

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: 052779	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2010
NAME OF PROVIDER OR SUPPLIER RAI - MISSION GORGE - SAN DIEGO			STREET ADDRESS, CITY, STATE, ZIP CODE 7007 MISSION GORGE RD 1ST FLOOR SAN DIEGO, CA 92120	
(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: 22383 The following represents the findings of the Department of Public Health during a recertification visit. The facility census at the time of the visit was 263 patients. The sample size consisted of 12 hemodialysis patients, 2 peritoneal dialysis patients and 1 home hemodialysis patient. Representing the Department were: HFEN's 22383, 15930, 17130 Glossary of Abbreviations: CVC Central Venous Catheter CHT Certified Hemodialysis Technician P&P Policy and Procedure RN Registered Nurse mS/cm Siemens per cubic centimeter	V 000		
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 and interview, the facility failed to ensure that staff changed gloves when switching from a "dirty" to a "clean" task for 1 nonsampled patient (16) creating a potential for cross contamination. Findings:	V 113		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 113	Continued From page 1 During the tour and observations of the facility on 5/18/10 at 8:55 A.M., Patient 16 was in the initial stage of beginning her dialysis treatment. Patient 16 had a CVC in the right upper chest. (a Central Venous Catheter is a thin tubing inserted into a large vein in the neck, chest, or groin which is used to draw blood, give medications, or administer a dialysis treatment). RN 1 cleaned the 2 ports of the CVC catheter and connected the dialysis tubing to the catheter ports, with gloved hands. RN 1 used the same gloved hands to make adjustments to the controls on the front of the dialysis machine, went back to Patient 16's catheter, touched each port to ensure a tight connection between the patient and the dialysis machine with the same soiled gloves. On 5/18/10 at 9:25 A.M., RN 1 stated, "Once the patient and machine are connected, they are treated as one." On 5/18/10 at 3:00 P.M., the Medical Director acknowledged that the technique used by RN 1 was not the best practice and further stated that gloves should be changed when going from the machine back to the patient.	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.	V 122		7/2/10	

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V 122	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation, interview, and P&P review, the facility failed to ensure that 12 of 32 patient treatment chairs were clean and free from blood splatters (2, 7, 10, 18, 19, 20, 21, 22, 23, 24, 25 and 30).</p> <p>Findings:</p> <p>During the tour and observations conducted on 5/18/10 at 8:55 A.M., 12 of the facility's 32 treatment chairs had blood splatters on either the right or left sides of each chair.</p> <p>RN 4 stated in an interview on 5/18/10 at 10:00 A.M., that the treatment chairs were wiped down with a bleach solution between patients. RN 4 stated that the entire chair needed to be cleaned.</p> <p>An observation of the chairs with blood splatters was conducted with RN 4 on 5/18/10 at 10:30 A.M. RN 4 acknowledged that the above numbered chairs did have blood splatters on them and needed further cleaning.</p> <p>RN 4 stated that the facility did not do terminal cleaning of the treatment chairs and further stated that the chairs needed to be cleaned completely between patients, including the sides of the chairs.</p> <p>On 5/21/10 at 9:30 A.M., the facility provided the policy and procedure entitled, "Cleaning & Disinfection of Equipment, Supplies & Treatment Area" read in part as follows: "...Spills or splashes of blood are cleaned up immediately. Caregivers</p>	V 122		

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V 122	Continued From page 3 will ensure that cracks/crevices come in contact with the bleach solution. This includes, but is not limited to the following: a) dialysis machine b) chair c) table d) TV, phone..."	V 122		
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].	V 147		7/2/10

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V 147	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation and interview, the facility failed to follow aseptic technique during a catheter dressing change for 1 non sampled patient (16). Findings: On 5/18/10 at 8:55 A.M., during the tour and observations of the facility, Patient 16 was in the initial stage of starting her dialysis treatment. Patient 16 had a CVC inserted in the right upper chest (a CVC is a Central Venous Catheter is a thin plastic tubing which is placed in a large vein in the neck, chest, or groin. The catheter is used to obtain blood for laboratory testing, the administration of medications, or to give a dialysis treatment). RN 1 used gloved hands moving from touching the controls on the front of the dialysis machine to the patient's catheter and proceeded to do the catheter dressing change wearing the same soiled gloves. RN 1 stated during an interview on 5/18/10 at 9:25 A.M., that changing the dressing for the catheter was not a sterile technique, it was only a clean technique. RN 1 further stated that once the patient and the machine were connected together, they were thought of as one and only clean technique was used. The Medical Director stated on 5/18/10 at 3:00 P.M. that the cleanest technique should be used	V 147			

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V 147	Continued From page 5 when changing CVC dressing. The Medical Director acknowledged that the technique used by RN 1 was not the best practice and further stated that gloves needed to be changed between touching the machine and starting a dressing change.	V 147		
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: 17130 Based on observation, interview and record review, the facility failed to ensure that 1 of 15 sampled patients (10) received the dialysis prescription as ordered by the physician. The facility failed to ensure blood sugar (glucose) monitoring for 2 of 15 sampled patients (2,7) as ordered by the physician. The facility failed to ensure that 7 of 15 sampled patients (2,3,4,5,7,8,10) received intradialytic heparin according to the physician orders and facility P&P. Findings: 1. During a tour of the Patient Care Area on 05/18/10 at 3:00 P.M., Patient 10 reclined in a chair while receiving dialysis in Station 30. A hard copy of Patient 10's Hemodialysis Orders, in effect on 5/18/10, were located at chairside. The Orders specified a bicarbonate setting of "38". (Bicarbonate added to dialysate helped maintain	V 463		7/2/10

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V 463	<p>Continued From page 6</p> <p>the pH of a dialysis patient's blood.) RN 3, who was caring for Patient 10, brought up the current bicarbonate setting on the dialysis machine. The bicarbonate on the dialysis machine showed a setting of "40", contrary to the physician's order. Patient 10's treatment started at 2:27 P.M. After a discussion with the surveyor at 3:05 P.M., RN 3 acknowledged the discrepancy and changed the bicarbonate setting to "40", in accordance with the physician's order. Patient 10 received 13 minutes of dialysis on an incorrect bicarbonate setting.</p> <p>During an interview on 05/18/10 at 3:05 P.M., RN 3 stated that she normally checked the bicarbonate setting on the machine before starting the dialysis treatment. RN 3 added, " But, I missed that one." RN 3 agreed that the bicarbonate setting should be verified with another staff member prior to starting the dialysis treatment.</p> <p>During an interview on 5/20/10 at 11:30 A.M., the Biomedical Technician stated he set the bicarbonate on all the dialysis machines at "38". The direct care staff changed the bicarbonate to whatever the physician ordered.</p> <p>On 5/21/10, the facility P&P for "Monitoring and Documentation of Patient Care During Treatment", approved by the Governing Body in September 2009, specified that staff review and verification of all patient treatment data and machine set-up information must be documented before starting the treatment.</p> <p>2. On 5/21/10, the facility provided the P&P, approved by the Governing Body in September 2009, titled "Blood Glucose Monitoring". The</p>	V 463			

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V 463	<p>Continued From page 7</p> <p>policy specified that "1. Blood glucose monitoring is done per physician order." In addition, "3. Blood glucose test results shall be documented in the patient's electronic treatment record: If testing is ordered pre-treatment, the actual value is documented in the designated area of the pre-treatment data."</p> <p>a. Patient 7 was admitted to the facility on 11/11/06 with diagnoses which included diabetes. On 5/21/10, the medical record showed that the physician ordered "Blood Glucose Test q (every) treatment." starting 1/07/10. Nine hemodialysis flowsheets from 4/24/10 through 5/13/10 were reviewed. There was no evidence that Patient 7's blood sugar was checked before starting dialysis on 5 of 9 treatment days.</p> <p>b. On 5/21/10, the facility provided Patient 2's medical record for review. On 1/7/10, the physician ordered pre treatment blood sugars to be tested every treatment day. The clinical did not contain documentation for Patient 2's blood sugar for the date of 5/6/10.</p> <p>During an interview on 5/21/10 at 10:00 A.M., RN 5 stated that CHT's were responsible to check the blood sugar.</p> <p>During an interview on 5/21/10 at 10:30 A.M., the Administrator stated that RN's were responsible for ensuring that blood sugars were done by the CHT's as ordered by the physician.</p> <p>3. On 5/21/10, the facility provided the P&P titled "Monitoring and Documentation of Patient Care During Treatment" which was approved by the Governing Body in September 2009. The policy specified that "Continuous heparin dose must be</p>	V 463			

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V 463	<p>Continued From page 8</p> <p>documented at each 30 minute check." and "To do this calculation properly, caregivers must read and document the exact volume in mL (milliliters) of heparin in the syringe in the dialysis machine heparin pump. This must be documented with the very first data entry of the treatment, at each 30 minute check..., and at the final entry of data for the treatment."</p> <p>a. On 5/21/10, the facility provided Patient 7's medical record for review. On 1/21/10, the physician ordered a heparin bolus (a dose of heparin given at one time) of 1000 units at the beginning of each hemodialysis treatment and 1000 units each hour during the treatment for a total of 4500 units. Nine flowsheets from 4/24/10 through 5/13/10 were reviewed. There was no clear documentation that the patient received the heparin bolus as ordered during 9 of 9 treatments. In addition, during 9 of 9 treatments, the medical record specified that Patient 7 received either no hourly heparin or up to 3000 units for the entire treatment, contrary to the physician's order for a total of 4500 units.</p> <p>b. On 5/21/10, the facility provided Patient 8's medical record for review. On 1/12/10, the physician ordered a heparin bolus of 1000 units at the beginning of each hemodialysis treatment and 1000 units each hour during the treatment for a total of 5000 units. Ten treatment flowsheets from 2/23/10 through 3/16/10 were reviewed. There was no clear documentation that the patient received the heparin bolus as ordered during 10 of 10 treatments. In addition, during 10 of 10 treatments, the medical record specified that Patient 8 received either no hourly heparin or up to 1500 units for the entire treatment, contrary to the physician's order for a total of 5000 units.</p>	V 463			

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V 463	Continued From page 9 c. On 5/21/10, the facility provided Patient 10's medical record for review. On 1/16/10, the physician ordered a heparin bolus of 2000 units at the beginning of each hemodialysis treatment and 1000 units each hour during the treatment for a total of 6000 units. Nine treatment flowsheets from 1/19/10 through 2/09/10 were reviewed. There was no clear documentation that the patient received the heparin bolus as ordered during 9 of 9 treatments. In addition, during 9 of 9 treatments, the medical record specified that Patient 10 received either no hourly heparin or up to 4000 units for the entire treatment, contrary to the physician's order for a total of 6000 units. Surveyor: 15930 d. Patient 2's plan of care included a physician's order dated 1/7/10, for heparin 3000 units bolus and 1000 units of heparin per hour of treatment for maintenance for a total of 7,000 units of heparin. The medical record contained documentation which included, Patient 2 receiving 500 units over the prescribed dosage to 500 units less than the physician's order for the maintenance dosage. There was no clear documentation that the patient received the heparin bolus as ordered for 10 of 10 treatment days. e. On 5/21/10, the facility provided Patient 3's medical record for review. The medical record review included the treatment flowsheets from 4/28/10 through 5/19/10, for a total of 10 treatment days. Patient 3's plan of care included a physician's order to administer a 2000 unit bolus of heparin at the beginning of treatment day and to administer 1000 units of heparin per hour of	V 463			

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V 463	<p>Continued From page 10</p> <p>treatment for maintenance for a total of 5500 units of heparin. The documentation contained heparin dosing from 500 units over the dose ordered, to 1000 units less than what was ordered for the maintenance dose for 6 of the 10 treatment days. There was no clear documentation that the patient received the heparin bolus as ordered for 10 of the 10 treatment days.</p> <p>f. On 5/21/10, the facility provided Patient 4's medical record for review. The medical record review included the dialysis treatment flowsheets from 4/26/10 through 5/19/10, for a total of 10 treatment days. Patient 4's plan of care included a physician's order to administer a 2000 unit bolus of heparin. There was no documentation that the heparin bolus was given.</p> <p>g. On 5/21/10, the facility provided Patient 5's medical record for review. The medical record review included the dialysis treatment flowsheets from 4/28/10 through 5/19/10, for a total of 10 treatment days. Patient 5's plan of care included a physician's order dated 8/24/09, for a 2000 unit bolus of heparin to be given at the beginning of each treatment and 1750 units of heparin to be given over each 3.5 hour treatment day for a total of 3750 units of heparin. The medical record documentation contained heparin 1800 units to 3000 units for the maintenance dosing for 10 of 10 treatment days.</p> <p>During an interview on 5/21/10 at 10:50 A.M., the Administrator stated that the staff heparin data entry should "match" the physician's order. The Administrator stated that staff should manually enter the amount of heparin remaining in the syringe every 30 minutes. The Administrator</p>	V 463			

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V 504	<p>acknowledged that a problem existed with the heparin documentation.</p> <p>494.80(a)(2) PA-ASSESS B/P, FLUID 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: 17130 Based on interview and record review, the facility failed to ensure complete vital sign assessments and documentation for 1 of 15 sampled patients (7) according to the facility P&P. The facility failed to implement their policy and procedure and the patient care plan to include, post treatment weights for 1 of 15 sampled patients (2).</p> <p>Findings:</p> <p>1. On 5/20/10, the facility provided the P&P titled "Monitoring and Documentation of Patient Care During Treatment", approved by the Governing Body in Sept 2009. The policy specified blood pressure and heart rate assessment and documentation on each patient "at least every 30 minutes....".</p> <p>In addition, the policy indicated that patient temperatures must be manually entered in the computer program at the time care was provided. Implementation of the policy ensured patient safety, proper documentation during and after each hemodialysis treatment, and accurately reflected what occurred during each treatment.</p>	V 504		7/2/10	

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(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 504	<p>Continued From page 12</p> <p>On 5/21/10, nine treatment flowsheets for Patient 7 from 4/24/10 through 5/13/10 were reviewed. There was no evidence that Patient 7's blood pressure and pulse were monitored during the treatment on 4/27/10 from 11:42 A.M. to 12:32 P.M., a period of 50 minutes. There was no evidence that Patient 7's blood pressure and pulse were monitored during the treatment on 5/06/10 from 11:24 A.M. to 12:24 P.M., a period of 60 minutes.</p> <p>On 5/18/10, the facility provided the Infection Log from April 2010. According to the Log, the infection in Patient 7's CVC exit site was treated with an intravenous antibiotic from 4/27/10 through 5/13/10. On 5/21/10, 9 flowsheets from 4/24/10 through 5/13/10 were reviewed. On 4/24/10, the flowsheet specified "purulent drainage" from Patient 7's CVC exit site. There was no documentation in 3 of the 9 flowsheets (4/24/10, 4/29/10 and 5/11/10) that staff monitored Patient 7's temperature prior to the hemodialysis treatments. Elevated body temperature could be an indication of an infectious process.</p> <p>During an interview on 5/21/10 at 10:00 A.M. RN 5 stated that the PCT's were responsible for taking all patient vital signs prior to each treatment. In addition, RN 5 stated that the registered nurse should remind the PCT if the vital signs were not completed.</p> <p>Surveyor: 15930 2. On 5/21/10, the facility provided Patient 2's medical record for review. The review included the treatment flowsheets from 4/27/10 through 5/18/10, for a total of 10 treatment days. Three of</p>	V 504			

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

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NAME OF PROVIDER OR SUPPLIER RAI - MISSION GORGE - SAN DIEGO		STREET ADDRESS, CITY, STATE, ZIP CODE 7007 MISSION GORGE RD 1ST FLOOR SAN DIEGO, CA 92120		
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V 504	Continued From page 13 10 treatment days contained no documentation of the patient's post treatment weights. The policy and procedure entitled, "Monitoring and Documentation If Patient Care During Treatment" read in part as follows: "15. All patient care data that must be entered manually (such as assessments findings, weights, temperature, residual sterilant readings, medication administration, etc.) must be documented at the time those actions are performed by the person making the observation or providing the patient care."	V 504		