

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

PRINTED: 02/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052599</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/26/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY HILLS DIALYSIS CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 NORTH LA CIENEGA, SUITE 300 BEVERLY HILLS, CA 90211</b>	
(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  The following represents the findings of the Department of Public Health during a Recertification and complaint visit.  Complaint Intake Number: CA00213110 - Substantiated CA00224420 - Substantiated  Representing the Department of Public Health: Sylvia Villaflores, REHS, HFE I Rosalinda Ramos, HFEN	V 000		
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS  The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain contracts with 6 nursing homes.  Findings:  A review of the agreements manual revealed the facility did not have documentation of contracts with 6 nursing homes where the patients lived.  During an interview on May 25, 2010, at 1:20 p.m., the facility administrator stated the contracts with the respective nursing homes were still being formulated.	V 101		10/21/10
V 111	494.30 IC-SANITARY ENVIRONMENT  The dialysis facility must provide and monitor a	V 111		5/22/10

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 111	<p>Continued From page 1</p> <p>sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility staff failed to monitor a sanitary environment to minimize the transmission of infections within the unit.</p> <p>Findings:</p> <p>On May 20, 2010, at approximately 7:30 a.m., during the tour of the treatment area, the following were observed:</p> <p>There were metal carts parked by the wall beside a bio-hazard trash bin that contained saline bags, dialysis tubings, gallons of different baths and 2 boxes of gloves.</p> <p>There were several pieces of tapes hanging by the side of the armchair that were touching the trash cans in stations 6, 25, 26, and 30. The tapes were prepared by the patient care technicians prior to patients being put onto the machine and were used for the patients .</p> <p>There were several concentrate wands noted hanging by the computer stand while patients were dialyzing in stations 23 and 24. Interview with the facility administrator, he stated that the wands should not be there but in the dialysate container while patient is receiving dialysis treatment.</p> <p>There were gallons of dialysate baths in different concentrations in the following stations while the patients were receiving hemodialysis treatment. In Station 24, the patient was on 1 Potassium (K) /2.5 Calcium (Ca) bath and there was a 1 K/3.0</p>	V 111			

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V 111	Continued From page 2 Ca bath not in use. In Station 27, the patient was on 2 K/2.5 CA bath. There were three gallons of different dialysate baths such as 3 K/2.5 Ca; 2 K/2.5 Ca and 1 K/3.0 Ca bath not in use. In Station 29, the patient was on 2 K/ 2.25 Ca bath and there was a 3 K/3 Ca baths not in use.  A review of the facility's policy on Infection Control For Dialysis Facilities stipulated that teammates would not store extra dialysis supplies near patient stations where contamination of such supplies could possibly occur.	V 111			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE  Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to wash hands after removing gloves between each patient or station. The facility staff failed to wash hands for 15 seconds. The facility staff failed to follow the manufacturer's directions for use for the hand sanitizer. Findings: During an observation on May 20, 2010, from 8:20 a.m.-10:15 a.m., the following was observed: 1. Staff A was observed using the hand sanitizer for approximately 10 seconds. 2. Staff B placed Purell hand sanitizer to the palm of one hand and put on gloves in both hands	V 113		5/22/10	

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V 113	Continued From page 3 without applying the hand sanitizer to both hands. 3. Physician A washed hands for approximately 6 seconds. 4. Staff C applied the hand sanitizer for approximately 12 seconds. During an observation on May 21, 2010, from 8:41 a.m.-9:20 a.m., the following was observed: 5. Staff D applied hand sanitizer for 10 seconds. 6. In the nurses' station, the paper towel dispenser is the manual type. When a towel is pulled out, a portion of the next towel is hanging exposed. The towel dispenser is within the splash zone and the portion of the clean towel hanging is exposed to contamination. 7. Staff E adjusted the treatment chair of a patient undergoing treatment and with the same gloves touched the panel of the dialysis machine. With the same gloves the staff touched the patient's leg and then proceeded to touch the dialysis machine panel. The staff went back to massage the patient's right foot and leg. Without changing gloves Staff E went to get an oxygen concentrator and applied the nasal cannula. With the same gloves the staff removed the dialyzer and the bloodlines. With same gloves Staff E removed the tubing from the dialyzer and disposed of the tubing in the biohazard container. The staff placed the dialyzer in a plastic bag. Staff E removed his gloves and put new gloves on. There was no hand washing observed.	V 113			

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V 113	<p>Continued From page 4</p> <p>8. Staff E cleaned the dialysis machine and treatment chair but did not include the priming container and the sharps container.</p> <p>9. Staff F washed hands for 12 seconds.</p> <p>10. Staff G washed hands for 8 seconds.</p> <p>11. Staff H washed hands for 10 seconds.</p> <p>During an interview on May 24, 2010, at 9:35 a.m., the facility administrator stated everything in the dialysis machine should be disinfected after each treatment including the priming container and the sharps container.</p> <p>A review of the facility's policy and procedure on Infection Control for dialysis Facilities revealed hand hygiene is to be performed upon entering the facility, prior to gloving , after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area. Physicians, allied health professionals, social workers and dieticians are to follow these same requirements for glove use and hand hygiene. Alcohol -based hand rubs may be used before gloving and after glove removal, and may be used if the gloves and/or other personal protective equipment have had no exposure to or contact with blood or other potentially infectious materials. Gloves should be changed when moving from a contaminated body site to a clean body site of the same patient.</p> <p>A review of the manufacturer's directions for use of the hand sanitizer revealed to place the palm 2-3 inches under the dispenser (green light activates on front) and to keep the palm under the dispenser until the green light turns off. The final instruction was to remove hand(s) and rub briskly</p>	V 113			

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V 113	Continued From page 5 for 15-20 seconds, until dry.	V 113			
V 115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK  Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurtng or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff wore a cover garment and did not chew gum in the treatment area while patients were receiving treatment.  Findings:  a. On May 20, 2010, at approximately 8 a.m., during an observation tour of the treatment area, a physician was observed without a cover garment (lab coat or gown) while seeing patients. The physician took the patient's medical records to the hemodialysis station and took the record back to the nurses' station without disinfecting the record.  b. On May 21, 2010, at approximately 9 a.m., during an observation tour of the treatment area, a caregiver was observed seating beside the patient receiving treatment. The caregiver was not wearing a cover garment.  c. On May 21, 2010, at approximately 10 a.m.,	V 115		5/22/10	

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V 115	Continued From page 6 during an observation tour of the treatment area, a physician was not wearing a cover garment while with a patient. RN 4 noticed that the physician was not wearing cover garment, and handed him a gown as he moved on to see the next patient.  d. On May 24, 2010, at approximately 12:30 p.m., during observation tour of the treatment area, a physician was observed chewing gum while seeing patients in the treatment area. The physician was wearing a cover garment. At the nurses' station, Staff C while working on the computer was observed chewing gum as well.  The facility administrator was in the treatment area and was made aware of the staff chewing gum and he stated that it was not allowed in the treatment area.  A review of the facility's policy on Infection Control for Dialysis Facilities stipulated appropriate lab coats or gown should be worn at all times when in the treatment floor.	V 115			
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: Based on observation, interview and record	V 122		5/27/10	

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V 122	Continued From page 7 review, the facility failed to properly label the containers with the disinfectants for clamps and wipes.  Findings:  During an observation on May 20, 2010 at 8:40 a.m., there were two plastic containers with a solution labeled 10% bleach for clamps and the other container 10% bleach for wipes near station 13. The solution in both containers was cloudy. The two stickers on the outer surface of both plastic containers were dated 4/9/10 and 3/29/10. The sticker label indicated "Good for 24 hours only."  During an observation on May 21, 2010, at 9:40 a.m., there were two plastic containers with a solution labeled 10% bleach with the sticker labeled 5/21/10.  A review of the facility's policy and procedure on Preparation of 1:10 Bleach Solution and Preparation of 1:100 Bleach solution revealed the solution must be changed when the maximum allowable time is exceeded (24 hours) or when the solution becomes cloudy or turbid.  During an interview on May 24, 2010, at 9:54 a.m., the facility administrator stated both bleach concentrations 1:10 and 1:100 should be prepared daily.	V 122			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS  [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous	V 143		5/22/10	

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V 143	<p>Continued From page 8</p> <p>medications from vials and ampules; and</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that pre-drawn medication syringes were dated, timed and initialed by the staff who withdrew the medications, multidose vials were dated and initialed when first entered/opened and expired medications were not available for use alongside current medications in the medication refrigerator. The facility staff also failed to demonstrate compliance with current aseptic technique of cleaning the top of the intravenous vial prior to drawing medication.</p> <p>Findings:</p> <p>On May 20, 2010, at approximately 8:30 a.m., during the refrigerator medication storage observation with RN 1, the following were noted:</p> <p>There was a tray of syringes filled with medications Zemplar, Epogen, and Venofer for eight (8) patients. The syringes had a label that contained patient's name and the amount of medications. The label did not have the time the medications were drawn and the licensed nurse's initial who drew the medications. At 9 a.m., during an interview, RN 1, stated that the time the medication was drawn and initial of the licensed nurse/patient care technician who withdrew the medications should be in the label.</p> <p>There were multi-dose vial medications opened and undated such as: a vial of 20,000 units of Epogen, a vial of Influenza Virus Vaccine, a vial of</p>	V 143			

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V 143	Continued From page 9 Pneumococcal Vaccine Polyvalent Pneumovax and two (2) vials of Influenza (H1N1) 2009 Monovalent Vaccine.  There were three (3) boxes of Aranesp, (four (4) vials of 25 mcg/ml in each box) with expiration date of January 2009 and February 2010, for a patient, who had been in the facility on October 15, 2007.  On May 21, 2010, at approximately 10:30 a.m., during medication preparation observation, Staff A was noted to have two syringes and a label in front of him. He then drew up medication from an opened vial of Heparin and attached the label to a syringe and set it aside. He then drew up Heparin from the same vial on the second syringe failing to wipe the top of the heparin vial.  During an interview with Staff A shortly thereafter, he acknowledged that he should have wiped the top of the heparin vial prior to drawing up the medication.  A review of the facility's policy on Preparation and Administration of Parenteral Medications (Non-Epo) stipulated a new alcohol prep pad is used prior to each time a vial is entered.	V 143			
V 318	494.50(b)(1) REPROCESSING AREA & VENTILATION  ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1) 8 Physical plant and environmental safety considerations 8.1 Reprocessing area and ventilation The reprocessing area should be designed to suit the operation carried out and maintain acceptable ambient concentrations of harmful substances	V 318		5/22/10	

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V 318	<p>Continued From page 10 (see Table 1). The area should be kept clean and sanitary. It may be part of the dialysis treatment area, as long as equipment used is properly designed and vented to meet the requirements for environmental safety (see [AAMI] 8.5).</p> <p>Table 1-OSHA environmental exposure limits (29 CFR 1910, 1 July 1998), except as indicated</p> <table border="0"> <tr> <td>Substance/material</td> <td>Limits (PEL)a</td> </tr> <tr> <td>Acetic acid</td> <td>10 ppm TWAb</td> </tr> <tr> <td>Chlorine dioxide (syn: chlorine oxide)</td> <td>0.1 ppm TWA</td> </tr> <tr> <td>Citric acid</td> <td>None developed</td> </tr> <tr> <td>Formaldehyde</td> <td>0.75 ppm TWA 2 ppm STELc(15 min)</td> </tr> <tr> <td></td> <td>0.5 ppm action level</td> </tr> <tr> <td>Glutaraldehyde</td> <td>0.2 ppm ceiling NIOSH/OSHA</td> </tr> <tr> <td>Hydrogen peroxide</td> <td>1 ppm TWA</td> </tr> <tr> <td>Peracetic acid</td> <td>None developed</td> </tr> <tr> <td>Phenol</td> <td>5 ppm TWA</td> </tr> </table> <p>ppm = parts per million a) PEL (permissible exposure limit) represents the limit of what employees can be exposed to; PELs can be TWAs or STELs. b) TWA (time-weighted average) represents the limit of what an employee can be exposed to in an eight-hour period. c) STEL (short-term exposure limit) represents the limit of what an employee can be exposed to</p>	Substance/material	Limits (PEL)a	Acetic acid	10 ppm TWAb	Chlorine dioxide (syn: chlorine oxide)	0.1 ppm TWA	Citric acid	None developed	Formaldehyde	0.75 ppm TWA 2 ppm STELc(15 min)		0.5 ppm action level	Glutaraldehyde	0.2 ppm ceiling NIOSH/OSHA	Hydrogen peroxide	1 ppm TWA	Peracetic acid	None developed	Phenol	5 ppm TWA	V 318		
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V 318	Continued From page 11 in any 15-minute time period.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain vapor testing supplies.  Findings:  On May 20, 2010, a review of the vapor testing log revealed the vapor test was done every other month. The last vapor test was done in March, 2010. There was no vapor test done for the month of May, 2010.  At the same time, during an interview, the reuse technician stated the air testing supplies expired in April.  The reuse technician showed the evaluator the air testing supply for acetic acid and hydrogen peroxide. Both testing supplies had an expiration date of April, 2010.	V 318			
V 331	494.50(b)(1) REPROCESSING-TRANSPORTATION & HANDLING  11 Reprocessing 11.1 Transportation and handling Persons handling used dialyzers during transportation shall do so in a clean and sanitary manner maintaining Standard Precautions until the dialyzer is disinfected both internally and externally. To inhibit bacterial growth, dialyzers that cannot be reprocessed within 2 hours should be refrigerated and not allowed to freeze. Other transportation and handling issues (such as prolonged delays in reprocessing) not described	V 331		5/22/10	

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

PRINTED: 02/11/2011  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052599</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/26/2010</b>
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V 331	Continued From page 12 in this recommended practice shall be validated and documented by the responsible party.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the plastic bag containing dialyzer to be reprocessed prior to refrigeration was dated, timed and initialed by the staff.  Findings:  During an observation on May 20, 2010, at 9 a.m., there were 2 dialyzers in plastic bags in the refrigeration unit in the reuse room. One of the dialyzers had no date, time and initial of the staff written on the plastic bag. The other dialyzer had no date written on the plastic bag.  At the same time, during an interview, the reuse technician stated the plastic bag containing the dialyzer for reprocessing should be dated, timed and initialed prior to being placed in the refrigeration unit in the reuse room.	V 331			
V 400	494.60 CFC-PHYSICAL ENVIRONMENT  This CONDITION is not met as evidenced by: Based on observation and interview, it was determined that the facility did not meet the Conditions of Participation for Physical Environment by failing to :  1. Maintain a safe environment for the dialysis patients, staff and public. (Refer to V401).  2. Ensure patients' access sites were visible during hemodialysis treatment. (Refer to V407).	V 400		5/31/10	

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V 400	Continued From page 13  3. Conduct fire drills. ( Refer to V408).  4. Ensure that nursing staff members were trained in the use of the facility's suction machine and glucometer (blood glucose) machine. (Refer to V411).  5. Ensure that emergency equipment and supplies including oxygen and normal saline were readily available for use (Refer to V413).  The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 400			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT  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.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, functional and comfortable environment for dialysis patient, staff and the public. Findings: During an observation on May 19, 2006, from 7:44 a.m.-10:15 a.m., the following was observed: 1. In station 1 bicarbonate outlet, there was a kidney basin that was inserted vertically between the wall of the concentrate outlet and the bicarbonate outlet. At the same time, during an interview, the patient	V 401		5/28/10	

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V 401	<p>Continued From page 14</p> <p>care technician stated the kidney basin was used to keep the loose bicarbonate outlet in place.</p> <p>2. In station 3, the concentrate box had brown deposits.</p> <p>3. In stations 1, 3, 5, 6, 8, 9, 11, 12, 13 there were wipes on top of the base of the dialysis machines.</p> <p>At the same time, during an interview, the patient care technician stated he was going to use the wipes to wipe the machines after the treatment.</p> <p>4. Under the sink labeled " dirty sink " located between station 5 and 8, there was an accumulation of brown debris on top of the pipe.</p> <p>5. In station 10, the concentrate box had brown deposits.</p> <p>6. In stations 11, 12, 13, 16, 19, 20 the starter kit consisting of the tape, choc, syringe was on top of the side table of the treatment chairs. Several cut tapes were hanging from the side of the side table. In station 12, the edge of the tape was approximately 1 inch from the rim of the trash receptacle.</p> <p>At the same time during an interview, Patient 1 stated there were instances when the edge of the tapes were touching the rim of the trash bin when staff moved the trash receptacle.</p> <p>7. There were water stained ceiling tiles in the:</p> <ul style="list-style-type: none"> <li>a. Biomed room</li> <li>b. Housekeeping room</li> <li>c. Staff lounge</li> <li>d. Water treatment room</li> <li>e. Reuse room</li> </ul> <p>7. The wall vent was dusty in the reuse room.</p> <p>8. On May 20, 2010, at 7:30 a.m., during the tour of the treatment area, in stations 2, 23, 26 and 30, start up kits which consisted of 2 syringes of</p>	V 401			

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V 401	Continued From page 15 Heparin ( bolus and Infusion), 2 by 2 gauze, alcohol pads, 2 needles for cannulation and a blue chux were observed on top of the armchair. There were no patients in the stations at that time. The start up kits and its contents are potentially accessible to patients, visitors and other staff if left unattended on the armchair during treatment.	V 401			
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS  Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).  This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to ensure patients' access sites were visible during hemodialysis treatment.  Findings:  On May 20, 2010, at approximately 7:30 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 27, 25, 24, 1 and 6. At 1:45 p.m., during an observation, it was noted again that the patients' access sites were not visible in stations 1,5, 11, 20, 22 and 26.  On May 21, 2010, at approximately 7:30 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 2, 6, 7, 11, 12, 14 and 15.  During observation rounds, it was noted that facility staff members were passing by patients without reminding them that their access sites were fully covered and not visible during	V 407		5/27/10	

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V 407	Continued From page 16 treatments.	V 407			
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES  The dialysis facility must implement processes 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.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills. Findings: During an interview on May 25, 2010, at 9:37 a.m., Patient 2 stated the facility did not conduct any fire drills. A review of the fire drill log revealed no documentation of any fire drills conducted in 2008, 2009 and 2010. During an interview on May 25, 2010, at 12:55 p.m., the facility administrator stated they did quarterly emergency procedure patient instruction on all patients.	V 408		5/31/10	
V 411	494.60(d)(1) PE-NURS STAFF TRAINED IN ER EQUIP & MEDS	V 411		5/21/10	

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V 411	<p>Continued From page 17</p> <p>Staff training must be provided and evaluated at least annually and include the following: (iii) Ensuring that nursing staff are properly trained in the use of emergency equipment and emergency drugs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that nursing staff members were trained in the use of the facility's suction machine and glucometer (blood glucose) machine.</p> <p>Findings:</p> <p>On May 20, 2010, at approximately 8:35 a.m., during an emergency equipment (suction machine) and glucometer (blood glucose) machine check the following was observed:</p> <p>1. Three RNs were requested to demonstrate the use of the suction machine (Mada, Inc) in an event of an emergency and all were unable to make the suction machine work. RN1 took a little while to locate the tubing and connect the canister ports. RN 2 and RN 3 were given an opportunity to demonstrate the use of the suction machine and proved unsuccessful.</p> <p>During a concurrent interview with the three RNs, they unanimously stated that they were not provided in-service training and/or return demonstration on the use of the new suction machine, which was purchased last February 2010. At 11:30 a.m., the facility administrator agreed that an in-service on the new suction machine was not done yet for the facility staff members.</p>	V 411			

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V 411	Continued From page 18  Review of the in-service record log failed to show written documentation to indicate training on the use of the suction machine was done for the licensed staff members of the facility.  On the same day, an in-service was immediately conducted by the Clinical Service Specialist to the Registered Nurses on duty on the proper use of the suction machine per manufacturer's recommendation. A return demonstration was performed by all RN after verbalizing understanding on how to use the suction. The Charge Nurse will conduct a daily check of one RN for return demonstration for a week and once a month a part of the Administrator Monthly Audit.  2. The daily glucometer quality control monitoring log was reviewed and the staff who performed the morning quality control monitoring was requested to explain and demonstrate the process. Staff B readily admitted that he did not know how to do it and he simply copied the information in the log from the previous day.  On the same day and the following day, an in-service was immediately conducted by the Facility Administrator to the clinical teammates on the proper use of the glucometer manufacturer's recommendation. A return demonstration was performed by all clinical teammates after verbalizing understanding on how to use the glucometer. The Charge Nurse will conduct a daily check of one clinical teammate for return demonstration for a week and once a month a part of the Administrator Monthly Audit.	V 411			
V 413	494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION	V 413		5/21/10	

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V 413	<p>Continued From page 19</p> <p>Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that emergency equipment and supplies including oxygen and normal saline were readily available for use</p> <p>Findings:</p> <p>On May 20, 2010, at approximately 8:35 a.m., during emergency equipment and drugs check, the following was noted:</p> <ol style="list-style-type: none"> <li>1. There were two (2) portable oxygen tanks alongside the emergency cart. RN1 was requested to check if the oxygen tanks were filled. One of the oxygen tanks was empty. During a concurrent interview with the facility administrator, he stated that the empty oxygen tank should not be by the emergency cart alongside with the filled oxygen tank.</li> <li>2. The evacuation kit had 10 bags of 0.9% normal saline available for use. The facility's policy on Evacuation Kit stipulated the contents of the evacuation kit should include, at a minimum, enough supplies to provide care for a full shift of patients to be present in the facility at any one time. The facility had thirty (30) stations.</li> <li>3. The key to the emergency cart was left in the</li> </ol>	V 413			

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V 413	Continued From page 20 keyhole. During a concurrent interview with the facility administrator, he stated it should not be left in the keyhole when not in use.	V 413			
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX  The patient's comprehensive assessment must include, but is not limited to, the following:  (2) Evaluation of the appropriateness of the dialysis prescription,  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to follow physician's order for blood flow rate (BFR) for 6 of 9 sampled patients (Patients 1, 2, 3, 4, 7 and 8).  Findings:  1. On May 20, 2010, at approximately 10:50 a.m., Patient 1 was observed receiving hemodialysis treatment via right subclavian permacath. The patient was on a 2 potassium (K) and 2.5 calcium (Ca) dialysate bath. The blood flow rate (BFR) was 300 and dialysate flow rate (DFR) was 800.  A review of the daily treatment record from May 11 through 20, 2010, revealed the BFR was 350. A review of the physician's order dated May 6, 2010, indicated the BFR was 300 and DFR was 800.  2. On May 21, 2010, at approximately 8 a.m., Patient 2 was observed receiving hemodialysis treatment via right subclavian catheter. The	V 503		5/27/10	

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V 503	<p>Continued From page 21</p> <p>patient was on 2 K and 2.5 Ca dialysate bath. The BFR was 400 and DFR was 800.</p> <p>A review of the daily treatment record from April 23 through May 19, 2010, revealed the BFR was between 300 to 350. A review of the physician's order dated April 12, 2010 indicated the BFR was 400 and DFR 800.</p> <p>3. On May 20, 2010, at approximately 9:45 a.m., Patient 3 was observed receiving hemodialysis treatment via left upper arm V Fistula. The patient was on 2 K and 2.25 Ca dialysate bath. The BFR was 450 and DFR was 800. The patient was on isolation for Hepatitis B.</p> <p>A review of the daily treatment record dated April 22 through May 13, 2010, revealed the BFR was between 350 through 438. A review of the physician's order revealed an order BFR of 450.</p> <p>4. A review of the daily treatment record for Patient 4 dated April 15 through May 22, 2010, revealed the BFR was between 258 to 294. A review of the physician's order on admission indicated the BFR was 300 and DFR was 800.</p> <p>In an interview with the facility administrator, on May 25, 2010, while reviewing the clinical records, he stated that it should be documented why the physician's order for BFR had not been met.</p> <p>5. A review of the medical record revealed Patient 7 had an order for blood flow rate of 400.</p>	V 503			

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V 503	Continued From page 22 A review of the treatment records from April 21, 2010-May 22, 2010 (12 treatments), revealed the blood flow rate was from 270-355.  During an interview on May 24, 2010, at 1:45 p.m., the facility administrator stated the patient's access was a catheter. He stated if the blood flow rate is not reached, there should be documentation for activase or catheter was replaced. After reviewing the medical record, there was no documentation for activase or that the catheter was replaced.  6. A review of the medical record revealed Patient 8 had an order for dialysate flow rate of 600.  A review of the treatment record from May 1-24, 2010 revealed there were five days when the dialysate flow rate was 800 (May 1,4,11,17 and 20).  During an interview on May 24, 2010, at 12:40 p.m., the facility administrator stated there should be a physician order if the dialysate flow rate is on autoflow and it should be documented as autoflow for the dialysate flow rate.	V 503			
V 508	494.80(a)(5) PA-ASSESS RENAL BONE DISEASE  The patient's comprehensive assessment must include, but is not limited to, the following:  (5) Evaluation of factors associated with renal bone disease.  This STANDARD is not met as evidenced by: Based on observation, interview and record	V 508		5/27/10	

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V 508	Continued From page 23 review, the facility staff failed to ensure bone disorder medication Zemplar was administered as ordered by the physician for Patient 5.  Findings:  On May 21, 2010, at approximately 8:30 a.m., Patient 5 was observed receiving hemodialysis treatment via left upper arm antero-venous fistula. The patient was on 1 K and 2.5 Ca dialysate bath.  A review of the patient laboratory values result dated May 22, 2010, for PTH (parathyroid hormone) was 34 picogram/milliliter(pg/ml). The accepted parameter was between 100-300 pg/ml. On the same day the physician ordered Zemplar 2 microgram (mcg) intravenous push (IVP) every treatment. The daily treatment record revealed that on May 12, 14, 17, 19, 21 and 24, 2010, the patient received 6 mcg of Zemplar.  On May 25, 2010, at approximately 8:25 a.m., during an interview, the facility administrator agreed that the physician's order for Zemplar was not administered as ordered.	V 508			
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS  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	V 541		10/21/10	

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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY HILLS DIALYSIS CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 NORTH LA CIENEGA, SUITE 300 BEVERLY HILLS, CA 90211</b>		
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V 541	Continued From page 24 professionally-accepted clinical practice standards.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a coordinated care plan with the skilled nursing facility where 2 sampled patients were residing (Patient 7 and 9).  Findings:  1. A review of the medical record revealed Patient 9 was living in a skilled nursing facility. The patient had low albumin and there was an order of 1-2 Nepro/day or 3-4 scoops procal if patient will take it. There was no coordinated care plan with the skilled nursing facility regarding this order.  2. A review of the medical record revealed Patient 7 was living in a skilled nursing facility. The patient was on 1200 milliliter (ml) fluid restriction. There was no coordinated care plan with the skilled nursing facility on how the fluid intake was monitored.  During an interview on May 25, 2010 at 12:55 p.m., the facility administrator stated he was not aware of any coordinated care plan with the skilled nursing facility.	V 541			
V 681	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY  All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the	V 681		10/21/10	

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V 681	<p>Continued From page 25</p> <p>personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide the hospital affiliations and current appointments for 10 of 10 physicians.</p> <p>Findings:</p> <p>On May 26, 2010, a review of the medical staff files revealed no documentation of hospital affiliations and no current appointment on file for 10 of 10 physicians.</p> <p>At the same time during an interview, the clinical services specialist could not explain why the hospital affiliations and appointments of the physicians were not in their respective files. A review of the facility's Medical Staff By-Laws revealed initial appointments and reappointments shall be for a period not to exceed two (2) years. All applications for appointment to the Medical Staff shall include detailed information concerning the applicant's professional qualifications and experience: 1) Information as to whether the applicant's membership status or privileges have ever been revoked, suspended, reduced, or denied.</p>	V 681			

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V 757	<p>494.180(b)(1) GOV-STAFF # &amp; RATIO MEET PT NEEDS</p> <p>The governing body or designated person responsible must ensure that-</p> <p>(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients;</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an adequate number of qualified personnel are present when ever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients.</p> <p>Findings:</p> <p>During an interview on May 24, 2010, at 1:45 p.m., the facility administrator stated the staffing for Tuesday, Thursday and Saturday was 2 registered nurses and 6 patient care technicians - a total of 8. After reviewing the staffing for December, the facility administrator stated on December 19, 2009, 2 patient care technicians called in sick, so staff was short.</p> <p>A review of the staff schedule revealed on December 19, 2009, there were 3 registered nurses and 4 patient care technicians.</p> <p>A review of the facility's individual timecard report revealed that on February 13, 2010, two patient care technicians came late. At the start of the shift, staff was short. On May 1, 2010, two patient care technicians came in late. At the start of the</p>	V 757		6/1/10

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V 757	Continued From page 27 shift, staff was short.	V 757			