

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: 552516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2010
NAME OF PROVIDER OR SUPPLIER FMCNA DIALYSIS SERVICES OF RANCHO			STREET ADDRESS, CITY, STATE, ZIP CODE 11031 VIA FRONTERA SUITE C SAN DIEGO, CA 92127		
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V 000	INITIAL COMMENTS Surveyor: 17130 The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 7/13/10 through 7/16/10. The facility census at the time of the visit was 67 patients. The sample size was 7. Representing the Department were HFENs: #17130 and #15930. Glossary of Abbreviations: CHT Clinical Hemodialysis Technician CCHT Certified Clinical Hemodialysis Technician CM Clinic Manager RN Registered Nurse P&P Policy and Procedure RCIT Regulatory Control Inventory Technician	V 000			
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.	V 117			7/24/10

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 117	<p>Continued From page 1</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview, and P&P review, the facility failed to prevent potential cross-contamination, when they used a common medication cart to deliver medications to patients in the treatment area.</p> <p>Findings:</p> <p>During the initial tour of the patient care area on 7/13/10 at 8:31 A.M., the RN wheeled a medication into the treatment area between Stations 14 and 15. There were multiple syringes on top of the portable cart that contained Epogen (a medication used to treat anemia in dialysis patients.)</p> <p>During another observation of the patient care area, on 7/15/10 at 11:40 A.M., RN 1 wheeled the same medication cart to the treatment area near Station 8. The top of the cart had multiple clean syringes and vials of Epogen and Zemplar (a man-made vitamin D used to treat an overactive parathyroid gland in dialysis patients.) At 11:46 A.M., RN 1 drew up doses of Epogen and Zemplar and administered both medications to Patient 13 in Station 8.</p> <p>During an interview on 7/15/10 at 11:45 A.M., RN 1 stated that she did not draw up medications ahead of time but "draws medication up (from the cart) as she goes along" between patients.</p>	V 117			

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V 117	Continued From page 2	V 117		
V 122	<p>On 7/15/10, the facility provided the P&P titled "Medication Handling," effective as of 10/10/08. The mandatory guidelines in the policy specified, "Prepare all medications in a clean (centralized) medication area away from the dialysis stations and deliver separately to each patient." The policy further specified, "Do not use common medication carts to deliver medications to patients."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation, interview and record review the facility failed to clean and disinfect all surfaces of 6 of 16 dialysis treatment chairs (4,5,6,7,11 and 15) in between patient treatments. The facility failed to disinfect an oxygen concentrator, located in the splash zone at Station 11. The facility also failed to disinfect the glucometer staff used to test blood sugars on multiple patients.</p> <p>Findings: 1. On 7/13/10 at 2:15 P.M., the cleaned dialysis chairs at Stations 4, 5, 6, and 7 were in the reclined position. Observations were as follows:</p>	V 122		7/24/10

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V 122	<p>Continued From page 3</p> <p>a. Four chairs had dried brownish red liquid splatters along the outside surfaces on either the right or left sides of the chairs. When interviewed on 7/13/09 at 3:00 P.M., RN 3 stated that the brownish-red liquid, on the chairs, was dried blood. RN 3 stated that the blood stains indicated that staff did not thoroughly wipe down the chairs, after each patient treatment. RN 3 acknowledged that the treatment chairs were not properly disinfected .</p> <p>b. During an interview on 7/13/10 at 10:55 A.M., CHT 2 stated that the dialysis chair in Station 11 was clean and ready for the next patient; however at 10:58 A.M., the left side of the chair in still had three 4 inch long dried drips of brownish substance and a 3 inch long strip of tape residue along the left side of the chair, beneath the arm rest. The metal frame on the bottom of the chair had a visible layer of dust.</p> <p>c. During an observation on 7/13/10 at 2:49 P.M., the "clean" chair in Station 15 had 1 splatter of dried brownish substance between the seat and left arm rest. The chair had debris and crusty crumbs between the seat and the back which were visible when staff placed the chair in the Trendelenburg position (fully reclined flat with the foot section positioned higher than the head. The metal frame, on the bottom of the chair, had a visible layer of dust.</p> <p>d. During an observation at the first shift turnover on 7/14/10 at 10:22 A.M., CCHT 1 discontinued the dialysis treatment on Patient 3, in Station 5. At 10:48 A.M., Patient 3 walked out of the building, and 2 minutes later, CCHT 1 wiped down the chair in Station 5 with a cloth soaked in 1:100 bleach solution. CCHT 1 did not place the</p>	V 122			

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V 122	<p>Continued From page 4</p> <p>chair in Trendelenburg position, during disinfection.</p> <p>On 7/15/10, the facility provided the P&P titled "Cleaning the Dialysis Station Between Patient Treatments", effective 10/10/08. The procedure specified the steps for staff to follow for disinfection after each dialysis patient. Under Step 4 of the cleaning process, the procedure specified, "Place the chair in Trendelenburg position so all surfaces are accessible. Wipe all surfaces and under the arms and side table with the 1:00 bleach solution."</p> <p>2. On 7/14/10 at 11:30 A.M., there was an oxygen concentrator in the splash zone around Station 11. As treatments continued throughout the day, the oxygen concentrator remained at the station. On 7/15/10 at 7:15 A.M., the oxygen concentrator still remained within the splash zone of Station 11. On 7/15/10 at 2:00 P.M., CCHT 4 and CHT 2 both stated they could not tell whether the oxygen concentrator was disinfected. CCHT 4 stated he overlooked the concentrator and did not disinfect it.</p> <p>On 7/15/10 at 2:30 P.M., the CM stated that any equipment within the splash zone needed to be disinfected between patient treatments.</p> <p>On 7/16/10 at 9:00 A.M., the facility provided a policy and procedure entitled, "Disinfection Standards for Equipment", read in part as, "Examples of other external surfaces that should be disinfected after each use are: crash cart, EKG machine, defibrillator, centrifuge, suction machines, exam table, and hematocrit machine..."</p> <p>On 7/16/10 at 9:00 A.M., the Regional Director of Education stated, the above mentioned policy and procedure applied to the oxygen concentrator.</p> <p>Surveyor: 17130</p>	V 122			

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V 122	<p>Continued From page 5</p> <p>3. During an interview on 7/15/10 at 1:55 P.M., RN 1 explained how staff used the facility's glucometer (a machine used to test blood sugars.) RN 1 said that staff put on gloves, obtained the blood specimen, placed it on a test strip, brought the strip to the glucometer machine that was located away from the dialysis station, and then turned the machine on. RN 1 stated staff used "alcohol" to clean the glucometer between patient use.</p> <p>In 2009, the Association for Professionals in Infection Control and Epidemiology published "Position Paper: Safe Injection, Infusion and Medication Vial Practices in Healthcare". The position paper specified "Clean and disinfect glucometers if they must be reused between patients". The paper further indicated, "Disinfect the exterior surfaces of the glucometer after each use following the manufacturer's directions. Use an EPA-registered disinfectant effective against HBV, HCV and HIV,(hepatitis and aids)or a 1:10 bleach solution(one part bleach to 9 parts water)."</p> <p>On 7/16/10, the facility provided the manufacturer's recommendations for cleaning the glucometer. The cleaning recommendations included using "A mix of one part household bleach, nine parts water."</p> <p>During an interview, on 7/16/10 at 9:07 A.M., the Regional Director of Education stated that staff should clean the glucometer with a 10% bleach solution This was contrary to RN 1's explanation as to how staff cleaned the glucometer with alcohol.</p> <p>During an interview on 7/16/10 at 10:12 A.M., the CM acknowledged that alcohol did not disinfect</p>	V 122			

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V 122	Continued From page 6 the glucometer and staff should use a bleach solution.	V 122			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview and record review, the facility failed to ensure that staff wrote the date and time on the medication label when they opened 1 multidose vial of Epogen (a medication used to treat anemia.) Findings: During an observation on 7/13/10 at 11:08 A.M., the medication refrigerator in the patient care area contained 1 opened multidose vial of Epogen 20,000 IU (International Units). The vial lacked the date and time when staff opened it. During an interview on 7/13/10 at 11:09 A.M., RN 1 stated "The vial was opened today and we will date it at the end of the day." On 7/14/10, the facility provided the P&P titled "Medication Policy". The policy specified that "Vials of Epogen ...will be dated and timed upon opening."	V 143		7/24/10	
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE	V 401		7/24/10	

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V 401	<p>Continued From page 7 ENVIRONMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15930 Based on observation and interview, the facility failed to maintain 3 of 4 exit doors in optimal condition. The doors lacked door sweeps, weather stripping and/or door adjustments which allowed the entry of insects and vermin.</p> <p>Findings:</p> <p>During an observation of the patient care area on 7/13/10 at 8:16 A.M., there was a large dead black insect and a vector box (a pest control trap) beneath the sink adjacent to the isolation room.</p> <p>On 7/14/10 at 9:30 A.M., there were 4 small vector boxes, on the floor, near the rear door that exited to the parking lot. The rear exit door lacked a door sweep and provided an open area where insects and vermin could enter the building. The emergency exit door, located behind the nurse's station, and the facility entrance doors lacked weather stripping and required an adjustment to close the gaps between the two doors and the door frame.</p> <p>On 7/14/10 at 9:45 A.M., the CM stated, that when the pest control company technician made any recommendations, the RCIT was supposed to forward the information to her and also to the RCIT supervisor.</p>	V 401			

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V 401	Continued From page 8	V 401		
V 403	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU</p> <p>The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17130 Based on interview, P&P review and machine maintenance log review, the facility failed to perform semiannual electrical safety testing , on 1 of 5 dialysis machines (8).</p> <p>Findings:</p> <p>On 7/15/10 at 9:19 A.M., the facility provided the dialysis machine Preventive Maintenance logs. A review of the log entries from 1/09 through 6/30/10 showed that dialysis machine 8 had electrical safety testing done on 3/10/09. On 1/03/10, 9 months later, the facility staff performed the next electrical safety testing.</p> <p>During an interview on 7/15/10 at 10:05 A.M., the Central Technical Program Manager stated that the electrical testing should have been done "semi-annually"(every 6 months).</p>	V 403		7/24/10

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V 403	Continued From page 9	V 403			
V 407	<p>On 7/15/10, the facility provided the P&P's titled "Electrical Leakage Testing" and "Ground Wire Resistance Testing". The policies specified that both the electrical leakage and ground wire resistance tests must be formed "twice a year".</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS</p> <p>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation and interview, the facility failed to ensure that patients' access sites were visible, during dialysis, during first shift observations on 7/13/10, for 3 of 16 patients (7, 8 and 9).</p> <p>Findings:</p> <p>During the initial tour of the patient care area, on 7/13/10 at 8:16 A.M., access sites were not visible for 3 patients in Stations 1, 6 and 7 as follows:</p> <p>a. On 7/13/10 at 8:16 A.M., Patient 7 received dialysis in Station 1. A blanket covered the patient's access site.</p> <p>b. On 7/13/10 at 8:18 A.M., Patient 8 received dialysis in Station 6. Patient 8's access site was not visible.</p> <p>c. On 7/13/10 at 8:20 A.M., Patient 9 received dialysis in Station 7. Patient 9's access site was</p>	V 407		7/24/10	

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V 407	Continued From page 10 not visible.	V 407			
V 413	<p>On 7/15/10 at 9:00 A.M., the Regional Quality Manager agreed that access sites should be visible at all times, during dialysis.</p> <p>494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION</p> <p>Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview, and record review, the facility failed to ensure that 1 of 1 crash carts contained functional suction equipment for use in an emergency.</p> <p>Findings:</p> <p>On 7/13/10 at 10:42 A.M., during an inspection of the crash cart, a test of the emergency suction equipment showed that there was a broken connector on top of the suction container. The broken connector made the suction equipment unusable.</p> <p>The facility Emergency Tray Checklist, located on top of the crash cart, showed that a RN checked the cart on 6/30/10. The checklist specified that the suction machine should have a "Vankauer [Yankauer suction tip] (a hollow plastic tube to remove thick secretions from the mouth and back of the throat) attached". There was no Yankauer tip on the cart.</p>	V 413		7/24/10	

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V 413	Continued From page 11	V 413			
V 541	<p>During an interview on 7/13/10 at 10:47 A.M., RN 3 stated that staff only checked the crash cart monthly.</p> <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview, and record review, the facility failed to use the correct dialyzer, during a dialysis treatment for 1 of 7 sampled patients (7). Findings: Patient 7 was admitted to the facility on 4/24/10, per the face sheet. During an observation on 7/13/10 at 8:20 A.M., Patient 7 received a dialysis treatment that started 2 hours earlier at 6:26 A.M., per the dialysis treatment sheet. Staff used an "Optiflux 180RE" dialyzer.</p> <p>During an interview on 7/13/10 8:21 A.M., RN 1 accessed the physician's orders for the patient's dialysis prescription, on the computer screen.</p>	V 541		7/24/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2010
NAME OF PROVIDER OR SUPPLIER FMCNA DIALYSIS SERVICES OF RANCHO			STREET ADDRESS, CITY, STATE, ZIP CODE 11031 VIA FRONTERA SUITE C SAN DIEGO, CA 92127		
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V 541	Continued From page 12 Concurrent review of the physician's order with RN 1 showed that the physician ordered an "Optiflux 160RE" dialyzer, be used for Patient 7. RN 1 agreed that Patient 7 should be dialyzed on the Optiflux 160RE, not the "Optiflux 180RE" already in use.	V 541			
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Surveyor: 15930 Based on interview and record review, the facility frequently failed to meet the estimated dry weight for 1 of 7 sampled patients (4). Findings: On 7/15/10 at 8:00 A.M., the facility provided Patient 4's medical record for review. The dialysis treatment sheets for 5/27/10 through 6/10/10, indicated that upon completion of 7 of 9 consecutive dialysis treatments, Patient 4 was above his estimated dry weight, as prescribed by the physician. Patient 4 was hospitalized on 6/12/10 for fluid overload, 2 days after his last treatment. Further review of the medical record showed that there was no documentation concerning the facility's failure to meet the patient's estimated dry weight goal. There was no documentation that the IDT reviewed/addressed the patient's fluid volume.	V 543		7/24/10	

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V 543	Continued From page 13 On 7/16/10 at 12:39 P.M., the CM acknowledged that the medical record lacked documentation concerning Patient 4's inability to meet his dry weight. The CM also stated that once the patient had a problem meeting the targets, the patient would be considered unstable in that area and the IDT should meet and discuss just that aspect of the patient's care and address it with a care plan.	V 543			
V 544	On 7/16/10 at 3:15 P.M., the Medical Director acknowledged that Patient 4's medical record lacked documentation concerning the failure to meet the estimated dry weights. He further stated that because of their inability to meet the target goal, the patient would be considered unstable and require further assessment in that area. 494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Surveyor: 15930 Based on interview and record review, the facility failed to meet the Kt/V goal for 1 of 7 sampled patients (10). Findings: On 7/15/10 at 8:00 A.M., the facility provided Patient 10's medical record for review. The laboratory values for the months of March, April, and May of 2010 indicated that Patient 10 did not meet the Kt/V (laboratory test that measures the	V 544		7/24/10	

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V 544	<p>Continued From page 14</p> <p>adequacy of the dialysis prescription) goal of 1.2</p> <p>In reviewing Patient 10's medical record, there was no documentation concerning the inability to meet the patient's Kt/V goal in any of the nurse's notes, physician progress notes or the IDT notes. The IDT did not recommend adjustment of the dialysis prescription to meet the minimum KT/V goal.</p> <p>On 7/16/10 at 12:39 P.M., the CM agreed that the medical record lacked documentation concerning Patient 10's not meeting his Kt/V goal. The CM also stated that once the patient had a problem meeting target goals, the patient was considered unstable and the IDT should have met to discuss and address the issue with a care plan.</p> <p>On 7/16/10 at 3:15 P.M., the Medical Director agreed that Patient 10's medical record lacked pertinent documentation related to the patient's Kt/V goal. He stated there should have been a continuing assessment with appropriate care plan interventions.</p>	V 544			