

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:  <b>052599</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/08/2009</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</b> <b>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  Surveyor: 15727 The following reflects the findings of the Department of Public Health during a complaint visit.  Complaint Intake Number: CA00169680-Unsubstantiated CA00180736-Substantiated CA00183298-Substantiated  Representing the Department of Public Health: Sylvia Villaflores, REHS, HFE I	V 000		
V 401	494.60 PHYSICAL 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: Surveyor: 15727 Based on observation, interview and record review, the facility failed to maintain the dialysis facility in order to provide dialysis patients, staff, and the public a safe and functional treatment environment.  Findings:  During a tour of the facility on April 8, 2009, from 7:30 a.m.- 8 a.m., the following was observed: 1. The front door was partially open. 2. In the waiting area, the locking mechanism of the public restroom door was non-functioning. There was a sign on the door "Please Knock-Lock is not functioning." 3. A gnat was observed in the sink area where	V 401		5/5/09

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>the coffee machine was located. A gnat was observed in the treatment area.</p> <p>At 9:16 a.m., a gnat was observed in the conference room.</p> <p>At 11: 15 a.m., a gnat was observed in the reuse room.</p> <p>4. In the reuse room, there was a pail with tubings soaked in a solution on the floor under the sink. The pail was labelled "clean tubings."</p> <p>At the same time during an interview, the facility administrator stated the pail with the reuse tubings should not be on the floor under the sink.</p> <p>During an interview on April 8, 2009 at 8:28 a.m., the facility administrator stated the front door and the public restroom locking mechanism has been non-functioning for 2-3 months.</p> <p>During an interview on April 8, 2009, at 10:45 a.m., the pest control company supervisor stated follow-up visits needed to be done for the gnat problem.</p> <p>A review of the pest control service invoices dated 9/18/08, 10/16/08, 11/20/08, 12/18/08, 1/22/09, 2/19/08 and 3/19/08 revealed the target was roaches and ants. There was no documentation of the gnat problem.</p>	V 401			