

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>052689</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/28/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WALNUT CREEK DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH WIGET LANE</b> <b>WALNUT CREEK, CA 94598</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: 21174 The following reflects the findings of the California Department of Public Health during the investigation of a complaint.  Complaint number: CA00195350.  Representing the Department: Nikki Kratt, HFEN  The inspection was limited to the specific complaint investigated and does not represent a full inspection of the facility.  One deficiency was identified as a result of CA00195350. See V 327.	V 000		
V 327	494.50(b)(1) HEMODIALYZER LABELING-UNIQUE TO PT  10 Hemodialyzer labeling: unique to patient Each reprocessed hemodialyzer shall be used for only one patient. The labeling shall uniquely identify the patient who is using the dialyzer. The dialyzer should also be labeled with other information essential to proper reuse procedure.  This STANDARD is not met as evidenced by: Surveyor: 21174 Based on interview and record review, the facility failed to ensure that every reprocessed hemodialyzer was used for only one patient. Patient 1 received hemodialysis with another patient's reprocessed dialyzer, potentially exposing him to an infectious disease.  Findings:  During a telephone interview on 8/24/09 at 9:55 a.m., Patient 1 stated he was dialyzed on 7/15/09	V 327		

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 327	<p>Continued From page 1</p> <p>for two hours with the wrong dialyzer. He stated staff told him the dialyzer belonged to another patient.</p> <p>Record review on 5/28/10 showed Patient 1 was admitted to the facility on 3/27/08 for hemodialysis. Prior to his first treatment on 3/27/08, on 3/26/08, he signed a form that showed he consented to the use of reused (reprocessed) dialyzers for his dialysis treatments. According to physician orders for 7/15/09, Patient 1 was to receive an extra treatment consisting of two hours of fluid removal due to fluid overload, that would supplement his usual four hour treatments three times a week.</p> <p>Review of Patient Progress Notes, dated 7/28/09, showed "Late Entry: SW (social worker) was informed by team mates on 7/15/09 that pt. (patient) had been given another pt.'s dialyzer and had been dialyzing on it for the last 90 minutes. FA (facility administrator) requested that SW was to speak with pt. after she spoke with him. SW reassured pt. and offered (sic) him support about the incident. Pt. wanted to know what steps were going to be taken?" The social worker documented "Labs would be drawn that day for Hep(atitis) C, Hep(atitis) B and HIV (from Patient 1 and the patient whose dialyzer was mistakenly used for Patient 1) and the results would be given to him." The social worker documented in a subsequent Patient Progress Note dated 7/30/09 "SW was relieved that all the blood work had come back negative. Pt. reported he was also relieved."</p> <p>The facility administrator of record on 7/15/09 (FA 2) was interviewed on 5/28/10 at 1:35 p.m. and asked how staff ensured the correct dialyzer</p>	V 327			

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V 327	<p>Continued From page 2</p> <p>would be used for a patient. According to FA 2, the technician responsible for setting up the dialysis machine would confirm the patient's correct dialyzer even before putting it on the machine. Then, the technician and another staff member would verify the patient's correct dialyzer. The second staff might be the nurse who was coming over to perform the pre-assessment of the patient. Finally, the dialyzer would be displayed to the patient.</p> <p>During the interview with FA 2, the current facility administrator (FA 1) stated the technician involved in the incident on 7/15/09 (CHT 1) was not employed at the facility but had floated in from another facility. According to FA 1, CHT 1 "had been here before". According to FA 2, CHT 1 would have received numerous inservices over the years at the other facility regarding the importance of verifying the correct dialyzer.</p> <p>FA 2 stated on 5/28/10 at 2:05 p.m., "(RN 1) insisted she didn't do the dialyzer check. Each (CHT 1 and RN 1) gave a different account." FA 2 stated she was unable to determine exactly how the wrong dialyzer was put on the dialysis machine but agreed that all three identification checks could not have been performed.</p> <p>Review of the facility policy "Prescription Verification and Safety Checks" indicated "Trained teammates will verify the dialysis prescription and perform safety checks prior to each treatment initiation." The rationale was "Ensures the patient will receive a safe and effective treatment as prescribed." A safety check included "Verify and document on patient electronic treatment record the following prior to every dialysis treatment. Prescribed: Dialyzer"</p>	V 327			

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V 327	Continued From page 3 Rationale was "Ensures the patient prescription is verified by teammate prior to initiation of treatment."  Furthermore, review of the Post Treatment run sheet for Patient 1 on 7/15/09 showed that the Dialyzer model ordered and documented as used was a Polyflux 24 R. According to FA 2, the dialyzer belonging to the other patient was a Polyflux 21 R, an appropriate dialyzer for a lighter patient, not a heavy set man like Patient 1.	V 327		