

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

PRINTED: 10/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052546	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2009
NAME OF PROVIDER OR SUPPLIER DALY CITY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1498 SOUTHGATE AVE DALY CITY, CA 94015	
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V 000	INITIAL COMMENTS Surveyor: 22301 The following reflects the findings of the California Department of Public Health during the investigation of three complaints. Complaint numbers: CA00175767, CA00155329 and CA00166031. Representing the Department: Lutgarda F. Sturms, HFEN. The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint CA00155329(See V0117). One deficiency was issued for complaint CA00175767 (See V0348). One deficiency was issued for complaint CA00166031 (See V0766)	V 000		
V 117	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare	V 117		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 117	<p>Continued From page 1</p> <p>individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and record review, the facility failed to separate the clean area designated for the preparation, storage and handling of medications from potentially contaminated area. This failure increased the risk of cross contamination.</p> <p>Findings:</p> <p>During a facility tour on 3/19/09 at approximately 9 a.m., in the presence of the charge nurse, observation of the medication room, located in a hallway across the Reuse room and away from the treatment room, showed the following: The entire room was not more than approximately 14 feet wide and 11 feet long. On the right side, there was a counter designated for the medication preparation and handling. At the far end of the counter there was a refrigerator for medication storage. On the left side of the room there was a counter designated for laboratory use (handling of blood specimens) and on top of the counter there was a centrifuge. (A centrifuge is a laboratory equipment used to separate the blood sediment from the plasma, the liquid part of the blood. This machine rotates very fast and even if the tubes with blood are covered, there is still the</p>	V 117			

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V 117	Continued From page 2 possibility of breakage and splatter.) In the left corner, at the end of the counter there was a refrigerator for storage of blood samples, labeled " Biohazard " . There were only 5 feet between the refrigerator for medication storage and the refrigerator for blood samples. The charge nurse stated that the medication area and the blood sample storage area had been there for as long as she can remember. A review of the facility policy titled " Medical Policy " revealed on page 2, under number 15, "An aseptic environment and aseptic technique is used when preparing medications." Webster's dictionary defines aseptic " free from or keeping away disease producing or putrefying microorganism."	V 117			
V 348	494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE 12.2 Verification of patient identification: 2 people Except in the case of home dialysis, two persons should check that the first and last names on the dialyzer and any other appropriate identifying information correspond to the identifying information on the patient's permanent record. If possible, one of the persons checking identification should be the patient. Completion of this step shall be recorded, along with the signature or other unique means of identifying the person verifying patient identification. NOTE-This step may be done later in the procedure but shall precede initiation of dialysis. This STANDARD is not met as evidenced by: Surveyor: 22301	V 348			

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V 348	<p>Continued From page 3</p> <p>Based on observation, interview, and record review, the facility failed to ensure, in accordance with the facility policy, that two persons checked that the first and last names on the dialyzer corresponded to the patient ' s information on the permanent record, for one (Patient P) of one patients reviewed. This failure resulted in Patient P receiving treatment with another patient ' s dialyzer and being placed at risk of exposure to blood borne infections.</p> <p>Findings:</p> <p>The facility policy and procedure for Reuse, reviewed during an unannounced visit to the facility on 3/19/09, stated, "6. Prior to initiation of dialysis treatment, verify that the identity of the patient matches the label on the reuse dialyzer. Two teammates (staff members) will confirm and document the identity of the patient and the dialyzer on the electronic medical record. The patient may also initial as the third verifier." The policy further stated, "8. The dialyzer should be checked to ensure: It is the correct dialyzer for the correct patient."</p> <p>Patient P's treatment electronic flowsheet, dated 1/13/09, indicated that Patient Care Technician (PCT) 1 and PCT 2 both have electronically signed the flowsheet under " Dialyzer Checked " .</p> <p>During an interview on 3/19/09, the Facility Administrator (FA) stated that the nurse on duty on 1/13/09 noticed while doing the assessment rounds, that Patient P was receiving treatment with Patient H ' s dialyzer. The treatment was stopped immediately. PCT 1 had admitted setting up the machine for Patient H, who did not show up being in the hospital, and placing Patient P in</p>	V 348			

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V 348	Continued From page 4 Patient H ' s chair. Furthermore, the FA stated that PCT 2, who was to do the 2nd check, was busy and PCT 1 did not wait for him to check the dialyzer. PCT 1 went ahead and started the treatment. According to FA, the patients were also to be involved in the dialyzer check but could not sign in the computer. " It was really negligence on the technician ' s part! " FA stated during the interview. A review of the patient schedule for 1/13/09 indicated that Patient P was assigned to station 11 and Patient H was assigned to station 12. The treatment flowsheet indicated that Patient P received his treatment at station 12. Patient P was interviewed on 3/19/09 at approximately 2:40 p.m. He expressed his worry and stress related to the incident of receiving treatment with some other patient ' s dialyzer. He said that usually he checked his name on the dialyzer ' s label but that day he just got out of the hospital and was not feeling well. He could not remember whether he checked his name or not. Patient P said, "I could not sleep at night thinking about this."	V 348			
V 766	494.180(f) INVOL DISCHARGE/TRANSFER POLICY/PROCEDURE The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless - (1) The patient or payer no longer reimburses the facility for the ordered services; (2) The facility ceases to operate; (3) The transfer is necessary for the patient's	V 766			

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V 766	<p>Continued From page 5</p> <p>welfare because the facility can no longer meet the patient's documented medical needs;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to follow the policy and procedure for involuntary discharge for one (Pateint R) of one patients reviewed when the patient made, in the presence of other patients, threats to kill a staff member. This failure placed patients and staff at risk for harm.</p> <p>Findings:</p> <p>On 3/19/09, record review showed that Patient R was admitted to the facility on 2/27/08. Upon admission, the patient was made aware of the " Patient Rights ", the " Patient Responsibilities " and the " Patient Standard of Conduct " and, by signing, he had agreed " to abide by these standards at all times while registered as a patient with this facility ". Patient R was expected to " treat other patients and staff members with mutual respect ", to " not endanger other by their actions ", to " not threaten any staff or other patients in the unit with violence, " and to " not bring any weapons or any device that would reasonably be interpreted to be a weapon into the facility. "</p> <p>Review of the social worker ' s (SW) documentation showed that Patient R experienced ongoing psychosocial issues and had difficulty adjusting to the dialysis treatments. The note dated 8/5/08 showed that Pateint R yelled threats at the staff and used abusive</p>	V 766			

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V 766	<p>Continued From page 6</p> <p>language. On 8/26/8, the SW documented that the patient was counseled and was given a letter of concern due to his outbursts in the unit. The letter stated "You shall not threaten any patient or staff member of the dialysis unit with violence. You understand that if you commit any act of violence in the unit, you will be required to seek treatment at another dialysis center." On 10/8/08 SW noted that Pateint R called and was shouting and cursing on the phone, then the patient " showed up in the unit for his treatment demanding that he wants to be moved to 1st shift starting next week. Once again, pt (patient) started shouting and cursing in front of other pts., visitors and staff. "</p> <p>During an interview on 3/19/09, the facility administrator (FA) stated that Patient R had numerous outbursts before the October 8 incident. Patient R threatened staff by saying, "I'll shoot you all, I don't care if we all go to jail! I've been there before and I can handle it." The FA also said that the patient cussed, yelled and made the staff and the other patients feel bad. She said that Patient R had mentioned gang affiliation to threaten staff and on one occasion the staff witnessed Patient R having a knife while in the facility.</p> <p>Further record review showed that on 10/8/08, the Registered Nurse asked the SW to intervene and calm the patient. The MD also talked to the patient on the phone. Patient R was given full treatment, despite his threatening and abusive behavior. There was no documented evidence that Patient R was given an involuntary discharge notice.</p> <p>The facility policy and procedure for involuntary</p>	V 766			

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V 766	Continued From page 7 discharge, reviewed on 3/19/08, instructed the staff, " If a patient makes a direct or indirect threat to a teammate or another patient then we will move to immediately discharge the patient from the facility. Some examples of a direct threat are: "I am going to kill you." ...The facility may be required to notify the proper law enforcement agencies if the situation escalates and immediate harm is imminent." It was on 10/10/08 that the facility gave Patient R the involuntary discharge notice. The notice/letter read, " On October 8, 2008, you stated to a teammate (staff) " I ' ll shoot you all " . According to the facility's policy and procedure this was considered a direct threat and the patient should have been immediately discharged from the facility and the law enforcement should have been notified.	V 766			