on the treatment sheet. The initial 200 mL of NS and the 100 mL of NS given for cramping during treatment were the only fluids documented in the fluid administered column. 	V 726			

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V 726	<p>Continued From page 66</p> <p>4. The treatment sheet for Patient 10 dated 1/19/10, showed the patient's treatment had been initiated at 0520 hours. The sheet showed the only BFR/DFR, arterial/venous pressure and amount of fluid removed status during treatment were recorded was at 0838 hours. The initial saline bolus was also not recorded on the treatment sheet. The only safety and access checks recorded were at 0838 hours and at completion of treatment at 0900 hours.</p> <p>5. Patient 4's record review was initiated on 2/11/10.</p> <p>Review of the treatment sheet dated 1/6/10, showed the treatment started at 1049 hours and the initial BP was 107/53. At 1202 hours, the BP was down to 80/48. The PCT comment stated, "Ultrafiltration rate was off; patient BP low; alert and resting comfortably." There was no normal saline documented as infused and no BP documented the next 5-15 minutes but after 30 minutes the BP was up to 92/56. At 1317 hours, the BP was down to 87/53. The comment stated "UF off; BP low; NS given"; however, no amount of fluid was documented as administered.</p> <p>On 1/11/10, the treatment for Patient 4 started at 1045 hours with the BP at 112/74. At 1302 hours, the BP was down to 81/55 with the patient feeling dizzy per the PCT's documented comment. Another BP was documented as 93/47. The ultrafiltration rate was turned off and 200 mL NS was infused; however, no follow-up BP was taken until after 30 minutes.</p> <p>During the treatment of Patient 4 on 1/15/10, the BP was down to 86/59 at 1203 hours. The low BP was recognized and was treated by turning off the</p>	V 726			

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V 726	Continued From page 67 UF and administering 200 mL NS. At 1206 hours, the BP was up to 100/65 yet another 100 mL of NS was infused with the PCT comment that the BP remained low. On treatment completion at 1308 hours, there was no documented 400 mL NS rinse back to return the patient's remaining blood. Further review of the treatment sheets dated 1/25/10, 1/29/10, 2/3/10, 2/5/10, revealed that Patient 4's BP had been dropping significantly down to 76/44 with no follow-up BP check, with inconsistent documentation of the amount of NS administered and inconsistent documentation of the amount of rinse back to be able to return the patient's remaining blood. On 2/10/10 at 1130 hours, the findings on the treatment sheets were discussed with Employees 1 and 10, who both stated that they had not identified these problems.	V 726			
V 750	494.180 CFC-GOVERNANCE This CONDITION is not met as evidenced by: Surveyor: 21262 Based on observation, staff interview and record review, the governing body failed to demonstrate safe facility operation as evidenced by: Findings: The governing body failed to ensure QAPI program data was collected from June to September 2009 and addressed adverse outcomes. Cross Reference V756, V634 and V638. The Governing Body failed to identify and	V 750		4/30/10	

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V 750	Continued From page 68 follow-up on significant problems and its causes, and provide guidance to correct the problems. Cross Reference V756.	V 750			
V 756	There was lack of oversight from the Governing Body regarding medical staff adherence to the facility's P&P as evidenced by physicians not participating in the IDT process to ensure the plan of care addressed and prevented adverse events. Cross Reference to V541, V503. The cumulative effect of these systemic problems resulted in the failure to ensure the provision of quality care in a safe environment. 494.180(a)(4) GOV-ADM RESP FOR RESOURCES FOR QAPI The governing body or designated person responsible must appoint an individual who serves as the dialysis facility's chief executive officer or administrator who exercises responsibility for the management of the facility and the provision of all dialysis services, including, but not limited to- (4) Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program as described in §494.110. This STANDARD is not met as evidenced by: Surveyor: 21262 Based on record review and staff interview, the governing body failed to oversee the facility's safe operation as evidenced by lack of oversight regarding review of QAPI's data collection, analysis and outcomes to be communicated by the Medical Director. In addition, there was lack of	V 756		8/23/10	

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V 756	<p>Continued From page 69</p> <p>oversight with regard to furnishing staff education on management of hypotension at the beginning of dialysis, during dialysis and after dialysis.</p> <p>Findings:</p> <p>On 2/11/10, review of the facility's training manual on Complications/Treatment/Charting, page 7 of 72 showed that prolonged hypotension could lead to heart attack, stroke and sudden death. For this reason, the ultimate goal of nursing care was to prevent hypotensive episodes rather than merely treat them.</p> <p>On page 8 of 72, under management of hypotension after dialysis, the note showed that, "Recurrent episodes of hypotension warrant physician notification, team conferences and evaluation of the patient at patient care conferences. Hypotension should never be allowed to occur on a recurrent basis without assessment and intervention."</p> <p>1. On 2/10/10 at 0930 hours, review of the facility's adverse events for the year 2009 revealed that from 1/27/09 to 5/19/09, 8 non-sampled patients were reported to have adverse events categorized from "Other Patient Event" (involving severe headache and nausea, weakness and hypotension) to Cardiac cases (involving chest pain with fast heart rate), and Patient Falls.</p> <p>Per review of Variance reports for further investigation on 2/10/09 at 1100 hours, the following were revealed:</p> <p>a. On 1/27/09, non-sampled Patient A complained of severe headache necessitating hospitalization.</p>	V 756			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052861	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2010
NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES SOUTH ORANGE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 EAST FIRST STREET, SUITE 110 SANTA ANA, CA 92705		
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V 756	<p>Continued From page 70</p> <p>b. On 2/26/09, non-sampled Patient B was found on the ground in the parking lot trying to transfer from his wheelchair to the car after dialysis treatment. Due to weakness and hypotension, non-sampled Patient B was taken to hospital for further evaluation.</p> <p>c. On 2/28/09, non-sampled Patient D complained of chest pain with tachycardia (fast heart rate) while having his dialysis treatment. 911 was called and the patient was taken to the hospital.</p> <p>d. On 4/25/09, non-sampled Patient F lost consciousness in the treatment area on her way to the restroom. The patient was later taken to the hospital for further evaluation.</p> <p>e. On 4/13/09, sampled Patient 14 was waiting for his ride after dialysis treatment when the patient developed chest pain. The patient was examined by a dialysis physician. 911 was called to take the patient to the hospital.</p> <p>f. On 5/19/09, non-sampled Patient H fell while standing for a BP check and suffered a laceration on the back of the head and was sent to ER for further evaluation.</p> <p>Further review of the adverse events analysis showed that these events were not marked as an identified trend. The events were submitted for review by the QAPI team; however, there was no follow-up action noted as implemented to prevent further recurrence of the same events. Further review of QAPI records failed to reveal the cases were discussed by the interdisciplinary team or whether individualized patient care conferences took place to discuss respective adverse events.</p> <p>On 2/11/10 at 1100 hours, record review of nine of 15 randomly sampled, current patients, revealed frequent episodes of hypotension on an</p>	V 756			

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V 756	<p>Continued From page 71</p> <p>ongoing basis. Further record review of the sampled patients failed to reveal the plan of care was consistently adjusted by physicians per patients' needs.</p> <p>On 2/11/10 at 1600 hours, the ongoing decreased BP and its subsequent adverse events was discussed with the Facility Administrator, the Medical Director and the Regional Vice President. They agreed that monitoring, root-cause analysis with the necessary follow-up needed improvement.</p> <p>2. On 2/11/10, review of the facility's training manual with regard to management of hypotension recommended Trendelenburg position, administration of 100-200 mL NS intravenously and decreased ultrafiltration rate. The vital signs would be checked 5 minutes after interventions were instituted, 15 minutes after interventions and as necessary thereafter. The physician should be notified if the BP and symptoms did not respond to 500 mL of NS. The maximum volume of NS should be determined by the physician.</p> <p>Review of the facility's policy on treating hypotension recommended Trendelenburg position. administration of 100-200 mL NS bolus intravenously and turning the ultrafiltration to "OFF." Give additional saline up to 500 mL and "if unresponsive, notify the physician and nursing supervisor." Rechecking the BP was included in the instruction, however, the frequency, was not mentioned.</p> <p>Review of the management of hypotension during a staff meeting held on 2/10/10 - 2/11/10 showed that the RN and physician should be notified of</p>	V 756			

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V 756	<p>Continued From page 72</p> <p>patient's abnormality. Instructions on how to manage hypotension included Trendelenburg position, ultrafiltration minimal, document how much normal saline given, recheck the BP (no frequency) and check how the patient felt. For BP less than 90 systolic, administer normal saline up to 1000 ml. Call the physician if patient did not respond.</p> <p>On 2/11/10, record review of 8 of 15 randomly sampled patients revealed that 200-800 mL of normal saline were infused intravenously to hypotensive patients during the course of treatments with the BP being inconsistently checked after the saline infusions, the physician was not notified and the ultrafiltration rate inconsistently turned on or off.</p> <p>On 2/11/10 at 1000 hours, the Facility Administrator verified that the agendas discussed during 2/10/10 to 2/11/10 should be the most current instructions on hypotension management despite current inconsistency with the attached policy. Moreover, the meeting stressed complete documentation on treatment rather than on prevention of hypotension. Cross Reference to V715.</p>	V 756			