

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:<br><br><b>052877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>01/29/2010</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>PLUMAS STREET DIALYSIS CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>640 PLUMAS STREET<br/>YUBA CITY, CA 95991</b>                       |   |
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| V 000  | <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 25755<br/>The following represents the findings of the California Department of Public Health during a Recertification Survey from 1/26/10 - 1/29/10.</p> <p>Representing the Department:</p> <p>Susan McBride, HFEN<br/>Glenn Ingo, HFEN<br/>Steve Gardner, HFEN</p> <p>Census 75<br/>Sample size 7</p> <p>Abbreviations used in this document:</p> <p>Admin Administration<br/>cc cubic centimeter<br/>CCHT Certified Clinical Hemodialysis Technician<br/>DON Director of Nurses<br/>EDW Estimated Dry Weight<br/>Kg Kilogram<br/>PPE Personal protective equipment<br/>P&amp;P Policy and Procedure<br/>RN Registered Nurse<br/>Tech Technician<br/>TB tuberculin</p> | V 000   |   |   |
| V 101  | <p><b>494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS</b></p> <p>The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.</p>   | V 101   |   | 2/8/10  |

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 101  | Continued From page 1<br>This STANDARD is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation and interview, the facility failed to ensure compliance with State regulations by not posting a diagram of the facility's water piping system at the nurse's station.<br><br>Findings:<br><br>During the initial tour of the facility, on 1/26/10 at 10:27 am, the patient treatment area was observed. The schematic diagram of the Water Treatment System piping installed in the facility was not posted at the nurse's station as required by the California Code of Regulations, Title 24, Section 613.8 of the California Plumbing Code.<br><br>On 1/28/10 at 8:40 am, Tech B was interviewed. Tech B verified there was no diagram of the facility's water system posted at the nurse's station. | V 101   |   |                      |   |
| V 110  | 494.30 CFC-INFECTION CONTROL<br><br>This CONDITION is not met as evidenced by:<br>Surveyor: 25755<br>Based on observations, interviews, and record reviews, it was determined that the facility did not meet the Conditions for Coverage (CfC) for Infection Control by failing to:<br><br>Findings:<br><br>1. Ensure two of 11 patients had their access sites washed prior to their dialysis treatments to minimize their risk of infection. (See V 111)<br><br>2. Ensure that staff members wore gowns, face   | V 110   |   |                      | 3/30/10   |

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| V 110  | Continued From page 2<br>shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur. (See V 115)<br><br>3. Ensure that items taken into the dialysis stations were either disposed after use, dedicated for a single patient's use only, or cleaned and disinfected before being taken to a common clean area or used on another patient. (See V 116)<br><br>4. Ensure that staff cleaned and disinfected contaminated surfaces, medical devices, and equipment after the use by each patient. (See V 122)<br><br>5. Ensure that all medications that were available for patient use were not expired. (See V 143)<br><br>The cumulative effect of these systemic failures resulted in the facility's failure to maintain a functional, sanitary, safe, and comfortable setting for patients, staff, and the public. | V 110   |   |   |
| V 111  | 494.30 IC-SANITARY ENVIRONMENT<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation, interview, and record review, the facility failed to ensure that patients were being safeguarded from risk of infection when two of 11 patients, (Patients 8 and 9) did not have their vascular access sites washed prior to their dialysis treatment.  | V 111   |   | 3/30/10   |

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| V 111  | <p>Continued From page 3</p> <p>Findings:</p> <p>1. During an observation on 1/26/10 at 1:27 pm, Patient 8 entered the patient treatment room, weighed himself on the scale, and walked over to Station 2. The Patient 8 did not wash his vascular access site (a blood vessel used to connect blood tubing from the patient to the dialysis machine).</p> <p>During an observation on 1/26/10 at 2 pm, Patient 9, wearing a long sleeved shirt, walked into the patient treatment room, weighed himself on the scale, and sat down on Station 8 without washing his vascular access site.</p> <p>An interview was conducted with CCHT F on 1/26/10 at 2:30 pm. CCHT F stated she did not wash Patient 8's access site nor did she remind the patient to wash it himself.</p> <p>The facility policy and procedure titled, "Assessing Patient Vascular access," PRO-2-80, was reviewed on 1/27/10. The policy indicated that patients should wash the limb containing the their vascular access prior to being seated for dialysis. Assist patient to access washing sink and instruct them to wash access using antimicrobial soap and water.<br/>Surveyor: 27519</p> <p>2. During a review of personnel files on 1/27/10 at 4 pm, documentation indicated that three of six facility staff members were not initially evaluated upon hire or annually screened for tuberculosis (TB).</p> <p>During a review of the facility's Employee Health</p> | V 111   |   |                      |   |

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| V 111  | Continued From page 4<br>policy on 1/28/10 at 9:20 am, documentation at number four under "New Hires" indicated that, "PPD (tuberculosis skin test) by Two Step Method on employees who have not had a PPD in the last year or if PPD+ (positive), a chest x-ray." Documentation in the same policy under "All Employees - Annually,"documentation indicated that, " PPD at least annually."   | V 111   |   |                      |   |
| V 115  | 494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK<br><br>Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27519<br>Based on observation, interview, and facility document review, the facility failed to implement their personal protective equipment policy when facility staff were observed at the dialysis stations without gowns, gloves, or face protection while the treatments were in progress.<br><br>Findings: | V 115   |   | 3/30/10              |   |

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| V 115  | Continued From page 5<br><br>During the initial tour on 1/26/10 at 10:50 am, RN C and CCHT I were observed in Station 5 not wearing any personal protective equipment (PPE) which would include gloves, face protection, and gowns while a patient was receiving treatment.<br><br>In an interview on 1/26/10 at 10:55 am, RN C and CCHT I said that they were not aware PPE had to be worn while in a patient treatment station during treatment. They thought PPE had to be worn only when doing patient care.<br><br>A review of a facility document posted on the treatment area wall above the crash cart indicated that all PPE was to be worn when performing any clinical duties on patients.  | V 115   |   |                      |   |
| V 116  | 494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT<br><br>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.<br>-- 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.<br>-- 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.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27519 | V 116   |   | 3/30/10              |   |

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| V 116  | Continued From page 6<br>Based on observation and interview, the facility failed to ensure that items taken into the dialysis station were either disposed of ,dedicated for single patient use, or cleaned and disinfected before the items were removed from the dialysis station. These items had the potential to become contaminated with blood and other body fluids and serve as a means for cross contamination to all patients.<br><br>Findings:<br><br>During the initial tour on 1/26/10 at 11:15 am, the following items were observed on a counter behind nine of 15 patient treatment stations:<br><br>Station 1, a blood pressure cuff, and a box of facial tissue.<br>Station 3, a blood pressure cuff.<br>Station 4, a blood pressure cuff, a clear plastic bag containing several blue clamps, and a box of tissue.<br>Station 5, two boxes of facial tissue.<br>Station 6, a cleaning cloth.<br>Station 8, a live plant.<br>Station 10, a box of facial tissue.<br>Station 13, a rolled towel.<br>Station 14, a blood pressure cuff, a box of exam gloves, and a statue of a red doll.<br><br>In an interview on 1/28/10, at 1:05 pm, Admin Staff A confirmed that there were non-patient items on the counter behind the patient treatment stations. Admin Staff A stated that there should not be anything on the counter unless it belongs to a patient. | V 116   |   |   |
| V 122  | 494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL  | V 122   |   | 3/30/10   |

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| V 122  | <p>Continued From page 7</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:<br/>Surveyor: 25755<br/>Based on observation and interview, the facility failed to ensure that:</p> <ul style="list-style-type: none"> <li>* Five of 15 dialysis treatment chairs were properly disinfected between patient use.</li> <li>* An oxygen concentrator was disinfected between patient use.</li> </ul> <p>This resulted in the potential for transmission of blood borne pathogens between patients, via the dialysis chairs and oxygen concentrators.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 1/26/10, in the patient treatment area, the following observations were made: <ol style="list-style-type: none"> <li>a. At 10:50 am, Station 8's treatment chair had a three inch tear on the seat and a one inch tear on the upper cushion.</li> <li>b. At 2:05 pm, the upholstery on Station 6's treatment chair was worn through exposing a white fabric backing. The upholstery on the headrest had multiple cracks.</li> <li>c. At 2:12 pm, the seat and headrest of the treatment chair at Station 5 was worn and cracked.</li> </ol> </li> </ol> | V 122   |   |   |

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| V 122  | Continued From page 8<br><br>d. At 2:15 pm, the seat cushion of Station 3's treatment chair had a three inch tear and a two inch tear. The cushion that supports the patient's back had a 6 inch tear.<br><br>e. At 4:55 pm, Station 14's chair seat and head rest had multiple small tears in the upholstery.<br><br>On 1/26/10 at 4:40 pm, Admin A acknowledged that the chairs with damaged upholstery could not be properly sanitized.<br>Surveyor: 27519<br><br>2. During an observation and concurrent interview on 1/26/10 at 2:45 pm, CCHT H moved a contaminated oxygen concentrator (a device used to provide oxygen therapy) from Station 10 which was contaminated to Station 3 which was clean. He confirmed that Station 10 had not been decontaminated and that he had not cleaned the contaminated oxygen concentrator before he moved it to the clean Station 3.<br><br>In an interview on 1/26/10 at 4:55 pm, RN E said that the oxygen concentrators should be, "Washed down," before being moved from a contaminated area to a clean area.<br><br>On 1/28/10 at 1:20 pm, a review of the facility's undated AirSep NewLife Elite Oxygen Concentrator Maintenance Policy under the heading Between Patients indicated, "Clean exterior of unit with 1% Bleach Solution or other disinfectant." | V 122   |   |                      |   |
| V 143  | 494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS<br><br>[The facility must-]  | V 143   |   | 3/30/10              |   |

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| V 143  | <p>Continued From page 9</p> <p>(2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p> <p>This STANDARD is not met as evidenced by:<br/>Surveyor: 27519<br/>Based on observation, interview, facility policy and procedure review, the facility failed to ensure that expired medications were not available for use. The use of expired medications put patients at risk to receive medications that were unstable with fluctuating potency.</p> <p>Findings:</p> <p>1. During a tour of the lab area on 1/26/10 at 11:30 am, an opened multi-dose vial of flu vaccine dated 12/22/09, and an opened multidose vial of TB testing fluid (used to test for tuberculosis) dated 9/15/09, were observed in the medication refrigerator, available for use.</p> <p>On 1/26/10 at 11:30 am, the manufacturer's recommendations for the flu vaccine were reviewed. The manufacturer recommended that the multi-dose vials of flu vaccine be discarded 28 days after opening. The flu vaccine had been opened for 35 days, exceeding the manufacturer's recommended discard date by seven days.</p> <p>On 1/26/10 at 11:32 am, the manufacturer's recommendations for the TB testing fluid were reviewed. The manufacturer recommended that the multi-dose vial of TB testing fluid be discarded 30 days after opening. The TB testing fluid had</p> | V 143   |   |                      |   |

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| V 143  | Continued From page 10<br>been opened for 133 days, exceeding the manufacturer's recommended discard date by 103 days.<br><br>In an interview on 11/26/10 at 11:35 am, RN E confirmed that the expired medications were available for use.<br><br>2. During an observation and concurrent interview on 1/26/10 at 2:20 pm, a 50 mL vial of 50% Dextrose (medication used to increase blood sugar) with an expiration date of 8/1/09, was found in the top drawer of a medication cart in the treatment area. RN E confirmed that the vial of Dextrose found in the medication cart had been available for use for 179 days past the expiration date.<br><br>On 1/28/10, a facility policy and procedure titled, "Medication Policy," dated 8/15/08 indicated, "Multi-dose vials are only good for 30 days once they have been opened. Medications left in vials must be discarded. | V 143   |   |   |
| V 400  | 494.60 CFC-PHYSICAL ENVIRONMENT<br><br>This CONDITION is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation, interview, and policy and procedure review, the facility failed to ensure that the physical environment was clean, sanitary, functional, and safe. This Condition is not met as evidenced by:<br><br>Findings:<br><br>1. The facility failed to ensure that the building was constructed, equipped, and maintained to  | V 400   |   | 3/30/10   |

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| V 400  | Continued From page 11<br>provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment (See V 401).<br><br>2. The failed to implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) were maintained and operated in accordance with the manufacturer's recommendations. (See V 403)<br><br>3. The facility failed to ensure that all vascular access site and bloodline connections were visible throughout the patients' dialysis treatments (See V 407).<br><br>4. The facility failed to ensure that staff could demonstrate a knowledge of emergency procedures, and develop a plan for natural disasters in their geographic locations (See V 409).<br><br>5. The facility failed to ensure that the emergency equipment was clean, complete, and ready for use (See V 413)<br><br>The cumulative effects of these systemic problems resulted in th failure of staff to provide care in a clean, sanitary, and functional environment and ensure the safety of the patients and others during dialysis. | V 400   |   |                      |   |
| V 401  | 494.60<br>PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT<br><br>The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment   | V 401   |   | 3/30/10              |   |

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| V 401  | <p>Continued From page 12 environment.</p> <p>This STANDARD is not met as evidenced by:<br/>Surveyor: 25755<br/>Based on observation, interview, and record review, the facility failed to ensure:</p> <ul style="list-style-type: none"> <li>* That the treatment environment was safe when two unlabeled syringes were found in the patient treatment area containing an unknown liquid.</li> <li>* That expired chemical test strips were available for use.</li> <li>* That chemical test strips were stored according to the manufacturer's directions.</li> <li>* That open medication vials were labeled per the facility's policy.</li> <li>* That medications were being monitored for proper storage and the medications' expiration dates were being monitored by a nurse.</li> <li>* That medications were securely stored per the facility's policy.</li> </ul> <p>Findings:</p> <p>1. On 1/26/10 at 11:02 am, an unlabeled 60 cc syringe containing 30 cc of a clear yellowish fluid was observed in the patient treatment area near the sink at the nurses station. A second unlabeled 60 cc syringe containing 45 cc of a clear yellowish fluid was sitting on top of a gray cart in the patient treatment area near Station 15.</p> <p>During an interview with CCHT F, on 1/26/10 at 11:21 am, she stated that both 60 cc syringes contained solid bleach (undiluted) that was used to clean the dialysis machines at the end of the night. CCHT F stated that according to the facility policy, the syringes should have been labeled and thrown away after they were used.</p> | V 401   |   |                      |   |

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| V 401  | <p>Continued From page 13</p> <p>2. On 1/27/10 at 9:42 am, two expired containers of chemical testing strips were observed on the shelf of the refrigerator door, in the water treatment room. Both containers had an expiration date of 11/09. At 10:58 am, in the bottom right hand drawer of the refrigerator, eleven additional containers of expired chemical testing strips were observed. Seven had an expiration date of 11/09. Two had expired in 10/09. One had expired in 7/09 and one in 4/09.</p> <p>During an interview with Tech B, on 1/27/10 at 11:03 am, he stated he uses the chemical test strips to check for residual Renalin (Germicide used for disinfection. According to the manufacturer, exposure to small amounts of Renalin could cause nausea, vomiting, chest pain or tightness, dizziness, low blood pressure, a numbness and tingling sensation, itching, and sweating). Tech. B stated, "I must have forgotten to order more strips."</p> <p>The manufacturer's instructions for storage and use were reviewed. Listed under the heading, "Warnings and Precautions," the manufacturer lists, "Do not use test strips after the expiration date."</p> <p>3. During an interview with Tech B, on 1/24/10 at 4:15 pm, he stated that both the opened and unopened containers of chemical test strips were kept in the refrigerator. Tech B stated they have always stored them in the refrigerator.</p> <p>On 1/27/10, the manufacturer's instructions for storing the chemical test strips were reviewed. The manufacturer's instructions for storage were as follows:</p> <p>a. Store in a cool dry environment.</p> | V 401   |   |   |

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| V 401  | <p>Continued From page 14</p> <p>b. Once opened store at room temperature.</p> <p>c. Failure to store test strips properly will result in inaccurate readings.<br/>Surveyor: 27519</p> <p>4. During the initial tour on 1/26/10 at 11:30 am, an open, undated and not dated, vial of H1N1 flu vaccine in a 5mL multi-dose vial was observed available for use in the medication refrigerator located in the laboratory area.</p> <p>On 1/26/10 at 11:40 am, Admin Staff A said that, "Medication vials should be dated and initialed when opened."</p> <p>On 1/28/10 at 1:20 pm, a review of the facility's Medication Policy dated 8/15/08, indicated that, "Vials of medication will be dated, timed and initialed when opened." In the same section the policy indicated that, "Multi-dose vials are only good for 30 days once they have been opened. Medications left in the vials must be discarded."</p> <p>5. In an interview on 1/26/10 at 12:10 pm, RN E said that the medications in the medication cabinets and refrigerator were checked by Tech B, an unlicensed staff member.</p> <p>On 1/28/10 at 1:20 pm, a review of the facility's Medication Policy dated 8/15/08, indicated that, "A list of all medications...must be maintained and expiration dates monitored on a monthly basis. The nurse doing the check must sign and date the form."</p> <p>6. During an observation on 1/26/10 at 11:35, the medication cabinet labeled, "IV (intravenous) MEDS " in the laboratory area was unlocked.</p> | V 401   |   |   |

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| V 401  | <p>Continued From page 15</p> <p>7. During an observation on 1/26/10 at 12:05 pm, of the treatment area, a syringe with 1cc of heparin 1: 1000 (a blood thinner) and a syringe with three ccs of heparin 1: 1000 were found in an unlocked drawer near the sink across from Station 5.</p> <p>8. During an observation on 1/26/10 at 2:20 pm, an open 30 mL vial of heparin 1,000 units/mL (units per milliliter) without an open date or initials written on the label, was found unsecured at the nurse's station.</p> <p>9. During an observation on 1/27/10 at 11:20 am, multiple vials of heparin 1,000 units/mL were observed unsecured at the nurse's stations and desks in the treatment area.</p> <p>In an interview on 1/28/10 at 8:30 am, Admin Staff A said that medication vials were not suppose to be left where they would be accessible to patients, family, or visitors.</p> <p>On 1/28/10 at 1:20 pm, a review of the facility's Medication Policy dated 8/15/08, indicated that medications were to be stored in a secured area.</p> <p>10. During observation of the laboratory area, on 1/26/10 at 4:35 pm, the following supply items were expired and still available for use:</p> <ul style="list-style-type: none"> <li>· Two 15 mL bottles of Hemocult (a test to detect blood in stool) developer expired on 1/09 and 3/09.</li> <li>· 28 Hemocult Patient Kits (used to collect stool samples) expired on 9/08.</li> <li>· 50 Fecal Occult Blood Tests (used to detect</li> </ul> | V 401   |   |                      |   |

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| V 401  | Continued From page 16<br>blood in stool) expired on 1/08.<br><br>· Three 15 mL vials of Para-Pak Zn-PVA Fixative 10% buffered neutral formalin (used to preserve stool samples that may contain parasites) with expiration date 1/03.<br><br>11. On 1/27/10 at 8:30 am, in the hallway across from the laboratory area, five oxygen E-cylinders (small oxygen tanks with 660 liters of oxygen under 1900 pounds of pressure per square inch) were observed not to be secured to the wall.<br><br>On 1/27/10 at 9:30 am, a review of the facility's Disaster Preparedness policy under Facility Preparation indicated that, "Oxygen cylinders in use or as standby need to be secured, either in crates or stands and then chained to the walls."<br><br>12. During an inspection in the laboratory area on 1/27/10 at 8:40 am, the following supply items were found to be expired but still available for use:<br><br>· 21 blood collection tubes with light blue tops expired on 12/09.<br><br>· One 40 mL bottle of Bactec anaerobic and one bottle of Bactec aerobic (used for preserving blood samples) expired on 11/30/08.<br><br>· 19 Cepti-Seal Blood Culture Prep Kits (used to clean the skin before drawing blood) expired on 9/06.<br><br>In an interview on 1/27/10 at 9 am, RN D confirmed that he supplies were expired, but still available for use. | V 401   |   |                      |   |
| V 403  | 494.60(b) PE-EQUIPMENT   | V 403   |   | 2/12/10              |   |

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| V 403  | <p>Continued From page 17</p> <p><b>MAINTENANCE-MANUFACTURER'S DFU</b></p> <p>The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>This STANDARD is not met as evidenced by:<br/>Surveyor: 25755<br/>Based on observation and interview, the facility failed to maintain five of 15 patient treatment chairs that had worn and torn upholstery.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 1/26/10, in the patient treatment area, the following observations were made: <ol style="list-style-type: none"> <li>a. At 10:50 am, Station 8's treatment chair had a three inch tear on the seat and a one inch tear on the upper cushion.</li> <li>b. At 2:05 pm, the upholstery on Station 6's treatment chair was worn through exposing a white fabric backing. The upholstery on the headrest had multiple cracks.</li> <li>c. At 2:12 pm, the seat and headrest of the treatment chair at Station 5 was worn and cracked.</li> <li>d. At 2:15 pm, the seat cushion of Station 3's treatment chair had a three inch tear and a two inch tear. The cushion that supports the patient's back had a 6 inch tear.</li> </ol> </li> </ol> | V 403   |   |   |

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| V 403  | Continued From page 18<br>e. At 4:55 pm, Station 14's chair seat and head rest had multiple small tears in the upholstery.   | V 403   |   |   |
| V 407  | On 1/26/10 at 4:50 pm, Admin A acknowledged that the chairs with damaged upholstery were in need of repair.<br><br>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS<br><br>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 25755<br><br>Based on observation, interview, and record review, the facility failed to ensure that the patient's vascular access sites were visible at all times during the dialysis treatment for three of 12 randomly observed patients, resulting in the potential for undetected needle dislodgement leading to heavy, uncontrolled bleeding and death.<br><br>Findings:<br><br>1. On 1/26/10 at 11:25 am, in the patient treatment room, a sign that read, "Your access site must be uncovered at all times," was posted on the wall near Station 9.<br><br>During an observation on 1/26/10 at 12:34 pm, a patient seated at Station 13 was wearing a purple blanket that covered her vascular access site and the bloodlines which were connected to the dialysis machine. | V 407   |   | 3/30/10   |

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| V 407  | <p>Continued From page 19</p> <p>On 1/28/10, an undated facility policy titled, "Patient's Laundering Instructions for Blankets Brought to the Unit," was reviewed. The policy read, "For safety reasons, your access must remain uncovered for the entire treatment." On page 10 of a facility policy titled, "Patient Treatment Information," dated 10/9/00, the policy indicated, "It is the responsibility of the patient to comply with all of the rules and regulations of the facility.<br/>Surveyor: 27519</p> <p>2. During an observation on 1/28/10 at 8:30 am, a patient in Station 4 had a central venous catheter site covered by a blanket and a patient in Station 7 had a left upper extremity access site covered by a sweater.</p> <p>In an interview on 1/28/10 at 8:35 am, RN D and CCHT G said the facility policy was that access sites were to be exposed. It was further said that the patient in Station 4 had been told not to cover the access site, but allowed to continue to cover it.</p> <p>On 1/28/10 at 8:40 am, a review of notices, one posted in the lobby and four posted in the treatment area visible to all patients indicated that, "Your access must be uncovered at all times."</p> <p>On 1/28/10 at 1:20 pm, a review of an undated facility document, Patient's Laundering Instructions for Blankets Brought to the Unit, indicated, "For safety reasons, your access must remain uncovered for the entire treatment."</p> <p>On 1/28/10 at 1:20 pm, a review of the facility's Patient Treatment Information policy dated</p> | V 407   |   |                      |   |

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| V 407  | Continued From page 20<br>10/9/00, at number 11 indicated that, "It is the responsibility of the patient to comply with all of the rules and regulations of the facility and to question any of these that are not understood."  | V 407   |   |   |
| V 409  | 494.60(d)(1) PE-ER PREP<br>STAFF-INITIAL/ANNUAL/INFORM PTS<br><br>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:<br>(i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of-<br>(A) What to do;<br>(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;<br>(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<br>(D) How to disconnect themselves from the dialysis machine if an emergency occurs.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation, interview, and facility document review, the facility failed to ensure that staff were knowledgeable of what to do in case of an emergency when:<br>* RN D did not respond to a fire drill.<br>* Staff members failed to close doors, that would | V 409   |   | 3/30/10   |

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| V 409  | <p>Continued From page 21</p> <p>contain a fire.</p> <ul style="list-style-type: none"> <li>* The facility was conducting "tabletop" fire drills, not actual fire drills.</li> <li>* The facility failed to conduct fire drills in the first and fourth quarter of 2009.</li> <li>* The facility failed to conduct annual disaster drills.</li> <li>* CCHT K did not know where the emergency shut offs were located for the gas, electricity, or water.</li> </ul> <p>The lack of staff's knowledge for emergency preparedness has the potential to threaten the health and safety of the patients, staff, and the public.</p> <p>Findings:</p> <p>On 1/27/10 at 10:10 am, a mock fire drill was conducted. The staff in the patient treatment area were observed during the drill. RN D was observed standing at Station 11. She stood there and looked around as the fire alarm was sounding, and did not respond to the fire alarm. Two patient care technicians were observed near Station 4. They continued to care for their patients, and did not respond to the drill.</p> <p>On 1/29/10, a facility document titled, "Critique of Drill", was reviewed. The critique of the staff included:</p> <ol style="list-style-type: none"> <li>a. Were all the windows and doors closed?</li> <li>b. Did everyone meet at the nurse's station?</li> <li>c. Were patients instructed on evacuation and evacuation procedures?</li> </ol> <p>Surveyor: 27519</p> <p>2. During an observation of a fire drill on 1/27/10 at 10:10 am, the seven doors were observed left</p> | V 409   |   |   |

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| V 409  | <p>Continued From page 22</p> <p>open instead of being closed in an effort to contain a fire.</p> <p>3. On 1/27/10 at 9:25 am, a review of the facility's Fire/Disaster Drill Reports indicated that the first and fourth quarter fire drills for 2009 were not conducted. The documentation also indicated that a fire drill was conducted on 1/26/10. There was no documentation that the facility had conducted any annual disaster drills.</p> <p>In an interview on 1/27/10 at 9:35 am, Admin Staff A was informed that no fire drill was observed on 1/26/10. He stated that a fire drill was conducted on 1/25/10, by Tech B. He explained that he printed the pre-dated Fire/Disaster Drill Reports on 1/21/10 and gave them to Tech B and anticipated that the fire drills would be done on 1/25/10 and 1/26/10. He also confirmed that the documentation for the first and fourth quarter fire drills was missing.</p> <p>In an interview on 1/27/10 at 9:40 am, Technical Staff B said that the fire drills conducted, on 1/25/10 and 1/26/10, were not simulations. Tech B described the fire drill as, a scenario. He would describe a fire situation to random staff and then ask them questions about how they would respond.</p> <p>4. In an interview on 1/27/10 at 10 am, Admin Staff A stated that, "The Clinic has not had annual disaster drills."</p> <p>In an interview on 1/28/10 at 2 pm, CCHT K said that she knew where the main shut-offs were for gas, electricity, and water, but she was unable to locate the shut-offs without the assistance of Tech B.</p> | V 409   |   |   |

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| V 409  | Continued From page 23<br><br>During an observation on 1/28/10 at 2:15 pm, the shut-offs for gas and electric where located in a locked exterior room on the South side of the building adjacent to Scott Street. The main water shut-off valve was located in the water room in a corner near the Bio-hazard room.<br><br>During an observation and concurrent interview on 1/28/10 at 2:30 pm, RN E demonstrated the locations of the gas, electric, and water shut-offs, but stated that she did not know the location of the keys that unlock the gas/electrical room.<br><br>On 2/8/10 at 1:40 pm, a review of the facility's Disaster Policy dated 10/9/00, indicated that, "On a quarterly basis, all staff will participate in fire/disaster drills ... The drill will simulate a real fire/disaster .." and, "On a yearly basis, the staff will receive an in-service on different emergencies and disasters that could occur in the area." | V 409   |   |   |
| V 413  | 494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION<br><br>Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27519<br>Based on observation, record review, and interview, the facility failed to ensure that the emergency cart was properly maintained. This had the potential to result in failure to deliver appropriate care to patients.   | V 413   |   | 2/2/10  |

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| V 413  | <p>Continued From page 24</p> <p>During an observation with Admin Staff A of the facility's emergency cart on 1/27/10 at 11:00 am, the emergency cart was dirty and dusty. The vacuum apparatus (used to remove secretions from a patient's mouth and throat in an emergency) was not functioning.</p> <p>Admin Staff A identified that the vacuum port on the lid of the collection canister, where the connecting tube from the vacuum pump connects to the collection canister to create suction, had broken off.</p> <p>During a comparison of the contents of the emergency cart and the a checklist used for the emergency cart on 1/27/10 at 11:15 am, the following was identified:</p> <ul style="list-style-type: none"> <li>* The check list documented that the Atropine Sulfate 1 mg had an expiration date listed as 8/10. The actual expiration date on medication was 8/1/10.</li> <li>* Five Epinephrine 1:1,000 (1 mg) were on the check list but 50 doses were found in the cart.</li> <li>* Lidocaine 2% 100 mg/5 mL had an expiration date listed as 3/10. The actual expiration date was 3/1/10.</li> <li>*Dextrose 50% 50 cc had an expiration date listed as 2/10. The actual expiration date was 2/1/10.</li> <li>* Sodium Bicarbonate 50 mg had an expiration date listed as 3/10. The actual expiration date was 3/1/10.</li> <li>*Verapamil 5 mg/2 mL had an expiration date listed as 3/10. The actual expiration date was</li> </ul> | V 413   |   |   |

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| V 413  | Continued From page 25<br>3/1/10.<br><br>*The check list had two 1000 cc bags of Normal Saline with no expiration dates. The actual expiration dates were 4/10. No expiration date indicated on the list.<br><br>*The check list had three 150 cc bags of Normal Saline with no expiration dates. The actual expiration dates were 3/10.<br><input type="checkbox"/> There was no quantity indicated on the checklist for several items found in the emergency cart such as syringes, tape, gloves, scissors, clamps, airways, and masks. There were several items in the emergency cart but not listed on the checklist.<br><br>In an interview on 1/27/10 at 11:15 am, Admin Staff A said that he was the person that checked and signed off the emergency cart checklist for 1/10. A review of the "Medication List" indicated that the cart had been checked for 1/10. | V 413   |   |   |
| V 540  | 494.90 CFC-PATIENT PLAN OF CARE<br><br>This CONDITION is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation, policy and procedure review, and staff interview, the facility failed to ensure that patients were provided the necessary care and services to manage their fluid volume status as follows. This Condition is not met as evidenced by:<br><br>1. The facility failed to perform post treatment assessments for their fluid status.<br>(See V 543)  | V 540   |   | 3/30/10   |

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| V 540  | Continued From page 26<br>2. The facility failed to provide the necessary care and services to manage volume status for one of seven sampled patients. (Patient 2) (See V 543)   | V 540   |   |   |
| V 543  | <p>The cumulative effect of these systemic failures had the potential to result in the failure to identify and meet the necessary care needs of all 75 patients. The facility failed to ensure compliance with the Condition of Participation: Plan of Care 494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>The plan of care must address, but not be limited to, the following:<br/>(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>This STANDARD is not met as evidenced by:<br/>Surveyor: 25755<br/>Based on observation, interview, record review, and facility policy review, the facility failed to: (1.) Implement their post treatment assessment policy and procedure. (2.) Failed to provide the necessary care and services to manage volume status for Patient 2, one of seven sampled patients.</p> <p>Findings:</p> <p>1. On 1/26/10 at 1:38 pm, following dialysis treatment, RN E was observed applying tape to Patient 10's forearm at Station 9. RN E did not listen to his lungs after his dialysis treatment. Or check his ankles for swelling.</p> <p>During an interview with RN E on 1/26/10 at 1:38 pm, in the patient treatment area, RN E stated the technician had written down Patient 10's vital</p> | V 543   |   | 3/30/10   |

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| V 543  | <p>Continued From page 27</p> <p>signs and spoke to him to make sure he was ok.</p> <p>On 1/26/10 at 1:55 am, after the completion of the dialysis treatment, Patient 10 was interviewed in the front lobby of the facility. He stated, "RN E listened to my heart but did not put anything on my back."</p> <p>The "Patient Treatment Record", dated 1/26/10, was reviewed on 1/26/10. The post assessment for lung sounds, heart rhythm, edema (swelling), signs of infection, complaints of nausea, vomiting, pain, and shortness of breath, were blank.</p> <p>2. During an observation on 1/26/10 at 1:57 pm, Patient 11, seated at Station 6, had left the patient treatment area without a post assessment by an RN.</p> <p>On 1/26/10 at 1:59 pm, Patient 11 was interviewed. The Patient 11 stated the RN did not listen to his chest or heart after he finished his dialysis treatment.</p> <p>The "Patient Treatment Record", dated 1/26/10, was reviewed on 1/26/10. The post assessment for lung sounds, heart rhythm, edema (swelling), signs of infection, complaints of nausea, vomiting, pain, and shortness of breath, were blank.</p> <p>3. During an interview with Patient 12, seated at Station 13 in the patient treatment area, she stated the RN did not listen to her lungs, heart, or check her ankles for swelling, "But they are still there."</p> <p>The "Patient Treatment Record", dated 1/26/10, was reviewed on 1/26/10. The post assessment for lung sounds, heart rhythm, edema (swelling),</p> | V 543   |   |                      |   |

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| V 543  | <p>Continued From page 28</p> <p>signs of infection, complaints of nausea, vomiting, pain, and shortness of breath, were blank.</p> <p>4. On 1/26/10 at 2:20 pm, Patient 13, seated at Station 1, was interviewed. She stated the RN did not listen to her chest or back, or check her ankles for swelling.</p> <p>The "Patient Treatment Record", dated 1/26/10, was reviewed on 1/26/10. The post assessment for lung sounds, heart rhythm, edema (swelling), signs of infection, complaints of nausea, vomiting, pain, and shortness of breath, were blank.</p> <p>The facility policy and procedure titled, "Medical Records - Documentation," PRO-8-10 was reviewed. The policy read, "The patient's medical record gives a synopsis of the patient's condition, showing progress or deterioration, with health care goals and team planning. If not documented, not done." "Do not leave blank areas on the document."</p> <p>On 1/27/10, a facility policy titled, "Assessing Patient Heart Rate, PRO-2-50" was reviewed. The policy indicated the procedure for determining patients' heart rate pre treatment, during treatment, and post treatment. The procedure listed in the policy was to affix the earpieces of the stethoscope in the ears, listen to the heart for one full minute, and document the heart rate on the patient's treatment sheet. To determine a radial (pulse that can be felt when grasping the wrist) pulse, locate the pulse and feel the pulse while looking at a timepiece for one full minute.</p> <p>On 1/27/10, the facility policy, "Assessing Patient Lung Sounds," PRO-2-20, was reviewed. The</p> | V 543   |   |                      |   |

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| V 543  | <p>Continued From page 29</p> <p>purpose of the policy was to assess the patient's breathing pre treatment and post treatment. The procedure was to apply the stethoscope to the patient's back above the shoulder blade on the left side. Listen and move the stethoscope from the left to the right side for comparison. Move the stethoscope down the patient's back comparing the two sides until reaching the bottom of the rib cage. Document the assessment.</p> <p>The facility policy and procedure titled, "Assessing Patient Edema," PRO-2-30 was reviewed on 1/27/10.<br/>The procedure is as follows:</p> <ol style="list-style-type: none"> <li>1. Look at the patient's ankles for swelling while the patient is seated.</li> <li>2. Lightly hold patient's ankles and gently squeeze noting indentation. Checking for ankle swelling.</li> <li>3. Lightly press down on the skin with fingers noting for indentation and remaining pitting marks once fingers are removed.</li> <li>4. Assess how far up the leg the edema is found.</li> <li>5. Look at patient's eyes for swelling around the eye sockets.</li> </ol> <p>Surveyor: 26654</p> <p>5. Patient 2 was a 52 year old admitted on 2/25/08 with a diagnosis of end stage renal disease.</p> <p>On 1/28/10, Patient 2's medical record and treatment sheets were reviewed and indicated the following:</p> <p>(a.) Patient 2's EDW on admission was 73 kg.</p> <p>(b.) Due to non-compliance, the patient was unable to meet this goal.</p> | V 543   |   |                      |   |

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| V 543  | Continued From page 30<br><br>(c.) A physician's order dated 8/6/09 increased the patient's EDW to 81kg.<br><br>(d.) The patient treatment sheet dated 1/7/10 indicated an EDW of 81kg, The patient pre treatment weight was 93.3 kg and the post treatment weight was 90.4 kg<br><br>(e.) The patient treatment sheet dated 1/9/10 indicated an EDW of 90 kg, The patient pre treatment weight was 93.8 kg and the post treatment weight was 90.8 kg<br><br>(f.) The patient treatment sheet dated 1/23/10 indicated an EDW of 87 kg, The patient pre treatment weight was 88.8 kg and the post treatment weight was 87 kg<br><br>(g.) A review of the physician's treatment orders indicated no changes to Patient 2's EDW since 8/6/09.<br><br>On 1/28/10 at 8:30 am, in a concurrent interview and record review, Admin Staff A conceded that there was no evidence in the physician's orders that the physician had been made aware of the increases in Patient 2's EDW. | V 543   |   |                      |   |
| V 714  | 494.150(c)(1) MD RESP-DEVELOP, REVIEW & APPROVE P&P<br><br>The medical director must-<br>(1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility;<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 26654  | V 714   |   | 2/10/10              |   |

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| V 714  | Continued From page 31<br>Based on record review and interview, the facility failed to establish policies and procedures which reflect current facility practice for monitoring patients on high doses of ESAs (erythropoietin stimulating agents).<br><br>Findings:<br><br>In an interview and concurrent record review of anemia management records on 1/28/10 at 8:30 am, Admin Staff A indicated the procedure in use for monitoring patients on higher than normal doses of ESAs. Admin Staff 1 could produce no facility policy outlining the procedure for the increased monitoring of these patients.  | V 714   |   |   |
| V 729  | 494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY<br><br>(1) Current medical records and those of discharged patients must be completed promptly.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27519<br>Based on interview and record review, the facility failed to complete four of six medical records within the 30 day timeframe that was indicated in the facility's, Admission, Transfer, and Discharge policy.<br><br>During a record review on 1/28/10 at 10:15 pm, there was no physician signature on the Discharge Summary for four of six medical records reviewed and no date on a Discharge Summary for one of six medical records reviewed.<br><br>In an interview on 1/28/10 at 10:30 am, Social Worker J confirmed that the Discharge Summaries from the medical records that were | V 729   |   | 3/1/10  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>052877</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>01/29/2010</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PLUMAS STREET DIALYSIS CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>640 PLUMAS STREET<br/>YUBA CITY, CA 95991</b>                       |   |
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| V 729  | Continued From page 32<br>reviewed were not signed and dated by the physician. She said that she had been Completing and signing the Discharge Summaries.<br><br>During the same record review on 1/28/10 at 10:15 am, documentation on the Discharge Summary of one of the reviewed medical records indicated that the Licensed Clinical Social Worker signed and dated it on 11/8/09, a Sunday.<br><br>In an interview on 1/28/10 at 10:30 am, Social Worker J was asked if she worked on Sundays. She replied, "No, I don't work on Sundays." She was unable to provide a reason why the Discharge Summary dated 11/8/09, had her signature on it.<br><br>On 1/28/10 at 11:50 am, a review of the facility's Admission, Transfer, and Discharge policy dated 4/15/08, indicated that, "The Discharge Summary must be completed and signed by the physician within 30 days of the patient's discharge from the facility." | V 729   |   |   |
| V 750  | 494.180 CFC-GOVERNANCE<br><br>This CONDITION is not met as evidenced by:<br>Surveyor: 25755<br>Based on observation, staff interview, policy and procedure review, the governing body failed in its responsibility for the governance and operation of the facility. This Condition was not met as evidenced by:<br><br>Findings:<br><br>The governing body has full legal authority and  | V 750   |   | 3/31/10   |

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| V 750  | Continued From page 33<br>responsibility for the governance and operation of the facility. The ability of the health care team to provide a safe level of care to patients cannot be ensured as evidenced by the seriousness of the deficiencies cited throughout this document as follows:<br><br>1. The facility failed to provide and monitor for a sanitary, functional, and safe environment to minimize the transmission of infectious agents within the facility. (See V 110 and V 400)<br><br>2. The facility failed to ensure that staff members wore gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur. (See V 115)<br><br>3. The facility failed to ensure that items taken into the dialysis stations were either 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, (See V 116)<br><br>4. The facility failed to ensure that staff cleaned and disinfected contaminated surfaces, medical devices, and equipment after each patient's treatment. (See V 122)<br><br>5. The facility failed to ensure that all medications that were available for patient use were not expired.(See V 143)<br><br>6. The facility failed to ensure that the interdisciplinary team provided the necessary care and services to manage the patient's volume status. (See V 543) | V 750   |   |                      |   |

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| V 750  | Continued From page 34<br><br>7. The facility failed to ensure that the medical director participated in the development, periodic review, and approval of patient care policies and procedures for the facility. (See V 714)<br><br>8. The facility failed to ensure that current medical records and those of discharged patients were completed promptly. (See V 729)<br><br>The cumulative effects of these systemic problems resulted in the inability of the governing body to ensure the provision of quality care in a clean, safe, and sanitary environment, that medications administered to the patients were safe for patient use, that necessary care and services were provided to manage the patient's volume status, that medical records were completed promptly, and that staff demonstrated a knowledge of emergency procedures. | V 750   |   |                      |   |