

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

PRINTED: 10/04/2010  
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>01/06/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNION CITY DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32930 ALVARADO NILES ROAD, SUITE 300</b> <b>UNION CITY, CA 94587</b>	
(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: 22301 The following represents the findings of the California Department of Public Health during the investigation of three complaints.  Complaint numbers: CA00194118, CA00196416, and CA00210068  Representing the Department: Lutgarda F. Sturms, HFEN.  The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility.  No deficiencies were issued for complaint number CA00194118 and complaint number CA00196416.  Two deficiencies were written for complaint number CA00210068.	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.	V 348		

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 348	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to ensure that prior to initiation of treatment the re-used dialyzer was verified as pertaining to one sampled patient (Patient 1). This failure resulted in the use of Patient 2's dialyzer to provide treatment to Patient 1, increasing the risk for infection by cross contamination, and making Patient 1 anxious and upset.</p> <p>Findings:</p> <p>On 1/6/10 at 2 p.m., review of Patient 1's dialysis treatment flowsheet, dated 11/18/09, showed,"tx (treatment) discontinued d/t (due to) pt (patient) on dialyzer was used in error, RN (registered nurse) notified, unable to returned the bld (blood), bld loss approximately 300 ml, pt was informed of the incident, bld drawn, set up new system w/ (with) the right pt dialyzer."</p> <p>Staff M was interviewed on 1/6/10 at 2:30 p.m. Staff M said that the error was discovered when another staff was setting up for the next shift and could not find Patient 2's dialyzer. This staff went to see if Patient 2's dialyzer was hooked up at the machine where Patient 1 was getting her treatment. When the staff found out that Patient 1 was using Patient 2's dialyzer, the treatment was immediately stopped.</p> <p>The facility policy and procedure for "Predialysis dialyzer inspection", dated March 2004, instructed, "The dialyzer should be checked to ensure: It is the correct dialyzer for the correct patient," and "If dialyzer fails inspection, return dialyzer to the Reuse Room (where the dialyzer</p>	V 348			

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V 348	Continued From page 2	V 348			
V 715	<p>are processed and stored for reuse) and inform the Reuse Technician."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P</p> <p>The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to follow their own policy and procedure regarding patient assessment pre dialysis. This failure may increase the risk of harm for patients and may lead to medical errors.</p> <p>Findings:</p> <p>The facility policy for "Pre/Post Dialysis Treatment Data Collection", dated December 2006, instructed, "A registered nurse will complete the patient assessment pre dialysis."</p> <p>During the facility visit conducted on 1/6/10, Patient's 1 treatment flowsheet dated 11/28/09, was reviewed with Staff I. It showed that Patient 1's treatment was initiated at 6:10 a.m. and that the nursing pre assessment was documented at 6:35 a.m., after the patient was put on the machine. Staff I said that the facility protocol required the nurse to complete the patient's assessment before the treatment was initiated.</p>	V 715			