

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>552591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEST SACRAMENTO DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3450 INDUSTRIAL BLVD. WEST SACRAMENTO, CA 95691</b>	
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 21174 The following reflects the findings of the California Department of Public Health during a recertification survey from 7/20/10 to 7/22/10.</p> <p>Representing the Department: Nikki Kratt, HFEN; Lutgarda Sturms, HFEN; and Doina Vlasache, HFES.</p> <p>The census of the facility on 7/20/10 was 98 in-center and 15 home training.</p> <p>Acronyms and Abbreviations commonly used in this report:</p> <p>ESRD-end-stage renal disease. Treatment options include hemodialysis [using a manufactured artificial kidney to remove fluid and waste]; peritoneal dialysis [using the patient's peritoneal membrane in their abdominal cavity as a filter to remove fluids and waste]; or kidney transplant.</p> <p>EDW - estimated dry weight. The weight of a person when all excess fluid is removed.</p> <p>Dialyzer - an artificial kidney using a membrane to filter and remove excess fluid and waste from the body.</p> <p>Dialysate - specific mixture of treated water, acidified concentrate with variable ratios of potassium (K) and calcium (Ca), and bicarbonate used in the dialyzer to clean the blood.</p> <p>Dialysis machine - the delivery system for hemodialysis.</p>	V 000		

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 000	<p>Continued From page 1</p> <p>Cross-contamination - spread of infection from a patient to another through breaks in infection control practices.</p> <p>Measurements of Dialysis Adequacy: Kt/V = kinetic modeling for dialysis adequacy reflecting clearance, time and volume URR = Urea reduction ratio (percentage of urea reduction)</p> <p>Blood Flow Rate (BFR) -the speed of blood flow from the patient into the lines and dialyzer and back to the patient. BFR is determined by the blood pump on the dialysis machine and the condition of the patient's vascular access. The higher the rate, the more dialysis occurs.</p> <p>Vascular Access - the site on patient's body where blood is removed and returned during dialysis. AVF - arteriovenous fistula-surgically created direct connection between an artery and vein in the patient's body, usually on the lower or upper arm. AVG - arteriovenous graft: a synthetic type material utilized to create a connection between an artery and vein. Catheter- a synthetic tube outside the body that inserted into a large vessel in the circulatory system: a tunneled catheter is tunneled beneath the skin usually through the internal jugular vein or into the subclavian vein.</p> <p>Hepatitis B - a serious disease affecting the liver caused by Hepatitis B virus.</p> <p>Antigen - a substance that prompts the generation of antibodies and could cause an</p>	V 000			

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V 000	Continued From page 2 immune response. Used in Hepatitis B testing to denote a person who has been exposed to Hepatitis B.  Antibody - particle generated by the body in response to an antigen. Used in Hepatitis B testing and vaccination to measure the degree of immunity to Hepatitis B.  Two types of Peritoneal Dialysis (PD) methods: - CAPD continuous ambulatory peritoneal dialysis (done manually) - CCPD continuous cycling peritoneal dialysis (done with machine)  PPE - personal protective equipment  QAPI - quality assurance performance improvement  Venous Pressure - a measurement of the extracorporeal (outside the body) blood circuit at some point after the dialyzer and before the blood enters the patient's body. A sudden drastic increase in the venous pressure from 50 to 150 mm Hg (mercury) could indicate clotting conditions.  MSW-Social worker RN-Registered Nurse CHT-Certified Hemodialysis Technician PCT-hemodialysis technician who has not received national certification RD-Registered Dietitian  CDC - Centers for Disease Control  mm - millimeter mg. - milligrams	V 000		

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V 000	Continued From page 3 mcg. - micrograms ml. - milliliter cc - cubic centimeter F - Farenheit C - Celsius	V 000		
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL  [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.  This STANDARD is not met as evidenced by: Surveyor: 16558 Based on observation, staff interview and record review, the facility failed to implement infection control precautions when:  Staff failed to clean the chair side computer keyboards at the end of each treatment day, in accordance with facility policy, for 12 of 12 keyboards observed;  Staff used same gloves to care for a patient and to prepare a clean dialysis machine for the next patient;  Staff did not wipe with disinfecting solution the prime containers, between patients' use for two randomly observed patients;  Staff did not disinfect the blood pressure cuff between patients for two randomly observed	V 122		8/19/10

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V 122	<p>Continued From page 4 patients;</p> <p>Staff stored nursing supplies and patient's belongings on the cart carrying the chairside computers for three carts affecting six randomly observed patients.</p> <p>This practices placed patients at risk for spread of infections.</p> <p>Findings:</p> <p>1. During the facility initial tour on 7/20/10 at approximately 9 a.m., there were 12 chair-side computers in the treatment area. The computer keyboards had plastic covers which presented with deposits of grayish matter between the keys.</p> <p>Deposits of grayish matter on the keyboards plastic covers were observed again on 7/21/10 at 7:30 a.m. and at 3:05 p.m. At 3:50 p.m., CHT F stated the keyboards were to be cleaned by staff on duty at the end of the day. During an interview on 7/21/10 at 3:55 p.m., CHT H and CHT G stated they were assigned to work until the end of the treatment day and that the computer keyboards were wiped with bleach solution one time a week, to the most.</p> <p>The facility policy for "Infection Control for Dialysis Facilities", dated March 2010 and reviewed on 7/21/10, instructed staff to clean the keyboard cover, "with a disposable wipe moistened with a 1:100 bleach solution at the end of each treatment day."</p> <p>2. On 7/21/10 at 1:10 p.m., CHT E was observed cleaning the machine at station #20. The patient was still in the chair, holding pressure to the</p>	V 122			

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V 122	<p>Continued From page 5</p> <p>access site. As she walked away to other duties, CHT E stated she prepared the machine for the next patient as the patient holding the site needed more time for clotting. Few minutes later, CHT E returned, put on clean gloves, helped the patient to stand up by holding her arm, placed the blood pressure cuff on the patient's left upper arm, and helped the patient put on a jacket, as she continued to hold the arm with the blood pressure cuff. When the machine started alarming, CHT E touched the screen and changed the settings, with the same gloves she used to care for the patient who's treatment ended. CHT E did not clean the machine after touching it with gloves potentially contaminated. At 1:25 p.m. Patient 12 arrived, was seated at station #20, and had her treatment initiated.</p> <p>On 7/22/10 at 1:15 p.m. the facility administrator confirmed that staff should have changed gloves and performed hand hygiene before touching the clean machine.</p> <p>3. On 7/21/10 at 1:50 p.m., CHT F took the normal saline container from the machine at Station #20, emptied the normal saline bag into the sink designated "dirty", rinsed the container, and placed it back on the machine.</p> <p>Later in the day, at 4 p.m., CHT F emptied another prime container into the sink, rinsed it with water from the faucet and stated, "It is clean now!" CHT F stated she was instructed to empty the prime container after each patient, to rinse it, and to place it back on the machine.</p> <p>Review of the facility policy for "Infection Control for Dialysis Facilities, dated March 2010 and reviewed on 7/22/10, showed the policy instructed</p>	V 122			

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V 122	<p>Continued From page 6</p> <p>the staff to wipe down, "the inside and outside of the prime container". According to CHT F the staff had bleach solution available for use for wiping down equipment.</p> <p>4. On 7/21/10 at approximately 2 p.m., CHT F proceeded to take off the clamps holding the access site of a patient at station # 19 and to tape a dressing over the site. Then, CHT F wiped the chair and the machine at station 19. CHT F did not wipe the blood pressure cuff between patients. In an interview on 7/22/10 at 12:02 p.m., the facility administrator stated that the blood pressure cuffs should be cleaned/wiped with bleach solution between patients' use. Surveyor: 21174</p> <p>5. During the initial tour on 7/20/10 at 10:10 a.m. observation showed that staff had stored clean supplies on the bottom shelves of several computer carts (called the ChairSideSnappy cart), each cart serving two adjacent patient treatment stations. Between treatment stations 3 and 4, the bottom shelf of the computer cart contained a bag of normal saline and a set of blood tubing. By treatment station 11, the bottom shelf of the computer cart contained two bags of normal saline, two sets of blood tubing, and a patient belongings bag stored directly against the saline bags. Between treatment stations 19 and 20, the bottom shelf of the computer cart contained three bags of normal saline and three sets of blood tubing. Several of the computer carts were located within two or three feet from a patient treatment station, risking contamination from a blood or fluid spill.</p> <p>Review of the facility policy "Infection Control for Dialysis Facilities", dated March 2010, indicated, "The ChairSideSnappy cart, monitor, and</p>	V 122			

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V 122	Continued From page 7 keyboard are considered clean areas" and, "Disposable gloves and alcohol based hand rub containers may be stored on the ChairSideSnappy cart shelves." According to the policy, staff were not to store "extra dialysis supplies like saline and blood lines (tubing) on countertops near patient stations where contamination of such supplies could possibly occur."	V 122			
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE  Recommendations for Placement of Intravascular Catheters in Adults and Children  I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.  II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.  Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.  VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI	V 147		8/19/10	

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V 147	Continued From page 8 [catheter related blood stream infections].  This STANDARD is not met as evidenced by: Surveyor: 16558 Based on observation, staff interview, and record review, the facility failed to ensure that staff used infection control precautions when changing the dressing of a central catheter site for one (Patient 3) of 11 sample patients. This failure placed Patient 3 at risk of infection.  Findings:  On 7/21/10 at 12:45 p.m., RN A removed the old dressing covering Patient 3's catheter site. Without changing gloves and performing hand hygiene, RN A proceeded to disinfect the skin surrounding the catheter insertion site, and to redress the site.  During an interview at 3:50 p.m., RN A stated she should have discarded the gloves used to remove the potentially contaminated dressing, should have performed hand hygiene, and then clean and disinfect the catheter site.  The facility policy for "Central Venous Catheter (CVC) Cleaning and Dressing Change", dated September 2007 and reviewed on 7/22/10, instructed the staff to use clean gloves to remove the old dressing and then to "remove gloves and discard. Wash hand and re-glove."	V 147			
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES  The dialysis facility must implement processes	V 408		7/22/10	

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V 408	<p>Continued From page 9</p> <p>and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 16558 Based on staff interview and record review, the facility failed to ensure top administrative personnel had in their possession outside the facility a copy of the disaster plan with all emergency numbers, a roster of patient addresses and phone numbers, and a roster of all facility staff home phone numbers, in accordance with facility disaster plan. In the event staff would not be able to reach the facility, the management of a disaster would be impeded by this failure.</p> <p>Findings:</p> <p>The facility "Disaster and Emergency Preparedness" plan (not dated) was reviewed on 7/22/10. On page 7 of 21, it read, "The Facility Administrator and the Clinical Nurse Manager will retain the following in their possession outside the clinic (using reasonable efforts to safeguard the information) in order to be able to manage a disaster in the event either may not be able to reach the facility: A roster of patient addresses and phone numbers, A completed Facility Disaster Plan with all emergency numbers, A roster of all facility staff home phone numbers."</p> <p>During an interview on 7/22/10 at approximately</p>	V 408		

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V 408	Continued From page 10 11:15 a.m., the facility administrator stated he did not have the documents outside the facility as listed in the disaster plan , and did not think the clinical manager had them either, as he was not aware this was required by the facility disaster plan.	V 408		
V 412	494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED  The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.  This STANDARD is not met as evidenced by: Surveyor: 16558 Based on staff interview and record review, the facility failed to provide training to all patients (current census of 98 patients receiving in-center treatments) on emergency procedures, such as a fire that would require evacuation. This failure placed patients at risk of not being able to safely evacuate.  Findings:  The facility emergency preparedness plans and policies and procedures were reviewed on 7/22/10. The policy titled "Fire Safety Preparedness Guidelines", dated September 2008, instructed, "Fire drills will be conducted quarterly on all shifts." Further facility documents review showed fire drills were conducted on 1/12/10 at 10:15 a.m., on 1/13/10 at 6:30 a.m., on 4/16/10 at 6:30 a.m., and on 4/20/10 at 10 a.m., covering only two patient shifts each quarter.  According to the facility administrator in an interview on 7/22/10 at 11:30 a.m., during the fire drills, patients were trained on how to disconnect	V 412		7/23/10

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V 412	Continued From page 11 themselves from the machine in case of an emergency requiring evacuation and that there were three shifts of patients dialyzed on the Monday-Wednesday-Friday schedule and three shifts on Tuesday-Thursday-Saturday schedule. The facility administrator stated that six fire drills should have been conducted quarterly in order to train all patients receiving treatments.	V 412			
V 416	494.60(d)(4)(iii) PE-CONTACT LOCAL EOC ANNUALLY  The facility must-  (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency.  This STANDARD is not met as evidenced by: Surveyor: 16558 Based on interview and record review, the facility failed to contact its local disaster management agency. This failure increased the risk that life saving dialysis services will not be available in the event of an emergency and/or the restoration of such services would be delayed.  Findings:  Review of the facility emergency preparedness plan on 7/22/10 showed no evidence that the local disaster management agency was contacted and made aware of the facility's needs in the event of a disaster and interruption of services. During an interview on 7/22/10 at 1:30 p.m., the facility administrator stated that the local disaster management agency has not been yet contacted.	V 416		7/22/10	
V 470	494.70(c) PR-RIGHTS POSTED,STATE/NW	V 470		7/22/10	

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V 470	<p>Continued From page 12 ONTACT INFO</p> <p>The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 16558 Based on observation and staff interview, the facility failed to post a copy of the patients' rights in the facility, and the State agency's and the ESRD network's mailing addresses and telephone complaint numbers, in a place that could easily be seen by the 113 patients receiving in-center and home dialysis. This failure placed the patients at risk of being uninformed of all of their rights and unable to file complaints confidentially.</p> <p>Findings:</p> <p>During the initial tour on 7/20/10 at 9 a.m., observation showed the patient waiting room had a very short extension hallway leading to a door with a sign, "Notice: Authorized staff only" posted above it. Hung on the short wall to the left of this door was a bulletin board with various papers posted. Among the papers was a posting of patient rights and the contact information for the Network and local State Agency for patients who might want to file a confidential complaint or grievance.</p> <p>On 7/21/10, the facility administrator acknowledged that the patients's rights and the</p>	V 470			

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V 470	Continued From page 13 other consumer information were not posted where the information could be easily seen by patients.	V 470		
V 506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY  The patient's comprehensive assessment must include, but is not limited to, the following:  Immunization history, and medication history.  This STANDARD is not met as evidenced by: Surveyor: 21174 Based on interview and record review, the facility failed to ensure one (Patient 9) of 11 sampled patients was screened for tuberculosis (TB) as outlined in the facility policy and by the Center for Disease Control (CDC) guidelines. This failure placed other patients and staff at risk for possible exposure to TB.  Findings:  Record review on 7/22/10 showed Patient 9 was admitted to the facility on 9/17/09 for in-center hemodialysis. Review showed no documentation indicating Patient 9 was screened for TB or received TB testing via a PPD (purified protein derivative) skin test. Review of the computerized physician orders dated 9/17/09 entitled PRN (as needed) Orders indicated, "TB test-Purified Protein Derivative .10 ml Intradermal (under the skin). On admission; PRN for travel; PRN annually". The clinical manager reviewed the record on 7/22/10 at 11:35 a.m. and confirmed there was no record of Patient 9 being screened or tested for TB. The clinical services specialist	V 506		8/19/10

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V 506	Continued From page 14 confirmed patients should be screened and tested for TB upon admission and yearly.  The facility policy "Tuberculosis Infection Control Policy", dated March 2008, was reviewed on 7/22/10. The policy indicated, "Permanent patients must be screened for tuberculosis (TB) utilizing the Purified Protein Derivative (PPD) Mantoux Tuberculin Skin Test prior to admission" and, "On admission, all patients will be administered a Tuberculosis Risk Appraisal Questionnaire by a licensed nurse teammate."  According to the CDC recommendations, all dialysis patients should be tested at least once for baseline tuberculin skin test results and re-screened if TB exposure is detected.	V 506			
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: 21174 Based on patient and staff interview, and record review, the facility failed to decrease one (Patient 9) of 11 sampled patients' target or estimated dry weight (EDW) to reflect actual weight loss. This failure increased the potential that Patient 9 might not have sufficient fluid removed during dialysis, leaving her fluid-overloaded and susceptible to complications.  Findings:  Record review on 7/20/10 showed that Patient 9	V 543		7/23/10	

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V 543	Continued From page 15 was admitted to the facility for in-center hemodialysis on 9/17/09. A review of her six most recent treatment runs dated 7/7/10 through 7/19/10 showed the physician's printed order for the Dry Weight (EDW) was 74.9 kg. Review showed Patient 9's pretreatment weight was less than the printed order EDW of 74.9 kg. on three of the six runs. On all six treatment runs, her post-treatment weight was over two kilograms less than her EDW, potentially dangerous for hypotension or vascular access collapse if her EDW were a true reflection of her normal volume status.  During an interview on 7/21/10 at 10 a.m., Patient 9 was asked why her EDW was so much higher than many of her pre-treatment weights. Patient 9 stated, "I don't know why they haven't changed it (EDW). I have lost weight. I think my dry weight is actually 71 (kg). They need to change that (EDW)."  During an interview on 7/22/10 at 11:18 a.m., the Clinical Manager was apprised of the unchanged EDW throughout Patient 9's recent treatment runs despite her frequent low weights. She stated, "We need to change it. All her nurses need to address it. We can do a .5 to 1 kilogram (EDW) change. More than that (over one kilogram) we need to notify the MD that her dry weight needs to be changed." After review of the last six treatment runs, Clinical Manager agreed Patient 9 was consistently under her dry weight when she came in for dialysis treatments.	V 543			
V 585	494.100(a)(3) H-TRAIN CONTENT INCLUDES ER PREP HOME PTS  The training must- (3) Be conducted for each home dialysis patient	V 585		8/31/10	

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V 585	<p>Continued From page 16</p> <p>and address the specific needs of the patient, in the following areas:</p> <p>(i) The nature and management of ESRD.</p> <p>(ii) The full range of techniques associated with the treatment modality selected, including effective use of dialysis supplies and equipment in achieving and delivering the physician's prescription of Kt/V or URR, and effective administration of erythropoiesis-stimulating agent(s) (if prescribed) to achieve and maintain a target level hemoglobin or hematocrit as written in patient's plan of care.</p> <p>(iii) How to detect, report, and manage potential dialysis complications, including water treatment problems.</p> <p>(iv) Availability of support resources and how to access and use resources.</p> <p>(v) How to self-monitor health status and record and report health status information.</p> <p>(vi) How to handle medical and non-medical emergencies.</p> <p>(vii) Infection control precautions.</p> <p>(viii) Proper waste storage and disposal procedures.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to conduct a necessary color blindness test for 8 of eleven home hemodialysis patients and for each of their helper. This failure prevented the facility to evaluate if the patients or their helpers were capable to do the required safety checks to ensure the quality of the water needed to perform the treatment. This failure also placed the patients at risk for medical complications such as</p>	V 585			

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V 585	<p>Continued From page 17 hemolysis or even death.</p> <p>Findings:</p> <p>At approximately 2 p.m. on 7/21/10, during an interview for home treatment training and monitoring, CHT K said that she was not sure if all the home hemodialysis patients and or their caregivers were "color tested" (a test to screen the ability to differentiate colors for the use of the test strips or kits utilizing color based readings).</p> <p>Later that same day, the facility administrator for home hemodialysis services stated that there were 15 home hemodialysis patients and all the patients used the NxStage machine with the Pureflow. The manufacturer's DFU ( direction for use) stated on page 5, "The pureflow requires chlorine/chloramine testing after the preparation for each batch of dialysate." According to the administrator, only three patients had recorded results for the color testing. "By August, everyone will be tested," the administrator stated.</p> <p>Chlorine/chloramine are inorganic substances that most city water companies add to the community water supplies to kill bacteria fungi and viruses but if present in the water used for dialysis, the substances can cause hemolysis (break down of red blood cells) and can cause injury or even death to a dialysis patient.</p> <p>The facility's policy and procedure for "Teammate/Patient/Helper Color Vision Evaluation" was reviewed with the home hemo nurse on 7/21/10. The policy indicated, "Teammates/patients/helpers who will be utilizing test kits or strips that rely on color differentiation for test results will be evaluated for ability to see</p>	V 585			

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V 585	Continued From page 18 colors" and, "Only teammates/patients/ helpers who can discern the colors displayed by a particular test strip or kit will perform testing with that strip or kit."	V 585			
V 715	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: Surveyor: 16558 Based on interview and record review, the facility failed to ensure that staff followed patient care policies as evidenced by:  A) Staff administered medication (Clonidine) ordered by the physician to be given only as needed under specified circumstances for three (Patient 3, 6, 9) of 8 sampled in-center patients. This failure increased the risk that patients would experience a drastic drop in blood pressure, increasing their risk for ischemic effects on the major organs (i.e. brain and heart) and,  B) Staff decreasing the blood flow rate (BFR) without implementing corrective interventions, without informing the nurse and the physician for four (Patients 7,3, 1, and 2) of 8 sampled in-center patients. This failure increased the risk that patients would experience inadequate hemodialysis treatments.	V 715		8/31/10	

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V 715	<p>Continued From page 19</p> <p>Findings:</p> <p>1. Record review on 7/20/10 showed Patient 3 was admitted to the facility on 1/13/10. The current physician orders included a prescription for Clonidine 0.10 mg PO (orally) one POST DIALYSIS if BP (blood pressure) &gt; 170/100 at the end of dialysis. On 7/7/10, the nurse documented on the treatment flowsheet that Patient 3 was given Clonidine 0.1 mg at 1:38 p.m. for a blood pressure of 208/102, and then again, 30 minutes later, at 2:08 p.m. for a blood pressure of 186/102.</p> <p>On 7/21/10, RN A was asked to review Patient 3's physician orders for medications. RN A used the chair side computer to bring up on the monitor's screen the page with medication orders, and read the following order, "Clonidine 0.1 mg po". The order did not specify that the drug was to be given after the treatment and only if the patient's blood pressure was still elevate to certain parameters. During interview, RN A stated that she would administer Clonidine for high blood pressure, but was unable to specify the parameters specific to Patient 3. RN A also stated that after reading the order as it appeared on her computer's screen, she would repeat the dose, if the patient's blood pressure would not go down. Again, RN A was unable to specify what was the goal for Patient 3's blood pressure. RN A explained that each physician having admitting privileges at the facility, had a set of prn (as needed) orders which were added at the time of admission to the treatment orders, and that those orders were not specific to the respective patient, but were implemented for all patients admitted.</p> <p>Clinical Manager and Clinical Services Specialist</p>	V 715			

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V 715	<p>Continued From page 20</p> <p>were interviewed on 7/21/10 at 5 p.m. and stated that the physician order for Clonidine for Patient's 3 was written as a prn order and should have not been given during the treatment. They explained that, for the past three weeks, the chair side computer, in use by the nursing staff administering the medications, did not have the software that allowed them to read the order in its entirety. Clinical Manager further explained that the nurses were to call the physician, report elevated blood pressure readings and obtain medication orders when indicated.</p> <p>2. The facility policy for "Blood Flow Problems", dated September 2007, listed multiple intervention that could be implemented by the certified hemodialysis technician in case there were blood flow problems and the prescribed BFR was not achieved. Such interventions included, needle repositioning, checking for extracorporeal circuit kinks or line separation, arterial and venous pressure changes, and treating hypotension. The policy instructed, "If blood flow problem remains unresolved, notify licensed nurse." The nurse was to "Determine need to reduce blood flow and extend treatment time" and "Notify nephrologist for further evaluation and/or intervention." On page 2 of 2, the policy read, "Document findings and interventions in patient's medical record."</p> <p>a. Patient 7's record review on 7/21/10 showed the patient was admitted to the facility on 3/29/07 and had current physician orders for a blood flow rate (BFR) of 380 ml/min. The treatment flowsheets showed an average BFR of 300 ml/min for the treatment on 7/7/10, of 350 ml/min on 7/9/10, of 365 ml/min on 7/12/10 and on 7/14/10, and of 350 ml/min on 7/19/10 and on</p>	V 715			

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V 715	<p>Continued From page 21</p> <p>7/21/10. Further record review showed no evidence that interventions were taken to address the blood flow problems before the rate was decreased, that the licensed nurse was aware of the problems, and that the physician was notified.</p> <p>On 7/21/10 at 8:10 a.m., Patient 7 had the BFR set at 350 ml/min. CHT L stated the BFR was initially set at 380, but soon the machine alarmed and he decreased the BFR at 350 ml/min. CHT L further stated he did not inform the licensed nurse and did not document the blood flow problem in Patient 7's clinical record. At 8:15 a.m., RN A stated that there were certain interventions available to staff that would improve the blood flow and allow for the prescribed rate to be reached. RN A further explained that it was important to maintain the BFR as prescribed in order to obtain the desired dialysis adequacy (blood does not get cleaned as it should if the blood flow rate is not achieved).</p> <p>b. Clinical record review on 7/20/10 showed Patient 3 was admitted to the facility on 1/13/10 and had current physician order for a BFR of 350 ml/min. Review of the treatment flowsheets showed an average BFR of 268 ml/min on 6/23/10, of 250 ml/min on 6/28/10, of 300 ml/min on 7/7/10 and on 7/9/10, and of 341 on 7/14/10. There was no documented evidence that the licensed nurse was aware of the blood flow problems, that interventions were tried before lowering the blood flow rate, and that the physician was made aware.</p> <p>c. Patient 1 was admitted to the facility on 5/3/10 and had current physician orders for a BFR of 350 ml/min. Review on 7/21/10 of the treatment flowsheets showed that the average blood flow</p>	V 715			

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V 715	<p>Continued From page 22</p> <p>rate was 250 ml/min on 7/6/10 and 307 ml/min on 7/13/10. There was no documented evidence that the licensed nurse was aware of the blood flow problems, that interventions were tried before lowering the blood flow rate, and that the physician was made aware.</p> <p>Surveyor: 22301</p> <p>d. Patient 2's dialysis prescription at the time of review on 7/20/10 was BFR 450 ml/min. The treatment flowsheets from 7/6/10 to 7/17/10 were reviewed and showed that the BFR was 350 (except on 7/10/10 which was 300). Treatments on 7/20, 7/21 and 7/22 were observed and the BFR was 350 on all three treatments, instead of 450 as prescribed by Patient 2's physician. The clinical record did not contain any documentation of interventions taken, of nurse and physician notification.</p> <p>4. Patient 6's medication orders were reviewed and showed a PRN ( as needed) order, dated 3/6/09, for "Clonidine 0.1 mg PO one POST DIALYSIS if BP&gt;170/100 at the end of dialysis". Patient 6's treatment flowsheet, dated 7/7/10, showed Patient 6 came in with a blood pressure of 258/90. Patient 6 was given two doses of Clonidine 0.1 mg at 9:50 a.m. There was also another dose of Clonidine 0.1 mg administered at 11:20 a.m. There was no evidence in Patient's 6's record that the physician was contacted and ordered the Clonidine to be given during the treatment.</p> <p>Surveyor: 21174</p> <p>7. Record review on 7/22/10 showed that Patient 9 was admitted to the facility on 9/17/09 for in-center hemodialysis. Review of her physician's admitting orders on 9/17/10 showed "Clonidine</p>	V 715			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/22/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEST SACRAMENTO DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3450 INDUSTRIAL BLVD. WEST SACRAMENTO, CA 95691</b>		
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V 715	Continued From page 23 0.10 mg PO (orally) one (tablet) POST DIALYSIS if BP>(more than) 170/100 at the end of dialysis." Review of her treatment run on 3/19/10 indicated Patient 9 was given Clonidine (a blood pressure medication) 0.1 mg for high blood pressure 20 minutes after starting her dialysis treatment, not after treatment as ordered. On 7/22/10 at 10:45 a.m. the Clinical Manager confirmed Patient 9 did not receive Clonidine as prescribed.	V 715			