

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:  <b>053521</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/22/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEE MEMORIAL OUTPATIENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>809 BROADWAY</b> <b>KING CITY, CA 93930</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: 05189 The following represents the findings of the Department of Public Health during the investigation of a complaint.  Complaint number: CA00222196.  Representing the Department of Public Health: Dorothy Rice, HFEN.  The inspection was limited to the specific complaint being investigated and does not represent the findings of a full inspection of the facility.	V 000		
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS  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.  This STANDARD is not met as evidenced by: Surveyor: 05189	V 541		

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 541	<p>Continued From page 1</p> <p>Based on staff interview and record review, the facility failed to develop an individualized comprehensive plan of care based on the assessment of Patient 1's behavior. The failure to develop a plan of care when Patient 1 started exhibiting the behavior increased the risk that the behavior would continue and escalate, creating anxiety for staff and other patients in the facility.</p> <p>Findings:</p> <p>On 6/22/10, record review showed that Patient 1 was admitted to the facility on 12/06/06. The review of the flowsheet records, dated 4/20/09 and 4/22/09, and Termination from Hemodialysis document, dated 4/24/09, showed Patient 1 requested early termination of his treatment. On 5/1/09, the social worker documented in the Social Service/Discharge Planning Progress Record that Patient 1, "verbally abused the RN and other staff members...Patient signed a Treatment of Agreement which states that there will be no tolerance to verbal abuse."</p> <p>Review of the Multidisciplinary Care Plan, dated 6/10/09, showed only the following statement: "Behavior significantly improved, very proud of pt [patient]." The care plan did not specify patient's behavior that needed to be changed and did not specify the goal for improvement.</p> <p>On 1/13/10, the staff documented in a Progress Record, that Patient 1 was "swearing" and on 3/1/10, that Patient 1 was, "verbally abusive and mean spirited to the staff...and disruptive to the other patients." Again, on 3/5/10 staff documented that Patient 1 was "verbally disrespectful to the staff and was disruptive to the other patients." There was no reference to</p>	V 541			

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V 541	Continued From page 2 Patient 1's behavior in the Multidisciplinary Care Plan, dated 3/8/10.  Further review of the Progress Records, showed that on 3/22/10 Patient 1 was "verbally disruptive", on 3/24/10 Patient 1 "became verbally abusive and argumentative with the staff. This behavior continued the entire run [treatment] of the shift, escalating to the point where [Patient 1] was cursing loudly and yelling comments to other patients across the floor. This was disruptive to other patients and to staff." However, the Multidisciplinary Care Plan, dated 6/7/10 showed no reference to the verbal abuse behavior or attempted interventions and goal.  Staff B acknowledged the deficient practice on 6/22/10 and stated that the care plan for the verbal abuse behavior with attempted interventions and goal should have been developed.	V 541			
V 726	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: Surveyor: 05189 Based on staff interview and record review, the facility failed to maintain complete records that showed when Patient 1 started verbally abusing staff. This failure made it difficult to determine how long Patient 1 had verbally abused staff.	V 726			

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V 726	Continued From page 3  Findings:  On 6/22/10 during the visit, the record review showed that Patient 1 was admitted to the facility on 12/06/06. The review of the Social Service/Discharge Planning Progress Record, dated 9/22/08 showed Patient 1 "does not have any concerns at this time..." Further review of the Social Service/Discharge Planning Progress Record, dated 12/31/08 continued to show Patient "does not have any concerns or issues at this time..." However, the review of the Social Service/Discharge Planning Progress Record, dated 5/1/09 showed the following: "He [Patient 1]verbally abused the RN and other staff members...Patient signed a Treatment of Agreement which states that there will be no tolerance to verbal abuse...this is not the first time that he swears at staff or patients. The only reason why nothing was done in the past was because staff and patient did not want to file a complaint." There was no indication in the record that included when Patient 1 began the verbal abuse.  Subsequently after extensive research that included the computerized system record review, Staff B acknowledged the deficient practice. Staff B further stated that although she was not employed at the facility until 8/09, staff should have included prior documentation of the initial abuse occurrence.	V 726			