

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

PRINTED: 09/30/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552519</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/05/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>RANCHO DIALYSIS CLINIC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10294 ROCKINGHAM DRIVE RANCHO CORDOVA, CA 95827</b>	
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V 000	INITIAL COMMENTS  Surveyor: 17151 The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey.  Representing the California Department of Public Health: Barbara Ebert, Health Facilities Evaluator Nurse. Juanita Glick, Health Facilities Evaluator Nurse.  The patient census was 47, on 3/1/10 and the facility was licensed and certified for 16 hemodialysis stations.  Abbreviations:  AVF - arterio venous fistula CVC - central venous catheter LVN - Licensed Vocational Nurse	V 000		
V 110	494.30 CFC-INFECTION CONTROL  This CONDITION is not met as evidenced by: Surveyor: 16932 Based on observation, patient interview, staff interview, and document review, the facility failed to meet the condition of infection control when the facility failed to provide a sanitary environment to prevent the transmission of infection.  Findings:  1. The facility failed to ensure that two sinks designated, "dirty sinks," had counter top that could be effectively cleaned, resulting in the potential for bacterial growth and contamination (See V111).	V 110		3/30/10

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  2. The facility failed to ensure that items used for one patient were not contaminated prior to being stored in a common area, resulting in the potential for cross contamination (See V116, V113).  3. The facility failed to maintain clearly defined clean versus dirty areas in the treatment area. Resulting in potential for cross contamination (See V117).  4. The facility failed to ensure that intravenous medications intended for single use were not used for multiple patients resulting in the potential for cross contamination (See V118).  5. The facility failed to ensure that staff were aware of and maintained infection control practices when cleaning and setting up dialysis stations resulting in the potential for cross contamination (See V122).  6. The facility failed to have a surveillance program that included investigation into the source of identified venous access site infections and to identify lapses in staff compliance with infection control practices. This resulted in the facilities failure to identify and correct deficient infection control practices which may have contributed to the occurrence of access site infections (See V148).  The cumulative effect of these systemic failures resulted in the facility's failure to maintain a sanitary, safe, and comfortable environment and to provide surveillance to determine the source of the infections and further prevent the transmission of infections for patients, staff, and	V 110			

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V 110	Continued From page 2 the public.	V 110			
V 111	494.30 IC-SANITARY ENVIRONMENT  The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.  This STANDARD is not met as evidenced by: Surveyor: 16932 The hospital failed to ensure that two sinks designated, "dirty sinks," had counter top that could be effectively cleaned, resulting in the potential for bacterial growth, contamination and potential spread of infectious organisms to patients.  Findings:  During observation of the treatment area on 3/1/10 at 10:25 a.m., there were two sinks designated as "dirty sinks" in the treatment area located at either end of the nurses station. The sinks had metal rims and were set in a formica (a plastic laminate sheeting that is used as counter tops) counter top. The formica counter top immediately adjacent to the metal ring was worn off all the way around the sink to a width of approximately 1.5 inches, revealing the rough base under the formica. Both sink areas had a mildew smell.  During interview on 3/4/10 at 10:00 a.m., Administrative Staff U corroborated that the sink counter top area would be difficult for staff to clean and stated that the facility planned to replace the sinks in the future.	V 111		3/30/10	
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND	V 113		5/30/10	

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V 113	<p>Continued From page 3</p> <p><b>HYGIENE</b></p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 16932 Based on observations and interview, staff failed to remove gloves and wash hands between each patient or stations leaving a potential for cross contamination of patients and equipment.</p> <p>Findings:</p> <p>During observation on 3/2/10 at 9:00 a.m., the patient at Station 13 was coming off therapy. The Patient at Station 11 was going on therapy. Staff X, wearing gloves, took the temperature of the patient at Station 11 then, wearing the same gloves went to Station 13 to retrieve a pen. Staff X, wearing the same gloves, then went to the nursing station and opened a drawer in which plastic bags with blood pressure cuffs were stored. Staff X touched the bags looking for the bag that belonged to the patient at Station 11 but did not select one. A few moments later Staff X returned to the drawer with gloves off to look again for the patient's bagged blood pressure cuff.</p> <p>During observation on 3/2/10 at 3:30 p.m., Staff X was taking the patient at Station 11 off dialysis. Staff X was wearing gloves. After touching the patient, Staff X put the patient's blood pressure cuff in a plastic bag, carried the bag to the nursing</p>	V 113			

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V 113	Continued From page 4 station and put the bag in the drawer with the other plastic bags.  During interview on 3/2/10 at 4:00 p.m., Staff X stated that the blood pressure cuffs in the plastic bags were to be used by one designated patient only. All the plastic bags were stored in drawers in the nursing station. Staff X stated that soiled gloves should not be worn when touching clean areas and said that the nursing station was a clean area. Staff X stated that clean gloves could be worn in the nursing station but agreed that it would be difficult to tell by observation whether someone was wearing clean gloves or not. Staff X acknowledged that touching the bags containing the blood pressure cuffs with both clean and dirty gloves could cause contamination of the bags.	V 113		
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT  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. -- 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. -- 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.  This STANDARD is not met as evidenced by:	V 116		5/30/10

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V 116	<p>Continued From page 5</p> <p>Surveyor: 16932</p> <p>Based on observation and staff interview the facility failed to ensure that items taken into the dialysis station should be disposed of, dedicated for single patient use, or cleaned and disinfected before the items are removed from the dialysis station prior to being stored in a common area, resulting in the potential for cross contamination.</p> <p>Findings:</p> <p>During observation on 3/2/10 at 9:00 a.m., the patient at Station 13 was coming off therapy. The Patient at Station 11 was going on therapy. Staff X, wearing gloves, took the temperature of the patient at Station 11 then, wearing the same gloves went to Station 13 to retrieve a pen. Staff X, wearing the same gloves, then went to the nursing station and opened a drawer in which plastic bags with blood pressure cuffs were stored. Staff X touched the bags looking for the bag that belonged to the patient at Station 11 but did not select one. A few moments later Staff X returned to the drawer with gloves off to look again for the patient's bagged blood pressure cuff.</p> <p>During observation on 3/2/10 at 3:30 p.m., Staff X was taking the patient at Station 11 off dialysis. Staff X was wearing gloves. After touching the patient, Staff X put the patient's blood pressure cuff in a plastic bag, carried the bag to the nursing station and put the bag in the drawer with the other plastic bags.</p> <p>Observations indicated staff brought wore soiled gloves and equipment handled with soiled gloves into clean areas and handled equipment in clean stations.</p>	V 116			

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V 116	Continued From page 6	V 116			
V 117	<p>During interview on 3/2/10 at 4:00 p.m., Staff X stated that the blood pressure cuffs in the plastic bags were to be used by one designated patient only. All the plastic bags were stored in drawers in the nursing station. Staff X stated that soiled gloves should not be worn when touching clean areas and said that the nursing station was a clean area. Staff X stated that clean gloves could be worn in the nursing station but agreed that it would be difficult to tell by observation whether someone was wearing clean gloves or not. Staff X acknowledged that touching the bags containing the blood pressure cuffs with both clean and dirty gloves could cause contamination of the bags.</p> <p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS</p> <p>Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they</p>	V 117		5/8/10	

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V 117	<p>Continued From page 7</p> <p>must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 16932 Based on observation, staff interview, and policy and procedure review, the facility failed to maintain clearly defined "clean" versus "dirty" areas in the treatment area, resulting in potential for cross contamination.</p> <p>Findings:</p> <p>During an observation on 3/2/10 at 8:45 a.m., Staff Y disconnected the dialyzer and tubing from the patient at Station 4 and carried the dialyzer to a cart that was sitting at the end of the nursing station. On one side of the cart was large red bio hazardous trash can with a pull off lid. On the other side of the cart was an empty clear plastic bin labeled, "dirty." In the middle of the cart was a stack of white paper clothes and a squirt bottle labeled as disinfectant solution.</p> <p>Staff Y removed the lid of the bio hazardous trash container and, standing over it with the tubing hanging into the bio hazardous trash can, disconnected the bloody tubing from the dialyzer, dropped the tubing into the trash can and closed the lid. Staff Y put the dialyzer into a plastic bag and, reaching over the stack of clean wipes, placed the dialyzer in the plastic bin.</p> <p>Wearing the same gloves, Staff Y took a white cloth from the stack of clothes and sprayed it with disinfectant solution, went to Station 3 and wiped down the dialysis machine and the chair.</p> <p>During observation on 3/2/10 at 3:30 p.m., Staff X, using an elbow to keep the trash lid from</p>	V 117			

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V 117	Continued From page 8 falling, discarded used dialysis tubing into the red trash can. Staff X placed the dialyzer into a plastic bag and then set the plastic bag down next to the clean wipes and closed the trash lid. Wearing the same gloves Staff X took a clean wipe sprayed it with disinfectant and wiped down station 14.  During interview on 3/2/10 at 4:00 p.m., when asked to consider if it was appropriate to store the cleaning solution and clothes on the dirty cart, Staff X stated that it now seemed obvious that they should not be there.  During interview, and concurrent record review of the facility policies for infection control, on 3/3/10 at 10:15 a.m., Administrative Staff Z agreed that it was not appropriate for the cleaning supplies to be stored on the dirty cart. Staff Z stated that she was unable to locate a facility policy that defined "clean" versus "dirty" areas in the patient treatment area.	V 117			
V 118	494.30(a)(1)(i) IC-SINGLE USE VIALS  Intravenous medication vials labeled for single use, including erythropoietin, should not be punctured more than once.  This STANDARD is not met as evidenced by: Surveyor: 16932 Based on observation, staff interview, and policy review, the facility failed to ensure that intravenous medications intended for single use were not used for multiple patients resulting in the potential for cross contamination.  Findings:  During an observation on 3/2/10 at 10:15 a.m., there was an open bag of a 500 millimeter (ml)	V 118		5/3/10	

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V 118	Continued From page 9 solution labeled, "Anticoagulant Citrate in Dextrose" single use only, sitting on the end of the counter at the nursing station. (Anticoagulant is used to thin the blood to reduce the chance of clotting in central line catheters.) There was no patient identification on the bag and no date of when the bag was opened. Staff Y obtained two syringes from the nursing station and drew up the solution from the bag. Staff Y injected the solution into the central venous catheter (CVC) of the patient at Station 5.  During an observation on 3/3/10 at 10:00 a.m., there was a 500 ml bag of solution sitting on the end of the counter at the nursing station labeled, "Anticoagulant Citrate in Dextrose." Written directly on the bag with magic marker was the date, 3/3/10. There was no patient name on the bag. During a concurrent interview, Staff W stated that the solution was used as an anticoagulant instead of the usual anticoagulant, Heparin. Staff W stated that the bag was used for multiple patients during the day and then discarded at the end of the day.  Policy review on 3/4/10 at 9:00 a.m., indicated that there was no policy for the use of single dose IV medications for multiple patients. During a concurrent interview, Staff Z stated that the facility had not researched whether this product could be used as a multi dose system for multiple patients and had no policy for this issue.	V 118			
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	V 122		5/3/10	

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V 122	<p>Continued From page 10 with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 16932 Based on observation, staff interview, and policy review, the facility failed to ensure that staff were aware of and maintained infection control practices when cleaning and setting up dialysis stations resulting in the potential for cross contamination.</p> <p>Findings:</p> <p>During an observation on 3/2/10 at 9:00 a.m., Staff Y, wearing gloves, was disconnecting the patient at Station 3 from the dialysis machine. On top of the dialysis machine was a clip board with a clinical record on which to record the patient's treatment. Staff Y touched the screen of the machine and the dialysis tubing, then wearing the same gloves, documented on the paper chart. After the patient was moved from the station, Staff Y put the patient's treatment record on the counter of the nurses station and was later seen doing additional documentation on it without gloves. It was unclear if the clinical record was considered "clean" or "dirty."</p> <p>Staff Y, wearing gloves, then disconnected the dialyzer and tubing from the patient and the machine and carried the dialyzer to a bio hazardous container to discard the tubing. Staff Y removed the tubing and put the dialyzer into a plastic bag and then into a bin. Without changing gloves or washing hands, Staff Y, took a white</p>	V 122			

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V 122	<p>Continued From page 11</p> <p>cloth from the stack of clothes and sprayed it with disinfectant solution, then went to Station 3 and wiped down the dialysis machine and the chair.</p> <p>During an observation on 3/2/10 at 10:30 a.m., Staff Y, wearing gloves, helped the patient at Station 14 put on their shoes. From a kneeling position, Staff Y held the shoe by the sole and pushed it on the patient's foot then stood and, without changing gloves, took hold of the patient's intravenous solution (IV) bag and then touched the control face of the dialysis machine.</p> <p>Still wearing the same pair of gloves, Staff Y obtained the thermometer and took the patient's temperature. Staff Y put the thermometer back on the counter at the nursing station without cleaning it.</p> <p>During an observation on 3/2/10 at 10:45, Staff X was assisting Staff Y to set up for the next patient at Station 14. Staff Y was setting up the dialysis tubing and (IV). Staff X picked up the dirty sharps container that was sitting on one side of the treatment chair and moved it to the other side to a position under the dialysis machine. Then, without changing gloves, Staff X touched the control panel of the previously cleaned dialysis machine. Wearing the same gloves, Staff X picked up the clip board with the new treatment record on it, documented on the new treatment record then placed the clip board first on the arm rest of the patient's chair, and then moved it to the top of the dialysis machine.</p> <p>During an observation on 3/2/10 at 3:30 p.m., Staff X, using an elbow to keep the red biohazardous container lid from falling, discarded used dialysis tubing into the container. Staff X</p>	V 122			

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NAME OF PROVIDER OR SUPPLIER  <b>RANCHO DIALYSIS CLINIC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10294 ROCKINGHAM DRIVE RANCHO CORDOVA, CA 95827</b>		
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V 122	Continued From page 12 placed the dialyzer into a plastic bag and then set the plastic bag down next to the clean wipes. Wearing the same gloves Staff X took a clean wipe sprayed it with disinfectant and wiped down Station 14. Staff X wiped the face of the machine and the chair. Staff X failed to clean the, "bucket" used for flushing IV tubing, that was hanging on the dialysis machine.  During an interview on 3/2/10 at 4:00 p.m., Staff X stated that the staff were uncertain whether the clip board and treatment record it held was a "clean" or a "dirty" area and therefore, there was confusion about whether to wear gloves or not when documenting. Staff X stated that the sharps container was a dirty item and that it did not usually get cleaned when the station was cleaned. Staff X also stated that it was okay to wear gloves when handling the thermometer but stated that she was not certain if it was supposed to be cleaned after each use.  During policy review on 3/3/10 at 10:15 a.m., there was no policy found for designation of "clean" versus "dirty" areas in the treatment area. There was no written policy or procedure for cleaning the treatment stations between patients.  During concurrent interview on 3/3/10 at 10:15 a.m., Administrative Staff Z corroborated that the facility had no written policies for these issues.	V 122			
V 148	494.30(a)(2) IC-MONITOR CATH-RELATED BSI RATES/SURV  Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.  I. Surveillance	V 148		5/1/10	

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V 148	<p>Continued From page 13</p> <p>A. Conduct surveillance ...to determine CRBSI rates, monitor trends in those rates, and assist in identifying lapses in infection-control practices.</p> <p>C. Investigate events leading to unexpected life-threatening or fatal outcomes. This includes any process variation for which a recurrence would likely present an adverse outcome.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17151 Based on observation, interview, and record review, the facility failed to have a surveillance program that included investigation into the source of identified venous access site infections and to identify lapses in staff compliance with infection control practices. This resulted in the facility's failure to identify and correct deficient infection control practices which may have contributed to the occurrence of access site infections.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During observation on 3/2/10 at 10:30 a.m., Staff X prepared the access site of a random patient at station 11 for cannulation. Staff X wiped the site in two places with antiseptic solution then walked away from the station. Staff X returned to station 11 a few minutes later. The patient was wearing an ear piece. The cord of the ear piece was laying across the access site. Staff X moved the cord away from the access site, palpated the sites, and inserted the two cannulas. Staff X did not re-cleanse the site prior to inserting the cannulas.</li> <li>2. During an interview on 3/3/10 at 6:50 a.m.,</li> </ol>	V 148		

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V 148	<p>Continued From page 14</p> <p>Patient 3 stated that her CVC kept getting infected and that she had been, "septic" from the new catheter and had to have it removed.</p> <p>During an observation on 3/3/10 at 6:45 a.m., Licensed Staff A was performing a dressing change on Patient 3's CVC. Staff A removed the old dressing and cleaned the CVC site with disinfectant. Staff A left Patient 3 unattended with the site uncovered and crossed the room to attend to another patient. While Staff A was away from Patient 3, Patient 3's face mask fell down below her nose. Patient 3 put an ear phone in her left ear. The cord to the ear phone was stretched across the CVC site and each time the patient moved her head the earphone cord moved across the CVC site subjecting the site to contamination. Staff A came back about 5 minutes later, moved the cord away from the site, and dressed it. Staff A did not re-cleanse the site prior to applying the dressing.</p> <p>During an interview on 3/4/10 at 8:30 a.m., Staff A stated that she left the site while it was drying and acknowledged that she could not be sure that the site was not contaminated when she left the patient unattended. Staff A stated, "I should have stayed in front of the patient to wait for it to dry."</p> <p>A record review conducted on 3/3/10, revealed the following: Patient 3 was admitted to the facility on 5/2/05, with end stage renal disease requiring hemodialysis. Patient 3 had a left CVC for hemodialysis treatments scheduled for four times a week, 3 1/2 hours a day.</p> <p>A discharge summary from the acute care hospital dated 5/16/09, confirmed that Patient 3 had been admitted with sepsis (an infection of the</p>	V 148			

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V 148	<p>Continued From page 15</p> <p>blood) which started from her tunneled dialysis catheter (CVC catheter). The bacteria identified was Methicillin Resistant Staphylococcus Aureus (MRSA).(MRSA are bacteria that are not killed by most antibiotics and therefore, are of particular concern.)</p> <p>3. A record review conducted on 3/2/10, revealed the following: Patient 1 was admitted on 1/28/10, with chronic kidney disease requiring hemodialysis. Patient 1 had a right internal jugular catheter in which she received hemodialysis treatments 3 times a week for 3 hours a day.</p> <p>A discharge summary dated 2/12/10, revealed that Patient 1 had MRSA bacteremia (infection of the blood) secondary to an infected tunneled dialysis catheter that required hospitalization. Patient 3 had four positive blood cultures that identified the bacteria was MRSA.</p> <p>Review of the Infection Control Summary dated 9/1/09 to 3/3/10, indicated the following regarding Patient 1: 9/12/09 vascular access: catheter infection, organism staphylococcus aureus, treated with cefazolin.</p> <p>10/15/09: "Infection and inflammatory reaction due to other vascular device, implant, and graft (suspect)." The specific site was not given. Blood cultures grew no organisms and it was treated with cefazolin.</p> <p>11/21/09: "Infection and inflammatory reaction due to other vascular device, implant, and graft" The specific site was not listed. No organism was listed but the infection was treated with</p>	V 148			

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V 148	<p>Continued From page 16 vancomycin.</p> <p>It was not clear if the infection listed for 11/21/09 was the same as the infection for which the patient was hospitalized in February of 2010. There was no documentation of investigation of these infections to determine if they were facility acquired, and no documentation of discussion of these infections by the quality assurance committee. Surveyor: 16932</p> <p>4. Record review on 3/2/10 indicated that Patient 2 was admitted to the facility on 6/27/09, with a central line catheter. A history and physical (H&amp;P) dated 7/14/09, indicated that the patient was hospitalized in July of 2009 for an elevated white blood cell count (an elevation of the white blood cell count may indicate infection). The H&amp;P also indicated that the patient had a "history" of urinary tract infection with multiply resistant staph aureus (MRSA) and noted a urine culture dated 6/27/09, which was positive for MRSA.</p> <p>A care plan entry dated 9/12/09, indicated that the patient had a vascular access infection at the, "exit site." Another entry dated 10/15, indicted the patient had an infection of the, "vascular access device."</p> <p>A discharge summary dated 11/20/09 indicated that Patient 2 was again admitted to the hospital with an MRSA infection of the blood. The central line catheter was removed and the tip cultured positive for MRSA. The patient required four weeks of intravenous antibiotic therapy.</p> <p>A laboratory report dated 1/12/10 indicated that Patient 2 had a positive culture for MRSA from a, "wound site."</p>	V 148			

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V 148	Continued From page 17  Review on 3/3/10 of the, "Infection Control Summary," dated 9/1/09 to 3/310, indicated the following entries for Patient 2:  9/12/09: "Vascular access: catheter infection : exit site." The infection was treated with cefazolin. There was no culture result included in the report. There was no documentation that the source of this infection was investigated, or that the possibility that the infection was facility acquired had been discussed and ruled out by the QA committee.  10/15/09: "infection and inflammatory reaction due to other vascular device, implant, and graft (suspect)" Blood cultures had no growth but the infection was treated with Vancomycin The specific site was not listed and there was no documentation this infection was investigated or discussed by the QA committee.  11/25/09: "Infection and inflammatory reaction due to other vascular device, implant, and graft (confirm)" The infection was treated with Cefazolin. The specific site was not listed and there were no culture results. There was no documentation that the source of this infection was investigated or that facility acquired infection had been ruled out by the QA committee.  5. Record review on 3/3/10, indicated that Patient 5 was admitted to the facility on 12/2/09 with a CVC. A consultation report dated 1/2/10, indicated that the patient had been admitted to an acute care facility because he had pus draining from his catheter site.	V 148			

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V 148	<p>Continued From page 18</p> <p>During an interview on 3/1/10 at 4:40 p.m., Staff W stated that Patient 5 had recently had a central line infection. Staff W stated that the catheter site may have been contaminated by family who were responsible for performing dressing changes on the patient's infected pressure ulcer that was located on his tailbone.</p> <p>Review of the Infection Control Summary indicated the following for Patient 5:</p> <p>1/15/10: "Infection and inflammatory reaction due to other vascular device, implant, and graft (confirm)" The infection was treated with Vancomycin.</p> <p>1/16/10: "Infection and inflammatory reaction due to other vascular device, implant and graft (suspect)"</p> <p>1/17/10: "Infection and inflammatory reaction due to other vascular device, implant and graft (confirm)"</p> <p>It was unclear if all of these entries were referencing the same infection site. There were no culture reports included and there was no documentation that the source of the infection(s) was investigated by the facility or that the possibility that the infection(s) was facility acquired had been discussed and ruled out by the QA committee. There was no documentation of any investigation related to Staff W's theory: that infection of the catheter was cross contamination from the patient's own body.</p> <p>6. Patient 4 was admitted to the facility on 4/16/04 and had an arterio venous fistula (AVF) used for dialysis. A discharge summary, dated 2/5/10,</p>	V 148			

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V 148	<p>Continued From page 19</p> <p>indicated that Patient 4 had been in an acute care facility for treatment of an infection in her AVF. The organism was not listed, but the summary indicated that the patient was treated with Vancomycin and Gentamicin.</p> <p>The Infection Control Summary dated 9/1/09 to 3/3/10 indicated the following for Patient 4: 10/16/09: "Other specified disease of white blood cells (suspect)" The infection was treated with Vancomycin. There was no clear site identified, no organism identified, and no analysis of whether the infection was facility acquired.</p> <p>2/10/10: "Cellulitis and abscess or other specified sites (confirm)" There was no site identified, no organism listed, and no antibiotic listed.</p> <p>2/12/10: "Cellulitis and abscess of other specified sites (suspect)" The infection was treated with gentamicin. No site was listed and therefore, it was not clear whether this was a different site from the site listed on 2/10/10. There was no documentation that the QA committee had investigated or discussed whether Patient 4's infections were facility acquired.</p> <p>7. During interview on 3/3/10 at 10:15 a.m., Staff Z stated that the facility did not have a specific nurse assigned to perform infection control surveillance. Data about infections was provided to the facility via two computer generated reports. Staff Z stated that the facility did not generate the reports and she was uncertain where the data entry originated. Staff Z stated that the Quality Assurance (QA) Committee reviewed the computer reports titled, "Infection Control Summary" and "...Quality Management Report" at the quarterly QA meetings but did not have a</p>	V 148			

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V 148	<p>Continued From page 20</p> <p>system in place for investigating or analyzing the occurrences of infections to determine if they were facility acquired. Staff Z did not provide the facility's policy for infection control surveillance when requested.</p> <p>8. Review of the Quality Management Report for December 2009 indicated the format for the report was as follows:</p> <p>Indicator: Infections Benchmark: N/A Goal: N/A Frequency: Monthly</p> <table> <tr><td># of infections</td><td>4</td></tr> <tr><td># of patients with infections</td><td>3</td></tr> <tr><td># of blood Culture Tests</td><td>2</td></tr> <tr><td># of Patients with Blood Cultures</td><td>1</td></tr> <tr><td># of Tests with Positive Culture Result</td><td>0</td></tr> <tr><td># of Vancomycin doses Given</td><td>13</td></tr> <tr><td># of Patients Received Vancomycin</td><td>3</td></tr> <tr><td># of other Antibiotic Doses</td><td>14</td></tr> <tr><td># of Patients Received Other Antibiotics</td><td>3</td></tr> </table> <p>Review of the Quality Management Report for December 2009 indicated that there was a total of 4 infections in 3 patients. The report for January of 2010 indicated no infections. The report for February of 2010 indicated that there was a total of five infections in two patients.</p> <p>The names of the patients were not included in these reports. The specific bacteria treated were not listed on the reports. There was no documentation of analysis of the data or how it correlated with the Infection Control Summary. There was no documentation of discussion of the significance of the total number of infections or of</p>	# of infections	4	# of patients with infections	3	# of blood Culture Tests	2	# of Patients with Blood Cultures	1	# of Tests with Positive Culture Result	0	# of Vancomycin doses Given	13	# of Patients Received Vancomycin	3	# of other Antibiotic Doses	14	# of Patients Received Other Antibiotics	3	V 148		
# of infections	4																					
# of patients with infections	3																					
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V 148	Continued From page 21 trends over time.	V 148			
V 550	<p>9. During interview on 3/4/10 at 10:30 a.m., the medical director stated that the QA committee reviewed the data from the infection control summary quarterly but did not know how many infections would be considered acceptable. (A bench mark number) Therefore, the facility did not know when infection rates were high in the facility. The committee had been discussing the need for such bench marks.</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS</p> <p>The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17151 Based on resident interview, staff interview, record review, and document review, the facility failed to provide ongoing monitoring and a plan to achieve and sustain vascular access for two sampled patients. (Patient 1 and 3)</p> <p>1. A record review was conducted on 3/2/10 and revealed the following: Patient 1 was admitted on 1/28/10, with chronic kidney disease requiring hemodialysis. Patient 1 had a right internal jugular catheter in which she received hemodialysis treatments 3 times a week for 3 hours a day.</p> <p>During an interview on 3/2/10 at 10:30 a.m.,</p>	V 550		5/3/10	

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V 550	<p>Continued From page 22</p> <p>Patient 1 confirmed that she had been receiving dialysis treatments through her CVC since 5/6/09. The Center for Disease Control article regarding Hemodialysis catheters dated 3/16/09 indicated "To reduce the rate of infection, hemodialysis catheters should be avoided in favor of arteriovenous fistulas and grafts. If temporary access is needed for dialysis...the catheter is expected to stay in place for &gt; 3 weeks." A CVC left in greater than 90 days increases the risk of an infection. When asked if there had been any discussion of a plan about receiving a permanent vascular access device, Patient 1 stated that she did not know of a plan.</p> <p>The multidisciplinary team meeting 4/09, and the nursing plan care dated 4/09, did not indicate a plan regarding permanent vascular access. The facility could not provide a nursing plan of care or that the multidisciplinary team met after the above mentioned date.</p> <p>During an interview on 3/3/10 at 4:00 p.m., when requested, Licensd Nurse Z did not provide the multidisciplinary team notes and nursing plan of care after 4/09.</p> <p>During an interview on 3/2/10 at 3:00 p.m., Licensed Nurse A stated that Patient 1 was not compliant coming to the dialysis treatments. When asked what the plan was for Patient 1's permanent vascular access, Licensed Nurse A stated, she did not know and stated that we encourage her to go to her vascular access clinic. Licensed A stated that there were no multidisciplinary team notes or a nursing plan of care about Patient 1's permanent vascular access.</p>	V 550			

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V 550	<p>Continued From page 23</p> <p>2. A record review was conducted on 3/3/10 and revealed the following: Patient 3 was admitted to dialysis clinic on 5/2/05 with end stage renal disease requiring hemodialysis. Patient 3 had a left CVC in which she received hemodialysis treatments four times a week for 3 1/2 hours a day.</p> <p>During an interview on 3/3/10 at 6:50 a.m., Patient 3 stated that she was told by the surgeon that because of her repeated vascular access failures that she was not a candidate for another vascular access.</p> <p>The vascular access clinic notes dated 10/28/10, did not mention a plan for permanent vascular access and the notes did not indicate that Patient 3 was not candidate for permanent vascular access. Patient 3 confirmed that she has had her CVC for more than 90 days.</p> <p>The multidisciplinary team meeting and the nursing plan care dated 2/09, did not indicate a plan regarding permanent vascular access. The facility could not provide a nursing plan of care or that the multidisciplinary team met after the above mentioned date.</p> <p>During an interview on 3/3/10 at 4:00 p.m., when requested, Licensed Nurse Z was asked to provide the multidisciplinary team notes and nursing plan of care after 4/09. Nurse Z was unable to find the documentation.</p> <p>The facility's policy and procedure for a stable patient indicated under the care planning process an admission nursing plan of care and "also show any changes in the plan of care or adjustments made to the plan to meet goal. Identify ways the</p>	V 550			

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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:  <b>552519</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/05/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>RANCHO DIALYSIS CLINIC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10294 ROCKINGHAM DRIVE RANCHO CORDOVA, CA 95827</b>	
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V 550	Continued From page 24 clinic is trying to meet the goals for the patients." There is a three month interdisciplinary team discussion and joint development of care plan. "Monthly progress note addressing what was done during the month to meet goals of care plans."	V 550		
V 759	494.180(b)(2) GOV-RN PRESENT AT ALL TIMES  The governing body or designated person responsible must ensure that- (2) A registered nurse, who is responsible for the nursing care provided, is present in the facility at all times that in-center dialysis patients are being treated;  This STANDARD is not met as evidenced by: Surveyor: 17151 Based on observation, staff interview, and document review, a LVN was operating outside the scope of practice providing pre dialysis assessments resulting in the potential for patients to be inaccurately assessed.  Findings:  During an observation 3/1/10 at 10:10 a.m., an LVN was observed listening to Patient 7's heart beat, listening to lungs, checking patient's feet, and asking about changes in medications and health and making decisions regarding dialysis treatments regarding information. Licensed Nurse W, who was the charge nurse assigned to Patient 7 and a registered nurse, did not provide pre dialysis assessment prior to Patient 7 being put on dialysis.  The facility's policy and procedure titled, "Pre-treatment Patient Assessment" indicated	V 759	3/10/10	

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V 759	Continued From page 25 that a LVN and/or RN could provide an assessment of the patients, hear, lungs, and health status.  Licensed Vocational Nurses (LVNs) scope of practice dated 3/17/10 from the California State Licensing Board "provide basic bedside nursing care to clients under the direction of a physician or registered nurse. The LVN utilizes scientific and technical expertise and manual skills. Duties within the scope of practice of an LVN typically include, but are not limited to, provision of basic hygienic and nursing care; measurement of vital signs; basic client assessment; documentation; performance of prescribed medical treatments; administration of prescribed medications; and, performance of non-medicated intravenous therapy and blood withdrawal (requires separate Board certification.)"	V 759			