

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:  <b>052571</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/24/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNION CITY DIALYSIS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>32930 ALVARADO NILES ROAD, SUITE 300 UNION CITY, CA 94587</b>
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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
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V 000	INITIAL COMMENTS  Surveyor: 22301 The following represents the findings of the California Department of Public Health during the investigation of two complaints.  Complaint numbers: CA00226602 and CA00225875.  Representing the Department: Lutgarda F. Sturms, RN, HFEN.  The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.	V 000		
V 348	494.50(b)(1) VERIFY PT ID-2 PEOPLE  12.2 Verification of patient identification: 2 people Except in the case of home dialysis, two persons should check that the first and last names on the dialyzer and any other appropriate identifying information correspond to the identifying information on the patient's permanent record. If possible, one of the persons checking identification should be the patient. Completion of this step shall be recorded, along with the signature or other unique means of identifying the person verifying patient identification.  NOTE-This step may be done later in the procedure but shall precede initiation of dialysis.  This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to ensure the correct identification of	V 348		8/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 348	<p>Continued From page 1</p> <p>Patient A prior to initiation of treatment. Patient A received treatment using the dialyzer of another patient.</p> <p>This failure placed Patient A at risk for blood borne infections by cross contamination and also caused the patient a lot of stress and anxiety.</p> <p>Findings:</p> <p>The facility's policy and procedure on "Prescription Verification and Safety Checks" was reviewed on 6/24/10 at approximately 2 p.m. Under "Prescription Verification", the policy stated, "Two teammates are to check that the first and last names on reused dialyzer and any other appropriate identifying information correspond to the identifying information on the patient's permanent record. Completion of this step is recorded on the electronic treatment record, along with the signatures identifying the teammates verifying the patient's identification. Two teammates are to confirm and document the identity of the patient and reused dialyzer prior to initiating the dialysis treatment".</p> <p>Review on 6/24/10 at approximately 2:30 p.m. of Patient A's treatment electronic flowsheet dated 4/15/10, showed Staff 1's and Staff 2's electronic signatures of verification of the reprocessed dialyzer. Under notes, the flowsheet showed, "wrong dialyzer on pt. blood returned, pump off."</p> <p>During an interview with the Clinical Nurse Specialist at approximately 2:45 p.m., she said that obviously these two staff did not check the patient's name on the dialyzer, but went ahead and signed electronically.</p>	V 348		

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V 348	Continued From page 2 Further review of the flowsheet showed Patient A's primary dialysis access was a "CVC Catheter Subclavian (right)". The facility policy and procedure for treatment initiation using a CVC was reviewed on 6/24/10. Under number 18, the policy stated, "After 5 minutes, initiate dialysis per procedure" which goes back to the "Prescription Verification and Safety Checks" procedure requiring two teammates check the dialyzer identification. The Licensed Nurse who initiated Patient A's treatment on 4/15/10, failed to look at the dialyzer identification. Further review of facility records showed the nurse connected the patient's catheter lines into the dialysis machine and the nurse noticed it was another patient's dialyzer three minutes later.	V 348		
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P  The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;  This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to follow its own procedure when other patient's dialyzer was used to treat Patient A. This failure placed Patient A at risk for infection and emotional distress.  Findings:  Patient A's treatment flowsheet dated 4/15/10	V 715		8/2/10

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V 715	<p>Continued From page 3</p> <p>was reviewed during a facility visit on 6/24/10. The notes indicated that Patient A was treated with Patient B's dialyzer (Patient B was also scheduled for treatment on 4/15/10.)</p> <p>During an interview with the Clinical Nurse Specialist (CNS) on 6/24/10, she said that the facility did not have a policy for wrong dialyzer, because, "We don't expect that to happen but if it does, then we immediately stop the treatment and we call the doctor, inform the patient and the family. Then whatever the doctor orders, we follow. It is physician directed."</p> <p>The Clinical Nurse Specialist further said, that in the event of a wrong dialyzer, a Hepatitis Screen and HIV status of both patient were to be drawn, pending the order of a physician. Record review, showed the physician ordered lab tests for both Patient A and Patient B. The Clinical Nurse Specialist presented for review ON 6/24/10, the laboratory results of both patients. There was no result for Patient B's HBsAg screen and HBsAb quantity (tests for Hepatitis B infection) because according to the report, the samples were hemolyzed and a "Recollect request" was documented. The CNS said the facility failed to recollect or redraw another sample.</p>	V 715			