

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

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552545	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/18/2010
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NAME OF PROVIDER OR SUPPLIER ANAHEIM HILLS DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 & 4211 E LA PALMA AVENUE ANAHEIM, CA 92807
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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 RECERTIFICATION survey.</p> <p>The surveyors entered the facility on 8/16/10 at 1300 hours. The census at the time of the survey was 57 in-center hemodialysis patients. The patient sample consisted of 13 randomly selected patients.</p> <p>The Facility Administrator was the facility coordinator for the survey.</p> <p>Representing the Department of Public Health: Phyllis Weaver, HFEN and Raul Reyes, HFEN.</p> <p>GLOSSARY</p> <p>BP - Blood Pressure BPM - Beats Per Minute BFR - Blood Flow Rate DFR - Dialysate Flow Rate FA - Facility Administrator gm - gram HR - Heart Rate IDT - Interdisciplinary Team PPE - Personal Protective Equipment PCT - Patient Care Technician P&P - Policy and Procedure RN - Registered Nurse</p>	{V 000}		
{V 116}	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p>	{V 116}		

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 116}	<p>Continued From page 1</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation and facility policy review, the facility failed to ensure non-disposable items taken into the dialysis stations were disinfected prior to being returned to a common area or used on another patient, which could result in the possible spread of infection.</p> <p>Findings:</p> <p>Review of the facility's policy for Infection Control dated 10/8/08, showed that items taken into a dialysis station should be either disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common area or used on another patient.</p> <p>During observation of the treatment area on 8/18/10 at 0920, 0925, 0940, 1020 and 1030 hours, PCTs 1, 2 and 3 were observed taking a thermometer from a supply cart to dialysis stations 1, 2, 10, 11, and 19 prior to the initiation of the treatment. Patient temperatures were taken and the thermometers were returned to the supply cart. The thermometers were not disinfected prior to being placed back on the cart or used on another patient.</p>	{V 116}			

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V 147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE</p> <p>Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>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.</p> <p>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.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to ensure face masks were positioned properly prior to the exposure of the catheter exit site during cleaning</p>	V 147		9/18/10	

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V 147	Continued From page 3 and dressing of the site for one of one patient observed (Patient 12). This could result in the possible spread of infection. Findings: Review of the facility's Infection Control Policy dated 10/8/08, showed that staff should wear the appropriate protective equipment to anticipate potential exposure during manipulation of access needles or catheters. Per the American Nephrology Nurses' Association Vascular Access Fact Sheet dated 2007, the patient and the health care provider should wear a mask every time the catheter is accessed to prevent microbes from the nose and/or mouth from contaminating the catheter or exit site. During observation of the treatment area on 8/18/10 at 0942 hours, RN 2 was observed removing the dressing from Patient 12's catheter exit site. RN 2's face mask was positioned under his nose. RN 1 was asked about the positioning of RN 2's face mask. RN 1 observed the position of RN 2's face mask and stated the mask should be positioned over the bridge of RN 2's nose.	V 147			
{V 402}	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by:	{V 402}			

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{V 402}	Continued From page 4 Based on observation and staff interview, the plumbing connections in the chaise area for 4 of 21 dialysis stations (4, 5, 18 and 20) were not effectively maintained to be free of bicarbonate and acid accumulation around the metal joints. The failure predisposed the plumbing system to non-functional delivery of quality dialysis water. Findings: On 8/16/10 at 1400 hours, during an initial tour of the treatment area, the plumbing connections underneath the back counter (chaise area) were inspected. Stations 4, 5, 18, and 20 had acid and bicarbonate accumulation around the metal joints of the plumbing system. On 8/17/10 at 1000 hours, the location of the acid accumulation around the metal pipes that could cause corrosion was pointed out to the Biomedical Technician. A log book was presented to show the plumbing system was inspected last month. The Biomedical Technician acknowledged possible leaks that caused accumulation of acids around the pipe joints.	{V 402}			
V 502	494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co-morbid conditions. This STANDARD is not met as evidenced by: Based on record review and staff interview, the patients' individualized and comprehensive	V 502		9/18/10	

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V 502	<p>Continued From page 5</p> <p>assessments by the interdisciplinary team for six of 13 medical records reviewed (Patients 4, 5, 6, 7, 9, and 11) were lacking the physician's assessment. The Daily Trend Reports developed to determine patient treatment trends for five of 13 sampled patients (Patients 7, 8, 9, 10 and 13) did not consistently reflect the status of patients' treatments. The pooling of expertise by the interdisciplinary team working towards common goals (in order to deliver optimal care for the patients) cannot be accomplished without complete and accurate patient assessments.</p> <p>Findings:</p> <p>In response to the blood pressure, weight gain and heart rate issues found during the survey completed on 4/30/10, the facility developed a Daily Treatment Trend Report for each patient. Each treatment is recorded on these records to assist the staff and the physician in noting the patient's response to their treatments so adjustments can be made to prevent patients from being fluid overloaded, prevent the removal of too much fluid, or other issues encountered during treatment. The Daily Trend Reports and the medical records did not agree for the following patients:</p> <p>Review of patient records was initiated on 8/17/10.</p> <p>1. Review of the Daily Trend Report on 8/17/10, for Patient 13 showed the patient fell in the bathroom on 6/11/10. The nurses' notes did not reflect the event or the facility's intervention. However, it was noted in the facility's Daily Trend Report the event was the second fall incident. The first fall was on 7/18/08.</p>	V 502			

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V 502	Continued From page 6 2. Review of Patient 10's dialysis treatment sheet for 6/25/10 showed the patient had low blood pressures during the entire treatment requiring the use of minimum ultrafiltration, the administration of normal saline and 12.5 grams of Mannitol 25% to maintain their blood pressure. The information was not reflected on Patient 10's Daily Treatment Trend Report, in the nurses' notes or the physicians' progress notes. 3. Review of the nursing progress notes for Patient 8 showed an entry dated 7/21/10 that revealed Patient 8 had developed tachycardia (increased heart rate) ranging from 120-126 beats per minute during their treatment on 7/21/10. The patient's blood flow rate was decreased to 400 with no condition improvement and was then lowered to 300. The patient's pulse rate decreased to 106. The patient was given oxygen at 3 liters per minute by nasal cannula. Patient 10 did not complain of any other discomfort. It also showed the physician was aware of the episode. Review of the Daily Trend Report for Patient 8 showed the 7/21/10 treatment had not been documented on the report. 4. a. Review of the treatment sheets for Patient 9 showed on 7/26, 8/2, 8/6 and 8/9/10 the patient developed low blood pressure which required the ultrafiltration to be decreased or turned off, and in some cases, normal saline was given. The Daily Trend Report did not reflect the low blood pressures. b. Patient 9 had been admitted to the facility on 8/15/08. The Comprehensive Initial Assessment for Patient 9 showed a completion date of	V 502			

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V 502	<p>Continued From page 7</p> <p>6/30/10. The medical assessment area for the present medical history and co-morbid conditions had not been completed, but had been signed by the physician.</p> <p>5. a. Patient 7's treatment sheets for 8/2, 8/4, 8/6, 8/9 and 8/11/10 showed the patient had decreased blood pressures during the treatments and the ultrafiltration had been decreased or turned off. The Daily Trend Report did not reflect the decreased blood pressures during the treatments for 8/2, 8/4, 8/6, and 8/11/10.</p> <p>b. Per the facility's Comprehensive Initial Assessment dated 4/2/10, Patient 7 was admitted to the facility on 3/31/10. Review of the assessment showed it had been signed by the physician, but the medical assessment area for the present medical history and co-morbid conditions was blank.</p> <p>The facility failed to ensure the trend reports were complete and reflected the patients' response to treatments to enable accurate assessments of the patients in order to make adjustments to meet the patients' care needs.</p> <p>6. On 8/17/10, record review of Patient 6, admitted on 7/5/10, revealed the initial physician orders were signed off by the dialysis physician while the initial physician assessment was signed off by a nurse practitioner. The interdisciplinary team's comprehensive assessment was completed by the dialysis nurse, the dietitian, and the social worker, however, the dialysis physician's portion was left blank, though it was signed.</p> <p>7. Patient 5 was admitted to the facility on</p>	V 502			

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V 502	Continued From page 8 1/25/10. There was no history and physical examination by the dialysis physician. 8. Patient 4's medical record had a blank history and physical examination form. 9. Patient 11 had been admitted to the facility on 10/5/09. The Comprehensive Initial Assessment for Patient 11 had a completion date of 6/14/10, and in the present medical history and co-morbid condition area showed the patient had congestive heart failure, atherosclerotic heart disease and a history of hypertension, and had been signed by the physician. It did not reflect the patient also had insulin dependent diabetes mellitus, a below the knee amputation, peripheral vascular disease and a past history of a kidney and liver transplant. On 8/17/10 at 1330 hours, the Facility Administrator was asked how the plans of care were being developed by the IDT without the physician's assessment and input. She acknowledged that incomplete comprehensive assessments contribute to an incomplete plan of care.	V 502			
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure physician's orders were initiated for one	V 544		9/18/10	

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V 544	Continued From page 9 of 13 patients (Patient 3) which could have affected the patient's clinical outcomes. Findings: Review of Patient 3's medical record on 8/17/10 at 0840 hours, showed the patient had a standing order dated 2/12/10 for a blood flow rate of 450. Review of the physician's orders showed another order dated 3/22/10, for a blood flow rate of 450. There were no additional physician's orders regarding the patient's blood flow rate. The treatment records for Patient 3 from 7/7/10 to 8/11/10, showed the blood flow rate as 400. The treatment records showed the patient had been dialyzed at a blood flow rate of 400 from 7/7 to 8/11/10.	V 544			
V 714	494.150(c)(1) MD RESP-DEVELOP, REVIEW & APPROVE P&P The medical director must- (1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility; This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and facility policy review, the facility policy for Patient and Machine Monitoring During Dialysis did not address the current practice standards for the monitoring of patients' arterial pressures during treatment for five of 13 sampled patients (Patient 2, 3, 7, 9 and 11) and 11 of 30 non-sampled patients which could have resulted in possible breaking of the patients' red blood cells. Findings:	V 714		9/18/10	

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V 714	Continued From page 10 On 8/17/10, the facility's policy for Patient and Machine Monitoring During Dialysis dated 6/4/10, was reviewed. The policy showed that the patient's arterial pressure (the amount of pressure that is needed to pull the blood from the patient's dialysis access) was to be monitored. Any change in the arterial pressure indicated a potential or actual problems which included needle misplacement, kinks, separation or loose connections of blood lines, blood clots or venospasms. The pressure was to be recorded every 30 minutes. The facility's Policy for Patient and Machine Monitoring During Dialysis did not identify the standard of practice level of greater than -250 as the level at which the patient should be assessed to determine the cause for the high reading which placed the patients at risk for hemolysis (breaking of the red blood cells). The Core Curriculum for Nephrology Nursing, Fifth Edition, 2008, showed the arterial pressure reading was a negative number and the lower limit of the pressure monitor should not exceed -250 because of possible hemolysis from the high vacuum. Review of Patient 3's treatment sheets on 8/17/10 showed that on 7/21/10 at 0800 hours, the patient's arterial pressure was at -260 and continued to increase to -310 by the end of the treatment. Patient 2's treatment sheet for 8/11/10 showed that after 30 minutes of treatment his arterial pressure increased to -260. Patient 7's treatment sheets dated 6/25, 6/30, and 7/16/10 showed the patient's arterial pressure	V 714			

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V 714	<p>Continued From page 11</p> <p>was greater than -250 at times during the treatments.</p> <p>Patient 11's treatment sheets for 7/16 and 8/4/10, showed that during the treatments the patient had arterial pressures greater than -250.</p> <p>Patient 9's treatment sheet for 8/2/10 showed arterial pressures during treatment greater than -250.</p> <p>There was no documentation on the above treatment sheets to show that any action had been taken to determine the cause of the increased arterial pressures or any steps taken to decrease the pressures.</p> <p>On 8/18/10 at 0810 hours, PCT 1 stated that an arterial pressure greater than -250 could cause hemolysis of the blood. The PCTs should turn down the blood flow rate and assess the patient and the machine to see what was causing the increased pressure.</p> <p>On 8/18/10 at 0815 an interview was done with PCT 2 regarding arterial pressure monitoring. The PCT stated that the arterial pressure should not be greater than -250. She added the system and the patient should be assessed to see why the pressure was greater than -250.</p> <p>On 8/18/10 at 1140 hours, PCT 4 stated she had been trained by the school where she took her dialysis training, that if a patient's arterial pressure was greater than -250, the blood pump should be stopped.</p> <p>There was no documentation to show that the patients had been assessed for the cause of the</p>	V 714			

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V 714	Continued From page 12 arterial pressure readings greater than -250. There was no documentation of any actions taken to lower the arterial pressures. There was no indication of oversight by the nurses with regard to the arterial pressure readings greater than -250. On 8/18/10 at 1200 hours, an interview was done with the Facility Administrator regarding the arterial pressure readings greater than -250. The FA was shown that in addition to the five patients, a brief overview of treatment records for approximately 30 additional patients, showed that 11 of the additional 30 patients also had documented arterial pressures greater than -250 during treatment.	V 714			