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	052401	A. BUILDING ______ B. WING ______	C 06/08/2010

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SIERRA VIEW DISTRICT HOSPITAL DIALYSIS CENTER	**283 NORTH PEARSON DRIVE** **PORTERVILLE, CA 93257**

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V 000	INITIAL COMMENTS Surveyor: 26215 The following reflects the findings by the California Department of Public Health during a Recertification survey. Representing the Department: Carol Erickson, HFES Janet Parmelee, HFEN The census was 63 hemodialysis patients and the sample size was 7 hemodialysis patients.	V 000		
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS 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. This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to ensure standard nursing practice was followed by permitting a patient to stand during dialysis which resulted in a fall with injury to his head. Findings: An unannounced visit was made to the facility on April 2, 2010 to investigate a complaint of a fall by Patient 12 during hemodialysis treatment on January 2, 2010.	V 101		

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 During a record review of Patient 12's medical record on April 2, 2010, treatment records indicated his fluid removal goal for the date of the fall was 3.9 kilograms (8.5 pounds) over a period of 3.5 hours. This fluid removal goal was done at a rate of 2.6 pounds of fluid per hour. Patient 12 was 83 years old with coronary artery disease and alzheimer's disease. The treatment record indicated Patient 12 requested the use of a urinal at 12 PM. His blood pressure was 116/61 (normal is 120/80) and heart rate was 55 (normal is 60-80). Patient Care Technician (PCT) 6 placed a privacy curtain in front of the patient and allowed Patient 12 to stand up while hemodialysis continued. At this time, approximately 200 cc's of blood were outside of Patient 12's body in the dialysis tubing and he had lost 8 pounds of fluid. Patient 12 fell to the ground and hit his head on the privacy screen while still connected to the hemodialysis machine by a catheter inserted into his chest. Patient 12 was assisted to the chair and his blood was returned. He was transported to the emergency room where he received six staples to his forehead. During an interview on April 2, 2010 at 10:15 AM, Charge Nurse (CN)1 acknowledged Patient 12's blood had not been returned prior to allowing him to stand. She stated she was approximately 10 feet away from him when he fell. During an interview on April 2, 2010 at 10:45 AM, PCT 6 stated Patient 12 was standing up in front of the chair and fell. PCT 6 indicated she "couldn't catch him and he hit the privacy curtain and gouged his head." During an interview on April 2, 2010 at 11:35 AM, a policy on allowing patients to stand during	V 101		

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V 101	Continued From page 2 hemodialysis treatment was requested from the Director. She stated, "There is no policy." She also stated falls were reported to Risk Management who tracks and trends the falls.	V 101		
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to implement their emergency preparedness and disaster manual which had the potential to expose a universe of 63 patients to life-threatening conditions during a disaster. Findings: During a review on June 2, 2010, the facility policy titled "Emergency Preparedness and Disaster Manual" (undated) indicated the facility had an emergency box which should contain advance directives, flashlight, batteries, camera, list of critical services providers, and mutual aid agreements. The emergency box was inspected on June 4, 2010 at 2:30 PM and these items were not found. During an interview on June 4, 2010 at 10:45 AM,	V 408		

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V 408	Continued From page 3 Patient 7 stated he had received no training on what to do in an emergency situation. During an interview on June 4, 2010 at 10:50 AM, Patient 10 stated he did not know what to do in an emergency situation. During an interview on June 4, 2010 at 2:15 PM, the Director of Facility Engineering stated he was responsible for fire extinguisher, fire alarms, and fire drills but the patient evacuation drills were to be done by the facility director. The Director stated the facility had not conducted patient evacuation drills. During an interview with the Medical Director on June 8, 2010 at 8:30 AM, when asked if the patients were trained on what to do during an emergency, she stated, "I don't know if we train the patients or not."	V 408		
V 412	494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to train/retrain patients on emergency disaster procedures. Findings: During an interview on June 4, 2010 at 10:45 AM, Patient 7 stated he had not received training on what to do in an emergency situation.	V 412		

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V 412	Continued From page 4 During an interview on June 4, 2010 at 10:50 AM, Patient 10 stated he did not know what to do in an emergency situation. During an interview on June 4, 2010 at 2:15 PM, the Director of Facility Engineering stated he was responsible for fire extinguisher, fire alarms, and fire drills but the patient evacuation drills were to be done by the facility director. The Director stated the facility had not conducted patient evacuation drills. During a record review on June 7, 2010 at 2 PM, the Director provided signed copies of hemodialysis patients "Clamp and Cut or Clamp and Cap Procedures" which provided written instructions on emergency removal from the hemodialysis machines. Of 63 total patients, only 31 had signed the procedure (49 percent). No additional information was provided by the Director.	V 412		
V 458	494.70(a)(7) PR-INFORMED-ALL MODALITIES/SETTINGS The patient has the right to- (7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients;	V 458		

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V 458	Continued From page 5 This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to provide information on alternative modalities such as home dialysis and transplantation. Findings: During an interview on June 8, 2010 at 8:20 AM, the Medical Director (MD) 1 stated her goal for transplantation was for "everyone younger, like 35 to 40 years old, to have a transplant. I really urge them, even if they don't want to." During an interview on June 8, 2010 at 10 AM, Social Worker (SW) 2 stated she was not doing transplantation or home dialysis training and "that should come from the doctor." SW 2 did not know if any patients were interested in home dialysis or transplant and was unable to find a transplantation referral log. On June 8, 2010 at 2 PM, the Director provided a brochure titled "Living Kidney Donation" and stated "This is what we give our new patients." The brochure described the process for donating a kidney.	V 458		
V 513	494.80(a)(10) PA-TRANSPLANTATION REFERRAL The patient's comprehensive assessment must include, but is not limited to, the following: (10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral	V 513		

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V 513	Continued From page 6 must be documented in the patient's medical record. This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to evaluate patients for transplantation referral. Findings: During an interview with Patient 7 on June 4, 2010 at 10:45 AM, he stated he has required dialysis for about seven months and at first the doctor told him dialysis might be temporary but around January 2010, the doctor told him it was a permanent situation. Since that time, no one from the facility has discussed with him the option of kidney transplant. He stated he would consider a kidney transplant now that he knows dialysis will be a permanent treatment. When asked his current age, he stated, "I'm 68." The clinical record for Patient 7 was reviewed on June 4, 2010 at 11 AM. The Hemodialysis Multidisciplinary Assessment dated November 20, 2009 indicated Patient 7 had refused a kidney transplant because he had been told that the need for dialysis may be temporary. No other assessment for transplant suitability was found in his chart and no follow-up documentation was available. During an interview on June 8, 2010 at 8:20 AM, the Medical Director (MD) 1 stated her goal for transplantation was for "everyone younger, like 35 to 40 years old, to have a transplant. I really urge	V 513		

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V 513	Continued From page 7 them, even if they don't want to." During an interview on June 8, 2010 at 10 AM, Social Worker (SW) 2 stated she was not doing transplantation or home dialysis training and "that should come from the doctor." SW 2 did not know if any patients were interested in home dialysis or transplant and was unable to find a transplantation referral log. During a record review on June 8, 2010, Patient 11's comprehensive interdisciplinary assessment indicated patient was interested in home therapy by a check mark. The transplant assessment was blank. No follow-up documentation was available.	V 513		
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Surveyor: 26215 Based on interview and record review, the facility failed to: 1. Identify a benchmark for medical errors and injuries. 2. Failed to report medical errors and injuries. 3. Failed to trend medical errors and injuries. 4. Failed to identify an action plan to prevent medical errors and injuries. Findings:	V 634		

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V 634	Continued From page 8	V 634		

During an interview on April 2, 2010 at 11:35 AM, a policy on allowing patients to stand during hemodialysis treatment was requested from the Director. She stated, "There is no policy." She also stated falls were reported to Risk Management who tracks and trends the falls.

During an interview on April 5, 2010 at 3 PM, the administrator stated the Quality Assurance Performance Improvement (QAPI) program was performed by the Performance Improvement department of the hospital and stated he did not attend the Performance Improvement meetings. At this time, the policy titled, "Performance Improvement Plan" dated January 2002, reviewed February 2009 was reviewed. This policy indicated, "The Renal Services Clinical Coordinator is responsible for establishing and implementing a dialysis services performance improvement program." The administrator stated the title of Renal Services Clinical Coordinator was not used and stated the Director was responsible for performance improvement.

During an interview on April 5, 2010 at 4 PM, the Director of Performance Improvement stated she did not have minutes for dialysis QAPI. The Performance Improvement indicators for 2009 included access and infection. No adequacy, nutrition, mineral metabolism, anemia, grievances, or injuries were tracked.

The policy titled, "Performance Improvement Plan" indicated, "The frequency of reporting will be as defined in the hospital wide PI (Performance Improvement) plan, but not less than quarterly. Documentation and reports shall include: findings from monitoring activities; conclusions regarding identified opportunities for

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V 634	Continued From page 9 improvement; recommendations concerning potential actions; actions taken to effectuate change; outcome of actions effectiveness (results of follow-up monitoring performed to determine extent of effectiveness and that improvements made are sustained." During a review of the facility's 2009 Performance Improvement Report on April 5, 2010, no tracking was present for adequacy of dialysis, medical errors/injuries, nutrition, bone disease, or anemia management. The May 2010 meeting minutes indicated no medical injuries/errors were found; however, an occurrence report indicated on May 10, 2010 due to an incident, 911 was activated. Another occurrence on April 19, 2010 which required Emergency Medical Services contact was not indicated on the performance improvement minutes. During a record review and interview on June 8, 2010 at 1:30 PM, the facility director was asked to identify the benchmark for medical errors and injuries. The facility performance improvement document had no benchmark and reported no incidents for the first quarter of 2010. The facility director was not aware of any medical injuries or errors occurring in the facility (nine medical injuries and six medication errors were identified from occurrence logs). The director was unable to identify a benchmark or an action plan for performance improvement.	V 634		