

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

PRINTED: 01/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052861	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/26/2010
NAME OF PROVIDER OR SUPPLIER FMC DIALYSIS SERVICES SOUTH ORANGE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 EAST FIRST STREET, SUITE 110 SANTA ANA, CA 92705		
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{V 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a follow-up recertification survey. The facility census at the time of the survey was 151 in-center hemodialysis patients. The patient sample consisted of 16 hemodialysis patients. The Clinical Manager was the facility coordinator for this survey. Representing the Department of Public Health: Raul Reyes, HFEN; Phyllis Weaver, HFEN. GLOSSARY: CM - Clinical Manager Epogen - Medication to stimulate red blood cell production. mL - Milliliters NS - Normal Saline P&P - Policy and Procedure RN - Registered Nurse	{V 000}			
V 452	494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the Clinical Manager (CM) failed to demonstrate observance of Patient 16's representative's rights to respect, dignity and the	V 452		5/27/10	

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 452	<p>Continued From page 1</p> <p>patient's right to be free of restraints and recognition of her personal needs.</p> <p>Findings:</p> <p>On 5/25/10 at 1030 hours, a tour of the facility was conducted with RN (Registered Nurse) 2.</p> <p>At station 19, an upset visitor was noted to be pacing back and forth from the station to the front nurse's station while speaking softly to RN 1. RN 1 was observed offering a stool to the visitor who calmed down with the gesture.</p> <p>On 5/25/10 at 1100 hours, the visitor was asked what had caused him to be upset. The response was the wheelchair he had been sitting on for two weeks to watch his forgetful mother (Patient 16) while she was receiving her dialysis treatment was taken away without his knowledge. The wheelchair belonged to Patient 16 and the son had agreed with the physician's order to watch the patient to prevent her from pulling out her dialysis needles.</p> <p>RN 1 was asked on 5/25/10 at 1115 hours who had removed Patient 16's wheelchair. It was stated that a staff member removed the wheelchair per instructions by the CM because it was blocking the way. She stated the patient's representative was not informed and was not offered a chair to sit on for the patient's three hour treatment. This made him upset.</p> <p>Record review for Patient 16 revealed that on 4/22/10, the patient's representative found Patient 16 in the bathroom bleeding from the right upper arm dialysis access site. It was documented that Patient 16 had pulled out the venous needle with</p>	V 452			

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V 452	<p>Continued From page 2</p> <p>a resulting blood loss of approximately 200 milliliters (mL). The incident was repeated on 5/6/10 in the treatment area with approximately 50 mL of blood loss. The physician was informed on the same day and ordered soft wrist restraints during Patient 16's dialysis treatment to prevent her from pulling out the dialysis needles. By 5/11/10, it was agreed upon by the multidisciplinary team to discontinue the restraints and have the patient's son, the patient's representative, to be at the chair side to prevent Patient 16 from pulling out the dialysis needles.</p> <p>On 5/25/10 at 1230 hours, the CM volunteered her information regarding the incident with Patient 16's representative. She stated that she never spoke to him before asking staff to remove the wheelchair. She stated she had the wheelchair removed because a staff member complained the wheelchair was blocking the way around the treatment area.</p> <p>On 5/25/10 at 1530 hours, the social worker, in charge of grievances, was interviewed regarding Patient 16's representative. She stated that the representative was "a bit over caring for the patient, wanting to start her treatment on time." Aside from being on time, there was no other grievance or complaint reported to her about Patient 16's representative. She stated the representative paced back and forth, especially when upset, because of his difficulty expressing himself, but never yelled and screamed at the staff.</p> <p>On 5/26/10 at 0815 hours, RN 2 and PCT 1 stated there was no problem with Patient 16's wheelchair in the treatment area.</p>	V 452			
{V 451}	494.90 POC-GOALS=COMMUNITY-BASED	{V 451}			

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{V 541}	<p>Continued From page 3 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: Based on medical record review and staff interview, the facility failed to ensure the plan of care for three of 16 sampled patients (Patients 2, 6 and 16) was updated by the multidisciplinary team to identify changes in condition and interventions to address these changes. This resulted in the potential for the care provided to not be individualized for the patients' specific needs.</p> <p>Findings:</p> <p>1. Review of the treatment sheets for Patient 2 showed on 5/17/10 the total fluid removal goal for the patient had not included the 200 mL NS prime given to each patient at the beginning of the treatment and the 400 mL of NS to rinse back the patient's blood at the end of the treatment. When reviewed with the CM on 5/23/10 at 1400 hours, the CM stated that for this patient the NS prime and rinse back were not added to the patient's</p>	{V 541}			

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{V 541}	<p>Continued From page 4</p> <p>total fluid removal because the patient removed fluid easily during treatment. Review of the care plan for Patient 2 showed no documentation that the patient removed fluid easily and that the NS prime and rinse back should not to be included in the patient's fluid removal goals.</p> <p>2. Review of the May 2010 treatment sheets for Patient 8 showed that during treatment the patient's heart rate decreased to as low as 30 beats per minute (normal is 60-100 beats per minute). The Physician's Progress notes showed that the patient had this issue in April and the patient was seeing a cardiologist for the problem. Review of the patient's Plan of Care dated 2/9/10, showed the care plan had not been updated to reflect the patient's problem with a decreased heart rate or interventions to address the problem. During an interview with the Medical Director on 5/26/10 at 1445 hours, he stated that he was aware of this issue and had talked to the patient's physician regarding the decreased heart rate.</p> <p>3. On 5/11/10, the multidisciplinary team members met with Patient 16 and the patient's representative to assess Patient 16's mental status. The dangers of pulling out the dialysis needles out were discussed. Patient 16 was documented as unable to comprehend. The patient did not want to be restrained. The patient's son agreed to sit with the patient during treatment and to accompany her to the restroom when necessary. However, further record review failed to reveal that the plan of care was revised to reflect this information from the assessment.</p> <p>On 5/26/10 at 1600 hours, the Regional Director acknowledged that the plan of care was not</p>	{V 541}			

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{V 541}	Continued From page 5	{V 541}			
{V 726}	revised since the beginning of the year. 494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on review of medical records, facility policy and staff interview, the facility failed to ensure the medical records for 2 of 16 sampled patients (Patients 7 and 8) were complete and accurate with regard to the consistency of documentation of normal saline (NS) flushes given with the administration of Epogen, and to ensure the flushes were included in the patients' total fluid removal goal for accuracy of the total fluid removed from the patients. Findings: On 5/26/10, the facility's policy for the administration of Epogen showed that prior to injecting the medication into the line; the line was to be flushed with 50 mL of NS. After the medication had been injected into the line, another 50 mL of NS was to be used to flush the medication out of the line and into the patient. If other medications were given at the same time as the Epogen, a 50 mL NS flush was to be done between each of the medications. 1. Review of the May treatment sheets for Patient 8 showed the patient had received Epogen each	{V 726}			

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{V 726}	Continued From page 6 treatment, but there was no documentation to show that the 50 mL of NS had been given before and after the medication. 2. Review of Patient 7's treatment sheets for 5/4, 5/11 and 5/18/10 showed the treatment sheets for 5/4 and 5/18/10 had documentation showing that 100 mL of NS had been administered with medications. The treatment sheet for 5/11/10 showed no documentation the 100 mL of NS had been given with the Epogen administered during that treatment. Review of the treatment sheets showed that the normal saline was being documented by only two of the RNs giving medications to the patient. It also showed that when other medications were given at the same time the Epogen was given, the total NS flush did not reflect the 50 mL NS flushes that were to be done between medications. On 5/26/10 at 1400 hours, the treatments sheets were reviewed with the CM, the Quality Manager and the Director of Operations. The Quality Manager acknowledged the documentation of the normal saline flush was inconsistent.	{V 726}			
V 729	494.170(b)(1) MR-COMplete RECORDS PROMPTLY (1) Current medical records and those of discharged patients must be completed promptly. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to keep one of 16 sampled patients' (Patient 16) medical records current and completed promptly. Findings:	V 729			5/27/10

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V 729	Continued From page 7 On 5/25/10 at 1030 hours, Patient 16's representative was observed complaining to RN 1. The patient's representative was complaining that the wheelchair he had been sitting on for two weeks to watch his mother (Patient 16) while having her dialysis treatment had been removed without his knowledge. On 5/25/10 at 1630 hours, when the surveyor was on their way out, a Multidisciplinary Notes with a description of the morning incident. The note had a time of 1535 hours and failed to indicate it was a late entry for the event that happened earlier in the day.	V 729			