STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	052599	A. BUILDING ____ B. WING ____	C 05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY HILLS DIALYSIS CTR	**50 NORTH LA CIENEGA, SUITE 300** **BEVERLY HILLS, CA 90211**

(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 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 patient was on 2 K and 2.5 Ca dialysate bath. The BFR was 400 and DFR was 800. A review of the daily treatment record from April	V 503		5/27/10

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 503	Continued From page 1 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. 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. 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. 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. 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. 5. A review of the medical record revealed Patient 7 had an order for blood flow rate of 400. A review of the treatment records from April 21, 2010-May 22, 2010 (12 treatments), revealed the blood flow rate was from 270-355.	V 503		

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V 503	Continued From page 2 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 review, the facility staff failed to ensure bone disorder medication Zemplar was administered as ordered by the physician for Patient 5.	V 508		5/27/10

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V 508	Continued From page 3 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 professionally-accepted clinical practice standards.	V 541		10/21/10

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V 541	Continued From page 4 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 757	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS The governing body or designated person responsible must ensure that- (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;	V 757		6/1/10

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V 757	Continued From page 5	V 757		

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.

Findings:

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.

A review of the staff schedule revealed on December 19, 2009, there were 3 registered nurses and 4 patient care technicians.

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 shift, staff was short.