STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	052734	A. BUILDING ______ B. WING ______	C 04/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANAHEIM DIALYSIS	**1107 W LA PALMA AVENUE** **ANAHEIM, CA 92801**

(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: 14724 The following represents the findings of the Department of Public Health during investigation of complaint 182116 regarding patient abuse. Investigation was limited to the specific allegations of the complaint and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health was Teri Spencer, HFEN. Abbreviations used in this document: CC Clinical Coordinator FA Facility Administrator PCT Patient Care Technician RN Registered Nurse	V 000		
V 541	494.90 PATIENT PLAN OF CARE 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: 14724	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	Continued From page 1 Based on interview and record review, the facility interdisciplinary team failed to ensure the patient plan of care for Patient 1 was updated to address a change in transfer needs and physical capabilities, resulting in a difficult transfer which risked injury to the patient. Findings: Patient 1 was receiving hemodialysis treatments at the facility three times a week. A 4/2/09 review of Patient 1's medical record showed that the patient was hospitalized two times in 2009, in January and again in March. During a 4/2/09, 2:30 P.M. interview, Patient 1's physician stated that the patient was very weak with chronic cardiac disease and had declined in recent months, with increased confusion. When interviewed on 4/2/09 at 3:00 P.M., PCT E stated that he had taken care of Patient 1 frequently for about 6 months. PCT E explained that recently, due to increased weakness, Patient 1, who used to transfer with little assistance, had become difficult to transfer from the wheel chair to the dialysis chair. PCT E described Patient 1 as stiff and "resistive" during transfer, as if he were afraid of being dropped. PCT E stated that only the large male staff could transfer Patient 1 alone, and that "You just have to be really careful". Interviews on 4/2/09 with the CC at 1:40 P.M. and RN 1 at 3:15 P.M. supported the interview with PCT E: that Patient 1 had a recent change in his condition, and was no longer able to stand, bear weight and transfer without maximum assistance. RN 1 stated that only the "larger" male staff could transfer the patient alone, "because he is so	V 541		

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V 541	Continued From page 2	V 541		

weak". The CC stated that 2 staff were needed to transfer Patient 1 to the dialysis chair.

A 3/18/09 progress note showed that, on 3/17/09, Patient 1's family member informed the FA that Patient 1 sustained bruising on the legs while at the facility for dialysis on 3/14/09, and alleged that a staff member had caused the bruising. A 3/17/09 nursing progress note documented an examination of Patient 1's lower legs, showing abrasion, discoloration and 2 bandages in place. The most current laboratory reports showed that Patient 1 had a low albumin level, and was on an oral anticoagulant medication. Patient 1's medical record contained no documentation about the recent change in his condition, decline in strength, or the change in care needs for transfers.

When interviewed on 4/2/09 at 12:50 P.M., the FA stated that an investigation into the allegation of a staff member causing Patient 1's bruising was initiated immediately after Patient 1's family member reported it on 3/17/09. The FA stated that PCT A cared for Patient 1 on 3/14/09, and was interviewed about the allegation. PCT A told the FA that the only unusual thing that happened while caring for Patient 1 on 3/14/09 was that the patient was "dead weight" and difficult to transfer to the dialysis chair.

During an interview on 4/3/09 at 9:30 A.M., PCT A stated that he had taken care of Patient 1 frequently in the past, before he changed work schedules to the opposite days from Patient 1's dialysis treatments. PCT A stated that, prior to 3/14/09, he had not seen Patient 1 in several months, and was surprised to see Patient 1 appear so thin and frail on 3/14/09. PCT A stated

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V 541	Continued From page 3 that, in the past, Patient 1 had always required very little help to transfer from the wheel chair to the dialysis chair, so he tried to transfer the patient alone on 3/14/09. PCT A stated that he was shocked when Patient 1 was not able to bear weight and became spastic, causing PCT A to fear he would drop the patient. PCT A called out for help from the other staff, and struggled to keep Patient 1 from falling by "doing the best" he could to sit the patient on the edge of the chair. PCT A stated he used his own knees to keep Patient 1 on the chair edge until more staff could help. PCT A stated he thought Patient 1's shins may have been bumped during the difficult transfer. The facility interdisciplinary team failed to revise Patient 1's plan of care to reflect the change in his care needs for transfer and failed to communicate the changes in care needs to PCT A, who was assigned to care for the patient on 3/14/09.	V 541		