

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: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 reflects the findings of the California Department of Public Health during an INITIAL CERTIFICATION survey at Calvine Dialysis at 8243 E. Stockton Blvd, Suite 100, Sacramento, CA 95828 Representing the California Department of Public Health: Beverly VandeWeg, Health Facilities Evaluator Supervisor (HFES), Deidre Sakauye, HFES, Barbara Nelson, Health Facilities Evaluator Nurse (HFEN), Lori Moratto, HFEN, and Christine Douglas, HFEN.	V 000			
V 110	494.30 CFC-INFECTIOIN CONTROL This CONDITION is not met as evidenced by: Based on observations, staff interviews, and policy and procedure review, the clinic failed to ensure that services are provided in a sanitary and safe environment. Findings: 1. The clinic failed failed to ensure that patients were being safeguarded from risk of infection when the patients' access sites were not washed prior to needle cannulation (See V111). 2. The clinic failed to ensure that all staff washed their hands after the removal of their gloves and before donning (put on) gloves and between each patient and stations to prevent the transmission of contaminates (blood and body fluids) between patients (See V113) 3. The clinic failed to properly handle, store, and dispose of potentially infectious; personal	V 110			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 110	Continued From page 1 protective equipment (PPE- gloves) (See V121). 4. The clinic failed to ensure that all staff are trained and demonstrated knowledge of infection control by using proper techniques in the cleaning of the access sites prior to needle cannulation and prior to use of a CVC (See V132). 5. The clinic failed to ensure that staff that are preparing medications clean the septum of multi-use vials with alcohol prior to each time the vial is entered (See 143). 6. The clinic failed to ensure that dialyzer port caps are totally submerged in the disinfectant (Renalin®) to ensure complete sterilization (See V340). The cumulative effect of these systemic failures resulted in the facility's failure to maintain a functional, sanitary, safe, and comfortable setting for patients, staff, and the public.	V 110			
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Based on observation, patient and staff interview, and policy and procedure review, the clinic failed to ensure that patients' were being safeguarded from risk of infection when 2 of 2 patients, (Patient 1 and 3) did not have their vascular access sites washed prior to needle cannulation and the start of their dialysis treatment.	V 111			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 111	<p>Continued From page 2</p> <p>Findings:</p> <p>1. On 12/20/10 at 8:30 a.m., Patient 1 entered the patient care area on a gurney. Patient 1 was then transferred by a Hoyer Lift (An assistive device that allows patients to be transferred between a gurney and a chair using a sling). The patient was weighed and taken to Station 17. The patient was then transferred by the Hoyer Lift into the dialysis chair. The patient had an Arteriovenous (AV) access in his left arm. The Patient Care Technician (PCT A) prepped the access site with alcohol and Betadine® (A 10% povidone-iodine topical antiseptic). PCT A did not have the patient wash his access site prior to being seated at Station 17. The PCT A did not offer to clean the patient's access site with soap and water prior to prepping the access site for needle cannulation.</p> <p>2. On 12/20/10 at 9:10 a.m., Patient 3 entered the patient care area. The patient walked to Station 20 and put her belonging on the chair. The patient then walked to the scale and weighted herself (A sink with soap, water, and paper towels is adjacent to the scales). The patient returned to Station 20 and used a clear solution (hand gel) on her AV access on her left arm. PCT A prepped the patient's access site with alcohol and Betadine® and placed the needles. PCT A did not have the patient wash her access site prior to sitting down in the chair at Station 20. PCT A did not offer to clean the patient's access site with soap and water prior to prepping the access site for needle cannulation.</p> <p>During an concurrent interview, Patient 3 stated that she always uses the "hand gel," that they had given her at the last dialysis clinic. Patient 3 stated that she was unaware that she needed to</p>	V 111			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 111	Continued From page 3 wash her access site with soap and water at the designated sink. During a concurrent interview, PCT A corroborated the above findings and stated that she would " from now on " have the patients' wash their access sites with soap and water and if they cannot do it themselves, she would wash the access sites for them prior to prepping the access sites for needle cannulation. During a concurrent interview, the Clinical Services Specialist stated that it is the standard of practice of the clinic to have the patients' wash their access sites with soap and water, and pat dry with a paper towel, before the staff preps their access sites for needle cannulation. In addition, she stated that if the patient cannot wash their access sites, the staff is to do it for them, using soap and water and patting dry with a paper towel. Observation on 12/20/10 at 8:30 a.m., there was signage at the sink adjacent to the patient scale that requested that the patients' wash their access sites with soap and water for five minutes prior to going to their designated station. Review of the policy and procedure titled " Infection Control For Dialysis Facilities," dated September 2010, on 2/20/10, indicated that the patients are to be encourage by staff to wash their hands and access extremity upon entering the treatment area, prior to the initiation of dialysis and to wash their hands after the termination of treatment before leaving the patient care area.	V 111			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE	V 113			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 113	<p>Continued From page 4</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the clinic failed to ensure that all staff implemented the policy and procedure titled "Infection Control For Dialysis Facilities," as evidenced by the staff not washing their hands after the removal of their gloves and before donning (put on) gloves and between each patient and stations. This failure had the potential of the transmission of contaminants (blood and body fluids) between patients.</p> <p>Findings:</p> <p>1. During observations on 12/20/10 at approximately 9:30 a.m., 9:45 a.m., and 9: 55 a.m., PCT A and Registered Nurse (RN B) did not wash their hands after the removal of their gloves and before donning gloves.</p> <p>2. During an observation on 12/20/10 at 9:20 a.m., PCT A disposed of used personal protective equipment (PPE [gloves]) into a red Biohazard container, by lifting the lid with her bare hand (The Biohazard container had a foot peddle device to lift up the lid). PCT A walked back to Station 20 and touched the machine that was alarming. PCT A did not wash her hands prior to going over to Station 20 to attend to the alarming machine.</p> <p>During a concurrent interview, PCT A stated that she was aware of the policy and procedure</p>	V 113			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 113	Continued From page 5 regarding hand cleaning and gloving. The policy and procedure titled, "Infection Control For Dialysis Facilities," dated September 2010, was reviewed on 12/20/10 at 2 p.m., indicated that the dialysis clinic would provide a safe, clean environment for all patients and staff, to prevent the spread of infections or bloodborne pathogens. Staff are to perform hand hygiene 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.	V 113			
V 121	494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [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- (i) Handling, storage and disposal of potentially infectious waste; This STANDARD is not met as evidenced by: Based on observation and staff interview, the clinic failed to properly handle, store, and dispose of potentially infectious; personal protective equipment (PPE [gloves]) . Finding: Observation on 12/20/10, revealed a used glove hanging from under the lid of a red Biohazard container in the patient care area.	V 121			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 121	Continued From page 6	V 121			
V 132	<p>During a concurrent interview, the Clinical Services Specialist stated that all personal protective equipment (PPE [gloves and gowns]) that are used need to be disposed in the appropriate container and not be left hanging out from under the lid.</p> <p>494.30(a)(1)(i) IC-TRAINING & EDUCATION</p> <p>Infection Control Training and Education</p> <p>Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and policies and procedures review, the clinic failed to ensure that all staff demonstrated knowledge of infection control and implement the policies and procedures titled, "AV Fistula or Graft Cannulation With Safety Fistula Needles (SFN) And Administration of Heparin," "Predialysis Central Venous Catheter (CVC) Care," and "Central Venous Catheter (CVC) Cleaning and Dressing Change," and by using improper techniques in the cleaning of the access sites prior to needle cannulation and prior to use of a CVC. These failures had the potential for infection of the patients' access sites/catheter when proper disinfection techniques are not followed.</p> <p>Findings:</p> <p>1. Observation on 12/20/10 at 8:30 a.m. revealed that Patient 1 had an Arteriovenous (AV) access</p>	V 132			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 132	<p>Continued From page 7</p> <p>in his left arm. The Patient Care Technician (PCT A) prepped the access site with alcohol and Betadine® (A 10% povidone-iodine which is a multivalent broad spectrum local antiseptic having bactericidal and fungicidal antiseptic). The PCT A did not allow the Betadine® to dry on the patient's skin for 2 - 3 minutes prior to needle cannulation.</p> <p>2. Observation on 12/20/10 at 9 a.m. revealed that Patient 2 had a right chest Central Venous Catheter ([CVC] - A soft flexible plastic tube that is inserted surgically into the Superior Vena Cava [A short vein that enters the upper right chamber of the heart]. The CVC line is used for dialysis). Registered Nurse (RN B) removed the old dressings and proceeded to clean the CVC exit site. RN B did not wear a mask, kept touching the patient shirt with her gloves, left the chair side; leaving the site exposed and unprotected, did not have the patient turn his face to the side opposite the CVC exit site (to prevent aerosolize bacteria contaminating the exit site). RN B did not place the patient in a supine position (face up - body lying down - which increases the blood flow and diminishes the risk of an air embolism [air that enters the bloodstream]). At the completion of the dressing change, RN B completely sealed the new dressing with tape and did not date or initial the dressing.</p> <p>3. Observation on 12/20/10 at 9:15 a.m. revealed that Patient 3 had an AV access in her left arm. PCT A prepped the patient's access site with alcohol and Betadine® and placed the needles. The PCT A did not allow the Betadine® to dry on the patient's skin for 2 -3 minutes prior to needle cannulation.</p>	V 132			

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: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 132	Continued From page 8 During a concurrent interview, the Clinical Services Specialist stated that the Betadine® is to be allowed to thoroughly air dry (3 minutes) before the staff place the needles. The clinic's expectation is that the staff would follow the policies and procedures outlined when performing cannulation or accessing a CVC line. Review of the policy and procedure titled, "AV Fistula or Graft Cannulation With Safety Fistula Needles (SFN) And Administration of Heparin," dated September 2009, indicated that Betadine® (Povidone-Iodine) is to air dry for 3 minutes. Review of the policy and procedure titled, "Predialysis Central Venous Catheter (CVC) Care," dated June 2008, indicated that the staff is to ensure that the patient's face is turned to the side opposite of the CVC exit site, which decreases the risk of aerosolized bacteria contaminating the site. That the staff and patient both wear face masks, covering the nose and mouth during the catheter cleaning and dressing change, to prevent the exposure of the catheter and exit site to nasal droplets and infectious bacteria such as Methicillin-resistant Staphylococcus aureus [MRSA], which is a any strain of Staphylococcus aureus bacteria that has developed resistance to beta-lactam antibiotics, which include the penicillins That the staff is to place the patient in a supine position, to increase the blood flow and diminishes the risk for air embolism. The staff is to seal only the edges of the dressing with tape. The sealing of only edges allows the gauze to be non-occlusive. And, the staff is to place a label to the new dressing, which includes the date of dressing change and the initials of the staff performing the procedure.	V 132			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV	V 143			

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: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 143	Continued From page 9 MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Based on observation and policy and procedure review, the clinic failed to ensure that staff implement the policy and procedure titled "Preparation and Administration of Parenteral Medication (Non-EPO) to prevent cross-contamination. Findings: Observation on 12/20/10 at 8:15 a.m. revealed that Patient Care Technician (PCT A) was standing at a counter drawing up medication from a multiple-use vial. PCT A was using multiple syringes (approximately 6 syringes) to draw up the medication from the multiple-use vial. PCT A did not clean the septum (rubber stopper) of the multiple-use vial with an alcohol prep pad prior to each time she entered the multiple-use vial with a new syringe. Review of the policy and procedure titled "Preparation and Administration of Parenteral Medication (Non-EPO)," dated September 2010, indicated that if staff are using a medication vial, the staff are to clean the vial's rubber stopper with an alcohol prep pad prior to each time the vial is entered.	V 143			
V 340	494.50(b)(1) DIALYZER GERM=90%	V 340			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 340	<p>Continued From page 10 CONC/CAPS DISINFECT</p> <p>11.4.1.4 Chemical germicidal procedure: = 90% conc/port caps disinfected If applicable, the hemodialyzer shall be filled with the germicide solution until the concentration in the hemodialyzer is at least 90% of the prescribed concentration.</p> <p>The ports of chemically disinfected dialyzers shall be disinfected and then capped with new or disinfected caps. The caps may be disinfected with dilute bleach, with the chemical used for disinfecting the hemodialyzer, or with any other germicide approved by the FDA as a disinfectant that does not adversely affect the materials of the dialyzer.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview, and policy and procedure review, the clinic failed to ensure that dialyzer port caps were totally submerged in the disinfectant (Renalin®). This failure had the potential of the caps not being completely sterilized.</p> <p>Findings:</p> <p>During an observation on 12/10/10 at approximately 11:15 of the reuse procedure of the used dialyzers, revealed that the Reuse Technician did not ensure that the port caps were totally submerged in the Renalin®. The Reuse Technician stated that there was an apparatus that fits in the container and prevents the caps from floating to the top while soaking in the Renalin®. The Reuse Technician could not find the apparatus in the reuse room. The Reuse Technician left the reuse room looking for this</p>	V 340			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 340	Continued From page 11 apparatus, but was not able to locate the apparatus. During a concurrent interview, the Clinical Services Specialist stated that the Reuse Specialist was contacted and the Reuse Specialist stated that there was an apparatus-like-grid, which fits into the soaking container that keep the caps submerged in the Renalin®, thus ensuring proper disinfection. Review of the policy and procedure titled "Cleaning and Disinfection of Reuse Supplies Policy," dated March 2007, indicated that the Reuse Technician is to ensure that the reuse supplies are cleaned and disinfected with a 1% peracetic acid solution (Renalin®) for a minimum of 30 minutes. Blood and dialysate port caps, and barrier adapters must be disinfected for a period of at least 30 minutes but no greater than 24 hours prior to use. During a concurrent interview, the Facility Administrator corroborated that the policy did not include the usage of the "apparatus-like-grid," which fits into the soaking container that keep the caps submerged in the Renalin®, thus ensuring proper disinfection. The Facility Administrator stated that it is the standard of practice in the clinic to have the caps submerged in the Renalin® for 30 minutes to ensure that the caps are properly sterilized.	V 340			
V 452	494.70(a)(1) PR-RESPECT & DIGNITY 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	V 452			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 452	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and staff interview, the clinic failed to ensure that the patients' are treated with dignity and respect, as evidenced by Registered Nurse (RN B) pulling up Patient 2's T-shirt during the Central Venous Catheter (CVC) dressing change, thus exposing the patient's chest and not providing any form of privacy for the patient. Findings; Observation on 12/20/10 at 9:15 a.m., RN B pulled up Patient 2's T-shirt to access the patient's right upper chest CVC for cleaning, assessing, and for the dressing change. RN B used a blue clamp to hold the patient's T-shirt in place, while she removed the old dressings and completed the assessment, the cleaning and applied a new dressing. Half way through the dressing change, RN B placed a Chux (A waterproof pad) on the patient's chest. During dialysis, half of the Chux kept slipping down and exposing the patient's chest. Neither RN B nor Patient Care Technician (PCT A) repositioned nor secured the Chux to ensure it would stay in place. Observation revealed that another patient had walked past the patient during the catheter dressing change. Observation revealed that the clinic had a privacy screen which could have been unitized to provide privacy for the patient during the procedure. During a concurrent interview, the Clinical Services Specialist stated that the staff are to ensure that the patients' are treated with dignity	V 452			

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: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 452	Continued From page 13 during dressing changes.	V 452			
V 727	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts. (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the clinic failed to safeguard the patients' electronic information on the computer screen from unauthorized persons. Findings: On 12/20/10 at approximately 8:55 a.m., 9:25 a.m., and 10 a.m. observation revealed that 3 of 3 patients (Patient 1, 2, and 3) medical information was left up on the computer screen after the Registered Nurse and the Patient Care Technician had completed their documentation. Observation revealed that a patient walked past the computers when the medical information was visible. During a concurrent interview, the Facility	V 727			

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: 630012740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2010
NAME OF PROVIDER OR SUPPLIER CALVINE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8243 E STOCKTON BLVD STE 100 SACRAMENTO, CA 95825		
(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 727	Continued From page 14 Administrator stated that the staff is to log off (terminate) the session when they finish their documentation. The staff is not to leave the patients' medical information on the computer screen if they are not using the computer. Review of the policy and procedure titled "Workstation Use," dated March 2010, indicated that the staff are required to log off terminals or use the "lock workstation" function prior to leaving the work area.	V 727			