STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	552508	A. BUILDING ___ B. WING ___	04/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FMC DIALYSIS SERVICES OF WOODLAND HILLS	19836 VENTURA BLVD SUITE C WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS Surveyor: 15727 The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: Sylvia Villaflores, REHS, HFE I Rosalinda Ramos, HFEN	V 000		
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview, and record review, the facility failed to monitor a sanitary environment to minimize the transmission of infectious agents within the unit. Findings: 1. During an observation on March 30, 2010, at 8 a.m., a licensed nurse was observed washing her hands for approximately 10 seconds. 2. During an observation on March 30, 2010, at 8:02 a.m., a staff was observed washing her hands for approximately 10 seconds. 3. During an observation on March 30, 2010, at 8:04 a.m., a staff was observed applying the hand sanitizer located at the side of the dialysis machine and rubbing the hands for approximately 15 seconds. 4. During an observation on March 30, 2010, at 8:06 a.m., a staff was observed applying the hand	V 111		7/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 111	Continued From page 1 sanitizer located at the side of the dialysis machine and rubbing the hands for approximately 5 seconds. During an interview on April 6, 2010, at 10:20 a.m., the clinical manager stated hand washing should be 15 seconds, the length of "Happy birthday" sang once. A review of the sanitizer label revealed to wet hands thoroughly with product, rub hands together covering all surfaces until hands are dry about 30 seconds.	V 111		
V 128	494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY) Isolation of HBV+ Patients To isolate HBsAg positive patients, designate a separate room for their treatment. For existing units in which a separate room is not possible, HBsAg positive patients should be separated from HBsAg susceptible patients in an area removed from the mainstream of activity. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to ensure the isolation door was kept closed during withdrawing of blood and administering of normal saline from the arterial line of Patient 1 during treatment. Findings: On April 5, 2010, at approximately 7:30 a.m., Patient 1 was observed receiving hemodialysis	V 128		7/2/10

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V 128	Continued From page 2 treatment via catheter on her right upper thigh. The patient was diagnosed with hepatitis B positive antigen and uses the isolation room for treatment. There were adjacent stations with patients receiving hemodialysis treatment at that time. Employee B with complete personal protective equipment was observed to disconnect the tubing connected to the arterial port of the catheter. The staff administered normal saline, withdrew blood and reconnected the tubing, while the isolation door was left opened. On the same day, at approximately 8:15 a.m., during an interview with Employee B she stated that she should have closed the door, just like during initiation and take off because of the opportunity of blood spurting or splattering. A review of the facility ' s policy on Dialyzing Patients with Positive Hepatitis B Antigen (HbsAg+) stipulated that the door must be closed during times when blood spurting or spattering is possible.	V 128		
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: 11683	V 143		7/2/10

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V 143	Continued From page 3 Based on observation, interview and record review, the facility staff failed to demonstrate compliance with current aseptic technique of wiping top of a medication bottle when drawing intravenous medications. Findings: On March 30, 2010, at approximately 8:35 a.m., during medication preparation observation, Employee A was noted to have two syringes and a label in front of her. She then drew up medications from an opened vial of Heparin and attached the label to a syringe and set it aside. She then drew up Heparin from the same vial on the second syringe failing to wipe the top of the heparin vial. During an interview with Employee A shortly thereafter, she acknowledged that she should have wiped the top of the heparin vial prior to drawing up medication. A review of the facility's policy on Heparin Bolus Administration stipulated to use alcohol pad, wipe the top of the heparin vial to disinfect the top, allow top of vial to dry and withdraw the medication.	V 143		
V 186	494.40(a) ENVIRONMENT- ALARMS IN TREATMENT AREA 8 Environment: alarms in treatment area Critical alarms, such as those associated with deionizer exhaustion or low water levels in a storage tank, should be configured to sound in the patient treatment area, as well as in the water treatment room. This STANDARD is not met as evidenced by:	V 186		7/8/10

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V 186	Continued From page 4 Surveyor: 15727 Based on observation and interview, the facility failed to configure the alarm for low water levels in a storage tank to sound in the water treatment room. Findings: During a tour of the water treatment area on March 30, 2010, at 8:36 a.m., there was no alarm noted for the low water level in the storage tank. During a tour of the patient treatment area on March 30, 2010, at 9 a.m., a panel for the alarms was observed in the nursing station. During an interview on April 6, 2010, at 9:30 a.m., the chief technician stated the alarm for the low water level in the storage tank only sounded in the patient treatment area because that was where the staff were. He further stated there was no alarm in the water treatment area for the low water level in the storage tank.	V 186		
V 187	494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take	V 187		7/8/10

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V 187	Continued From page 5 in the event performance is not within an acceptable range. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to include the valves and sample ports in the schematic diagram of the water system. Findings: During a tour of the water treatment area, a schematic diagram of the water system was posted on the wall. A review of the schematic diagram of the water system revealed the valves and sample ports were not included in the diagram. During an interview on April 5, 2010, at 9:10 a.m., the chief technician after reviewing the schematic diagram of the water treatment system stated the valves and sample ports were not included.	V 187		
V 191	494.40(a) SOFTENERS: TESTING HARDNESS/LOG 6.2.4 Softeners: Testing hardness/log Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total hardness monitoring requirements of the reverse osmosis machine manufacturer. Total hardness of the water exiting the water softener should be measured at the end of each treatment day. Water hardness test results should be recorded in a water softener log. This STANDARD is not met as evidenced by:	V 191		7/8/10

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V 191	Continued From page 6 Surveyor: 15727 Based on record review and interview, the facility failed to measure the total hardness of the water exiting the water softener at the end of each treatment day. Findings: A review of the water softener log from August 2009 - March, 2010, revealed there were days when the total hardness was not done at the end of the treatment day. The following dates were August 11 and 21, 2009, September 20, 2009, November 13, 2009, February 11, 2010 and March 9, 13, 16, 19 and 30, 2010 (a total of 10 days). At the same time during an interview, the chief technician stated the total hardness needed to be checked at the end of each treatment day.	V 191		
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain a safe and comfortable environment for patients, staff and the public. Findings: During a tour of the facility on March 30, 2010,	V 401		7/2/10

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V 401	Continued From page 7 from 7:30 a.m.- 9:04 a.m., the following was observed: 1. In the waiting room, the chairs had stains on the upholstery and the floor had black stains. 2. In the treatment area, the floor had black stains. The concentrate outlets had an accumulation of yellowish brown deposits. The lower portion of the wall next to the dirty sink near the weighing scale was damaged. 3. In the exam room, the exam bed had stains, dust and debris. 4. In the laboratory area, the flooring under the sink had a brown stain. There was a styrofoam container stored under the sink. There was a sign which read "Do not store anything here." 5. In the medical waste room, the floor had peeling paint. 6. In the water treatment area, there were sections of the floor that were damaged creating an uneven, not easy to clean surface. Under the bicarbonate mixing tank, there was a plywood supporting the base of the tank because the surface was uneven. At the same time, during an interview, the equipment technician stated the requisition had been made for the repair of the floor in the water treatment area. 7. In the storage closet containing oxygen cylinder tanks, there were three cylinder tanks that were not secured. During an interview on April 6, 2010, at 12:20 p.m., the clinical manager stated the oxygen tanks should be secured.	V 401		
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU	V 403		7/2/10

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V 403	Continued From page 8 The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain two back-up dialysis machines. Findings: During a tour of the "Biomed" room on March 30, 2010, at 8:40 a.m., there were two dialysis machines that were not ready for use. At the same time during an interview, the equipment technician stated they did not have any back-up machine available. One of the machines got pulled out from the treatment area that morning. He further stated the parts ordered for the other machine had not been delivered yet. During an interview on March 30, 2010, at 10:55 a.m., the chief technician stated the facility should have two back-up machines ready for use.	V 403		
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, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Surveyor: 11683	V 407		7/2/10

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V 407	Continued From page 9 Based on observation and interview, the facility staff failed to ensure the patients' access sites were visible during hemodialysis treatment. This deficient practice provides an opportunity for accidental needle dislodgement or line disconnection to go undetected. Findings: On March 30, 2010, at approximately 8:30 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 2 and 19. At 10 a.m., during an observation round, the patients' access site were not visible in stations 17, 6 and 3. At 1:45 p.m., it was observed that patients' access sites were not visible in stations 13 and 11. On April 5, 2010, at approximately 7:30 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 2, 10, 13 and 14. At approximately 8:30 a.m., together with the Clinic Manager, patients' access sites were observed not visible. The facility staff members were passing by without reminding the patients that their access sites were not visible while receiving the treatments. On April 5, 2010, at approximately 9 a.m., during an interview with the clinic manager, she stated that the staff members would be reminded to have patients' access sites visible during treatment.	V 407		
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS	V 409		7/1/10

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V 409	Continued From page 10 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: 15727 Based on interview and record review, the facility failed to evaluate annually staff training in emergency procedures. Findings: A review of the emergency preparedness staff training revealed no documentation that the annual staff training was provided and evaluated. During an interview on April 6, 2010, at 11 a.m., the director of operations stated he conducted the	V 409		

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V 409	Continued From page 11 training and he would provide the survey team documentation of the training. As of April 13, 2010, the facility was not able to provide documentation of the annual staff training on emergency preparedness.	V 409		
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following: (2) Evaluation of the appropriateness of the dialysis prescription, This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to follow physician's order for blood flow rate (BFR) for six (6) of eleven (11) sampled patients (Patients 1, 2, 3, 5, 9 and 10). In addition, the facility staff failed to obtain blood sugar for Patient 1 and Patient 2 every treatment and administer oxygen to Patient 6 as ordered by the physician. Findings: 1. On April 5, 2010, at approximately 7:30 a.m., Patient 1 was observed receiving hemodialysis treatment via catheter on her right upper thigh in station 21. A review of the daily treatment record dated from March 24 through 31, 2010, documented the blood flow rate (BFR) was between 300 to 359.	V 503		7/2/10

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V 503	Continued From page 12	V 503		

A review of the physician's order dated November 4, 2009, indicated the BFR was 450 and to check blood sugar every treatment.

Further review of the treatment record on the above dates failed to show written documentation that patient's blood sugar was being checked every treatment day as ordered by the physician.

2. On March 30, 2010, at approximately 10:15 a.m., Patient 2 was observed receiving dialysis treatment via AV fistula on his right upper arm.

A review of the treatment record dated March 19 through 31, 2010, documented the blood flow rate was between 400 to 465. A review of the physician's order dated November 23, 2009, indicated a BFR of 500 and to check blood sugar every treatment.

Further review of the clinical record on the above dated failed to show written documentation the patient's blood sugar was being checked every treatment day as ordered by the physician.

On March 30, 2010, at approximately 8:30 a.m., Patient 3 was observed
receiving dialysis treatment via ash split catheter on the right chest.

A review of the treatment record dated March 6 through March 13, 2010, documented the blood flow rate was between 252 to 306. A review of the physician's order dated January 30, 2010, indicated BFR of 350.

4. On April 5, 2010, at approximately 8 a.m., Patient 5 was observed receiving dialysis treatment via AV fistula on the left upper arm.

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V 503	Continued From page 13 A review of the treatment record dated March 19 through 29, 2010, documented the blood flow rate between 400 to 450. A review of the physician's order dated November 9, 2009, indicated BFR of 300. On March 30, 2010, at approximately 2 p.m., during an interview with the Clinic Manager, she stated that if the BFR order was not reached during treatment, the reason for not achieving it should be documented in the clinical record. 5. On March 30, 2010, at approximately 7:30 a.m., Patient 6 was observed receiving dialysis via AV fistula on his left upper arm. The patient was receiving 3 liters of oxygen via nasal cannula. A review of the physician's order dated January 30, 2010, indicated oxygen 2 liters via nasal cannula as needed for chest pain or shortness of breath. Surveyor: 15727 6. A review of Patient 10's medical record revealed a physician's order for the blood flow rate at 400. A review of the treatment records from February 24, 2010-March 31, 2010 revealed Patient 10's prescribed blood flow rate ranged from 426-464 which was higher than the prescribed blood flow rate. During an interview on April 5, 2010 at 1:30 p.m., the clinical manager after reviewing the medical record could not explain why the blood flow rate was higher than the prescribed blood flow rate. She further stated the blood flow rate should be followed as ordered by the physician.	V 503		

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FMC DIALYSIS SERVICES OF WOODLAND HILLS	19836 VENTURA BLVD SUITE C WOODLAND HILLS, CA 91364

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 503	Continued From page 14 7. A review of Patient 9's medical record revealed a physician's order dated January 30, 2010 for blood flow rate of 500 cc/min. A review of the physician's order dated February 23, 2010 revealed an order to start blood flow rate at 400 and slowly increase to 500. A review of the treatment records from March 18, 2010-April 1, 2010 revealed Patient 9's blood flow rate ranged from 300-450. The blood flow rate of 500 was not achieved. During an interview on April 5, 2010, at 1:45 p.m., the clinical manager after reviewing the patient's medical record could not give a reason why the prescribed blood flow rate was not achieved. There was no documentation why the blood flow rate of 500 was not achieved during treatment.	V 503		
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: 11683 Based on record review and interview, the facility staff failed to ensure the patient's comprehensive interdisciplinary assessment included immunization history for influenza, Pneumovax, Hepatitis B, TB skin test and other, for five (5) of eleven (11) sampled patients (Patients 1, 2, 3, 4 and 6). Findings:	V 506		7/8/10

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V 506	Continued From page 15 1. Patient 1 was admitted to the facility on February 21, 2009, with diagnoses of end stage renal disease and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated February 14, 2010, under the Vaccination/Immunization Status documented influenza vaccination on September 23, 2009, and the rest of the section was not completed. 2. Patient 2 was admitted to the facility on July 21, 2007, with diagnoses of end stage renal disease, hepatitis B antigen positive and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated November 23, 2009, under the Vaccination/Immunization Status documented hepatitis B antigen positive and the rest of the section was not completed. 3. Patient 3 was admitted to the facility on August 5, 2008, with diagnoses of end stage renal disease and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated September 3, 2009, under the Vaccination/Immunization Status, it was documented the patient refused influenza vaccine on October 25, 2008. On September 30, 2008, patient received vaccine for Hepatitis B. The rest of section was not completed. 4. Patient 4 was admitted to the facility on May 18, 2006, with diagnoses of end stage renal disease, stricture and stenosis of cervix and	V 506		

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V 506	Continued From page 16 diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated January 21, 2010, under the Vaccination/Immunization Status documented influenza and hepatitis B were done on October 25, 2008 and June 22, 2009. The rest of the section was not completed. 5. Patient 6 was admitted to the facility on February 21, 2009, with diagnoses of end stage renal disease and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated February 14, 2010, under the Vaccination/Immunization Status documented influenza vaccine given on September 23, 2009. The rest of the section was not completed. During an interview on April 5, 2010, at 1:35 p.m., the clinic manager stated that the immunization history should have been completed.	V 506		
V 513	494.80(a)(10) PA-TRANSPLANTATION REFERRAL The patient's comprehensive assessment must include, but is not limited to, the following: (10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record.	V 513		7/8/10

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V 513	Continued From page 17 This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the facility staff failed to ensure the evaluation of suitability for a transplantation referral, based on the criteria developed by the prospective transplantation center and its surgeons, was documented in the medical records for four (4) of eleven (11) sampled patients (Patients 1, 2, 3 and 5). Findings: 1. Patient 1 was admitted to the facility on February 21, 2009, with diagnoses of end stage renal disease and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated February 14, 2010, did not have written documentation to indicate the patient was assessed for the suitability for transplantation. Further review of the clinical record revealed a letter from a transplant center notifying the dialysis center social worker the inactive status of the patient for failure to provide tests and reports needed at the time of evaluation on January 9, 2009. The letter also documented the transplant center would be grateful if the dialysis social worker would discuss the concern with the patient and let them know of the result. On March 5, 2010, at approximately 1:30 p.m., interview with the Clinic Manager while reviewing the clinical record revealed there was no written documentation to indicate the transplant concern and/or actions taken to address the concern. 2. Patient 2 was admitted to the facility on July 21,	V 513		

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V 513	Continued From page 18 2007, with diagnoses of end stage renal disease, hepatitis B antigen positive and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated November 23, 2009, under the transplant assessment was blank. The multidisciplinary progress notes dated August 24, 2009, documented the patient wanted to be on the transplant list. Further review of the clinical record failed to show written documentation addressing the transplant concern. 3. Patient 3 was admitted to the facility on August 5, 2008, with diagnoses of end stage renal disease and diabetes mellitus type 2 with renal manifestation. The comprehensive interdisciplinary assessment dated September 3, 2009, documented the patient was interested in transplantation. However, there was no written documentation to indicate if the patient was referred or not for transplantation. 4. Patient 5 was admitted to the facility on July 11, 2007, with diagnoses of end stage renal disease, hypertension with renal manifestation and anemia in chronic kidney disease. The comprehensive interdisciplinary assessment dated July 6, 2009, revealed the section under transplant assessment was not filled out.	V 513		
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	V 715		7/2/10

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V 715	Continued From page 19 admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the medical director failed to ensure that the policy relative to changing catheter dressing was adhered to by the licensed nursing staff. The facility staff cleaned and went over the catheter exit site twice using the same gauze for Patient 3. Findings: On March 30, 2010, at approximately 8:30 a.m., Patient 3 was observed being prepped by Employee C to receive dialysis treatment. The employee was wearing gown, face shield and gloves and the patient was wearing a mask. The employee cleaned the catheter ports and hooked up the patient to the hemodialysis machine. The employee then proceeded to remove the old dressing from the catheter exit site on the right chest. With soaked gauze on hand, the employee started to clean the exit site from the center and moving outward in a circular motion. This process was done twice on the exit site with the same soak gauze initially used. A review of the facility's policy on changing catheter dressing stipulated do not go over areas already cleaned and use new sterile gauze each time.	V 715		

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V 715	Continued From page 20 On April 6, 2010, at approximately 12 noon, during an interview with Employee C, she acknowledged that she should not use the same gauze to go over a cleaned area such as the exit site.	V 715		