

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:  <b>052878</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FMC DIALYSIS SERVICES OF SAN B</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>636 EAST BRIER DRIVE, SUITE 150 SAN BERNARDINO, CA 92408</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 25868 The following reflects the findings of the California Department of Public Health during a Recertification Survey conducted on 4/19/2010.</p> <p>Representing the California Department of Public Health: Lourdes Singh, RN, HFEN Patricia Chisholm, RN, HFEN Sue Torres, RN, HFEN</p> <p>Census: 114 Patients</p> <p>Sampled Patients: 11 Patients</p> <p>Acronyms and Abbreviations: MD Medical Director OM Operations Manager FA Facility Administrator Group FA Group Facility Administrator CSS Clinical Service Specialist CNM Clinical Nurse Manager RN Registered Nurse PCT Patient Care Provider MSW Masters Social Worker RD Registered Dietitian Pt Patient IJ Immediate Jeopardy tx treatment K+ Potassium Na+ Sodium B/P Blood Pressure HD Hemodialysis HHD Home Hemodialysis ESRD End Stage Renal Disease Hct Hematocrit</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 000	Continued From page 1 Hgb Hemoglobin Rx Prescription Wt Weight DFU Directions for Use PoC Plan of Correction CP Care Plan IDT Inter-Disciplinary Team QAPI Quality Assurance Program Improvement P&P Policy and Procedure AOR Adverse Occurrence Report HTN High blood pressure DM Diabetes Mellitus CDC Centers for Disease Control	V 000		
V 111	494.30 IC-SANITARY ENVIRONMENT  The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.  This STANDARD is not met as evidenced by: Surveyor: 25868  Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for an universe of 114 patients by failing to ensure that trash cans were placed at a sufficient distance away from the HD machines and they did not touch clean patient's blood lines, by failing to disposed of expired medical supplies, and by failing to label medication vials with the date the vials were opened.  Findings:  During initial tour of the facility, on 4/12/10, between 8:55 AM and 10:15 AM, in the treatment	V 111		6/12/10

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V 111	<p>Continued From page 2 floor, the following was observed:</p> <p>In the medication refrigerator located at the nurses station, a vial containing Epogen 20,000 units (medication used to stimulate the production of red blood cells in renal patients) was observed open, no documented date was located when the vial was initially opened.</p> <p>In the clean supply cart outside the isolation room, a vial of Heparin 1000 u/ml (medication used to prevent clotting of the blood in renal patients) was noted to be open but without the opening date.</p> <p>In the clean supply cart located in bay 2, 11 AV Fistula needle sets had an expiration date of 3/2006.</p> <p>In the laboratory room, 8 culture swab packages, 3 red/gray top vacutainers, and 32 blue top vacutainers were expired.</p> <p>In a drawer by the utility sink, 3 packages of oxygen tubing were open and without manufacturer's labeling.</p> <p>Review of the facility's policy titled "Medication Policy" dated 1/12/05, indicated that the Epogen 20,000 u/ml vial contained preservative and may be retained for 21 days after opening. The Epogen vial should be dated on the first day of use and initialed by personnel opening the vial. The policy also indicated that multi-dose vials of medication should be dated on the first date of use and discarded 30 days from this initial date.</p> <p>Interview with the Clinical Nurse Manager (CNM), accompanying this surveyor at the time of the</p>	V 111			

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V 111	Continued From page 3 observations, confirmed that the findings were true and accurate and stated that the open vials should have been labeled with the opening date at the time of opening and that the expired medical supplies should have been disposed of as soon as they became expired.	V 111			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE  A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.  This STANDARD is not met as evidenced by: Surveyor: 25868 Based on observation and interview, the facility failed to ensure that warm water was dispensed from all the sinks in the treatment floor to facilitate hand washing for staff, patients, and visitors. This failure had the potential to result in the transmission of infectious organisms between facility staff, patients, and visitors for an universe of 114 patients.  Findings:  During initial tour of the facility on 4/12/10, between 8:55 AM and 10:15 AM, all but 2 of the sinks in the treatment floor were noted to dispense cold water.  During an interview with the CNM, on 4/12/10, at 9:50 AM, in the treatment floor, the CNM confirmed that the water coming from the sinks in the treatment floor was cold to touch and should be warm.  During an interview with the Chief Technician, on 4/12/10, at 10:15 AM, in the treatment floor,	V 114		5/31/10	

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V 114	Continued From page 4 confirmed that the water coming out from the sinks was cold and stated that he would address the problem as soon as possible.	V 114			
V 132	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: 25868 Based on interview and record review, the facility failed to provide infection control training for 1 of 28 staff members (Staff Member 4). This failure had the potential to result in the transmission of infectious organisms from staff to patients in an universe of 114 patients.  Findings:  Review of the facility's personnel files conducted on 4/13/10 revealed that Staff Member 4's hire date was 3/15/99 and worked as the Chief Technician for the facility. The last documented infection control training and education was for the year of 2008.  Interview with the CNM conducted on 4/13/10, confirmed that Staff member 4 did not have mandatory infection control training and education and stated that all teammates were to have annual infection control training and education.	V 132		5/17/10	
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS	V 409		6/12/10	

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V 409	Continued From page 5  The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs.  This STANDARD is not met as evidenced by: Surveyor: 25868 Based on interview and record review, the facility failed to provide emergency preparedness for all staff members working for the facility. This failure had the potential to result in the implementation of inappropriate procedures if an emergency situation should occur in an universe of 114 patients.  Findings:  Review of the facility's personnel files conducted on 4/13/10 revealed that 11 out of 28 staff	V 409		

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V 409	Continued From page 6 members working for the facility did not have current emergency preparedness training. The last documented emergency preparedness training and education was for the year of 2008.	V 409		
V 504	Interview with the CNM conducted on 4/13/10, confirmed that 11 staff members working for the facility did not have the mandatory emergency preparedness training. The CNM stated all teammates are to have annual training and education for emergency preparedness. 494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS  The patient's comprehensive assessment must include, but is not limited to, the following:  Blood pressure, and fluid management needs.  This STANDARD is not met as evidenced by: Surveyor: 25868 Based on interview and record review, the facility failed to ensure that nursing assessments were performed pre and post patient treatments in a consistent manner for 11 of 11 sampled patients (Patients 1 to 11) and failed to ensure nursing assessments were provided before and after the administration of acetaminophen when patients complained of pain for 1 of 11 sampled patients (patient 3) in an universe of 114 patients. These failures resulted in the potential for delayed identification and treatment of abnormal signs and symptoms including serious health problems related to hemodialysis treatment.  Findings:	V 504	6/12/10	

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V 504	<p>Continued From page 7</p> <p>1. Review of the medical records for sampled Patients 1 to 11 conducted between 4/13/10 and 4/16/10, no documented evidence could be located in the medical records that nursing staff performed pre and post treatment assessments in a consistent manner.</p> <p>During an interview with sampled Patient 2, conducted on 4/13/10, at 8:30 AM, in the treatment floor, sampled Patient 2 stated that nursing staff did not always perform a pre and a post treatment assessment on her.</p> <p>During an interview with RN 1, conducted on 4/13/10, at 8:35 AM, RN 1 confirmed that a pre treatment assessment was not conducted that morning for Patient 2 by the nursing staff.</p> <p>During an interview with sampled Patient 5, conducted on 4/13/10, at 9:20 AM, sampled Patient 5 stated that pre and post treatment assessments were not always conducted on her by the nursing staff.</p> <p>During an interview with the CNM conducted on 4/15/10, at 10:00 AM, the CNM confirmed that the nursing staff did not conduct pre and post treatment patient assessments unless the PCTs would notify the nursing staff that the patient was experiencing an unusual sign/symptom that needed to be addressed by the nurse.</p> <p>2. The medical record for sampled Patient 3 was reviewed on 4/16/10. Patient 3 was a 67 year old female, admitted to the facility on 2/12/04 with diagnoses that included end stage renal disease and Diabetes Mellitus.</p> <p>Review of the treatment sheet dated 3/11/10,</p>	V 504			

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V 504	<p>Continued From page 8</p> <p>indicated Patient 3 received 2 325 mg acetaminophens (medication used to treat pain in some patients) by mouth at 7:16 AM. There was no documented evidence in the medical record that the patient made any complaints of pain, that the nursing staff performed a pain assessment to evaluate the type and severity of the pain; and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the treatment sheet dated 3/23/10, indicated Patient 3 received 2-325 mg acetaminophens by mouth at 4:45 AM. There was no documented evidence in the medical record that the patient made any complaints of pain, that the nursing staff performed a pain assessment to evaluate the type and severity of the pain; and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the treatment sheet dated 3/30/10, indicated Patient 3 received 2 325 mg acetaminophens by mouth at 5:25 AM. There was no documented evidence in the medical record that the patient made any complaints of pain, that the nursing staff performed a pain assessment to evaluate the type and severity of the pain; and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the treatment sheet dated 4/01/10, indicated Patient 3 received 2 325 mg acetaminophens by mouth at 4:45 AM. There was</p>	V 504			

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V 504	<p>Continued From page 9</p> <p>no documented evidence in the medical record that the patient made any complaints of pain, that the nursing staff performed a pain assessment to evaluate the type and severity of the pain; and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the treatment sheet dated 4/03/10, indicated Patient 3 complained of back pain and that prn med was given. There was no documented evidence in the medical record that the nursing staff performed a pain assessment to evaluate the type and severity of the pain; that the nursing staff documented in the medical record of the type, dosage, time, and the route of the medication given; and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the treatment sheet dated 4/06/10, indicated Patient 3 complained of back pain and that patient took her own Tylenol extra strength. There was no documented evidence in the medical record that the nursing staff performed a pain assessment to evaluate the type and severity of the pain and that a post medication administration assessment was conducted to evaluate how effective the pain medication was and if further interventions were necessary.</p> <p>Review of the facility's policy titled "Medication Policy" dated 1/12/05, indicated that for each medication administered, the nurse will record the date, time, name of medication, dosage, route of administration, and the nurse's signature and title should be clearly legible on the appropriate</p>	V 504		

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V 504	Continued From page 10 patient chart. It was also indicated that for each PRN (as needed) medications, the symptoms leading to administration as well as the patient's response to the medication shall be documented.	V 504		
V 506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY  The patient's comprehensive assessment must include, but is not limited to, the following:  Immunization history, and medication history.  This STANDARD is not met as evidenced by: Surveyor: 25868 Based on record review and interview, the facility failed to ensure that all patients were tested at least once for a baseline tuberculin skin test (TST), failed to ensure that chest x-rays were used for individuals for whom the TST was not an option, and failed to offer pneumococcal vaccines for 11 of 11 sampled patients (Patients 1 to 11). This failure had the potential to result in the transmission of infection which could result in the further decline of the compromised health of these patients.  Findings:	V 506		6/12/10

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V 506	Continued From page 11 1. The medical records for sampled Patients 1 to 11 were reviewed between 4/13/10 and 4/16/10, no documented evidence could be located in the medical records that any of the patients had been tested for a baseline TST, but instead, used the results of the patient's chest x-rays as an indicator of absence of tuberculosis (TB) in the patients.  Interview with the CNM, conducted on 4/14/10, at 1:12 PM, in the conference room, the CNM stated that the facility required a chest X-ray from each patient as part of their TB surveillance. The CNM confirmed that it was not the facility's practice to obtain patient's baseline tuberculin skin test, but that the facility had already developed a policy to implement the baseline tuberculin skin test and would be implemented as soon as possible.  2. The medical records for sampled Patients 1 to 11 were reviewed between 4/13/10 and 4/16/10, no documented evidence was located in the patients medical records to show that the facility offered pneumococcal vaccines when the patients were due for one.  Interview with the CNM, conducted on 4/14/10, at 1:12 PM, in the conference room, the CNM stated that it was not the facility's practice to offer pneumococcal vaccines, but instead the patients were referred to their primary care physician to be vaccinated.	V 506		
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS  The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the	V 541		6/12/10

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NAME OF PROVIDER OR SUPPLIER  <b>FMC DIALYSIS SERVICES OF SAN B</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>636 EAST BRIER DRIVE, SUITE 150 SAN BERNARDINO, CA 92408</b>		
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V 541	<p>Continued From page 12</p> <p>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: 25868 Based on interview and record review, the facility failed to develop a written, individualized comprehensive plan of care built from the results of the Interdisciplinary Team's (IDT) Comprehensive Assessment for 1 of 11 sampled patients (Patient 3), failed to revise the plan of care according to changes in the patient's individual health status for 3 of 11 sampled patients (Patient 2, 3, and 11), and failed to reassess and revise the patient's plan of care when the expected outcome/goal was identified as not met for 11 of 11 sampled patients (Patients 1-11) in an universe of 114 patients. This failure to develop and to address current health status changes in the patients, and to monitor and update care plans had the potential of the facility not providing and/or providing untimely and inappropriate interventions which may further compromise the patients health.</p> <p>Findings:</p> <p>1A. The medical record for sampled Patient 3 was reviewed on 4/16/10. Patient 3 was a 67 year old female, admitted to the facility on 2/12/04 with diagnoses that included ESRD and DM.</p>	V 541			

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V 541	<p>Continued From page 13</p> <p>Review of the final laboratory report dated 1/25/10, indicated that Patient 3's blood culture was positive for a staph Aureus infection.</p> <p>Review of the Acute Hospital discharge summary dated 1/30/10, indicated that Patient 3 was admitted to the hospital on 1/22/10 and was discharged on 1/30/10 with diagnoses that included sepsis (infection in the blood) due to Staph Aureus. Intra venous antibiotics were prescribed upon discharge to be given for the next 2 weeks of scheduled dialysis.</p> <p>Review of the physician's order sheet dated 2/01/10, indicated an order to administer intravenous antibiotics after each dialysis treatment for a 2 week regimen for a total of 6 doses.</p> <p>Review of Patient 3's Comprehensive InterDisciplinaray (ID) Assessment dated 2/25/10 indicated that Patient 3 was hospitalized on 1/23/10 due to sepsis.</p> <p>Patient 3's Plan of Care dated 2/25/10, no documented evidence was located that the identified infection, which resulted in hospitalization and the administration of antibiotics, was addressed in the plan of care or that measurable goals and expected outcomes and estimated timetables to achieve these outcomes were documented.</p> <p>During an interview with the CNM conducted on 4/16/10, at about 1:55 PM, in her office, the CNM confirmed that the Patient 3's plan of care did not reflect the infection and hospitalization identified in the comprehensive assessment. The CNM</p>	V 541			

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V 541	<p>Continued From page 14</p> <p>stated that the identified hospitalization due to the infection should had been addressed in the care plan, but the facility failed to do so.</p> <p>1B. The medical record for sampled Patient 3 was reviewed on 4/16/10. Patient 3 was a 67 year old female, admitted to the facility on 2/12/04 with diagnoses that included ESRD and DM.</p> <p>Review of Patient 3's Comprehensive ID Assessment dated 2/25/10 indicated that Patient 3's blood pressure was erratic (very high or very low) and was not stable during treatment. It was also identified that low blood pressure was an adverse intradialytic symptom.</p> <p>Review of Patient 3's Plan of Care dated 2/25/10, indicated no documented evidence that the results of the comprehensive assessment were used to develop a plan of care that included measurable goals and expected outcomes and estimated timetables to achieve these outcomes to address the identified erratic and unstable blood pressure that Patient 3 was experiencing.</p> <p>Interview with the CNM conducted on 4/16/10, at about 1:55 PM, in her office, the CNM confirmed that Patient 3's Plan of Care did not reflect the erratic and unstable blood pressure identified in the comprehensive assessment. The CNM stated that the identified blood pressure problems should have been addressed in the care plan, but the facility failed to do so.</p> <p>2A. The medical record for sampled Patient 3 was reviewed on 4/16/10. Patient 3 was a 67 year old female, admitted to the facility on 2/12/04 with diagnoses that included ESRD and DM.</p>	V 541			

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V 541	<p>Continued From page 15</p> <p>Review of the treatment sheets dated 3/11/10, 3/23/10, 3/30/10, 4/01/10, 4/03/10, and 4/06/10 indicated that Patient 3 received 2-325 mg acetaminophens (medication used to treat pain in some patients) for complaints of the back pain. There was no documented evidence in the medical record that the facility developed a plan of care that included measurable goals, specific interventions to address the back pain, and estimated timetables to achieve these goals.</p> <p>During an interview with the Facility Administrator (FA), conducted on 4/16/10, in the conference room, the FA confirmed that a care plan to address the complains of back pain was not developed for Patient 3.</p> <p>2B. The review of Patient 2's medical record was conducted on 4/14/10 and indicated that Patient 2 was a 61 year old female, admitted to the facility on 11/05/02, with a diagnoses that included end stage renal disease and high blood pressure.</p> <p>Review of the laboratory report with a draw date of 1/05/10, indicated that the Patient 2's blood culture was positive for Pseudomonas Aeruginosa infection.</p> <p>Review of the facility's form titled "Infection Reporting" for 2010, indicated that on 1/05/10, Patient 2 had an infection in the blood that resulted in hospitalization and a change of HD catheter.</p> <p>Review of the facility's form titled "Hospitalization Discharge Analysis" for the 2010 year, indicated that Patient 2 was hospitalized from 1/07/10 to 1/09/10 due to sepsis (infection in the blood).</p>	V 541			

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V 541	<p>Continued From page 16</p> <p>Review of the Patient Plan of Care dated 11/19/09, indicated no documented evidence that the care plan was updated to address the identified blood infection that resulted in Patient 2 been hospitalized and placement of a new HD catheter.</p> <p>During an interview with the CNM conducted on 4/14/10, at 1:12 PM, the CNM confirmed that the care plan was not updated as soon as Patient 2 was identified as having infection in the blood, was hospitalized, and a new catheter was placed.</p> <p>2C. Review of Patient 11's medical record conducted on 4/16/10, indicated that Patient 11 was a 60 year old male, admitted to the facility on 12/17/01, with diagnoses that included ESRD and high blood pressure.</p> <p>Review of the laboratory results for the months of 1/10, 2/10, and 3/10, indicated that Patient 11's Potassium (K+) levels were above normal range.</p> <p>Review of Patient 11's Plan of Care dated 12/22/09, indicated no documented evidence that the facility updated the plan of care with the identified elevated K+ levels and that a measurable goal, interventions, and estimated time tables were identified.</p> <p>During an interview with the CNM, on 4/16/10, at 2:00PM, the CNM confirmed that a care plan addressing the elevated K+ levels for Patient 11 was not developed. The CNM stated that the care plan had an additional section to address any other concerns not listed in the care plan, but it was not used to develop the identified elevated K+ levels.</p> <p>Surveyor: 20804</p>	V 541			

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V 541	Continued From page 17  3. Record review of the medical records for 11 of the 11 sampled patients conducted from 4/13/10 to 4/16/10, revealed that the facility developed the patient's care plans at the same time the comprehensive assessment was completed. The IDT team reviewed and developed the patient care plans, listing the expected outcomes for the patient and set goal dates for these outcomes to occur, in the patient care plans.  Further record review revealed the care plans for the 11 Sampled Patients had not been revised after the IDT team had met and developed the plan of care. The facility did not review and/or update the plan of care on the dates set by the team or revise the plan of care when the patient had not met the goals or had a change in condition which would indicate a need to revise and update the care plan.  On 4/15/10 at approximately 11:00 AM, the Clinical Nurse Manager (CNM) confirmed the facility had not reviewed and updated any of the patient health care plans after the patient's IDT team meeting. The CNM stated, "We don't update or go back to the nursing care plans, after their annual IDT meetings. We write a note in the IDT progress notes to address changes in the patient's condition but the care plans aren't revised". In addition, the CNM further confirmed the facility did not review the care plans on the dates set by the IDT team as goal dates and make revisions to the care as needed and further acknowledged that patients' care plans were not being updated when there were changes in the patients health status.	V 541			
V 550	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS	V 550		6/12/10	

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V 550	<p>Continued From page 18</p> <p>The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25868 Based on observation, record review and interview, the facility failed to ensure that Heparin 1000 units/ml (medication used to prevent clotting) was administered as prescribed for 1 of 11 sampled patients (Patient 5) and failed to ensure accurate labeling was done for the predrawn maintenance Heparin dosages. These failures had the potential to result in a clotted HD access site for Patient 5 and the administration of the incorrect heparin dosage for an universe of 114 patients.</p> <p>Findings:</p> <p>1. During observation of the treatment floor, on 4/12/10, at 9:30 AM, 5 syringes containing about 5 mls each of a clear liquid solution were found on top of the clean supply cart in Bay 2. The syringes were labeled Heparin 1000 units, but no patient's name, route, or time was noted on the label.</p> <p>During an interview with PCT 1, on 4/12/10, at 9:31 AM, in Bay 2, PCT 1 stated that she drew from the 1000 units/ml bottle of Heparin and that was what she wrote on the syringes' labels. PCT 1 also stated that these syringes contained the</p>	V 550			

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V 550	<p>Continued From page 19</p> <p>Heparin maintenance for the patients; PCT 1 further stated she did not know what each of the patients were prescribed, she just estimated about 5 mls per patient. In addition, PCT 1 stated that she should have labeled the syringes with the actual amount of Heparin instead of the concentration per ml of heparin in the syringes.</p> <p>Review of the facility's policy titled "Medication Policy" dated 1/12/05, indicated that medications other than Epogen or Zemplar must be labeled with the patient's name, medication, dosage, route of administration, date, time, and preparer's initials.</p> <p>2. Review of Patient 5's medical record was conducted on 4/14/10 and indicated that Patient 5 was a 82 year old female, admitted to the facility on 5/21/09, with diagnoses that included ESRD and DM type II.</p> <p>Review of the treatment sheets dated 4/03/10, 4/08/10, and 4/13/10, indicated a 2500 units bolus as the Heparin regimen. Review of the medication administered section on the same treatment sheets indicated that only 2000 units bolus was administered instead of the 2500 units prescribed.</p> <p>During an interview with the CNM, on 4/15/10 at 11:30 AM, in the conference room, the CNM confirmed that the 2000 units dosage was incorrect and stated that it should have been 2500 units bolus prior to each HD treatment.</p>	V 550			