

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: 052305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/17/2010
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NAME OF PROVIDER OR SUPPLIER SANTA CLARA VALLEY MEDICAL CENTER - ESRD	STREET ADDRESS, CITY, STATE, ZIP CODE 2220 MOORPARK AVENUE SAN JOSE, CA 95128
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{V 000}	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a follow-up visit (conducted 6/15/10 to 6/16/10) to the Recertification Survey (done 4/19/10 to 4/22/10).</p> <p>Representing the Department of Public Health: Dorothy Rice, HFEN.</p> <p>{V 115} 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 spurling 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: Based on observation and interview, the facility failed to ensure that a family member followed appropriate procedures when in the isolation treatment room while one (Patient 2, who was Hepatitis B positive) of 12 patients reviewed received hemodialysis treatment. This failure placed the family member at potential risk for blood borne illness.</p> <p>Findings:</p> <p>Staff interview on 6/16/10 indicated Patient 2 had mentation concerns and a family member's presence during treatment helped Patient 2 cope with the hemodialysis treatment. Patient 2 tested positive for Hepatitis B and received treatments in the isolation room.</p>	{V 000}		
		{V 115}		

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}	Continued From page 1	{V 115}			
{V 409}	<p>On 6/16/10 at approximately 3:15 p.m., Staff M and a family member were fully dressed in appropriate protective garment as Patient 2's treatment was initiated. At 3:20 p.m., the family member removed the gloves, left the room without removing the gown, and went to wash hands at the sink outside the isolation room. After returning to the isolation room, the family member took a wet paper towel, wiped the seat of the chair she had previously sat on, and without cleaning hands, put a fresh pair of gloves on.</p> <p>Shortly after, Staff J and Staff M acknowledged the deficient practice and stated that the family member was supposed to remove the protective garment and equipment before leaving the isolation room. Staff J further stated that the family member's act of wiping the stool with bare hands was done "just in opposite of what was supposed to be done".</p> <p>494.60(d)(1) PE-ER PREP STAFF-INICIAL/ANNUAL/INFORM PTS</p> <p>The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate</p>	{V 409}			

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{V 409}	<p>Continued From page 2</p> <p>emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and</p> <p>(D) How to disconnect themselves from the dialysis machine if an emergency occurs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that four of twelve patients reviewed were knowledgeable and trained about the emergency procedures during an outside disaster event (Patients 1, 6, 7, and 8). This failure placed the patients at risk of not knowing how to handle the emergency and what to do in the event of a disaster outside the facility.</p> <p>Findings:</p> <p>a. On 6/15/10 at approximately 12:20 p.m., after the catheter dressing change observation, the surveyor conducted a partial interview with Patient 6. When the surveyor asked Patient 6 what she was told to do in emergency situations, Patient 6 clearly described and demonstrated the appropriate procedure inside the facility which included the emergency procedure to disconnect herself from the machine. However, when the surveyor asked Patient 6 to verbalize how she would handle an emergency out of the facility such as an earthquake, Patient 6 stated, "They [staff] talked about what to do here [inside the facility], but not at home [outside the facility]."</p> <p>b. On 6/15/10 at approximately 12:25 p.m., during an interview, Patient 7 looked at the surveyor in a quizzical manner and stated, "I don't know what to</p>	{V 409}			

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{V 409}	Continued From page 3 do outside when an earthquake occurs." c. On 6/15/10 at approximately 12:30 p.m., when the surveyor asked Patient 8 to verbalize how she would handle an emergency out of the facility such as an earthquake, Patient 8 stated, "They [staff] gave us a paper telling you where there are other close clinics, but no-one said anything about the transportation to the other clinics!" When the surveyor asked about the emergency dietary information, Patient 6 further stated, "The Dietician was here last week, but nothing else [no additional emergency information] was given." d. On 6/15/10, the record review showed that Patient 1 was admitted to the CAPD (continuous ambulatory peritoneal dialysis) program on 5/10/10. Further review of the record showed that the Patient 1 had signed a document, dated 5/6/10, indicating that he had received the booklet entitled, "Preparing for Emergencies : A Guide for People on Dialysis". However, there was no documented evidence to include some measure of patient education and understanding, such as return teaching or demonstration. On 6/15/10, during an interview, Staff J acknowledged the deficient practice and stated that the facility was working on the problem that would ensure a measure of patient understanding of outside emergency procedures, such as return teaching or demonstration.	{V 409}			
{V 504}	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs.	{V 504}			

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{V 504}	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to implement the blood pressure monitoring policy and procedure for one (Patient 12) of 12 patients reviewed. This failure placed the patient at risk for negative outcomes. Findings: On 6/16/10 review of facility policy entitled, "Intradialytic Monitoring of Blood Pressure and Pulse" showed that when a patient had an abnormal blood pressure, the Registered Nurse would document the abnormal blood pressure and any symptoms in the (computerized system) under the Incident section. The policy further directed the staff to implement specific interventions for specifically defined hypotensive (low blood pressure) readings: for a patient with a systolic blood pressure below 90 and a diastolic level below 40 and with no related symptoms, the staff was instructed to turn off UF (ultrafiltration mechanism that removes fluid), to check BP (blood pressure) in 10 minutes, and if the blood pressure remained low, to give 200 ml Normal Saline IV (intravenously). For a patient with low BP reading who exhibited symptoms, the policy instructed the staff to turn off the ultrafiltration, to place the patient in Trendelenburg's position (patient is supine on a surface inclined 45 degrees, but head is at the lower end), to give 200 ml Normal Saline IV, and to call the physician if the blood pressure remained low or if the patient remained symptomatic. On 6/16/10, the record review showed that	{V 504}			

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{V 504}	<p>Continued From page 5</p> <p>Patient 12 was admitted to the facility on 7/23/07. The flowsheet, dated 6/14/10, showed Patient 12 had orders for "No Heparin [anti-clotting medication]" administration, and a 3.50 (three and one half hour) treatment duration. Patient 12's blood pressure before treatment was 123/75.</p> <p>Further review of the flowsheet showed that staff started Patient 12's treatment at 10:00 a.m. and the patient's blood pressure reading was 127/63. At 10:20 a.m., Patient 12 received 100 ml normal saline. By 10:30 a.m., Patient 12's blood pressure dropped to 71/41 and by 10:34 a.m., to 69/40. Review of the flowsheet showed that the ultrafiltration rate(UFR) was lowered (not turned off), and only 150 ml (as opposed to 200 ml) of normal saline was administered.</p> <p>There was no documentation in the "Incident" section of the flowsheet to indicate if the patient had or not any symptoms that would have warranted specific interventions.</p> <p>Further review showed that at 10:35 am, Patient 12's blood pressure was 103/68. However, at 11:00 am, the blood pressure dropped again to 73/38 and remained under 85/43 until 11:20 a.m. Again, there was no additional documentation in the "incident" section of the flowsheet indicating if the patient was or not symptomatic. At 11 a.m. the UFR was lowered (not turned off), and only 100 ml (as opposed to 200 ml) of normal saline was administered. At 11:17 p.m., Patient 12 received another 100 ml of normal saline.</p> <p>At approximately 2:35 p.m., Staff L stated that staff was to document if the patient had or had not had symptoms when the patient had low blood pressure incidents. Staff L also stated that she did not know why the policy and procedure</p>	{V 504}			

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{V 504} V 715	Continued From page 6 was not implemented as written, or at least the inclusion of an explanation or rationale when specifically not followed. 494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to consistently ensure the arterial chambers were 3/4 filled with blood during treatment at two of twelve stations observed (Stations A3 and B4) . This deficient practice increased the risk for clotting and air entering the circuit system and the patient's bloodstream. Findings: During the tour on 6/15/2010 at approximately 11:35 a.m. while patients were receiving treatment, at station A3, the arterial chamber was almost empty of blood and at Station B4, the arterial chamber was approximately 1/4 blood-filled with blood. On 6/15/10, Staff J and Staff L stated that the facility's practice and policy was to maintain the blood level in the arterial chambers at "the frosted demarcation line" or 3/4 filled with blood during patient treatment.	{V 504} V 715		7/14/10	