

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

PRINTED: 10/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052841	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/16/2009
NAME OF PROVIDER OR SUPPLIER ANTIOCH DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 DELTA FAIR BLVD ANTIOCH, CA 94509	
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 05189 The following represents the findings of the Department of Public Health during the investigation of three complaints.</p> <p>Complaint numbers: CA00175628, CA00179245, and CA00180281.</p> <p>Representing the Department of Public Health: Dorothy Rice, HFEN.</p> <p>The inspection was limited to the specific complaints being investigated and does not represent the findings of a full inspection of the facility.</p> <p>The complaints were substantiated. Three deficiencies were written for complaint CA00175628 (See V 401, V452 and V726). Three deficiencies were written for complaints CA 179245 and CA00180281 (See V452, V715, and V726).</p>	V 000		
V 401	<p>494.60 PHYSICAL ENVIRONMENT</p> <p>The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on observation, record review , and staff interview, the facility failed to maintain a safe environment that was clean and sanitary for all patients. This failure increased the risk of spreading infections and blood borne diseases.</p>	V 401		

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 401	<p>Continued From page 1</p> <p>Findings:</p> <p>During an onsite visit on 3/11/09 at approximately 12:00 p.m., the surveyor and Staff B observed the following when the treatment chairs were fully opened:</p> <p>a. At station 11, there was a large amount of dried, dark-colored, reddish-brown substance, (blood?) on the left deep side of the seat cushion. The treatment chair had also a moderate amount of tears on the top pane making it difficult to clean.</p> <p>b. At station 14, the chair had a moderate amount of dark-colored, reddish-brown substance on the left deep side of the seat cushion.</p> <p>At approximately 12:10 p.m., Staff B acknowledged the deficient practice and indicated that staff should have lowered the chair heads in a deep position to enable them to thoroughly clean the treatment chairs .</p> <p>On 3/11/09, the review of the facility policy for "Infection Control for Dialysis Facilities" showed that "equipment including...the dialysis chair...including opening the chair to reach crevices...will be wiped clean with a bleach of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment."</p> <p>Further observation on 3/11/09 between 1:25 p.m. and 1:55 p.m. in the presence of Staff D showed the following:</p> <p>a. At stations 2, 3, and 10, there were small amounts of dark-colored, reddish-brown</p>	V 401		

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V 401	Continued From page 2 substance on the right and left sides of the inside panels of the treatment chairs. b. At stations 4 and 17, there were small dark-colored, reddish-brown substances on the left deep lower inside panel of the treatment chair. c. At station 6, there was a large amount of dark-colored, reddish-brown substance on the right deep lower inner side of the treatment chair cushion, and a small amount of dark-colored, reddish-brown substance on the left lower inside panel of the treatment chair . f. At station 19, there was a small amount of dark-colored, reddish-brown substance on the rear cushion of the treatment chair.	V 401			
V 452	494.70(a)(1) PATIENTS' RIGHTS The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD; This STANDARD is not met as evidenced by: Surveyor: 05189 Based on record review, staff and patient interview, the facility failed to ensure that two (Patients 1 and 3) of three patients reviewed were treated with respect and dignity. 1. The facility's failure to provide all requested applicable and pertinent "blood borne disease"	V 452			

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V 452	<p>Continued From page 3</p> <p>medical information requested by Patient 1 created increased anxiety and apprehension for this patient.</p> <p>2. The facility's failure to adequately prepare for and promptly schedule Patient 3's treatments was not conducive to Patient 3's physical, mental, and psychosocial well being.</p> <p>Findings:</p> <p>1. On 3/11/09, review of the Nurses Notes dated 12/9/08, showed that Patient 1 received hemodialysis treatment for approximately one hour using Patient 2's reprocessed dialyzer.</p> <p>During an interview on 3/11/09 at approximately 11:30 a.m., Patient 1 stated that once the incident occurred, he and Patient 2 agreed in writing to exchange medical information containing the results of tests for blood borne diseases. Patient 1 anxiously and emphatically stated that he had waited for Patient 2's blood reports for months, but never received them.</p> <p>On 3/11/09, the review of Patient 1's and Patient 2's clinical records showed monthly blood test results. However, on 3/11/09 at approximately 1:20 p.m., Staff A stated (in presence of Staff B and Staff E) that she provided Patient 1 with his own test results, but she did not give him copies of Patient 2's blood borne diseases test results, as requested by Patient 1, who was at risk of contacting a blood borne disease due to the use of Patient 2's dialyzer.</p> <p>2. Review of Patient 3's clinical record on 3/11/09, showed a letter, dated 12/3/08 from the Medical Services Contracting agency that</p>	V 452			

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V 452	<p>Continued From page 4</p> <p>informed the facility of Patient 3's vacation plans and the request for treatment at the facility from 12/13/08 through 12/27/08. (On 12/13/08 [Saturday], Patient 3 received treatment at her home facility.) Patient 3's physician ordered a 3 hour and 45 minutes treatment.</p> <p>According to a letter dated 1/20/09 and signed by Patient 3's family member, on 12/16/08 (Tuesday), Patient 3 arrived at the facility for treatment. However, according to the treatment record reviewed on 3/12/09, Patient 3 did not receive any treatment at the facility on 12/16/08 and was to be rescheduled.</p> <p>On 3/12/09 at approximately 2:30 p.m., Staff K stated that Patient 3 arrived at the facility very early on the morning of 12/16/98 but was not provided treatment because the staff could not find Patient 3's signed consent for treatment. Staff K stated that she did not have accessibility to the computerized treatment authorization form, and could not generate one for Patient 3 to sign on 12/16/08.</p> <p>On 3/12/09 at approximately 3:10 p.m., during a telephone interview, Staff M stated that she was Patient 3's assigned caretaker on 12/16/08, but she did not put the patient on the machine because "of the patient not having the papers [consent form] filled out".</p> <p>Furthermore, record review showed that the facility failed to reschedule Patient 3. On 12/17/08, the progress notes showed the following: "Pt [patient] arrived at treatment early. Was not on the patient schedule. Called [physician]. Received orders to dialyze 3'15" [3 hours and 15 minutes instead of the previously</p>	V 452			

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V 452	Continued From page 5 ordered duration of 3 hours and 45 minutes]". In the letter dated 1/20/09, the family member stated , "I was told that they had to fit her (Patient 3) in so therefore she had to be cut short so she wouldn't go into the next patients time period."	V 452			
V 715	494.150(c)(2)(i) POLICIES AND PROCEDURES 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: 05189 Based on staff interview and record review, the medical director failed to ensure that the following policies and procedures were adhered to by the facility's staff: 1. The policies/procedures that ensured patients received the correct dialyzers (artificial kidneys) during treatment. This failure resulted in one patient (Patient 1) being treated with another patient's (Patient 2's) reprocessed/reused dialyzer increasing the risk of blood borne infections. 2. The policy for "Patient Requests To Release Their Protected Health Information" when Patient 1 requested and Patient 2 consented to the release of medical information containing blood tests. This failure resulted in emotional distress for Patient 1. 3. The policy for "Authorization for and Verification of Consent to Hemodialysis	V 715			

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V 715	<p>Continued From page 6</p> <p>Procedure" for Patient 3. This failure placed the patient at risk of not receiving the needed information for an informed consent.</p> <p>4. The policy for "Medical Emergency" regarding Patient 3's assessment of an emergent condition. This failure made it difficult to ascertain Patient 3's condition during a period of approximately one hour prior to her transfer to the acute care hospital.</p> <p>5. The policy for "Anticoagulation" when Patient 3 did not receive the prescribed doses of Heparin, placing the patient at risk for clotting of the hemodialysis access site.</p> <p>Findings:</p> <p>1. The interview with staff during an onsite visit on 3/11/09 revealed that the facility reprocessed/reused dialyzers and utilized Peracetic Acid as the sterilizing agent. (According to the "Review of Hemodialysis for Nurses and Dialysis Personnel, 2005, 7 th Ed., p. 77", Dialyzer reuse is the cleaning, processing, and sterilization of a dialyzer once used, to be used again on that same patient.)</p> <p>During an onsite visit on 3/11/09 at approximately 8:45 am, Staff I stated that Patient 1 had received treatment with another patient's dialyzer, but did not remember the exact date. At approximately 10:00 am, Staff A also stated that she was informed by Staff F (previous administrator) that Patient 1 "was put on the wrong dialyzer".</p> <p>On 3/11/09, the 12/9/08 dated Nurse's Progress Notes showed the following: "Found that pt [Patient 1] running on wrong pt Dialyzer</p>	V 715		

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V 715	<p>Continued From page 7</p> <p>approximately 1 hour now. Stopped hemodialysis..."</p> <p>On 3/11/09, the facility's Predialysis Dialyzer Inspection policy/procedure showed that the dialyzer should be checked to ensure "it is the correct dialyzer for the correct patient." The facility policy for "Prescription Verification and Safety Checks" instructed staff to verify prior to initiation of treatment that the re-used dialyzer pertained to the respective patient. Furthermore, the policy for "Preparation For Dialysis-Peracetic Acid Reuse Dialyzers ", reviewed on 3/11/09, read, "Prior to initiation of dialysis treatment, verify that the identity of the patient matches the label on the reuse dialyzer. Two teammates will confirm and document the identity of the patient and the dialyzer on the electronic medical record..."</p> <p>Review on 3/11/09 of the treatment record, dated 12/9/08, showed that Patient 1's treatment was started with a reprocessed/reused dialyzer at 13:30 (1:30 p.m.). The section for "Machine Setup" of the treatment record showed the names of two staff (Staff N and respectively, Staff O) under "Dialyzer Checked" and "Dialyzer Checked 2".</p> <p>However, on 3/11/09, additional record review showed that on 12/9/08, Staff N initiated and gave partial treatment to Patient 1 utilizing Patient 2's dialyzer and that Staff O erroneously signed her initials (verifying the identity of the patient matching the label on the reused dialyzer) on the treatment record while he/she did not look at Patient 1's dialyzer for actual verification.</p> <p>On 3/11/09, Staff A acknowledged the deficient</p>	V 715			

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V 715	<p>Continued From page 8</p> <p>practice and verified that staff failed to implement the facility's policies and procedures that ensured patients received and utilized the prescribed and correct dialyzer.</p> <p>On 3/11/09 at approximately 11:30 am, Patient 1 stated that the staff had put him in Patient 2's chair and hooked him up to his/her dialyzer.</p> <p>On 3/11/09, record review showed that Patient 2 was admitted to the facility on 10/23/08. The pre-admission 10/4/08 dated History and Physical Note showed that Patient 2 had a past history diagnosis of Hepatitis C (blood borne disease).</p> <p>2. On 3/11/09, the 12/9/08 dated Nurse's Progress Notes showed the following: "Found that pt [Patient 1] running on wrong pt Dialyzer approximately 1 hour now. Stopped hemodialysis...Pt [patient] notified, asked that we have to obtain blood for hepatitis [blood borne disease] panel & HIV [human immunodeficiency virus-blood borne disease] screening...[Physician] notified and order lab[laboratory tests], sent to [acute care hospital] lab. Pt signed consent for HIV testing. No noted reaction, v/s[vital signs] BP[blood pressure] 132/85, HR [heart rate] 59; no respiratory distress noted, no c/o [complaint]."</p> <p>On 3/11/09 at approximately 11:30 am, Patient 1 stated that once the incident occurred, Patient 2 agreed in writing to the release of the blood tests results. Patient 1 stated that approximately 10 minutes after the incident, staff brought him some kind of flimsy, type-written paper for both of them to sign. Patient 1 anxiously stated that it was not done in a professional manner, and the paper did not even have the facility's name on it.</p>	V 715			

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V 715	<p>Continued From page 9</p> <p>The facility policy for "Patient Requests To Release Their Protected Health Information (PHI)", reviewed on 3/11/09 read, "1. Patients may initiate the release of their PFI [protected health information] to third parties[another patient]. 2. Patient complete Authorization form. A completed 'Authorization to Release Protected Health Information' form is to accompany patient-initiated releases of PHI."</p> <p>On 3/11/09, there were no completed official Authorization to Release Protected Health Information forms found for Patient 1 (or Patient 2) as per facility policy/procedure. As of 3/11/09, Patient 1 did not receive copies of Patient 2's blood tests reports.</p> <p>3. Record review on 3/11/09 showed that Patient 3 had received treatments at the facility in May 2008 and November 2008, as a transfer patient during her vacations in the area.</p> <p>A letter from the Medical Services Contracting agency, dated 12/3/08, showed that the facility was informed of Patient's 1's vacation plans and request for treatment at the facility from 12/13/08 through 12/27/08.</p> <p>The facility policy for Authorization for and Verification of Consent to Hemodialysis Procedure read, "Prior to the start of the first dialysis treatment, the patient ...must sign, and have witnessed by a Registered Nurse, the Authorization for and Verification of Consent to Hemodialysis Procedure Form." Review of the Authorization for and Verification of Consent to Hemodialysis Procedure form, dated 12/16/08, showed the signature of Staff P, as the witness to Patient 3's consent. Staff P was not a registered</p>	V 715			

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V 715	<p>Continued From page 10</p> <p>nurse. During an interview on 3/16/09 at approximately 3:45 p.m., Staff P stated that she was a new employee during that period of time and was not aware that she was not suppose to be a witness on the Verification of Consent to Hemodialysis Procedure form.</p> <p>4. Record review on 3/11/09 showed that Patient 3 requested to receive treatments at the facility as a transfer patient during her vacations in the area from 12/13/08 through 12/27/08. According to the "History and Physical", dated 8/25/08, Patient 3's primary diagnosis was aortic valve stenosis disease (outflow blood obstruction from the heart into the large artery). The chronic diagnoses included renal (kidney) failure and additional heart conditions .</p> <p>The physician admission orders , dated 12/16/08, included tri-weekly (Tuesday, Thursday, Saturday) dialysis treatments with the following prescription:</p> <ul style="list-style-type: none"> a. 170 (Non-Reuse dialyzer/artificial kidney) b. EDW (estimated dry weight -weight after excess fluid removal) of 68 kg (kilograms) c. Duration of 225 minute (3 hours:45 minutes). d. BFR (blood flow rate) of 450 (ml [milliliter]/min [minute]) e. Heparin (anti-clotting medication): <ul style="list-style-type: none"> - Bolus of 1,000 units - Hourly rate at 1, 000 units - Stop at 60 minutes before end of treatment. f. Zemplar (a synthetic Vitamin D medication that reduces parathyroid hormone levels in chronic renal failure), 0.5 mg, tri-weekly. <p>On 12/18/08, the pre-treatment assessments showed that Patient 3 was mentally alert,</p>	V 715			

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V 715	<p>Continued From page 11</p> <p>complained of nausea, had a temperature reading of 98.2 (Fahrenheit), had a blood pressure of 130/71, and a pulse rate of 82. Additional pre-treatment assessments showed Patient 3 had no edema (swelling), no respiratory problems, a functional access site, and a pre-treatment weight of 68.5 kg.</p> <p>On 12/18/08, the treatment record showed that treatment was started 7:10 am and the patient's blood pressure was 103/64.</p> <p>At 7:30 am, the treatment record showed that Patient 3's blood pressure lowered to 77/43. The corresponding "Notes" section at this time showed, "BP [blood pressure] low. RN [registered nurse] aware. UF [ultrafiltration= fluid removal mechanism] off. O2 [oxygen] given".</p> <p>At 9:00 a.m., Patient 3's blood pressure was 80/49 and she had her, "Eyes closed. Resting comfortably." At 9:30 am, the treatment record showed that Patient 3's blood pressure increased to 95/55 and that , " Pt stable. UF on per RN order."</p> <p>According to the treatment record, at 10:01 a.m., Patient 3's blood pressure was 108/64, but "Pt unresponsive. 300 ml NSS [normal saline solution] given. RN notified. TX ended. Pt referred to ER for further evaluation."</p> <p>According to the local Fire Department and Ambulance reports, staff did not arrive at the facility until 11:17 am (approximately 1 hour and 15 minutes later). There was no continuous assessments done and documented to determine the condition of the patient from from the last entry at 10:01 am to the time of the local Fire and Ambulance staff arrival at 11:17 a.m. Additionally, there was no indication that the</p>	V 715			

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V 715	<p>Continued From page 12</p> <p>physician was notified, or any evidence that an Adverse Occurrence Report (AOR) was completed.</p> <p>The facility policy for "Medical Emergency", reviewed on 3/11/09, instructed the staff to:</p> <ul style="list-style-type: none"> - Initiate emergency treatment according to the signs and symptoms shown by the patient. - Monitor the patient continuously. - Contact the patient's physician. - If the situation warrants, contact emergency medical system (EMS) (911). <p>-Document events in the patient's medical record. Complete Adverse Occurrence Report (AOR) if needed.</p> <p>On 3/12/09 at approximately 4:05 p.m., Staff M stated she could not remember why the physician wasn't contacted. When the surveyor asked Staff M about the continuing assessment, Staff M acknowledged the deficient practice, lowered her eyes, and stated,"I should have done more."</p> <p>On 3/16/09 at approximately 9:20 a.m., Staff B (Administrative staff) stated she expected Staff M to have followed the Medical Emergency policy and procedure. i.e., completed an AOR, notified the physician of the transfer, assessed the patient's condition upon leaving the facility.</p> <p>On 3/16/09 at approximately 9:25 a.m., Staff E stated that she expected Staff M to have obtained more assessment information.</p> <p>According to the acute care hospital records, Patient 3 was admitted on 12/18/08 "secondary to unresponsiveness" and was diagnosed with a new onset heart condition. Patient 3's condition deteriorated the following day due to a heart</p>	V 715			

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V 715	Continued From page 13 attack and she expired on 12/23/08. 5) Record review on 3/11/09 showed that Patient 3 requested to receive treatments at the facility as a transfer patient during her vacations in the area from 12/13/08 through 12/27/08. According to the "History and Physical", dated 8/25/08, Patient 3's primary diagnosis was aortic valve stenosis disease (outflow blood obstruction from the heart into the large artery). The chronic diagnoses included renal (kidney) failure and additional heart conditions . The physician admission orders , dated 12/16/08, included tri-weekly (Tuesday, Thursday, Saturday) dialysis treatments with the following prescription: Heparin (anti-clotting medication): Bolus of 1,000 units, hourly rate at 1, 000 units ,stop at 60 minutes before end of treatment. On 3/11/09, review of the treatment record, dated 12/18/09, showed that at 7:10 a.m., the staff noted, "TX [treatment started. No heparin per RN order." Further review showed that the hourly Heparin rate was not administered either. The facility policy for "Anticoagulation", reviewed on 3/11/09, instructed staff to administer Heparin as ordered by the physician.	V 715			
V 726	494.170 MEDICAL RECORDS 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.	V 726			

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V 726	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189</p> <p>Based on staff interview and record review, the clinical record for one (Patient 3) of three patients reviewed was not complete and accurate. This failure placed Patient 3 at risk for medical and clinical decision that might be made on inaccurate or incomplete information.</p> <p>Findings:</p> <p>On 3/11/09, the record review showed that Patient 3 was a vacationer from another facility who received treatment at the facility during May 2008, November, 2008 and December, 2008.</p> <p>1. During May, 2008 visit, the 5/14/08 dated physician orders included the following: - Duration: 210 minute (3 hours:30 minutes). - Heparin (anti-clotting medication): - Bolus of 1,000 units - Hourly rate at 1,000 units - Stop at 60 minutes before end of treatment. - Oxygen up to 6 Liter per minute, per nasal cannula, prn (whenever necessary).</p> <p>The review of the "Anticoagulation" policy and procedure showed that the purpose of the policy was "to deliver safe and effective anticoagulation [prevents clotting] therapy during the hemodialysis treatment in order to (1) reduce clotting within the extracorporeal circuit ..., (2) optimize dialyzer efficiency, (3) preventing bleeding secondary to over-anticoagulation.</p> <p>The review of the "Intradialytic Treatment Monitoring" policy/procedure showed the following:</p>	V 726			

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V 726	<p>Continued From page 15</p> <ul style="list-style-type: none"> - Treatment checks should be completed every thirty (30) minutes. - Heparin infusion, if applicable, is ordered on an hourly basis by the physician and should be documented every 60 minutes. - Significant changes are reported to the licensed nurse and documented. <p>The review of the 5/17/08, dated treatment record showed that the 1,000 heparin bolus dose was appropriately administered at 10:35 a.m. and treatment started at 10:40 a.m.. However, the documentation did not show the hourly heparin infusion, nor that it was stopped 30 minutes before the end of treatment. The review also showed that there was no documentation between 1:10 p.m. and 2:10 p.m., to indicate that treatment checks were completed every 30 minutes. Further review showed there was no documentation in the "Bleeding Stop Time" section of the treatment record that could indicate the time interval that the needle sites bled post treatment.</p> <p>The review of the treatment record , dated 5/20/08, showed that the treatment was initiated at 11:02 a.m., that Patient 3 had a blood pressure of 97/61, and that 300 ml of Normal Saline were administered . During an interview on 3/11/09, Staff B stated that the facility's established practice and policy was to give 200 ml of normal saline as the prime during treatment initiation. At 12:00 p.m., the patient 's blood pressure lowered to 84/49 and Patient 3 "C/O [complained of] Hypotension [low blood pressure". There was no documentation indicating that the patient's complaint was reported to the license nurse. Further review showed no documentation of the complete hourly</p>	V 726			

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V 726	<p>Continued From page 16</p> <p>heparin infusion, nor of the post treatment "Bleeding Stop Time" . On 3/12/08, Staff B stated that staff should have included the documentation in the treatment record.</p> <p>Review of the treatment record dated 5/22/08, showed that the treatment was initiated at 10:30 a.m. and the patient had a blood pressure of 115/64. At 11:19 a.m., the treatment record showed that the patient's blood pressure lowered to 90/50 and "UF off. Pt BP low. Oxygen given." There was no documentation that the nurse was notified of the oxygen intervention, nor was there any documentation of the number of liter/minute of oxygen administered. At 11:30 a.m., the treatment record showed the patient's blood pressure was 96/43 and the patient complained of hypotension. There was still no documentation that the licensed nurse was aware of the oxygen intervention and patient's complaint. Additionally, the hourly heparin infusion documentation was inaccurate and confusing. For example, from 10:30 a.m. to 11:00 a.m., the treatment record showed that 1,000 units of heparin was infused in 30 minutes (as opposed to one hour); from 11:00 a.m. to 12:00 p.m., only 300 units of heparin were infused; and from 12:00 p.m. to 12:30 p.m., 700 unit infusion.</p> <p>2. During November, 2008 visit, the 11/24/08 dated physician orders included the following:</p> <ul style="list-style-type: none"> - Treatment: 3 times per week - Zemplar (a synthetic Vitamin D medication that reduces parathyroid hormone levels in chronic renal failure), 0.5 mg, 3 time per week - Reuse Dialyzer - Duration: 3 hours:45 minutes 	V 726			

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V 726	<p>Continued From page 17</p> <ul style="list-style-type: none"> - Heparin (anti-clotting medication): <ul style="list-style-type: none"> - Bolus of 2,000 units - Hourly rate at 1,000 units - Stop at 60 minutes before end of treatment. <p>Review of the treatment record dated 11/25/08 , showed that the 2,000 heparin bolus dose was appropriately administered at 7:20 a.m. and treatment started at 7:25 a.m.. However, the documentation did not show the hourly heparin infusion.</p> <p>Further review showed no documentation that the Zemplar was administered, or any evidence of the "bleeding stop time" duration information.</p> <p>The review of the 11/27/08 (Thursday), dated treatment record showed that the treatment was started at 6:25 a.m. and ended at 10:10 a.m.. However, the treatment record inaccurately showed that the hourly rate heparin was stopped at 9:25 a.m. (instead of at 9:10 a.m., an hour before the end of treatment). Further review showed no documentation that the Zemplar medication was administered, nor any evidence that the duration of the "bleeding stop time" was recorded.</p> <p>The review of the 11/29/08 (Saturday), dated treatment record showed no documented evidence that the hourly Heparin dose was given as prescribed. Further review showed no documentation that the Zemplar medication was administered, or any evidence of the "bleeding stop time" duration information on 11/29/08.</p> <p>3. During December, 2008 visit, the 12/16/08 dated physician orders included the following:</p>	V 726			

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V 726	<p>Continued From page 18</p> <ul style="list-style-type: none"> - Treatment: 3 times per week - Zemplar (a synthetic Vitamin D medication that reduces parathyroid hormone levels in chronic renal failure), 0.5 mg, 3 time per week - Duration: 225 minutes (3 hours:45 minutes) - Heparin (anti-clotting medication): <ul style="list-style-type: none"> - Bolus of 1,000 units - Hourly rate at 1,000 units - Stop at 60 minutes before end of treatment. - Blood Flow Rate: 450 (ml/min) <p>The review of the 12/17/08 (Wednesday), dated Nurses Progress Notes showed that the physician ordered only a 3 hour and 15 minute treatment duration for this date. The review of the 12/17/08, dated treatment record showed that treatment was started at 10:30 a.m. when the patient's blood pressure was 157/105. There was no documentation that the patient care technician who was the patient caretaker notified the licensed nurse of the the abnormal high blood pressure (especially the diastolic [lower] blood pressure number). Additionally, while the treatment record documented that the treatment was started at 10:30 a.m., the treatment record documentation inaccurately showed the Heparin bolus was given at "07:00". Also, the treatment record showed that treatment ended at 13:45 (1:45 p.m.). However, the "Notes" section of the treatment record inaccurately showed that the heparin was stopped at 12:30 (instead of 60 minutes before the end of treatment at 12:45). Further review showed that at 11:30 a.m., Patient 3 had a lower blood pressure of 72/44. There was no documentation that the patient care technician notified the licensed nurse. The review of the</p>	V 726			

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V 726	Continued From page 19 11/27/08, dated treatment record also showed no documentation that the Zemplar medication was administered. The review of the 12/18/08 (Thursday) treatment record showed that the treatment was started at 7:10 a.m. and that "TX [treatment] started. No heparin per RN" There was no documented rational to explain why staff did not give and document the bolus and the hourly rate of heparin in accordance with the physician's prescription. Additionally, the treatment record documented that the blood flow rate ranged from only 200 ml/min. to 435 ml/min (as opposed to the ordered 450 ml/min. blood flow rate) without any documented rationale. There was no evidence that Zemplar was administered; that the 200 ml normal saline "prime" solution was given at the beginning of treatment. Additionally, there was no documentation of continuous assessments of Patient 3's condition from 10:01 a.m. when the patient was found to be unresponsive till 11:17 a.m. when the ambulance crew arrived. There was no documentation that the physician was notified, or any evidence that an Adverse Occurrence Report (AOR) was completed during the incident. (See V 715)	V 726			