

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

PRINTED: 10/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052835	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2010
NAME OF PROVIDER OR SUPPLIER RAI - BROADWAY - CHULA VISTA			STREET ADDRESS, CITY, STATE, ZIP CODE 1181 BROADWAY, SUITE 5 CHULA VISTA, CA 91911	
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 17130 The following represents the findings of the California Department of Public Health during a recertification visit from 6/28/10 through 7/06/10. The facility census at the time of the visit was 180 patients. The sample size was 15 patients.</p> <p>Representing the Department were HFEN's: #17130, #22383, and #15930.</p> <p>On 7/1/10 at 4:03 P.M., an immediate jeopardy was called due to staff members providing care to 5 hepatitis B susceptible patients at the same time as hepatitis B positive patients. The immediate jeopardy was abated on 7/1/10 at 5:22 P.M.</p> <p>Glossary of Abbreviations:</p> <p>CCHT Certified Clinical Hemodialysis Technician CD Clinical Director GB Governing Body P&P Policy and Procedure RN Registered Nurse</p>	V 000		
V 110	<p>494.30 CFC-INFECTON CONTROL</p> <p>This CONDITION is not met as evidenced by: Surveyor: 22383 Based on observation, interview, and record review, the facility failed to ensure that staff who cared for Hepatitis B positive patients did not simultaneously also care for patients who were susceptible to Hepatitis B (refer to V 131). The facility also failed to refer a Hepatitis B+ staff member to a physician, for follow up, after they</p>	V 110		8/2/10

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 110	Continued From page 1 were aware she positive for Hepatitis B, per their P&P (refer to V 131). The facility failed to ensure that a physician used proper hand washing technique when he moved from a dirty area to a clean area (refer to V 113). The facility additionally failed to ensure that staff disinfected 8 of 12 hemodialysis machine prime buckets in-between patients (refer to V 122). The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	V 110		
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation, interview and record review, the facility failed to ensure that a physician used proper technique when moving from a dirty area to a clean area. The facility failed to ensure that the physician wore gloves while touching patient equipment in 1 area then either washed his hands or used hand sanitizer before moving to the shared computer between stations 17 and 18. Ungloved/unwashed hands caused cross contamination of the shared computer station. Findings:	V 113		8/2/10

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V 113	Continued From page 2 On 6/28/10 at 8:15 A.M., while patients received dialysis, MD 1 used his personal mobile computer with ungloved hands. He then touched a treatment chair side table and used the mouse on the clean shared computer between patient stations 17 and 18. This cross contaminated the shared computer station. When interviewed on 6/28/10 at 8:25 A.M., MD 1 stated, his mobile computer screen froze up and he needed to use another computer. MD 1 further stated, "I should have washed my hands." On 7/2/10, the facility P & P entitled, "Keyboards in The Treatment Area: Infection Control", read in part as follows; "...Option I: The keyboard area and top of the cart that houses the monitor and Winterm are designated as clean areas. Before using the keyboard to enter patient data, hands must be washed...Option II: The keyboard area and top of the cart that houses the monitor and Winterm are designated as dirty areas. Before using the keyboard to enter patient data, clean gloves must be put on. Keyboards may not be touched with bare hands..."	V 113			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by:	V 122		8/2/10	

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V 122	<p>Continued From page 3</p> <p>Surveyor: 15930</p> <p>Based on observation, interview and record review, the facility failed to ensure staff disinfected 8 of 12 hemodialysis machine prime buckets between patients. This resulted in the potential for cross-contamination with blood borne pathogens from the prime buckets.</p> <p>Findings:</p> <p>The facility hemodialysis machines were equipped with prime buckets attached to the side of the machines. During machine preparation, staff members drained and discarded saline solution into the prime buckets.</p> <p>During observations on 6/30/10 from 12:30 P.M. to 2:30 P.M., staff members did not disinfect the inside or outside of the prime buckets located on machines at stations 24, 25, 26, 27, 28, 29, and 30 during turnover between second and third shift patients.</p> <p>Surveyor: 17130</p> <p>During observation on 6/30/10 at 12:42 P.M., CCHT 3 disinfected the surfaces of the dialysis machine in Station 14 with a disposable cloth soaked in a bleach solution during turnover between the second and third shift patients. The prime bucket on the machine contained discarded saline from the second shift patient. CCHT 3 did not remove, empty, and disinfect the prime bucket after disinfecting the machine.</p> <p>At 1:14 P.M., CCHT 3 attached and primed new tubing to the disinfected dialysis machine in preparation for the third shift patient. Then, CCHT 3 removed the prime bucket that held the discarded saline and emptied the fluid into the sink. CCHT 3 rinsed the prime bucket with tap</p>	V 122		

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V 122	<p>Continued From page 4</p> <p>water from the faucet and re-attached the bucket to the disinfected dialysis machine. CCHT 3 did not wipe down the inside or the outside of the prime bucket.</p> <p>During an interview on 6/30/10 at 1:40 P.M., CCHT 3 stated that the prime bucket must be disinfected with a "bleach wipe". He acknowledged that he forgot to clean the prime bucket in Station 14.</p> <p>During an interview on 7/01/10 at 1:45 P.M., RN 2 stated that staff should wipe down the inside and outside of the prime buckets between patients with a cloth soaked in the bleach solution.</p> <p>In the April, 2001 article, "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients", the Centers for Disease Control and Prevention specified that "contaminated priming buckets that were not routinely changed or cleaned and disinfected between patients" may have contributed to outbreaks of patient infections in dialysis facilities.</p> <p>During an interview on 7/01/10 at 2:11 P.M., the CD stated that she expected staff to wipe down the inside of the prime bucket just like they wipe down the dialysis machine.</p> <p>On 7/2/10, the facility P&P titled, "Cleaning and Disinfection of Equipment, Supplies & Treatment Area" read in part, "the external surface of the prime bucket will also be wiped with a disposable cloths soaked in the bleach/water mixture that is discarded after use." The P&P did not address the disinfection of the internal surface of the prime bucket, contrary to expected staff practices.</p>	V 122			

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V 131	<p>494.30(a)(1)(i) IC-HBV-ISOLATION-STAFFING</p> <p>Isolation of HBV+ Patients</p> <p>Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during the period when dialysis is terminated on one patient and initiated on another.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22383 Based on interview and record review, the facility failed to ensure that staff did not care for 5 of 60 patients (16, 17, 18, 19, 20) who were susceptible to Hepatitis B while also providing care for patients who were Hepatitis B+. The facility also failed to follow their P&P for an employee found to be Hepatitis B+.</p> <p>Findings: 1. The facility provided their Hepatitis tracking information on 6/30/10. The facility records indicated that they had 4 of 180 patients who were Hepatitis B+, and 60 of the 180 patients remained susceptible to Hepatitis B. The facility provided the patient seating schedule. It showed where each patient sat during treatment and their appointment times. The seating schedule also has the staff assignments. The seating schedule indicated an isolation station used for the 4 patients that were Hepatitis B+ as part of a pod of patients. Comparison of the seating schedule with the Hepatitis B tracking information identified that there were 5 patients susceptible to Hepatitis B who sat in the same pod as the isolation station. One staff member was assigned to care for that pod of patients. The CD stated on 7/1/10 at 2:34 P.M., that the patients' Hepatitis B status was not taken into</p>	V 131		8/2/10

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V 131	<p>Continued From page 6</p> <p>consideration when she made the seating schedule and staff assignments . This oversight placed the 5 susceptible patients at greater risk for contracting Hepatitis B, during their hemodialysis treatments. The Medical Director stated on 7/1/10 at 2:54 P.M., that if the susceptible patients were cared for by the same staff caring for the Hepatitis B+ patients, it would violate their P&P. He stated their policy stated that staff should not take care of Hepatitis B+ patients and susceptible patients, at the same time.</p> <p>The facility P&P Hepatitis B: Control Management last revised 7/09 read in part ..."37. Patients considered susceptible to Hepatitis B will not be dialyzed in or adjacent to the designated Hepatitis B isolation room/area. Staff may not care for both HBsAg positive patients and susceptible patients at the same time."</p> <p>2. The facility provided their employee Hepatitis B tracking record on 6/30/10. The facility had 1 staff member known to be Hepatitis B+. The facility had documentation that the employee tested positive for Hepatitis B when hired in 2004. The facility could not provide any other documentation related to her Hepatitis B+ status.</p> <p>The staff member stated on 7/1/10 at 2:31 P.M., that she was told, after being tested again in February of this year, after a needle stick, that she was Hepatitis B+ but did not have the disease and was not infectious.</p> <p>The facility P&P Employee Health Monitoring Program read in part..."7. New employees found to be Antigen (HBsAg) positive and Antibody (Anti-HBs) negative should also be referred to</p>	V 131			

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V 131	Continued From page 7 their personal physician for evaluation and further testing." The facility staff was unable to provide documentation that the facility referred the employee to her personal physician to evaluate her Hepatitis status between her date of hire in 2004 and February 2010. The survey team called Immediate Jeopardy and the survey team informed the CD and the Regional Quality Administrator on 7/1/10 at 4:03 P.M., The survey team discussed the requirements for the Plan of Correction (POC) to abate the Immediate Jeopardy with the CD. The immediate jeopardy was abated after the facility provided an acceptable POC on 7/1/10 at 5:22 P.M.	V 131		
V 250	494.40(a) DIALYS PROPOROT-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview, and record review, the facility failed to ensure that staff performed independent testing of dialysate pH (the measure of acidity or alkalinity of a solution), prior to starting treatment for 1 non-sampled	V 250		8/17/10

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V 250	<p>Continued From page 8</p> <p>patient (23). Findings:</p> <p>During observation on 6/30/10 at 12:42 P.M., CCHT 3 disinfected the surfaces of the dialysis machine in Station 14 in preparation for Patient 23's treatment. At 1:14 P.M., CCHT 3 attached and primed new tubing to the dialysis machine. CCHT 3 did not perform an independent test of the dialysate pH.</p> <p>At 1:21 P.M., Patient 23 arrived at the facility and sat in station 14. At 1:33 P.M., a second staff member (CCHT 2) took the patient's vital signs and began machine testing. CCHT 2 did not test the dialysate pH.</p> <p>During an interview on 6/30/10 at 1:35 P.M., CCHT 2 stated that she did not perform the independent test of the dialysate pH. CCHT 2 stated that CCHT 3 (who disinfected the dialysis machine) did the pH testing.</p> <p>During an interview on 6/30/10 at 1:38 P.M., CCHT 3 stated he did not test the pH after he disinfected the machine. CCHT 3 stated that the dialysate pH testing should be done "right before the patient treatment is started". CCHT 3 said he expected CCHT 2 to test the pH just before starting Patient 23's treatment. Each of the 2 staff members expected the other to perform the independent pH test. Neither staff member tested the pH.</p> <p>On 6/30/10 the facility provided the P&P titled "Dialysis Machine Set-up and Use" which was approved by the GB on 6/26/09. The P&P specified that the "Independent verification of dialysis machine dialysate... pH will be done</p>	V 250			

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V 250	Continued From page 9 before every dialysis treatment.."	V 250		
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation and interview, the facility failed to ensure that 1 of 15 sampled patients (15) received the dialysis prescription, as ordered by the physician. Findings: During the change over observation in the patient care area on 6/30/10, between 12:05 P.M. and 2:30 P.M., Patient 15 reclined in a treatment chair, at station 30. The patient's treatment began at 1:30 P.M. During an interview on 06/30/10 at 1:40 P.M., RN 3 stated that Patient 15 was on a 2K bath. A joint review of the physician's orders, in the chair side computer, confirmed that Patient 15 received a 2K bath. At 1:45 P.M., RN 3 looked behind Patient 15's chair. The jug of dialysate was labeled as 1K bath. RN 3 stated that he had not changed the K bath from the previous patient. RN 3 stated that the dialysis treatment prescription should be verified with another staff member, prior to starting the dialysis treatment. RN 3 confirmed that Patient 15 was on the wrong bath.	V 463		8/2/10
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID	V 504		8/2/10

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V 504	<p>Continued From page 10 MANAGEMENT NEEDS</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Blood pressure, and fluid management needs.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation, interview, and record review, the facility failed to ensure that licensed staff assessed 2 patients prior to treatment and completed post-assessments for 3 patients, according to their P&P.</p> <p>Findings:</p> <p>1. During the change over observation in the patient care area on 6/30/10 between the hours of 12:05 P.M., and 2:30 P.M. Patient 22 reclined in a treatment chair at station 25. CCHT 4 began Patient 22's treatment at 1:30 P.M.</p> <p>During an interview on 06/30/10 at 2:10 P.M., CCHT 4 stated that RN 2 did not conduct a pretreatment assessment on Patient 22.</p> <p>On 7/2/10, the facility policy and procedure for "Monitoring and Documentation of Patient Care During Treatment", read in part as, "Patient pre-assessment data must be collected and entered into the TIME system before initiation of treatment or within 30 minutes of starting treatment. Information that must be entered manually includes, but is not limited to: "...Pre-treatment assessment..." Surveyor: 22383</p>	V 504		

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V 504	<p>Continued From page 11</p> <p>2. On 6/30/10 at 12:15 P.M., while CCHT 5 initiated a treatment for a patient at station 1, RN 4 was at the chair side. She documented the pre-assessment in the computer. The assessment information in the computer indicated that the patient's heart rate was regular and the respirations were "OK", and the lungs were clear. Direct observation identified that RN 4 did not listen to the patient's chest or do any other assessment of the patient.</p> <p>3. On 6/30/10 at 12:20 P.M., CCHT 4 terminated the hemodialysis treatment for the patient in station 22. CCHT 4 completed the treatment and the post vital signs. The patient left without being seen, by a RN, to complete a post- assessment.</p> <p>4. On 6/30/10 at 12:30 P.M., CCHT 4 ended the dialysis treatment for the patient at station 21. CCHT completed all of the post treatment vital signs. The patient then left without seeing a nurse for a post treatment assessment.</p> <p>The CD stated on 6/30/10 at 2:32 P.M., that a pre and post assessment should be done and if there were concerns ,with the patent, during the pre assessment, they should be addressed at the post assessment. Surveyor: 17130</p> <p>5. During an observation on 6/30/10 at 12:42 P.M., CCHT 3 discontinued dialysis on Patient 21, at Station 14. At 12:55 P.M., Patient 21 stood up from the dialysis chair and ambulated to the scale for a post treatment weight.</p> <p>During an interview on 6/30/10 at 12:57 P.M., Patient 21 stated that the RN did not listen to her heart or lungs after the treatment. Patient 21 then left the dialysis center.</p>	V 504			

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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: 052835	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/06/2010
NAME OF PROVIDER OR SUPPLIER RAI - BROADWAY - CHULA VISTA			STREET ADDRESS, CITY, STATE, ZIP CODE 1181 BROADWAY, SUITE 5 CHULA VISTA, CA 91911		
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V 504	Continued From page 12 During an interview on 6/30/10 at 1:45 P.M., RN 1 (who provided care for Patient 21) stated that she did not listen to Patient 21's heart, lungs, and check her ankles for edema after the treatment. However, RN 1 stated that post dialysis the assessments should include "checking the patient's ankles for edema". RN 1 said that she routinely did not listen to a patient's heart and lungs post treatment, unless the patient had "problems". During an interview on 6/30/10 at 3:00 P.M., the CD stated that the post dialysis assessment included listening to heart, lungs, and checking for edema, among other assessments. On 6/30/10, the facility provided the P&P titled "Patient Assessments: Pre & Post Dialysis" which was approved by the GB on 6/26/09. The P&P specified that the pre and post dialysis assessments should include (among other assessments) heart rate, rhythm and sounds, breath sounds, effort of breathing, amount and location of edema. The P&P specified, "The post-dialysis assessment will be done before discharge of the patient from the center."	V 504			
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Surveyor: 22383	V 544			

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V 544	Continued From page 13 Based on interview and record review, the facility failed to ensure that staff accurately documented heparin doses that were administered during treatments, in the medication administration section, of the hemodialysis flowsheets for 15 of 15 sampled patients. Findings: The facility provided the hemodialysis flowsheets for all 15 sampled patients. The medication administration portion of the flowsheet, had documentation related to all medications given during their treatments. Staff documented the heparin, given bolus doses (a loading dose) and the heparin given throughout the treatments as given; but did not document the actual doses given. The staff only documented the heparin dose as Heparin 1000 u/ml (units per milliliter), not the actual number of units given to the patient. The CD stated on 6/30/10 at 9:36 A.M. that she previously discussed heparin documentation, given during treatments, with her staff. She was not aware that staff did not document actual doses given, on the medication record portion, of the flowsheets.	V 544			
V 750	494.180 CFC-GOVERNANCE This CONDITION is not met as evidenced by: Surveyor: 17130 Based on interview and record review, the GB failed to provide responsibility and oversight to ensure patient safety related to: Staff members providing care to Hepatitis B susceptible patients at the same time as Hepatitis B positive patients and follow-up of an employee who tested positive	V 750			

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V 750	<p>Continued From page 14 for Hepatitis B (refer to V131). Proper hand hygiene by a physician during patient care (refer to V113). Disinfection of 8 of 12 hemodialysis machine prime buckets between patients (refer to V 122).</p> <p>The cumulative effects of these systemic problems resulted in the facility's inability to provide quality health care in a safe environment.</p> <p>Findings:</p> <p>On 7/01/10, the facility provided the P&P titled "Governing Body" which was approved on 1/22/10. The policy specified that the GB ensured "proper management and oversight of each Renal Advantage Inc. (RAI) care center." According to the policy, the GB responsibilities included ensuring a level of care that met the patients needs.</p> <p>During an interview on 7/02/10 at 2:01 P.M., the Medical Director acknowledged his responsibility to inform the GB of patient care issues. In addition, the Medical Director stated that the GB should have been made aware of the "seating issue" relative to patients' Hepatitis B susceptibility and immunity.</p> <p>On 7/02/10, the facility provided the GB meeting notes from January 2009 through June 2010. There was no evidence the GB addressed the care of Hepatitis B susceptible patients and Hepatitis B positive patients.</p>	V 750			