

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey.</p> <p>The surveyors entered the facility on 6/14/10 at 1030 hours. The facility census at the time of the survey was 75 in-center hemodialysis patients. The patient sample consisted of 20 hemodialysis patients.</p> <p>The Clinical Manager and Clinical Services Specialist were the facility coordinators for this survey.</p> <p>Representing the Department of Public Health: Raul Reyes, HFEN; Phyllis Weaver, HFEN and Audrey Bui, HFEN Observer.</p> <p>GLOSSARY:</p> <p>AA - Administrative Assistant BP - Blood Pressure BFR - Blood Flow Rate CSS - Clinical Services Specialist DFR - Dialysate Flow Rate Diastolic - lower number of the blood pressure reading EDW - Estimated Dry Weight HBV - Hepatitis B Virus HBsAg - Hepatitis B Antigen Kg. - kilograms (equal to 2.2 pounds) mL - milliliters mL/minute - Milliliters per minute pH - Degree of acidity or alkalinity of a substance PPE - Personal Protective Equipment P&P - Policy and Procedure PCT - Patient Care Technician</p>	V 000			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	Continued From page 1 QAPI - Quality Assurance and Performance Improvement RN - Registered Nurse Systolic - upper number of the blood pressure reading	V 000			
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 and staff interview, the facility failed to maintain and continuously monitor a sanitary environment to minimize the transmission of infections. blood, secretions, excretions and all contaminated items could all potentially transmit infectious agents. Findings Review of the facility Policy:1-05-01, Infection Control for Dialysis Units last revised 9/09, showed that all red disposal bags and sharp containers that were 3/4 full would be removed from the treatment area. 1. On 6/14/10 at 1030 hours, during the initial tour of the facility conducted with the charge nurse, the patient's restroom was found with three pebble-like stools on the floor. The toilet seat lid was smeared with stool on both sides. The charge nurse called two PCTs to clean the restroom. On 6/15/10 at 0830 hours, the patients' restroom was noted to be blocked by signs saying the	V 111		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 2 restroom was "out of order." The toilet bowl was overfilled and the floor was wet. The charge nurse was not aware of the restroom's condition. PCT 2 stated that the signs had been by the restroom door since 0430 hours when she first opened the facility, with the maintenance staff working to unclog the toilet bowl. By 1030 hours, the Administrative Assistant (AA) notified the daytime maintenance staff who tried again to unclog the toilet bowl. By 1130 hours, the AA reported that the toilet bowl would be replaced. When the Facility Administrator was notified regarding the condition of the patients' restroom, she acknowledged that the patients' restroom should be monitored frequently for cleanliness and functionality for the patients' safety and convenience. 2. During further tour of the facility on 6/14/10 at 1100 hours were multiple, red biohazard trash containers were observed in the middle of the walkway in the treatment area. Blood tubing was noted to be hanging over the side of the container from under the closed lid. On 6/15/10 at 1625 hours, PCT 4 was asked if it was proper to have the blood tubing hanging out from the containers. PCT 4 acknowledged that the blood tubing could be a source of infection. He further stated that the containers should be emptied when they were 3/4 full and during every shift change.	V 111			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the	V 113		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 3</p> <p>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, staff interview and facility policy review, the facility failed to ensure the staff followed the P&P for central catheter dressing changes with regard to the changing of gloves and hand hygiene for three of 20 sampled patients (Patients 3, 8 and 15) in order to prevent the possible transmission of infection and an air embolism (obstruction of a blood vessel caused by an air bubble).</p> <p>Findings:</p> <p>Review of the facility's policies and procedures (P&P) was initiated on 6/15/10.</p> <p>Review of Procedure 1-04-02C, Central Venous Catheter (CVC) Cleaning and Dressing Change dated 9/2007, showed the patient should be in a comfortable supine (lying on their back with face upward) position. Per the procedure, the supine position increased blood flow and diminished the risk of an air embolism. The dressing was to be removed and discarded. The catheter exit site was then to be assessed for infection. After assessment of the exit site, the gloves were then to be removed, hands washed and new gloves placed prior to cleaning the catheter exit site.</p> <p>Review of facility Policy 1-05-01 for Infection Control for Dialysis Facilities last revised 9/09, showed gloves should be changed when going from a "dirty" area or task to a "clean" area or</p>	V 113			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 task.</p> <p>1. On 6/15/10 at 0914 hours, RN 1 was observed performing a catheter dressing change for Patient 3. Patient 3's treatment had just been initiated, and the patient was sitting upright in the dialysis chair with their feet in a downward position. Using the same gloves that were used to initiate the patient's treatment, RN 1 then removed the dressing covering Patient 3's catheter exit site. Using the same gloves, the exit site was cleaned and a new dressing applied.</p> <p>2. On 6/15/10 at 0955 hours, Patient 15 was observed sitting upright in their dialysis chair, with their feet in a downward position. The patient's treatment had just been initiated by RN 2. Still wearing the same gloves used to initiate the patient's treatment, RN 2 removed the dressing covering the catheter exit site. The site was then cleaned and a new dressing applied using the same gloves.</p> <p>3. On 6/15/10 at 1040 hours, Patient 8 was observed seated upright in the dialysis chair as the catheter was being prepared to initiate treatment. As RN 2 was preparing to change the dressing on the patient's catheter exit site, the machine alarmed. The RN went to the machine to correct the alarm and then returned to Patient 8 still wearing the same gloves, removed the dressing from the catheter exit site, cleaned the site and applied a new dressing.</p> <p>On 6/15/10 at 1055 hours, an interview was conducted with RN 1. When asked to describe how dressing changes were done for catheter patients, RN 1 stated they were done when the treatment was first started. RN 1 also stated that</p>	V 113			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 gloves were to be changed before and after the dressing changes, or if the gloves became contaminated with blood. When asked how the patient should be positioned for initiation of treatment and the dressing change, RN 1 stated he preferred to have the patient sitting up with their feet down to make it easier to access the catheter.	V 113			
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to discard/disinfect contaminated items from the computer carts at each dialysis station so as not to be shared with other patients. Any item taken to a patient's dialysis station could become contaminated with blood and other fluids and serve as a vehicle of infection transmission to other patients. Findings:	V 116		8/6/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 116	Continued From page 6 During the initial tour of the facility conducted on 6/14/10 at 1030 hours with the charge nurse, boxes of gloves, disposable paper tapes, non-disposable blood pressure cuffs and a bottle of vinegar spray were found by the computer carts located by dialysis stations 4 to 6. Boxes of new dialyzers were stored inside the isolation room upon entry. On 6/14/10 at 1130 hours, PCT 1 was asked regarding these items. He stated that the items were considered contaminated when taken to the dialysis stations and should be discarded or disinfected before the next shift. He further stated that these observation happened when there was not enough supervision around.	V 116			
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, staff interview and facility policy review, the facility failed to ensure the dialysis machines were disinfected per facility policy to prevent the possible transfer of bloodborne infections in the dialysis facility. Findings:	V 122		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 122	<p>Continued From page 7</p> <p>Review of the facility Policy 1-05-01, Infection Control for Dialysis Facilities, last revised on 9/09, showed the dialysis delivery system and IV poles should be wiped clean with a bleach solution of the appropriate strength after completion of procedures and before being used on another patient.</p> <p>Observation of the treatment area showed the following:</p> <ul style="list-style-type: none"> * At 0945 hours on 6/15/10, the disinfection of the the dialysis machine at Station 21 by PCT 1 was observed. The top, the side of the machine where the dialyzer was placed and the front down to the top of the blood pump was disinfected. The IV pole and clamps on the IV pole, the blood pump and the side of the machine near the patient were not disinfected. * On 6/16/10 at 0947 hours, the disinfection of the dialysis machine at Station 23 by PCT 1 was observed. The top, the side where the dialyzer was placed and the front of the machine down to the blood pump were disinfected. The IV pole and clamps on the IV pole, the blood pump, and the side of the machine next to the patient chair were not disinfected. * On 6/16/10 at 1045 hours, PCT 3 was observed disinfecting the dialysis machine at Station 17. The PCT disinfected the top of the machine, the sides, and the blood pump. The IV pole was not disinfected. <p>On 6/16/10 at 1047 hours, an interview was done with PCT 3. PCT 3 stated the items on the IV pole were considered sterile, but they do wipe the IV pole and entire machine with 1:100 bleach solution.</p> <p>On 6/16/10 at 1620 hours, an interview was done</p>	V 122			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 122	Continued From page 8 with PCT 1. PCT 1 stated that between patients, the machines were disinfected. They disinfect the top, front and everything but the back of the machine. Sometimes they disinfect the IV poles and remove the clamps.	V 122			
V 130	494.30(a)(1)(i) IC-HBV-ISOLATION-MACHINES/EQUIP/SUPPLIES Isolation of HBV+ Patients To isolate HBsAg positive patients, ... dedicate machines, equipment, instruments, supplies, and medications that will not be used by HBV susceptible patients. This STANDARD is not met as evidenced by: Based on observation, facility policy review and staff interview, the facility failed to ensure the isolation P&P's regarding the handling of blood specimens and the removal of PPE prior to leaving the isolation area were followed to prevent the possible spread of infection. Findings: Review of the facility Procedure 1-05-02B for Isolation: Obtaining and Handling of Blood Specimens with a revision date of 12/08, showed after the blood sample tube was removed from the centrifuge in the isolation area, it was to be placed in a biohazard bag. A second teammate was to hold a second biohazard bag outside the isolation area/room while the specimen was placed inside for transportation of the tube to the laboratory room. Policy 1-05-09 for Infection Control and Isolation Measures for Known or Suspected Hepatitis B	V 130		8/6/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 130	Continued From page 9 Surface Antigen Positive Patients revised 12/08 showed in the area for teammate practices, that when caring for the known or suspected Hepatitis B positive patient, the PPE would be removed, gloves discarded and hand hygiene performed immediately when leaving the room or area. On 6/16/10 at 1035 hours, PCT 1 was observed leaving the isolation area wearing the mask and gloves that were used while cannulating the patient for treatment. The gown had been removed. PCT 1 walked across the treatment area toward a door at the back of the treatment area which led to the laboratory room. When stopped by the surveyor, it was observed PCT 1 was carrying a tube containing a blood sample from the isolation patient in his gloved hand. PCT 1 was asked why he was wearing the mask and gloves from the isolation room. PCT 1 stated he was taking the blood sample from the isolation room to the laboratory room. When asked why the tube had not been placed into a biohazard bag for the transfer to the laboratory room, PCT 1 stated there were no biohazard bags in the isolation room. PCT 1 stated he was aware that he had left the isolation area wearing the mask and gloves and should not have worn them outside the area.	V 130			
V 132	494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.	V 132		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 10</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to ensure that all staff were aware of the proper use of personal protective equipment (PPE). One staff member did not complete the annual infection control test. Failure to enforce and educate staff on infection control would not prevent the spread of infection.</p> <p>Findings:</p> <p>1. On 6/16/10 at 1350 hours, when the surveyor entered the patient waiting area,, RN 3 was observed in the waiting area wearing their PPE. When RN 3 was asked regarding the facility's policy about wearing PPE outside of the treatment area, RN 3 stated she would have to check to see what the policy stated and would advise the surveyor later. At 1415 hours, RN 3 stated to the surveyor the policy was not clear if the PPE could be worn into the patient waiting area.</p> <p>Review of the facility Policy 1-05-01, Infection Control for Dialysis Facilities last revised 9/09, showed that PPE was to be removed prior to leaving the treatment area. PPE was not to be worn in non-treatment areas.</p> <p>2. On 6/16/10, review of the personnel file for PCT 1 showed the last mandatory Exposure Control/Infection Control test for PCT 1 was dated 6/9/08.</p> <p>On 6/16/10 at 1450 hours, an interview was conducted with the Clinical Service Specialist (CSS). When asked how often the clinical staff should take the mandatory infection control test per the facility's P&P, the CSS's response was annually.</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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 11	V 132			
V 143	<p>Further review of the personnel file showed PCT 1 had not passed the mandatory Exposure Control/Infection Control test on 1/15/10. When asked what actions the facility should take when staff failed the mandatory Infection Control test, the CSS stated the staff member should retake the test within 24 hours. When asked what happened if the staff member did not complete the annual infection control test, the CSS stated she would not let that staff member work.</p> <p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS</p> <p>[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</p> <p>This STANDARD is not met as evidenced by: Based on observation, facility policy review and staff interview, the facility failed to ensure medications were handled aseptically and discarded in accordance with manufacturer's accepted standards to prevent the possible spread of infectious agents, or the use of medications whose integrity may have been compromised.</p> <p>Findings: Review of the facility Policy 1-06-01, Medication Policy last revised 9/09, showed that all unopened ampules and/or vials should be stored according to the manufacturer's directions. Any ampule or vial that has been stored improperly or has</p>	V 143		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 12 expired was not to be used.</p> <p>Review of Procedure 1-06-01A for Preparation and Administration of Parenteral Medications (Non-EPO) last revised 9/09, showed if the medication was in a vial, the vial cap was to be removed and the vial stopper cleaned with an alcohol pad prior to entering the vial. A new alcohol pad was to be used prior to each time a vial was entered.</p> <p>Information from the manufacturer of Epogen showed that an indicator was packaged in the center of the tray containing the vials and would display a reddish discoloration when the tray and Epogen multi-dose vials had been exposed to freezing temperatures. If the white paper material of the indicator showed any sign of reddish discoloration, the product was not to be used. Multi-dose vials that had been exposed to freezing temperatures were found to be unstable after one freeze-thaw cycle.</p> <p>1. On 6/14/10 at 1434 hours, RN 3 was observed drawing medications from two different vials. The vial stoppers were not cleaned with an alcohol pad prior to inserting the needles into the vial.</p> <p>On 6/15/10 at 0940 hours, RN 2 was observed drawing one medication dose. The stopper of the vial was not cleaned with an alcohol pad prior to inserting the needle into the vial.</p> <p>On 6/15/10 at 1015 hours, RN 1 was observed drawing medications from nine different vials. RN 1 removed the vial caps and directly inserted the needle into the stopper without cleaning the stoppers with an alcohol pad.</p>	V 143			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 13</p> <p>On 6/15/10 at 1052 hours an interview was done with RN 1 regarding medication preparation. RN 1 stated if the vial was a multi-dose vial, the rubber stopper would be cleaned with an alcohol pad prior to each needle insertion. When RN 1 was asked if they were familiar with the facility's medication policy, RN 1 stated he had read the facility's P&P updates.</p> <p>2. On 6/14/10 at 1125 hours, during inspection of the medication refrigerator at the nurse's station with the Administrator, an open box of 20,000 unit per mL vials of Epogen was found. The 10 vial box had one opened vial and approximately five unopened vials. Four of the vials had been used for patients. Upon observation, the indicator strip in the box showed the white paper material in the indicator was a reddish color indicating the medications had been frozen.</p> <p>3. On 6/14/10 at 1400 hours, four uncapped vials of 1000 unit/mL heparin were shown to the CSS and the Facility Administrator. Two vials had the date and time when the vials were opened, and the initials of the staff written on the two vials signifying who had opened the vials. The other two vials were not labeled with the date and , time or initials of staff who had opened the vials.</p> <p>Inside a drawer beside the medication refrigerator were vials of 1000 unit/mL heparin and Lidocaine 1%. Both vials were not labeled with the date, time or initials of the staff who had opened the vials.</p> <p>While the Facility Administrator was taking notes of the findings, the CSS was asked when the vials were supposed to be discarded. She admitted that without the date and time it was first opened</p>	V 143			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 14	V 143			
V 401	<p>they were unable to tell when to discard the vial, and the P&P directed staff to discard vials that had been opened for more than 30 days.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE 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: Based on observation and staff interview, the facility failed to provide a safe environment for both staff and patients, including their visitors. Multiple biohazard trash containers and several sharps containers located in the middle of the treatment area walkway created obstacles which could present risks for trips and falls. In addition, the patients' restroom was found not operational restricting patients' access to a comfortable environment. The outside door leading to the water treatment area and supply room was propped open allowing entry of unauthorized individuals, insects or animals.</p> <p>Findings:</p> <p>1. On 6/14/10 at 1030 hours, during the initial tour of the facility conducted with the charge nurse, multiple red biohazard trash containers were noted in the middle of the walkway of in the treatment area. By stations 8 to 10 through stations 12 to14, three sharps containers were observed standing by the red biohazard trash containers, and not beside by the treatment chair, thereby exposing sharps containers to bumps and</p>	V 401		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 401	<p>Continued From page 15 falling on the floor.</p> <p>The sharps container had narrow bottoms and wide tops contributing to their instability when placed on the floor. Per the manufacturer's "do's and dont's for handling sharps containers," these containers should not be placed in areas where they might be bumped, which could cause spillage of the contents.</p> <p>The red biohazard trash containers stood approximately 1.5 ft. tall. These low containers presented an obstacle to the working staff when they turned around and switched from one treatment chair to another. In addition, patients with poor vision might not see these obstacles located in the middle of the walkway.</p> <p>On 6/16/10 at 1500 hours, the Facility Administrator acknowledged that the sharps containers and red trash containers presented an obstacle to the staff, patients and their visitors.</p> <p>2. Further tour of the facility conducted with the charge nurse revealed the patient's restroom with three pebble-like stools on the floor. The toilet seat's lid was smeared with stool on both sides. The charge nurse called two PCTs to clean the restroom.</p> <p>On 6/15/10 at 0830 hours, the patients' restroom was noted to be blocked by signs saying the restroom was "out of order." The toilet bowl was overfilled and the floor was wet. The charge nurse was not aware of the restroom condition. PCT 2 stated that the signs had been by the restroom door since 0430 hours when the facility was opened with the maintenance staff working to unclog the toilet bowl.</p>	V 401			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 401	Continued From page 16 By 1030 hours, the Administrative Assistant (AA) notified the daytime maintenance staff who tried again to unclog the toilet bowl. By 1130 hours, the AA reported that the toilet bowl would be replaced. When the Facility Administrator was notified regarding the condition of the patients' restroom, she acknowledged that the patients' restroom should be monitored frequently for cleanliness and functionality for patients' safety and convenience. 3. On 6/17/10 at 0600 hours, the outside door leading to the water treatment room and supply rooms was found propped open with no staff present. At 0605 hours, the Facility Administrator was notified. The staff were verbally reminded to keep the door closed to prohibit entry of unauthorized individuals, animals and insects.	V 401			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on observation, facility policy review and staff interview, the facility failed to ensure the fluids for the test machines that were used for independent verification of the dialysate pH and	V 403		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 403	<p>Continued From page 17</p> <p>conductivity (electrical charges) were checked for expiration and the machines calibrated prior to use that could result in a patient being dialyzed on an improper pH or conductivity and possibly result in harm to the red blood cells. The emergency crash cart had been unlocked since 3/10/10 exposing the contents to public tampering. A medication refrigerator at the nurses' station needed to have the freezer defrosted to assure proper storage temperature of medications.</p> <p>Findings:</p> <p>1. On 6/15/10, review of the facility Procedure 2-04-06I for Phoenix Meter Disinfection and Calibration Verification, last revised on 9/09, showed that after disinfection, calibration of the Phoenix Meter was to be verified prior to daily use or whenever inaccurate readings were suspected. After disinfection the syringe and cell of the meter were to be rinsed with dialysis quality water. The expiration dates on the conductivity standard and pH buffer solutions were to be checked to make sure they had not expired.</p> <p>On 6/14/10 at 1100 hours, review of the Phoenix Meter solutions showed the bleach solution was to be replaced daily. There was no date or initials on the container to show when the bleach solution was mixed. Review of the bottle of conductivity solution showed it expired 30 days after opening. The opening date on the bottle was 5/1/10. The dialysis quality water was to be changed daily, and there was no date to indicate when the bottle had been filled.</p> <p>On 6/14/10 at 1410 hours, during an interview with the Administrator and CSS, it was determined that the PCT who opened the facility</p>	V 403			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 403	<p>Continued From page 18</p> <p>was responsible for checking the dates on the bottles, filling the dialysis quality water bottle and preparing the bleach solution.</p> <p>On 6/17/10 at 0705 hours, a new container of conductivity solution had been obtained. However, the dialysis quality water and the bleach solution containers showed an expiration date of 6/16/10. During an interview with PCT 3, she stated she checked the meters at night and knew they were alright so they could be used in the morning. PCT 3 added that she calibrated one Phoenix Meter to check the machines for the first patient shift. It was pointed out that the dialysis quality water and bleach solution used to clean the meter had expired on 6/16/10. Review of the tracking log to show the cleaning and calibration of the meters showed no entries had been documented for 6/17/10.</p> <p>2. On 6/14/10 at 1030 hours, inspection of the facility's emergency crash cart revealed that the list of contents were checked off, including the medications, on a daily basis by the assigned staff. However, comments documented on the clipboard showed that the crash cart had not been locked since 3/10/10 up to the date of the survey.</p> <p>On 6/14/10 at 1130 hours, when the Facility Administrator was asked why the emergency cart was not locked, she admitted that the facility was unable to find and order such locks. The CSS asked if there was a state regulation concerning an unlocked emergency crash cart. The location of the crash cart was between the patients' restroom and the weighing scale by the entry/exit door of the treatment area exposing its contents, medications, needles and syringes, to public tampering. Locking the emergency cart was an</p>	V 403			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 403	Continued From page 19 assurance the cart was not tampered with, the needed equipment was functional, and medications were safe for patient use and present inside the cart according to their daily checklist. 3. On 6/14/10 at 1200 hours, the medication refrigerator by the nurses' station needed defrosting to assure medications were stored at the proper temperature. Heavy thick ice had accumulated around the freezer and its cover allowing no access to cubed ice. Review of the temperature log revealed temperatures were within the specified range set by the pharmaceutical company and were checked on a daily basis. However, a box of Epogen was found with its alert indicator colored "red" signifying the medications had been frozen. The manufacturer's package insert showed that the medication was not to be used if frozen.	V 403			
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 staff interview, the facility failed to ensure that all patients' vascular access sites were visible for two of 20 patients (Patients 12 and 13) to allow observation of possible leakage at the connection or needle sites and prevent patient blood loss. Findings: 1. On 6/15/10 at 1052 hours, observation of	V 407		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 407	Continued From page 20 Patient 12 showed the patient was asleep and their catheter access site was not visible. RN 1 was notified of the covered site. 2. On 6/16/10 at 0945 hours, Patient 13 was observed with a paper towel wrapped around her catheter connections. RN 3 was asked about the covered connections. RN 3 stated she covered the catheter connections if there was blood on the catheter ports to prevent getting blood on the patient's clothes. When asked what the facility policy was regarding covered access sites, she stated she would check and let the surveyor know. At 0950 hours, RN 3 told the surveyor that the sites should be uncovered while the patient was receiving treatment.	V 407			
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency	V 409		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 409	<p>Continued From page 21</p> <p>situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, four staff did not know where the main water and gas shut off valves were located. Emergency preparedness by the staff was expected to ensure patient safety during disasters.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 6/16/10, the facility policy on various disasters # 4-07-01B, page 1 was reviewed. Under tornadoes, No. 7 showed that teammates should know how to shut off water, power and gas lines. The proper wrenches should be available. On 6/16/10 at 1030 hours, the reuse technician and Biomed 2 were asked to locate the main water and gas shut off valves. The reuse technician paged the building maintenance staff to show them where the shut off valves were. On 6/16/10 at 1130 hours, PCT 5 led the surveyor to the water treatment area but remained unable to locate the water and gas shut off valves. On 6/16/10 at 1200 hours, the Facility Administrator acknowledged that the location of the water and gas shut off valves was not included in the facility's disaster preparedness training. She admitted to not knowing how many 	V 409			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 409	Continued From page 22	V 409			
V 412	and what kind of fire extinguishers the facility had including their respective locations. 494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Based on record review, staff and patient interview, a patient failed to describe how he would seek treatment in the event that a natural or man-made disaster resulted in the closure of the facility. Emergency preparedness training should be provided to the patients. Findings: On 6/15/10 at 0900 hours, Patient 18 was interviewed. When asked regarding what to do during a disaster while having a dialysis treatment, he explained how to disconnect himself from the machine and meet the rest of the staff at the specified location outside the building. When asked how he would seek dialysis treatment in case the building collapsed, he was not able to respond. PCT 2 acknowledged their instructions as part of emergency preparedness did not include optional treatment locations..	V 412		8/6/10	
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,	V 503		10/2/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	Continued From page 23 This STANDARD is not met as evidenced by: Based on medical record review, staff interview and facility policy review, the facility failed to ensure the blood flow rates (BFR), dialysate flow rates (DFR) and the related components, such as patients' estimated dry weights (EDW) were assessed, the patient weight gains were calculated per policy for accurate fluid removal, and high blood pressures were addressed and treatments evaluated to determine if it met the patients' needs for 14 of 20 sampled patients (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 17) which resulted in patients being discharged above or below their EDWs and with high blood pressures which could lead to possible strokes or hypotensive episodes. Findings: Patient Review Reports and treatment sheet review was initiated on 6/15/10. Patient Review Reports and electronic treatment sheets were reviewed and noted issues were discussed with the Clinical Services Specialist on 6/15 and 6/16/10. On 6/15/10, review of the facility Procedure 1-03-08B, Fluid Removal Calculation dated 9/07, showed that to determine the patient's intradialytic fluid removal, the patient's EDW was to be subtracted from their pre-treatment weight and the total amount of fluids the patient would receive during treatment should be added to determine the total amount of fluid to be removed. All patients had PRN (as needed) medication	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 24</p> <p>orders for Clonidine 0.1 mg for a BP reading greater than 180 systolic (upper number of the BP reading) or greater than 100 diastolic (lower number of the BP reading)</p> <p>1. Patient 7 had an ordered EDW of 53.0 Kg. The Patient Treatment Report for 14 treatments from 5/14 to 6/14/10, showed the weight gains for the patient were not accurate and had not been calculated per policy. For example:</p> <ul style="list-style-type: none"> * On 5/19/10 the patient's pre-treatment weight was 59.6 Kg. and the weight gain was calculated as 4.3 Kg. Per policy the weight gain should have been 6.6 Kg. * On 5/26/10 the pre-treatment weight was 59.0 Kg. and the weight gain was calculated as 2.8 Kg. Per policy the weight gain should have been 6.0 Kg. * On 6/19/10 the pre-treatment weight was 58.9 Kg. and the weight gain was calculated as 2.5 Kg. Per policy the weight gain should have been 5.9 Kg. <p>Patient 7's post-treatment weights were 2.3 to 6.6 Kg. over their EDW.</p> <p>1a. Pre-treatment standing BPs for nine of the 14 treatments showed Patient 7's BPs ranged from 207/105 to 241/96. Post-treatment standing BPs ranged from 105/61 to 208/118 on 6/14/10. The patient's pre and post-treatment assessments revealed the patient had a trace of facial edema.</p> <p>1b. Review of the treatment sheet for 6/14/10 showed Patient 7 had a pre-treatment sitting BP of 214/108 and a post-treatment standing BP of 220/109. The patient's systolic BP was greater than 200 for the first hour then decreased to 167/100. One hour and 30 minutes later, the</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 25</p> <p>patient's BP had increased to greater than 200 systolic and 100 diastolic and remained at that level for the last one hour and 30 minutes of the treatment. There was no documentation on the treatment sheet to show the nurse had been notified of the patient's increased BP. The patient's treatment was discontinued at 1444 hours. A BP medication was given to the patient at 1452 hours. There was no documentation to show a follow-up BP was taken before the patient was discharged to determine if the BP medication was effective.</p> <p>1c. Patient 7 had been hospitalized for chest pain and high blood pressure on 3/29/10. The patient had received two sublingual nitroglycerin tablets at dialysis and was transferred to the hospital where her presenting blood pressure was 250/124.</p> <p>1d. Review of the patient's care plan progress notes dated 6/26/09, showed in the cardiovascular area that the patient's BP control was stable and to continue the present plan and monitor. The area for weight/fluid gain also had been marked as stable and to continue with the present plan and monitor. There was a nursing note that showed the patient had elevated BPs at the beginning of treatments, decreased BPs during treatment and occasionally needed Clonidine. The care plan had not been revised regarding the patient's recent hospitalization for the high BP, the increased BPs during treatment or evaluation of the patient's post-treatments weights above his EDW.</p> <p>2. Review of the treatment records for Patient 6 showed an ordered EDW of 50.0 Kg. Review was done for 11 treatments from 5/21 to 6/14/10</p>	V 503			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 26</p> <p>showed the weight gains for the patient were not accurate and had not been calculated per policy. For example:</p> <ul style="list-style-type: none"> * On 5/24/10 the pre-treatment weight was 53.4 Kg. and the calculated weight gain was 2.4 Kg. Per policy the weight gain should have been 3.4 Kg. * For 5/31/10 the pre-treatment weight was 54.1 Kg. and the calculated weight gain was 2.8 Kg. Per policy the weight gain should have been 4.1 Kg. * On 6/9/10 the pre-treatment weight was 54.0 Kg. and the calculated weight gain was 1.7 Kg. Per policy the weight gain should have been 4.0 Kg. <p>For 11 of the 11 treatments reviewed, Patient 6 was discharged 1.0 Kg. to 2.3 Kg. over his EDW.</p> <p>3a. Patient 8 had an ordered EDW of 57.0 Kg. The Patient Review Report for Patient 8 for 14 treatments from 4/27 to 6/12/10, showed the weight gains for the patient were not accurate and had not been calculated per policy. For example</p> <ul style="list-style-type: none"> * On 5/1/10 the pre-treatment weight was 53.3 Kg., which was 4.0 Kg. under the EDW and the calculated weight gain was 1.2 Kg. * On 5/11/10 the pre-treatment weight was 52.8 Kg., which was 4.2 Kg. under the EDW and the calculated weight gain was 1.2 Kg. <p>Patient 8 was discharged 5.0 to 8.0 Kg below their EDW.</p> <p>3b. Review of Patient 8's care plan dated 4/26/10, showed the patient previously had an EDW of 67.0 Kg, but it had been decreased to 57.0 Kg on 3/30/10. The care plan showed the patient's</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 27</p> <p>post-treatment weights had been below the 57.0 Kg EDW from 3/30 to 4/24/10. The Plan of Care showed documentation dated 4/16/10, that the patient's average weight gain was acceptable, but no documentation was provided to show the difference between the patient's EDW decreased and post-treatment weights had been assessed.</p> <p>4a. The Patient Review Report for Patient 9 showed that on 5/17/10 the patient had an ordered EDW of 90.5 Kg. On 5/19/10, the EDW was decreased to 85.0 Kg. Review of the patient's pre-treatment weights for 13 treatments from 5/19 to 6/14/10, showed the patient's pre-treatment weights were 1.5 Kg. to 5.4 Kg. lower than the EDW. There was no documentation provided to show the patient's EDW had been evaluated to determine if it met the patient's needs.</p> <p>4b. Patient 9 had an ordered BFR of 250 mL per minute and a DFR of 600 mL per minute. The patient's treatment sheet dated 6/1/10, showed Patient 9 had an average BFR of 340 mL per minute for the treatment and a DFR of 800 mL per minute. There were no orders to cover the increased BFR and DFR.</p> <p>5a. Patient 10 had a physician's order for an EDW of 71.5 Kg. The Patient Review Report for 14 treatments from 4/30 to 6/14/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/7/10 the pre-treatment weight was 73.5 Kg and the calculated weight gain was 1.8 Kg. * On 5/14/10 the pre-treatment weight was 73.5 Kg. and the calculated weight gain was 0.9 Kg. * On 5/28/10 the pre-treatment weight was 70.2 Kg. and the calculated weight gain was -2.3 Kg.</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	Continued From page 28 5b. Patient 10 had an ordered treatment time of three hours. The Patient Review Report showed that on 6/14/10 the patient's time on dialysis was four hours and 55 minutes and on 5/24/10 was three hours and thirty-four minutes. Review of the physician's orders with the Clinical Services Specialist showed there were no orders for the increased treatment times. 5c. Patient 10 had physician's orders for a BFR of 400 mL per minute. Review of the treatment sheet for 6/14/10, showed the patient had an average BFR of 236 mL per minute for the treatment. There was no documentation on the treatment sheet to show why the ordered BFR was not achieved. 5d. On 6/11/10, Patient 10's pre-treatment weight was 75.8 Kg which was 4.3 Kg. over his EDW. The patient had a pre-treatment sitting BP of 212/82. Review of the treatment sheet for 6/11/10 showed the patient only ran 130 minutes of his ordered 180 minute treatment. The treatment was stopped because the patient had an infiltration of the venous portion of this dialysis access. The patient's BP on initiation of treatment was 159/75 but nine minutes later had increased to 212/82. The patient's systolic BP was greater than 200 for the remainder of the treatment. The pre-treatment assessment showed Patient 10 had slight wheezing in the right lung apex and the post assessment showed diminished lung sounds at the bases. There was no documentation to show the nurse had been notified of the patient's increased BP during treatment. The patient received no medication for the increased BP.	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	Continued From page 29 The treatment sheet showed Patient 10's treatment was started at 1053 hours. At 1242 hours, when the treatment was stopped, the fluid removed was 0.9 Kg. The patient was discharged at the same weight as his pre-treatment weight of 75.8 Kg., 4.3 Kg. over his EDW of 71.5 Kg. Patient 10 was discharged with a BP of 200/66. There was no documentation to show the physician had been notified of the patient's increased pre-treatment weight, that no fluid had been removed during the treatment and the patient had an increased BP during treatment. 5e. On 6/14/10, Patient 10's pre-treatment weight was 77.8 Kg. which was 2.0 Kg. over his discharge weight on 6/11, and 6.3 Kg. over his EDW of 71.5 Kg. The weight gain figured for the treatment was 2.0 Kg., and 1.8 Kg. was removed during treatment. The patient was discharged 4.5 Kg. over his EDW. The pre and post assessments showed the patient had diminished lung sounds at the bases and a trace of edema on his ankles. There was no documentation provided to show the patient's physician had been notified of the post-treatment weight or the post-treatment weight had been assessed. 6a. Patient 11 had an ordered EDW of 62.0 Kg. The pre-treatment weights and calculated weight gains for 14 patient treatments from 5/13 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/12/10 the pre-treatment weight was 65.0 Kg. and the calculated weight gain was 0.4 Kg. * On 5/25/10 the pre-treatment weight was 64.9 Kg. and the calculated weight gain was 0.4 Kg. * On 6/30/10 the pre-treatment weight was 65.3	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 30</p> <p>Kg. and the calculated weight gain was 0.4 Kg.</p> <p>Patient 11 had not achieved their EDW for the 14 treatments reviewed and was discharged 1.2 Kg. to 3.2 Kg. over his EDW. No documentation was provided to show that the patient's post-treatments weights had been reviewed.</p> <p>6b. Review of Patient 11's treatment sheets for 5/13, 5/15, 5/18, 5/20, 6/5, 6/12 and 6/18/10, showed the patient had been assessed for edema in his legs pre and post-treatment. On 5/20, 5/25, 5/27, 5/29, 6/1 and 6/12/10 the patient had a pre-treatment sitting BP greater than 200 systolic.</p> <p>6c. Patient 11 had an ordered BFR of 400 mL/minute and an ordered DFR of 800 mL/minute. Review of the patient's treatment sheets showed the following: On 5/13, 5/15, 6/5 and 6/12 the BFR was less than 400 mL/minute. On 5/13, 5/15, 5/18, 5/20, 6/5, 6/12 and 6/15/10 the DFR rate was 600 mL/minute. There was no documentation on the treatment sheets to show why the BFR and DFR rates were not to physician's order</p> <p>7a. Patient 12 had ordered EDW of 69.0 Kg. The Patient Treatment Review for 14 treatments from 5/13 to 6/12/10 showed the patient's post weights were 0.5 Kg. to 5.0 Kg. below the ordered EDW. There was no documentation to show the decreased post-treatment weights had been reviewed.</p> <p>7b. On 6/10/10 Patient 12's pre-treatment weight was 96.6 Kg. and the calculated weight gain was 28.3 Kg. There was no documentation to show</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 31</p> <p>the weight and the calculated weight gain for 6/10/10 were reassessed for accuracy.</p> <p>7c. The patient had an order for a DFR of 600 mL/minute. Review of the treatment sheet dated 6/10/10, showed the patient had a DFR rate of 800 mL/minute for the treatment.</p> <p>8a. Patient 13 had an ordered EDW of 46.0 Kg. The Patient Treatment Review for the last 14 treatments showed the patient had post-treatment weights of 0.9 Kg. to 2.4 Kg. over her EDW. Review of the treatment sheets for 5/21 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/24/10 the pre-treatment weight was 48.6 Kg. and the calculated weight gain was 1.6 Kg. * On 5/23/10 the pre-treatment weight was 49.4 Kg. and the calculated weight gain was 1.0 Kg. * On 6/12/10 the pre-treatment weight was 48.4 Kg. and the calculated weight gain was 0.6 Kg.</p> <p>8b. Review of the patient's medical record showed the patient had been admitted to the hospital on 5/2/10 for fluid overload, shortness of breath, and respiratory failure and high blood pressure..</p> <p>9. The Patient Treatment Review for Patient 14 for 14 treatments from 5/11 to 6/10/10 showed Patient 14 had an ordered EDW of 61.0 Kg. It also showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/18/10 the pre-treatment weight was 65.3 Kg. and the calculated weight gain was 3.7 Kg. * On 5/22/10 the pre-treatment weight was 63.3 Kg. and the calculated weight gain was 3.3 Kg.</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 32</p> <p>* On 6/8/10 the pre-treatment weight was 62.6 Kg. and the calculated weight gain was 3.2 Kg.</p> <p>10. Patient 17 had an ordered DFR rate of 600 mL/minute and BFR of 350 mL/minute Review of the patient's treatment sheet for 5/22/10 showed the patient had an average BFR of 277 mL/minute and a DFR of 800 mL/minute. There was no documentation on the treatment sheet to show why the ordered BFR and DFR were not achieved.</p> <p>11a. Patient 5 had ordered EDW of 105.0 Kg. Review of 14 treatments from 5/8 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/8/10 the pre-treatment weight was 108 Kg. and the calculated weight gain was 1.9 Kg. * On 5/18/10 the pre-treatment weight was 106.9 Kg. and the calculated weight gain was 6.9 Kg. * On 6/1/10 the pre-treatment weight was 109.8 Kg. and the calculated weight gain was 5.5 Kg.</p> <p>For the treatments from 5/8 to 6/3/10, Patient 5 was discharged from 0.7 Kg. to 5.0 Kg. below her EDW. From 6/5 to 6/12/10 Patient 5 was discharged from 2.5 Kg. to 9.6 Kg. over her EDW. There was no documentation provided to show the treatment sheets had been reviewed regarding her EDW.</p> <p>11b. Review of the treatment sheet for 6/8/10 showed the patient had a pre-treatment sitting BP of 201/128 and a post-treatment BP of 200/113. The pre and post-treatment assessments showed the patient had 2+ edema in her legs and generalized edema. Patient 5 was given two doses of BP medication during the treatment and</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 33</p> <p>was discharged with a BP of 200/113. There was no documentation provided to show the physician had been notified of the patient's BP during the treatment or that the patient had been discharged 9.6 Kg over their EDW of 105.0 Kg. There was no documentation of a follow-up BP being done prior to the patient leaving the facility.</p> <p>11c. Review of the treatment sheet for 6/9/10 showed the patient had a pre-treatment BP of 239/112 and a post-treatment BP of 248/112. The pre and post-treatment assessments showed the patient had edema in both legs. The recorded BP's showed the patient's BP remained greater than 200/100 for the entire treatment. The patient's treatment had been discontinued by a nurse and the post-sitting BP was also taken by a nurse. Review of the treatment sheet showed no BP medications had been given to the patient during treatment or prior to discharge. Patient 5 was discharged with a BP of 248/112. There was no documentation on the treatment sheet to show the physician had been notified of the patient's increased BP or the patient had left the facility 8.2 Kg. over their EDW of 105.0 Kg. There was no documentation of a follow-up BP being done prior to the patient leaving the facility.</p> <p>There was no documentation provided to show Patient 5's fluid gains and EDW had been assessed to determine if the patient's EDW was appropriate, and the reason for the recent increase in pre-treatment weights.</p> <p>12a. The Patient Review Report for Patient 4 showed an ordered EDW of 100.0 Kg. Review of 14 treatments from 4/29 to 6/12/10 showed the patient's post-treatment weights were from 5.3 to 10 Kg. below the patient's EDW. There was no</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 34</p> <p>documentation to show the EDW had been reviewed.</p> <p>12b. Patient 4 had a physician's order for a BFR of 390 mL/minute. Review of the treatment sheet for 6/12/10, showed the patient had an average BFR of 230 mL/minute for the treatment. There was no documentation on the treatment sheet to show why the ordered BFR was not achieved.</p> <p>Review of the care plans for Patient 4 dated 2/25/10 and 3/25/10, showed that from 1/23/10 to 3/18/10, and on 3/25/10 the patient's post-treatment weights were under his EDW of 100 Kg. The patient's plan of care for BP and fluid management showed no nursing documentation addressing the patient's BP and fluid status.</p> <p>13a. The Patient Review Report for Patient 1 for 14 treatments from 5/14 to 6/14/10 showed Patient 1 had pre-treatment systolic BP's greater than 200 for eight of the 14 treatments, and the patient's post-treatment BP's showed a systolic reading greater than 200 for 11 of the 14 treatments.</p> <p>13b. Review of the treatment sheet for Patient 1 dated 5/21/10 showed the patient had nine BP measurements done during his treatment. Seven of the BPs had a systolic reading of 211 or greater. The patient's pre-treatment BP was 211/119 and the post-treatment BP was 228/86. Review of the treatment sheet showed no BP medication had been given to the patient. There was no documentation on the treatment sheet to show that the nurse or the patient's physician had been notified of the increased BP.</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	<p>Continued From page 35</p> <p>13c. Review of the treatment sheet for 5/24/10 showed the patient had a pre-treatment sitting BP of 126/92. Thirty-one minutes after initiation of treatment the patient's systolic BP increased to 212 and remained greater than 200 for the balance of the treatment. There was no documentation to show the nurse or the patient's physician had been notified of the increased BP and no BP medications were given to the patient. The patient was discharged with a BP of 214/84.</p> <p>13d. The treatment sheet for 6/4/10 showed Patient 1 had a pre-treatment sitting BP of 253/148. The patient's systolic BP was greater than 200 during the treatment with the exception of a one hour period when it was below 200. There was no documentation to show the nurse or the patient's physician had been advised of the elevated BP. The patient was not given any BP medication during treatment and was discharged with a BP of 231/86.</p> <p>13e. Review of the nursing care plan for Patient 1 regarding his BP and fluid management, the interventions for January 2010, were to maintain the patient's BP through proper medication and diet with patient/family education. There was no documentation to show the care plan had been revised to address the patient's increased BP's.</p> <p>14. The Patient Review Report for Patient 2 showed an ordered EDW of 65.0 Kg. Review of the patient's post-treatment weights for 14 treatments, from 5/13 to 6/12/10, showed the post-treatment weights were 3.0 Kg. to 5.0 Kg. below her EDW. There was no documentation provided to show the post-weights had been reviewed with the physician for a possible adjustment in the patient's EDW</p>	V 503			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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	Continued From page 36 On 6/17/10 at 1205 hours an interview was conducted with the Medical Director. The Medical Director stated that EDW's were reviewed every month and the nurses review of the patients' EDW every dialysis is expected. The nurses were supposed to evaluate each patient. On 6/18/10 at 0900 hours, a telephone interview was conducted with RN 3. RN 3 stated that each PCT or RN manually figures the fluid removal for each patient and the fluid removal amount was manually entered into the machine. Nurses checked the fluid removal amounts for the patients and made changes if they felt it was needed. On 6/18/10 at 1055 hours, an interview was conducted with the RN instructor for the type of hemodialysis machine being used. The nurse stated that the patient's dry weight was subtracted from their pre-treatment weight and the amount of fluid to be removed needed to be manually programmed into the dialysis machine.	V 503			
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. This STANDARD is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to ensure assessment of patients' blood pressures (BP), weight gains, weight gain calculations and	V 504		8/6/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 504	Continued From page 37 estimated dry weights (EDW) were done for 13 of 20 sampled patients (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) to determine potential causes of increased BPs, patients not meeting their ordered EDWs, and weight gains not calculated to facility policy, which could have resulted in fluid overload, cardiovascular problems, hypotension and cramping. Findings: High blood pressures were not treated, assessed or reported to the patient's physician, weight gain calculations were not calculated to policy or overseen by the nurses, patients were discharged above and below their EDWs, EDWs were not assessed for appropriateness and for root causes. Cross reference V503	V 504			
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by:	V 520		8/6/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 520	Continued From page 38 Based on medical record review, staff interview and facility policy, the facility failed to reassess patients' EDWs to ensure patient's were not having volume overload or fluid depletion which could cause hypertension or hypotension for 13 of 20 sampled patients (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). Findings: Review of Patient Review Reports and treatment sheets was initiated on 6/15/10, and noted issues were discussed with the Clinical Services Specialist on 6/15 and 6/16/10 during review of electronic treatment records. Patient EDWs were not assessed on a regular basis to ensure they were appropriate for the patient and care plans were revised and updated to ensure proper interventions had been put in place for the patient to ensure safe patient care. Cross reference V503.	V 520			
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to ensure that accurate patient assessments were done to reflect and help revised care plans thereby attaining and improving individual patient goals. Findings: Patients were not being accurately assessed and care plans were not revised for 13 of 20 patients (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) regarding volume status with patients being	V 540		8/6/10	

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 540	Continued From page 39 discharged above or below their target EDW. Cross-reference V543, V503, V504. There was lack of BP monitoring as indicated by the patient's condition. Patients were being discharged with high BPs. Cross-reference V543, V503. Patients' high blood pressures (BP) were not being communicated to the nurse resulting in medications for high BP not being administered per standing protocols. Cross reference V503 The cumulative effect of these systemic failures resulted in the facility's inability to provide safe and quality care.	V 540			
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to ensure that care and services were provided to manage the volume status and to assess when the patients' EDW was not attained, to determine calculated weight gains were accurate, to check the inconsistencies between the calculated weight gains and the total fluid volume removed, and to determine the reason for not attaining the patients' EDW for 14 of 20 sampled in-center hemodialysis patients (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 17) to prevent possible hypertension, cardiovascular complications or hypotension and possible vascular access	V 543		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 40 clotting.</p> <p>Findings:</p> <p>Patient Review Reports and treatment sheet review was initiated on 6/15/10. Patient Review Reports and electronic treatment sheets were reviewed and noted issues were discussed with the Clinical Services Specialist on 6/15 and 6/16/10.</p> <p>On 6/15/10, review of the facility Procedure 1-03-08B, Fluid Removal Calculation dated 9/07, showed that to determine the patient's intradialytic fluid removal, the patient's EDW was to be subtracted from their pre-treatment weight and the total amount of fluids the patient would receive during treatment should be added to determine the total amount of fluid to be removed.</p> <p>All patients had PRN (as needed) medication orders for Clonidine 0.1 mg for a BP reading greater than 180 systolic (upper number of the BP reading) or greater than 100 diastolic (lower number of the BP reading)</p> <p>1. Patient 7 had an ordered EDW of 53.0 Kg. The Patient Treatment Report for 14 treatments from 5/14 to 6/14/10, showed the weight gains for the patient were not accurate and had not been calculated per policy. For example:</p> <p>* On 5/19/10 the patient's pre-treatment weight was 59.6 Kg. and the weight gain was calculated as 4.3 Kg. Per policy the weight gain should have been 6.6 Kg.</p> <p>* On 5/26/10 the pre-treatment weight was 59.0 Kg. and the weight gain was calculated as 2.8 Kg. Per policy the weight gain should have been 6.0 Kg.</p>	V 543			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 41</p> <p>* On 6/19/10 the pre-treatment weight was 58.9 Kg. and the weight gain was calculated as 2.5 Kg. Per policy the weight gain should have been 5.9 Kg.</p> <p>Patient 7's post-treatment weights were 2.3 to 6.6 Kg. over their EDW.</p> <p>1a. Pre-treatment standing BPs for nine of the 14 treatments showed Patient 7's BPs ranged from 207/105 to 241/96. Post-treatment standing BPs ranged from 105/61 to 208/118 on 6/14/10. The patient's pre and post-treatment assessments revealed the patient had a trace of facial edema.</p> <p>1b. Review of the treatment sheet for 6/14/10 showed Patient 7 had a pre-treatment sitting BP of 214/108 and a post-treatment standing BP of 220/109. The patient's systolic BP was greater than 200 for the first hour then decreased to 167/100. One hour and 30 minutes later, the patient's BP had increased to greater than 200 systolic and 100 diastolic and remained at that level for the last one hour and 30 minutes of the treatment. There was no documentation on the treatment sheet to show the nurse had been notified of the patient's increased BP. The patient's treatment was discontinued at 1444 hours. A BP medication was given to the patient at 1452 hours. There was no documentation to show a follow-up BP was taken before the patient was discharged to determine if the BP medication was effective.</p> <p>1c. Patient 7 had been hospitalized for chest pain and high blood pressure on 3/29/10. The patient had received two sublingual nitroglycerin tablets at dialysis and was transferred to the hospital where her presenting blood pressure was</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	Continued From page 42 250/124. 1d. Review of the patient's care plan progress notes dated 6/26/09, showed in the cardiovascular area that the patient's BP control was stable and to continue the present plan and monitor. The area for weight/fluid gain also had been marked as stable and to continue with the present plan and monitor. There was a nursing note that showed the patient had elevated BPs at the beginning of treatments, decreased BPs during treatment and occasionally needed Clonidine. The care plan had not been revised regarding the patient's recent hospitalization for the high BP, the increased BPs during treatment or evaluation of the patient's post-treatments weights above his EDW. 2. Review of the treatment records for Patient 6 showed an ordered EDW of 50.0 Kg. Review was done for 11 treatments from 5/21 to 6/14/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/24/10 the pre-treatment weight was 53.4 Kg. and the calculated weight gain was 2.4 Kg. Per policy the weight gain should have been 3.4 Kg. * For 5/31/10 the pre-treatment weight was 54.1 Kg. and the calculated weight gain was 2.8 Kg. Per policy the weight gain should have been 4.1 Kg. * On 6/9/10 the pre-treatment weight was 54.0 Kg. and the calculated weight gain was 1.7 Kg. Per policy the weight gain should have been 4.0 Kg. For 11 of the 11 treatments reviewed, Patient 6 was discharged 1.0 Kg. to 2.3 Kg. over his EDW.	V 543			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	Continued From page 43 3a. Patient 8 had an ordered EDW of 57.0 Kg. The Patient Review Report for Patient 8 for 14 treatments from 4/27 to 6/12/10, showed the weight gains for the patient were not accurate and had not been calculated per policy. For example * On 5/1/10 the pre-treatment weight was 53.3 Kg., which was 4.0 Kg. under the EDW and the calculated weight gain was 1.2 Kg. * On 5/11/10 the pre-treatment weight was 52.8 Kg., which was 4.2 Kg. under the EDW and the calculated weight gain was 1.2 Kg. Patient 8 was discharged 5.0 to 8.0 Kg below their EDW. 3b. Review of Patient 8's care plan dated 4/26/10, showed the patient previously had an EDW of 67.0 Kg, but it had been decreased to 57.0 Kg on 3/30/10. The care plan showed the patient's post-treatment weights had been below the 57.0 Kg EDW from 3/30 to 4/24/10. The Plan of Care showed documentation dated 4/16/10, that the patient's average weight gain was acceptable, but no documentation was provided to show the difference between the patient's EDW decreased and post-treatment weights had been assessed. 4a. The Patient Review Report for Patient 9 showed that on 5/17/10 the patient had an ordered EDW of 90.5 Kg. On 5/19/10, the EDW was decreased to 85.0 Kg. Review of the patient's pre-treatment weights for 13 treatments from 5/19 to 6/14/10, showed the patient's pre-treatment weights were 1.5 Kg. to 5.4 Kg. lower than the EDW. There was no documentation provided to show the patient's EDW had been evaluated to determine if it met the patient's needs.	V 543			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 44</p> <p>5a. Patient 10 had a physician's order for an EDW of 71.5 Kg. The Patient Review Report for 14 treatments from 4/30 to 6/14/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/7/10 the pre-treatment weight was 73.5 Kg and the calculated weight gain was 1.8 Kg. * On 5/14/10 the pre-treatment weight was 73.5 Kg. and the calculated weight gain was 0.9 Kg. * On 5/28/10 the pre-treatment weight was 70.2 Kg. and the calculated weight gain was -2.3 Kg.</p> <p>5b. On 6/11/10, Patient 10's pre-treatment weight was 75.8 Kg which was 4.3 Kg. over his EDW. The patient had a pre-treatment sitting BP of 212/82. Review of the treatment sheet for 6/11/10 showed the patient only ran 130 minutes of his ordered 180 minute treatment. The treatment was stopped because the patient had an infiltration of the venous portion of this dialysis access.</p> <p>The patient's BP on initiation of treatment was 159/75 but nine minutes later had increased to 212/82. The patient's systolic BP was greater than 200 for the remainder of the treatment. The pre-treatment assessment showed Patient 10 had slight wheezing in the right lung apex and the post assessment showed diminished lung sounds at the bases. There was no documentation to show the nurse had been notified of the patient's increased BP during treatment. The patient received no medication for the increased BP.</p> <p>The treatment sheet showed Patient 10's treatment was started at 1053 hours. At 1242 hours, when the treatment was stopped, the fluid removed was 0.9 Kg. The patient was</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 45</p> <p>discharged at the same weight as his pre-treatment weight of 75.8 Kg., 4.3 Kg. over his EDW of 71.5 Kg. Patient 10 was discharged with a BP of 200/66. There was no documentation to show the physician had been notified of the patient's increased pre-treatment weight, that no fluid had been removed during the treatment and the patient had an increased BP during treatment.</p> <p>5c. On 6/14/10, Patient 10's pre-treatment weight was 77.8 Kg. which was 2.0 Kg. over his discharge weight on 6/11, and 6.3 Kg. over his EDW of 71.5 Kg. The weight gain figured for the treatment was 2.0 Kg., and 1.8 Kg. was removed during treatment. The patient was discharged 4.5 Kg. over his EDW. The pre and post assessments showed the patient had diminished lung sounds at the bases and a trace of edema on his ankles. There was no documentation provided to show the patient's physician had been notified of the post-treatment weight or the post-treatment weight had been assessed.</p> <p>6a. Patient 11 had an ordered EDW of 62.0 Kg. The pre-treatment weights and calculated weight gains for 14 patient treatments from 5/13 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/12/10 the pre-treatment weight was 65.0 Kg. and the calculated weight gain was 0.4 Kg. * On 5/25/10 the pre-treatment weight was 64.9 Kg. and the calculated weight gain was 0.4 Kg. * On 6/30/10 the pre-treatment weight was 65.3 Kg. and the calculated weight gain was 0.4 Kg.</p> <p>Patient 11 had not achieved their EDW for the 14 treatments reviewed and was discharged 1.2 Kg. to 3.2 Kg. over his EDW. No documentation was</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 46</p> <p>provided to show that the patient's post-treatments weights had been reviewed.</p> <p>6b. Review of Patient 11's treatment sheets for 5/13, 5/15, 5/18, 5/20, 6/5, 6/12 and 6/18/10, showed the patient had been assessed for edema in his legs pre and post-treatment. On 5/20, 5/25, 5/27, 5/29, 6/1 and 6/12/10 the patient had a pre-treatment sitting BP greater than 200 systolic.</p> <p>7a. Patient 12 had ordered EDW of 69.0 Kg. The Patient Treatment Review for 14 treatments from 5/13/10 to 6/12/10 showed the patient's post weights were 0.5 Kg. to 5.0 Kg. below the ordered EDW. There was no documentation to show the decreased post-treatment weights had been reviewed.</p> <p>7b. On 6/10/10 Patient 12's pre-treatment weight was 96.6 Kg. and the calculated weight gain was 28.3 Kg. There was no documentation to show the weight and the calculated weight gain for 6/10/10 were reassessed for accuracy.</p> <p>7c. The patient had an order for a DFR of 600 mL/minute. Review of the treatment sheet dated 6/10/10, showed the patient had a DFR rate of 800 mL/minute for the treatment.</p> <p>8a. Patient 13 had an ordered EDW of 46.0 Kg. The Patient Treatment Review for the last 14 treatments showed the patient had post-treatment weights of 0.9 Kg. to 2.4 Kg. over her EDW. Review of the treatment sheets for 5/21 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/24/10 the pre-treatment weight was 48.6</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 47</p> <p>Kg. and the calculated weight gain was 1.6 Kg. * On 5/23/10 the pre-treatment weight was 49.4 Kg. and the calculated weight gain was 1.0 Kg. * On 6/12/10 the pre-treatment weight was 48.4 Kg. and the calculated weight gain was 0.6 Kg.</p> <p>8b. Review of the patient's medical record showed the patient had been admitted to the hospital on 5/2/10 for fluid overload, shortness of breath, and respiratory failure and high blood pressure..</p> <p>9. The Patient Treatment Review for Patient 14 for 14 treatments from 5/11 to 6/10 showed Patient 14 had an ordered EDW of 61.0 Kg. It also showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/18/10 the pre-treatment weight was 65.3 Kg. and the calculated weight gain was 3.7 Kg. * On 5/22/10 the pre-treatment weight was 63.3 Kg. and the calculated weight gain was 3.3 Kg. * On 6/8/10 the pre-treatment weight was 62.6 Kg. and the calculated weight gain was 3.2 Kg.</p> <p>10. Patient 5 had ordered EDW of 105.0 Kg. Review of 14 treatments from 5/8 to 6/12/10 showed the weight gains for the patient were not accurate and had not been calculated per policy. For example: * On 5/8/10 the pre-treatment weight was 108 Kg. and the calculated weight gain was 1.9 Kg. * On 5/18/10 the pre-treatment weight was 106.9 Kg. and the calculated weight gain was 6.9 Kg. * On 6/1/10 the pre-treatment weight was 109.8 Kg. and the calculated weight gain was 5.5 Kg.</p> <p>For the treatments from 5/8 to 6/3/10, Patient 5 was discharged from 0.7 Kg. to 5.0 Kg. below her</p>	V 543			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 48</p> <p>EDW. From 6/5 to 6/12/10 Patient 5 was discharged from 2.5 Kg. to 9.6 Kg. over her EDW. There was no documentation provided to show the treatment sheets had been reviewed regarding her EDW.</p> <p>10. Review of the treatment sheet for 6/8 showed the patient had a pre-treatment sitting BP of 201/128 and a post-treatment BP of 200/113. The pre and post-treatment assessments showed the patient had 2+ edema in her legs and generalized edema. Patient 5 was given two doses of BP medication during the treatment and was discharged with a BP of 200/113. There was no documentation provided to show the physician had been notified of the patient's BP during the treatment or that the patient had been discharged 9.6 Kg over their EDW of 105.0 Kg. There was no documentation of a follow-up BP being done prior to the patient leaving the facility.</p> <p>10. Review of the treatment sheet for 6/9 showed the patient had a pre-treatment BP of 239/112 and a post-treatment BP of 248/112. The pre and post-treatment assessments showed the patient had edema in both legs. The recorded BP's showed the patient's BP remained greater than 200/100 for the entire treatment. The patient's treatment had been discontinued by a nurse and the post-sitting BP was also taken by a nurse. Review of the treatment sheet showed no BP medications had been given to the patient during treatment or prior to discharge. Patient 5 was discharged with a BP of 248/112. There was no documentation on the treatment sheet to show the physician had been notified of the patient's increased BP or the patient had left the facility 8.2 Kg. over their EDW of 105.0 Kg. There was no documentation of a follow-up BP being done prior</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 49 to the patient leaving the facility.</p> <p>There was no documentation provided to show Patient 5's fluid gains and EDW had been assessed to determine if the patient's EDW was appropriate, and the reason for the recent increase in pre-treatment weights.</p> <p>11a. The Patient Review Report for Patient 4 showed an ordered EDW of 100.0 Kg. Review of 14 treatments from 4/29 to 6/12/10 showed the patient's post-treatment weights were from 5.3 to 10 Kg. below the patient's EDW. There was no documentation to show the EDW had been reviewed.</p> <p>11b. Review of the care plans for Patient 4 dated 2/25/10 and 3/25/10, showed that from 1/23/10 to 3/18/10, and on 3/25/10 the patient's post-treatment weights were under his EDW of 100 Kg. The patient's plan of care for BP and fluid management showed no nursing documentation addressing the patient's BP and fluid status.</p> <p>12a. The Patient Review Report for Patient 1 for 14 treatments from 5/14 to 6/14/10 showed Patient 1 had pre-treatment systolic BP's greater than 200 for eight of the 14 treatments, and the patient's post-treatment BP's showed a systolic reading greater than 200 for 11 of the 14 treatments.</p> <p>12b. Review of the treatment sheet for Patient 1 dated 5/21/10 showed the patient had nine BP measurements done during his treatment. Seven of the BPs had a systolic reading of 211 or greater. The patient's pre-treatment BP was 211/119 and the post-treatment BP was 228/86.</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	<p>Continued From page 50</p> <p>Review of the treatment sheet showed no BP medication had been given to the patient. There was no documentation on the treatment sheet to show that the nurse or the patient's physician had been notified of the increased BP.</p> <p>12c. Review of the treatment sheet for 5/24/10 showed the patient had a pre-treatment sitting BP of 126/92. Thirty-one minutes after initiation of treatment the patient's systolic BP increased to 212 and remained greater than 200 for the balance of the treatment. There was no documentation to show the nurse or the patient's physician had been notified of the increased BP and no BP medications were given to the patient. The patient was discharged with a BP of 214/84.</p> <p>12d. The treatment sheet for 6/4/10 showed Patient 1 had a pre-treatment sitting BP of 253/148. The patient's systolic BP was greater than 200 during the treatment with the exception of a one hour period when it was below 200. There was no documentation to show the nurse or the patient's physician had been advised of the elevated BP. The patient was not given any BP medication during treatment and was discharged with a BP of 231/86.</p> <p>12e. Review of the nursing care plan for Patient 1 regarding his BP and fluid management, the interventions for January 2010, were to maintain the patient's BP through proper medication and diet with patient/family education. There was no documentation to show the care plan had been revised to address the patient's increased BP's.</p> <p>13. The Patient Review Report for Patient 2 showed an ordered EDW of 65.0 Kg. Review of the patient's post-treatment weights for 14</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 543	Continued From page 51 treatments, from 5/13 to 6/12/10, showed the post-treatment weights were 3.0 Kg. to 5.0 Kg. below her EDW. There was no documentation provided to show the post-weights had been reviewed with the physician for a possible adjustment in the patient's EDW On 6/17/10 at 1205 hours an interview was conducted with the Medical Director. The Medical Director stated that EDW's were reviewed every month and the nurses review of the patients' EDW every dialysis is expected. The nurses were supposed to evaluate each patient. On 6/18/10 at 0900 hours, a telephone interview was conducted with RN 3. RN 3 stated that each PCT or RN manually figures the fluid removal for each patient and the fluid removal amount was manually entered into the machine. Nurses checked the fluid removal amounts for the patients and made changes if they felt it was needed. On 6/18/10 at 1055 hours, an interview was conducted with the RN instructor for the type of hemodialysis machine being used. The nurse stated that the patient's dry weight was subtracted from their pre-treatment weight and the amount of fluid to be removed needed to be manually programmed into the dialysis machine.	V 543			
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Based on observation, record review of 20 sampled patients, facility's P&P, and staff interview, the facility failed to demonstrate an effective QAPI program by failing to recognize	V 625		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 625	<p>Continued From page 52 and take actions in addressing the following problems.</p> <p>Findings:</p> <p>P&P regarding calculations of patient weight gain were not adhered to. Patient post-treatment weights and target EDWs were not assessed and evaluated against treatments' efficacy leading to patient care plans not being revised. Cross-reference V503, V504, V543, V712, V715.</p> <p>Patients' high blood pressures (BP) were not being recognized and addressed per standing protocols. There was lack of BP monitoring as indicated by the patient's condition. Patients were being discharged with high BPs. Cross-reference V543, V503, V504, V712.</p> <p>Adherence by the staff to the approved P&P on infection control as evidenced by not using aseptic techniques during dressing changes for central venous catheters, and not changing gloves from dirty to clean areas per P&P. Cross-reference V113</p> <p>Lack of staffs' training and education as manifested by their infection control practices with regard to dialysis machines not fully disinfected between patients or shift changes, observance of isolation techniques and PPE removal practices. Cross-reference V113, V122, V130</p> <p>Medications were not prepared with aseptic techniques per P&P. Cross-reference V143, V117.</p> <p>The cumulative effect of these systemic failures resulted in the facility's inability to provide safe</p>	V 625			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 625	Continued From page 53 and quality care.	V 625			
V 681	<p>494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY</p> <p>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 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 staff interview and document review, the facility failed to ensure one registered nurse complete the required competency test after being rehired.</p> <p>Findings:</p> <p>On 6/16/10, review of RN 1's personnel file showed the date of hire was 12/28/09. Further review of the personnel file showed RN 1 had not completed the required competency test.</p> <p>On 6/16/10 at 1610 hours, RN 1's incomplete competencies test was shown to the Clinical Services Specialist (CSS). The CSS reviewed the personnel file and could not show RN 1's completed competency test.</p> <p>On 6/17/10 at 0816 hours, during an interview with the Facility Administrator, she stated RN 1 should have completed the competency test after</p>	V 681		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 681	Continued From page 54	V 681			
V 710	<p>being rehired. She would ask the RN to take the competency test on the same day.</p> <p>494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR</p> <p>This CONDITION is not met as evidenced by: Based on record review and staff interview, the Medical Director failed to execute his full and complete oversight related to patient health outcomes and monitoring/evaluating these data on a continual basis to improve performance.</p> <p>Findings:</p> <p>Patient weight gain calculations were not according to policy. Patient post-treatment weights and patients' target EDWs were not assessed and evaluated against treatments' efficacy. Cross-reference V503, V543, V712, V715.</p> <p>Non-adherence by the staff to the approved infection control P&P as evidenced by dressing changes for central venous catheters, positioning of patients for treatment initiation and changing of gloves from dirty to clean areas per P&P. Cross-reference V113</p> <p>Lack of staffs' training and education manifested in their infection control practices such as dialysis machines not fully disinfected between patients, isolation techniques and when to change/remove PPE. Cross-reference V113, V122, V130</p> <p>Medications were not prepared using aseptic techniques per P&P. Cross-reference V143, V117</p>	V 710		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 710	Continued From page 55 The cumulative effect of these deficient practices resulted in the facility's inability to provide safe and quality patient care.	V 710			
V 712	494.150(a) MD RESP-QAPI PROGRAM Medical director responsibilities include, but are not limited to, the following: (a) Quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on record review and staff interview, the Medical Director failed to execute his full and complete oversight related to patient health outcomes and monitoring/evaluating these data on a continual basis to improve performance. Findings: On 6/16/10 review of the facility's Medical Director qualifications and responsibilities stated the Medical Director was accountable to the governing body for the delivery of patient care and outcomes in the facility. The Medical Director responsibilities include, but are not limited to: QAPI, staff education, training and performance, participation in the development, review and approval of patient care P&P, ensuring these P&P were adhered to by all individuals who treat patients in the facility (including attending physicians and non-physician providers), and overseeing the clinical operations of all modalities at the facility, including the activities of all other associate Medical Directors. On 6/15/10, review of the facility Procedure 1-03-08B, Fluid Removal Calculation dated 9/07, showed that to determine the patient's intradialytic	V 712		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 712	<p>Continued From page 56</p> <p>fluid removal, the patient's EDW was to be subtracted from pre-treatment weight. The difference should be added to the amount of fluid intake the patient would receive during treatment to determine the total amount of fluid to be removed.</p> <p>Review of 14 out of 20 sampled patients records (Patients 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 17) revealed the prescribed blood flow rates (BFR) and dialysate flow rates (DFR) were not being followed. The patients' estimated dry weights (EDW), and weight gains were not being calculated accurately. In addition, high blood pressures were not addressed and treated per standing protocol. These outcomes were found not evaluated to determine if the patients' needs/goals were met as evidenced by the following:</p> <ol style="list-style-type: none"> 1. Patient 7's post-treatment weights were 2.3 to 6.6 Kg. over their EDW from 5/14/10-6/14/10. The weight gains were not calculated per policy. 2. Patient 6 was discharged 1.0 Kg. to 2.3 Kg. over his EDW from 5/21/10-6/11/10. The calculated weight gains were not to policy. 3. Patient 8 was discharged 5.0 to 8.0 Kg below their EDW from 4/17/10-6/12/10. 4. Patient 9's BFR was ordered by the physician to be at 250 mL per minute and a DFR at 600 mL per minute. The patient's treatment sheet dated 6/1/10, showed Patient 9 had an average BFR of 340 mL per minute and a DFR of 800 mL per minute. There was no documented order to increase BFR and/or DFR. 	V 712			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 712	<p>Continued From page 57</p> <p>5. Patient 10 had a physician order for a BFR of 400 mL per minute and a DFR of 800 mL/minute. Review of the treatment sheet for 6/14/10 showed the patient had an average BFR of 236 mL per minute. There was no documentation on the treatment sheet to show why the BFR had been decreased during the treatment.</p> <p>6. Patient 11's target EDW was not achieved for the 14 treatments reviewed and was discharged 1.2 Kg. to 3.2 Kg. over his EDW. No documentation was provided to show that the patient's treatments had been reviewed with regard to the post-treatment weights. In addition Patient 11 had an ordered BFR of 400 mL/minute and a DFR of 800 mL/minute. Review of the patient's treatment sheets showed the average BFR from 5/13/10 to 6/12/10 was 307 to 357 mL/minute, and on 6/15/10 the DFR rate was 600 mL/minute. There was no documentation on the treatment sheets to show why the BFR and DFR rates were not according to the physician's order.</p> <p>7. Patient 13 had a prescribed EDW of 46.0 Kg. Review of the patient's 14 treatments from 5/21/10-6/12/10 showed the patient had post-treatment weights of 0.9 Kg. to 2.4 Kg. over target EDW.</p> <p>8. Patient 17 had a prescribed DFR rate of 600 mL/minute and BFR of 350 mL/minute. Review of the patient's treatment sheet for 5/22/10 showed the patient had an average BFR of 277 mL/minute and a DFR of 800 mL/minute. There was no documented rationale as to why the prescribed BFR and DFR were changed and if the physician or the nurse was notified regarding the change.</p>	V 712			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 712	Continued From page 58 9. On 6/12/10, Patient 4 was discharged below her prescribed EDW of 100 Kg. 10. On 6/12/10, Patient 2 was discharged below EDW of 65 Kg. 11. The treatment sheet for 6/4/10 showed Patient 1 had a pre-treatment sitting BP of 253/148. The patient's systolic BP was greater than 200 during the treatment with the exception of an hour period when it was below 200. There was no documentation to show the nurse had been advised of the elevated BP. The patient was not given any medication during treatment per standing protocol for high BP. Patient 1 was discharged with a BP of 231/86. On 6/17/10 at 1205 hours, the Medical Director was interviewed. He was aware of his responsibilities and verbalized the facility's procedures on data collection towards the achievement of their goals. However, when the above findings were shared, he acknowledged that other patients' EDW were overlooked because of his professional courtesy towards other nephrologists having difficulty on managing/directing them on achieving target patient goals.	V 712			
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P 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;	V 715		10/2/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 715	Continued From page 59 This STANDARD is not met as evidenced by: Based on record review, staff interview and document review, the facility failed to ensure that P&Ps relative to accurate calculations of fluid removal, infection control and safety practices were being adhered to by all individuals who treat patients in the facility. Findings: 1. Changing of gloves were not done per policy when changing dressings of dialysis catheter sites. Disinfection of dialysis machines and other items at dialysis stations were not done per policy. PPE used in isolation room was not changed and blood samples from the isolation room were properly handled per policy. PPE being worn on non-treatment area. Cross reference V113, V116, V122 V130 2. Medications not drawn using aseptic techniques, medication vials not labeled or stored per policy. Cross reference V143, V117 3. Patient dialysis access sites not kept in view of staff at all times. Cross-reference V407 4. Calibration of the conductivity meters not to policy. Cross-reference V403 4. Review of treatment sheets showed that fluid removal goals had not been calculated per policy, patient treatments were not being reviewed to ensure patients' goals were achieved, and high blood pressures were being addressed. The lack of assessment contributed to care plans not being revised to address these issues. Cross-reference V503	V 715			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 726	<p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, 2 of 20 medical records reviewed (Patients 19 and 20) were found not complete and accurate. The medical records did not clearly portray the patient and the care provided by the facility staff.</p> <p>Findings:</p> <p>1. On 6/16/10, Patient 19's medical record was reviewed. The patient had an unexpected hospitalization after in center hemodialysis treatment on 9/30/09. Per patient's documented history and physical examination, Patient 19 had kidney transplant at two different times from deceased donors but the transplant allograft failed twice, both secondary to acute cellulitis (inflammation of connective tissues) and antibody rejection. Patient 19's last dialysis treatment was recorded on 10/26/09. Patient 19 expired at the hospital on 10/29/09.</p> <p>Review of the facility's ESRD Death Notification form showed it was completed and signed by a physician on 11/27/09. The patient's state of residence was documented as "home." Questions on no. 15 asked if the deceased patient ever received a transplant. It was marked "unknown" and the date of transplant surgery was left blank</p>	V 726		8/6/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 726	<p>Continued From page 61</p> <p>by the physician. On the type of transplant received, whether living related or deceased donor, it was documented by the physician as "unknown." On the question whether the graft was functioning at time of death, the physician's response was "unknown." On the last question whether the patient resumed chronic maintenance dialysis prior to death, the physician's response was also "unknown."</p> <p>On 6/16/10 at 1400 hours, the inaccurate documentation was presented to the Facility Administrator who acknowledged that chart audits should be done more frequently to assure more accuracy in patients' medical records.</p> <p>2. Review of Patient 20's medical records on 6/16/10 revealed that the patient had a clotted dialysis access 19 minutes after the hemodialysis treatment was initiated. The treatment sheet documentation showed heparin 2000 units was not given intravenously when the treatment was initiated on 5/10/10 at 1256 hours. Moreover, review of the post treatment sheet showed that Patient 20's treatment lasted till 1457 hours, approximate total of two hours instead of 19 minutes as reported. Review of the physician's progress notes and the nurses' notes failed to reveal the reasons why the standard protocol was not done and why the treatment lasted two hours if the access was clotted.</p> <p>On 6/16/10 at 1130 hours, the post treatment sheet was shown to the Facility Administrator asking her why the heparin was not administered intravenously when the treatment was initiated. RN 3 was summoned to explain but was unable to show and/or remember why. Computer charting was retrieved at the nurse station. It</p>	V 726			

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: 552518	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER COSTA MESA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1590 SCENIC AVENUE COSTA MESA, CA 92626		
(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 726	Continued From page 62 showed additional documentation describing staff's difficulty to insert the second needle due to multiple clots and how the facility dealt with the insurance company. The rationale why heparin was not administered and the treatment time discrepancy lasting two hours were not documented.	V 726			