

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: 052747	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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NAME OF PROVIDER OR SUPPLIER WEST COAST DIALYSIS CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3780 KILROY AIRPORT WAY SUITE 110 LONG BEACH, CA 90806
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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	<p>INITIAL COMMENTS</p> <p>Surveyor: 19582 The following reflects the findings of the Department of Public Health during a Complaint visit:</p> <p>Complaint Intake Number: CA00189000 - Substantiated</p> <p>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health:</p>	V 000		
V 115	<p>494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK</p> <p>Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 19582 Based on observation, interview and record review, the facility failed to implement their Visitors Policy during initiation of treatment by failing to ensure that a visitor exits to the waiting area during initiation of dialysis treatment of Patient 1. The visitor, who was standing next to Patient 1, wore no protective equipment to protect him from potential spurting or spattering of blood.</p>	V 115		3/31/10

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 115	<p>Continued From page 1</p> <p>In addition, Patient 2 was seated on the window ledge, while waiting for her scheduled treatment by Station 4 and Station 5, which were occupied by patients undergoing dialysis treatments.</p> <p>Findings:</p> <p>1. On March 30, 2010 at approximately 1:15 p.m., during a tour observation, Patient 1 was observed in Station 6 with a visitor standing next to the treatment chair. The Dialysis Technician, who was wearing a white gown, face shield and gloves, initiated the dialysis treatment via the left arm in the presence of the visitor, who was wearing no protective equipment (gown, gloves, face shields), to protect him from potential spurting or spattering of blood.</p> <p>During an interview with Employee A on March 30, 2010 at 2:05 p.m., she stated there should be no visitor during initiation of treatment.</p> <p>A review of the Visitors in Hemodialysis Unit Policy indicated, "Visitors will be asked to exit to the waiting area during times of peak service (dialysis treatment initiation and termination), during patient emergencies, and any time the nursing staff judge their presence detrimental to the operation of the facility."</p> <p>2. On March 30, 2010 at approximately 1 p.m., during a tour observation, a female was observed, while waiting for her scheduled treatment, seated on the window ledge by Station 4 and Station 5 which were occupied by patients undergoing dialysis treatment.</p> <p>During an interview with Employee A, she identified the female seated by the window as</p>	V 115			

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V 115	Continued From page 2 Patient 2. Employee A stated that the patient should wait in the waiting room until called by the staff. Employee A further stated that patients had been informed that if they arrived early, they were to wait in the waiting area.	V 115			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Surveyor: 19582 Based on observation and interview, the facility failed to maintain a safe and comfortable treatment environment. Findings: During a tour observation with Employee A on March 30, 2010, from 1 p.m. to 1:45 p.m., the following were observed: 1. The door under the clean hand wash sink had a chipped and uneven front panel. 2. There was a plastic bottle labeled Vinegar under the sink. A sign inside the cabinet indicated "Do Not Store Vinegar."	V 401		4/1/10	

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V 401	<p>Continued From page 3</p> <p>3. Torn baseboard was observed along the Nurses' station and around the treatment area.</p> <p>4. The treatment area was cluttered. There were several face shields on top of the filling cabinets.</p> <p>5. Three portable fans were observed in the treatment area with heavy accumulation of dust.</p> <p>6. There were white spots observed on the treatment chairs and the arm rests had brownish stain. Two treatment chairs had torn seats. One treatment chair had an arm rest without the side molding exposing the joint compressed wood which had a potential for contamination with the patients' blood.</p> <p>During concurrent interview with Employee A, she acknowledged the brown stain on the arm rest and stated the white spots were probably from the bicarbonate.</p> <p>During an interview with Employee B on March 30, 2010 at 1:50 p.m., he stated the brown stain on the arm rests was difficult to remove even with a brush. Employee B stated the facility was in the process of changing the treatment chairs.</p>	V 401			