

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

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052674	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2010
NAME OF PROVIDER OR SUPPLIER DELANO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 905 MAIN STREET DELANO, CA 93215	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS The following reflects the findings by the California Department of Public Health during a Recertification survey. Representing the Department: Carol Erickson, HFES Jean Chiang, HFES Janet Parmelee, HFEN The census was 95 hemodialysis patients and the sample size was 10 hemodialysis patients.	V 000		
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Follow accepted nursing guidelines for assessment after hemodialysis treatments for four of 12 sampled patients (1, 4, 5, and 7) which had the potential for increased complications from hemodialysis. 2. Follow physician orders for low or elevated blood pressures before, during, and after hemodialysis treatments for seven of 12 sampled residents (1, 2, 3, 4, 6, 7, and 8). This failure caused patients to suffer complications from hemodialysis and prevented optimal outcomes.	V 101		11/1/10

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

TITLE

(X6) DATE

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

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V 101	Continued From page 1 3. Discard out-dated medication on the emergency cart which had the potential for adverse side effects to a universe of 95 patients. Findings: 1. During a record review on August 11, 2010, Patient 1's hemodialysis flowsheet dated July 30, 2010 indicated no post treatment assessment had been performed by a Registered Nurse (RN). During a record review on August 12, 2010, Patient 7's hemodialysis flowsheet dated July 27, 2010 indicated no post treatment assessment had been performed by an RN. During a record review on August 12, 2010, Patient 5's hemodialysis flowsheet dated July 27, 2010 indicated no post treatment assessment had been performed by an RN. During a record review on August 16, 2010, Patient 4's hemodialysis flowsheet dated July 31, 2010 indicated no post treatment assessment was charted by the RN. Nephrology Nursing Standards of Practice and Guidelines for Care by the American Nephrology Nurse's Associate dated 2005 indicate the nurse will "Assess the patient predialysis, during treatment, and after treatment" and"Notify the physician or advanced practice nurse of any assessment findings that might require modification of the hemodialysis prescription." 2. Patients 1, 2, 3, 4, 6, 7, and 8 had episodes of blood pressures outside of the normal range (120/80) and physician standing orders were not	V 101			

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V 101	<p>Continued From page 2 followed as indicated:</p> <p>a. The clinical record for Patient 1 was reviewed on August 11, 2010 and the hemodialysis flowsheets indicated on July 30, 2010, Patient 1's BP (blood pressure) was 97/64 at 11:43 AM (no interventions) and no repeat BP until 12:45 (1 hour later). Also, this record indicated no post treatment assessment had been performed by an RN.</p> <p>On August 16, 2010 at 11:50 AM, the clinical record for Patient 1 was reviewed with CC 1 and she verified the low BPs were not followed by another BP reading within 15 minutes. She also stated the patient's BP should be taken every 30 minutes during dialysis treatment and every 15 minutes if there was a doctor's order and the patient's pressure was low. She also stated a post treatment assessment should always be completed and charted.</p> <p>On August 4, 2010, Patient 1's BP was 71/45 at 11:39 AM and next BP of 95/62 was at 1:09 PM, (90 minutes later).</p> <p>b. During a record review on August 11, 2010, Patient 3's medical record contained physician standing orders dated November 12, 2009 which read "Hypotension (low blood pressure) -Decrease/Discontinue UFR (ultrafiltration rate), position patient in Trendelenburg (lay patient straight back with head below level of feet), and give 200 ml (milliliters) of NSS (normal saline solution), monitor bp (blood pressure) every 15 minutes, when bp stabilizes, gradually increase UFR." and "Hypertension (high blood pressure): Clonidine (a blood pressure lowering medication) 0.1 mg (milligram) po (by mouth) and may repeat</p>	V 101			

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V 101	<p>Continued From page 3 x1 if bp still uncontrolled. . . ."</p> <p>On July 29, 2010, a BP of 98/58 at 3:05 PM (no interventions performed) and the next BP was taken at 4:41 PM (one and one half hours later).</p> <p>On August 3, 2010, a BP of 107/30 at 3:11 PM(no interventions performed) and the next BP was taken at 4:18 PM(over one hour later).</p> <p>On August 5, 2010, a BP of 170/70 at 4:32 PM and the next BP of 183/92 was 5:21 PM (50 minutes later) and no interventions performed.</p> <p>c. During a record review on August 11, 2010, Patient 6's hemodialysis flowsheets indicated: On July 26, 2010, BP was 91/60 at 5:08 PM, the RN was notified and the fluid removal rate was decreased; however, no repeat BP was documented until 6:22 PM (over one hour later) when he had a BP of 96/57.</p> <p>d. During a record review on August 12, 2010, Patient 7's hemodialysis flowsheets indicated: On August 3, 2010 a BP at 2:06 PM of 174/77 and the next BP of 168/78 was over one hour later at 3:12 PM with no interventions performed.</p> <p>e. The clinical record for Patient 4 was reviewed on August 16, 2010. The Standing Orders dated November 12, 2009 read "Hypotension: Decrease/discontinue UFR, position patient in Trendelenburg, and give 200 ml NSS, monitor BP every 15 minutes, when BP stabilizes, gradually increase UFR."</p> <p>Patient 4's hemodialysis flowsheets indicated: On July 29, 2010, the BP taken at 12 PM was</p>	V 101			

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V 101	<p>Continued From page 4</p> <p>93/54 (no interventions or RN assessment performed) and the next BP of 102/54 was 39 minutes later at 12:39 AM.</p> <p>On July 31, 2010, BP at 11:34 was 96/69, and at 11:58 AM (24 minutes later) the BP was 94/69. No intervention was performed.</p> <p>On August 5, 2010, BP at 1:35 PM was 81/44. Patient Care Technician (PCT) 2 documented "BP low" and that the patient was stable and the RN was aware. No assessment by the RN was documented and no intervention was performed. The next BP was taken 25 minutes later at 2 PM.</p> <p>f. The clinical record for Patient 2 was reviewed on August 16, 2010 at 11:15 AM and the hemodialysis flowsheet indicated:</p> <p>On August 3, 2010, BP of 96/74, was taken at 1:45 PM and the next BP taken was at 2:35 PM, which was 50 minutes later.</p> <p>On August 4, 2010, Patient 2's BP at 10 AM was 83/47. The next BP was taken at 10:41 AM, which was 41 minutes later and his BP was 85/48.</p> <p>During an interview on August 16, 2010 at 11:15 AM, the Clinical Coordinator (CC) 1 stated she believed hypotension to mean a systolic blood pressure below 100 and they only call the physician if the patient continues have a drop in blood pressure. CC 1 stated the patient care technicians were to notify an RN if a patient had a blood pressure drop. CC 1 said hypertension "depends on the patient's normal blood pressure. It may be 160, 180, or 200." She acknowledged the physician should give parameters for blood</p>	V 101			

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V 101	<p>Continued From page 5 pressure.</p> <p>g. The clinical record for Patient 8 was reviewed on August 11, 2010 at 9:30 AM and contained standing orders dated November 17, 2009 which read "Hypotension: Decrease/discontinue UFR , position patient in Trendelenburg, and give 200 ml NSS, monitor BP every 15 minutes, when BP stabilizes, gradually increase UFR." No BP parameters were written with the order and his hemodialysis flowsheets indicated:</p> <p>On July 30, 2010, when Patient 8's dialysis treatment was completed his BP was 202/120 and his post treatment assessment by CC 1 indicated his BP was 188/120. (No interventions were performed or physician notified).</p> <p>On August 2, 2010, BP was 188/107 and his post treatment assessment by CC 1 indicated his BP was 179/110 (No interventions were performed or physician notified).</p> <p>On August 4, 2010, Patient 8's BP was 171/103 and his post treatment assessment by CC 1 indicated his BP was 181/104. (No interventions were performed or physician notified).</p> <p>During an interview and record review of Patient 8's clinical record with CC 1 on August 16, 2010 at 11:50 AM, she stated Patient 8 was incarcerated and his clinical problems were reported to the doctor who takes care of him there. She stated Patient 8's high BPs should have been reported to his doctor, but she verified no documentation of reporting them was in the chart. She also stated the patient's BP should be taken every 30 minutes during dialysis treatment and every 15 minutes if there was a doctor's</p>	V 101			

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V 101	Continued From page 6 order and the patient's pressure was low. She also stated a post treatment assessment should always be completed and charted. 3. During an observation of the medication drawers and interview with CC 1 on August 11,2010 at 8 AM, two bottles of nitroglycerin (a medication used to relieve chest pain) were found with the opened dates of November 11, 2009 on one bottle and on the other bottle only the numbers "09" were visible. The numbers before the "09" were smeared. CC 1 verified the dates as both bottles being opened in 2009. She stated, "These should have been discarded." The facility policy and procedure titled "Subject: Nitroglycerin" dated August 2010 read "Once the NTG (nitroglycerin) bottle is opened, it is good for 6 months after opening as long as it is stored per manufacturer recommendations." The facility policy and procedure titled "Medication Policy" revision date March 2010 read "Each vial is labeled with the date, time, and initials of the person opening the vial and the discard date. All medications are checked monthly for expiration dates."	V 101			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure hand hygiene was	V 113		10/14/10	

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V 113	Continued From page 7 performed properly by several staff which had the potential to spread infectious disease to a universe of 95 patients. Findings: During an observation on August 9, 2010 at 10:30 AM, Patient Care Technician (PCT) 2 donned his gloves, touched the front of the hemodialysis machine in use at station 10, took a full trash can through the supply room and then returned to the station without removing his gloves. He removed his gloves and washed his hands in the sink labelled "Dirty area". During an observation of Patient 10 on August 9, 2010 at 11:02 AM, PCT 3 was observed touching her un-gloved hands to her hair, the computer twice, and then placing items on top of Patient 10's dialysis machine while he was being dialyzed. She was not observed doing hand hygiene during this observation. The facility policy and procedure titled "Infection Control For Dialysis Facilities" revised March 2010 read, "Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. Gloves should be changed when going from a dirty area or task to a clean area or task."	V 113			
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS 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	V 117		10/19/10	

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V 117	<p>Continued From page 8</p> <p>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.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare 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: Based on observation and interview, the facility failed to ensure clean areas were separate from dirty areas, dirty items were not in clean areas, and clean items were not in dirty areas, which had the potential of spreading infection to the facility's patient population of 95 and to all staff.</p> <p>Findings:</p> <p>During an observation of the clean storage area with the Facility Administrator (FA) 1 on August 9, 2010 at 9:45 AM, four boxes of gloves, four boxes of acid concentrate used for bicarbonate dialysis, and one box of sharps containers were on the floor. FA 1 stated the items should have been put away and not placed on the floor.</p> <p>During an observation of the dialysis treatment area on August 9, 2010 at 11:02 AM, an unopened bottle of acid concentrate was on the</p>	V 117			

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V 117	<p>Continued From page 9</p> <p>floor in front of station 6 where Patient 10 was receiving dialysis treatment. The acid bottle being used at the time had less than one inch of fluid left inside.</p> <p>During an observation of the dialysis treatment area with the Clinical Coordinator (CC) 1 on August 10, 2010 at 8 AM, she verified the acid concentrate jugs located on stations 6 and 7 did not have the red caps screwed on. The caps were hanging on the side of each container with the clear tube coming from the bottom of the cap extended into the acid. She stated on some of the machines, the caps did not fit the top of the bottle and the cap had to lay on the side of the bottle. During this time, the medication preparation area was observed adjacent to a dirty sink area with a 1 1/2 inch wide piece of tape separating the areas. There was no splash guard in place. The medication area contained several opened boxes of medication and medication administration supplies. The CC 1 confirmed the sink was a dirty area and the medication was prepared in the area adjacent to it. On the opposite side of this dirty area was a clean area where an empty container of acid concentrate was present next to the clean sink. The CC 1 stated the container had come from a used hemodialysis machine and should not have been placed there.</p> <p>During an observation of the dialysis treatment area with the CC 1 on August 10, 2010 at 8:15 AM, two separate white carts were located on opposite sides of the central nursing station area. Each cart had three shelves. The top shelf of each cart had the words "Dirty Area" on one side. The top shelf had two plastic boxes with lids. One box located by the "Dirty Area" contained</p>	V 117			

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V 117	Continued From page 10 clamps (which are placed on patient accesses to control bleeding) submerged in a bleach solution. The CC 1 confirmed the clamps were placed in the box after they were used to stop bleeding of the patient access sites. In the second box, within one inch of the first box, multiple cloths were soaking in a bleach solution. The CC 1 confirmed the cloths were clean and were used to clean the dialysis stations after a patient's treatment. She stated the other two shelves contained clean items used for patient care. The facility policy and procedure titled, "Infection Control For Dialysis Facilities" revised March 2010 read, "If a common supply cart is used to store clean supplies in the patient treatment area,.....Items taken to the patient station during the treatment will not be returned to the supply cart. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Teammates will 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. Used or contaminated items should be handled in designated utility sinks."	V 117			
V 245	494.40(a) ACID CONC DIST-CONC LABELED & COLOR-CODED RED 5.5.3 Acid concentrate distribution systems: labeled & color-coded red Acid concentrate delivery piping should be labeled and color-coded red at the point of use (at the jug filling station or the dialysis machine connection). All joints should be sealed to prevent leakage of concentrate. If the acid system remains intact, no rinsing or disinfection is necessary.	V 245		10/14/10	

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V 245	Continued From page 11 More than one type of acid concentrate may be delivered, and each line should clearly indicate the type of acid concentrate it contains. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly seal two acid concentrate jugs, which had the potential to allow spillage and jeopardize patient safety for a universe of 95 patients. Findings: During an observation of the dialysis treatment area and interview with the Clinical Coordinator 1 on August 10, 2010 at 8 AM, she verified the acid concentrate jugs located on stations 6 and 7 did not have the red caps screwed on. The caps were hanging on the side of each container with the clear tube coming from the bottom of the cap extended into the acid. She stated on some of the machines, the caps do not fit the top of the bottle and the cap has to lay on the side of the bottle.	V 245			
V 246	494.40(a) BICARB CONC DIST-COLOR CODED BLUE & SEALED 5.5.4 Bicarbonate concentrate distribution systems: color coded blue & sealed Bicarbonate concentrate delivery piping should be color-coded blue at the point of use (at the jug filling station or dialysis machine connection). All joints should be sealed to prevent leakage of concentrate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly seal 14 bicarbonate jugs, which	V 246		10/14/10	

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V 246	Continued From page 12 had the potential to allow spillage and jeopardize patient safety for a universe of 95 patients. Findings: During an observation of the dialysis treatment area on August 9, 2010 at 10:25 AM, four filled bicarbonate jugs were sitting on a cart by the clean sink area. All four jugs had blue gloves covering the spout. During an observation and interview with the Clinical Coordinator 1 on August 11, 2010 at 8 AM, she verified 15 filled bicarbonate bottles on four different carts in the dialysis treatment area had blue gloves over the spouts instead of blue caps. She stated the containers should have blue caps to prevent spillage but the facility had ran out of the caps a few months ago. She stated the caps had been ordered.	V 246			
V 250	494.40(a) DIALYS PROPOR-T-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 12 sampled patient's (10) dialysis machine's conductivity and pH were measured and an alarm test performed before his dialysis started. This failure had the potential for	V 250		10/14/10	

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V 250	Continued From page 13 Patient 10 to receive an improper dialysate and treatment, causing him physical harm. Findings: The clinical record for Patient 10 was reviewed on August 11, 2010 at 11 AM. The patient progress notes dated July 28, 2010 read, "Tx (treatment) was initiated with 250 BFR (blood flow rate) and ran for 5 min (minutes) and Arterial (blood) pressure began to elevate." The Post Treatment record dated July 28, 2010 under Machine Setup the following areas were left blank: Area, Station, Machine #, Manual Conductivity, Machine Conductivity, Manual pH, Machine pH, air detector on pass, alarm test machine temperature, UF system, and dialysate verified. During an interview and record review of Patient 10's chart with the Clinical Coordinator 1 on August 16, 2010 at 11:25 AM, she verified Patient 10 had been on the machine and the record indicated the above Machine Setup was not done according to Patient 10's clinical record.	V 250			
V 340	494.50(b)(1) DIALYZER GERM=90% CONC/CAPS DISINFECT 11.4.1.4 Chemical germicidal procedure: = 90% conc/port caps disinfected If applicable, the hemodialyzer shall be filled with the germicide solution until the concentration in the hemodialyzer is at least 90% of the prescribed concentration. The ports of chemically disinfected dialyzers shall be disinfected and then capped with new or disinfected caps. The caps may be disinfected with dilute bleach, with the chemical used for disinfecting the hemodialyzer, or with any other	V 340		10/14/10	

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V 340	Continued From page 14 germicide approved by the FDA as a disinfectant that does not adversely affect the materials of the dialyzer. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly disinfect dialyzer port caps which had the potential to spread infectious disease to patients. Findings: During an observation on August 9, 2010 at 9:25 AM, Reuse Technician (RT) 1 was observed in the reuse room. Dialyzer port caps were in a plastic container with the words "Renalin 1%" written on the front of the container. The caps were not completely submerged and some were above the liquid level. During an interview on August 9, 2010 at 9:26 AM, RT 1 acknowledged the caps should be submerged in the disinfectant and stated, "They sometimes float, but they should be completely covered."	V 340			
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 and interview, the facility failed to discard the expired calibration solution	V 403		10/14/10	

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V 403	<p>Continued From page 15</p> <p>for the phoenix meter (a meter which independently measures the accuracy of the conductivity and pH of the dialysate used in the process of hemodialysis). The facility also failed to perform daily quality control testing for the glucose monitor. These failures had the potential to inaccurately calibrate the equipment required to verify the content of dialysate used in hemodialysis and inaccurately measure patients' blood glucose levels.</p> <p>Findings:</p> <p>During an observation and interview on August 9, 2010 at 11 AM, a container of conductivity calibration solution was observed on the counter with the date "7/3/10" written on the bottle. This solution is used to calibrate the phoenix meter each morning prior to usage on the hemodialysis machines. The bottle label read the solution expired 30 days after opening. Patient Care Technician 2 acknowledged the solution had expired and stated, "This solution is no good."</p> <p>During an observation of the dialysis treatment area with Clinical Coordinator 1 on August 10, 2010 at 11:30 AM, the glucose monitor control log was reviewed for the months of June 2010, July 2010, and August 2010. She stated the staff should calibrate the glucose monitor everyday before the patients arrive for dialysis in the morning. She verified the glucose monitor was not tested on the following dates: June 2, June 11, and July 1-11. The reason written on the log was no low and high controls (liquid that contains low and high levels of glucose for calibrating the monitor) for July 6, July 19, and July 21.</p>	V 403			

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V 403	Continued From page 16 The clinical record for Patient 10 was reviewed on August 11, 2010. The post treatment record dated July 28, 2010 indicated he had blood glucose tests on July 19, 2010 and July 21, 2010. Both of these days the calibration for the glucose monitor was not done according to the monitor log. The facility policy and procedure titled "Blood Glucose Testing" revised September 2009 read, under "Purpose: to provide a rapid and accurate means to determine patients' blood glucose levels." Under "Policy: Quality control testing is completed prior to the first use of the day when the (glucose monitor) is used for patient blood glucose testing."	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 interview, the facility failed to ensure patient safety by allowing Patient 13 to exit the building before post assessment for access bleeding was completed. This failure had the potential for unwitnessed and uncontrolled bleeding after dialysis which could result in death. Findings: During an interview and observation on August 9, 2010 at 10:10 AM, Patient 13 was seen entering the facility through the front door. She had two gauze bandages on her right upper arm and over those bandages were clamps used to control	V 407		10/14/10	

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V 407	Continued From page 17 bleeding. The Facility Administrator (FA) 1 observed this incident and acknowledged the patient had completed hemodialysis and should not have left the building with clamps on and until the post assessment for bleeding was completed.	V 407			
V 408	494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure for emergencies, which had the potential to cause harm to the facility's patient population. Findings: The facility's policy and procedure titled "Disaster and Emergency Preparedness Business Continuity Policy" revised March 2010 was reviewed on August 10, 2010 at 11:30 AM. Under "Creating a Disaster Plan", it read, "Patient Emergency Information Packet: One (1) - two (2) gallon plastic zip lock bag will be distributed to all patients within 30 days of admission. In addition, it is recommended that this packed be reviewed and updated quarterly and before a known event. Document patient instruction and receipt of this packet. Contents of Patient Emergency	V 408		10/14/10	

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V 408	Continued From page 18 Information Packet: Label with Patient Name and Facility Name, Emergency Dialysis Orders (patient specific), Emergency Renal Diet (patient specific), Rounding Report, Patient Demographic/Information Sheet, Most recent assessment, Plan of Care, Copy of Patient History/Physical, Emergency Wallet Card, Network Notification Letter, Patient Curfew Letter, Patient Armbands - Note: Dialysis wristbands are designed to be as an identification tool to assist disaster teams in locating and assisting dialysis patients in shelter situations." During a review of the above policy with the Facility Administrator 1 on August 10, 2010 at 11 AM, she stated, "We don't do any of that, but we will." She stated the facility gave each patient a card called "Patient Emergency Hotline". This card read, "Patients should call this number if they are displaced by an emergency." On the back was a website address each patient could access in case of an emergency. She stated she was not sure what the patient would do if electricity or telephone service was not available.	V 408			
V 470	494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to display state agency and End Stage Renal Disease network addresses and phone	V 470		8/16/10	

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V 470	Continued From page 19 numbers which could be seen by patients. Findings: During an observation on August 9, 2010 at 9:25 AM, no legible sign was present with state agency or phone numbers. Several typed papers were observed on the bulletin board in the lobby. During an interview on August 9, 2010 at 9:30 AM, the Facility Administrator (FA) 1 was unable to locate a sign with state agency or network numbers. During an interview and observation on August 9, 2010 at 2:30 PM, the Group Facility Administrator (GFA) 1 pointed out an 8 x 10 typewritten paper with type size of approximately 12 font and the sign was seven feet from the floor. The phone number depicted on the sign was the incorrect state agency. During an observation on August 9, 2010 at 4 PM, the sign had been changed to reflect the correct state agency but was illegible while seated in a chair; thus making it illegible for wheelchair patients.	V 470			
V 729	494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY (1) Current medical records and those of discharged patients must be completed promptly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to complete current patient records within a timely manner which had the potential to adversely affect patient care for a universe of 95 patients.	V 729		10/19/10	

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V 729	Continued From page 20 Findings: During a record review on August 11, 2010, Patient 6's progress notes contained an entry under nutrition dated February 12, 2010, which read "Late entry for December 2009. . ." signed by the Registered Dietician (RD) 1. This note was entered two months later. During a record review on August 11, 2010, Patient 9's progress notes contained entries under blood pressure/fluid management, dialysis adequacy, and nutrition which read "Late entry for June 2010....", "Late entry for May 2010. . . .", "Late entry for April 2010. . . ." and "Late entry for March 2010. . . ." signed by RD 1 and noted on August 10, 2010, up to seven months later. During a record review on August 11, 2010, Patient 3's progress notes contained an entry from Medical Doctor (MD) 1 which read "5/28/10 Late entry: P(atient)t is seen and examined. . . .Noted 6/21/20", twenty four days later. Also, in Patient 3's progress notes under nutrition were entries which read "Late entry for May 2010. . . .", "Late entry for April 2010. . . .", and "Late entry for March 2010. . . ." signed by RD 1 and noted on July 14, 2010, up to four months later. During a record review on August 12, 2010, Patient 7's progress notes contained entries under blood pressure/fluid management and osteodystrophy (bone disease) which read "Late entry for June 2010..." and "Late entry for April 2010. . . ." signed by RD 1 and noted on July 26, 2010, up to three months later. During a record review on August 12, 2010,	V 729			

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V 729	<p>Continued From page 21</p> <p>Patient 5's progress notes contained entries under nutrition which read, "Late entry for May 2010....", "Late entry for April 2010....", "Late entry for March 2010....", "Late entry for February 2010....", "Late entry for January 2010...." signed by RD 1 and noted on August 9, 2010, up to seven months later.</p> <p>The clinical record for Patient 1 was reviewed on August 11, 2010. The patient progress notes entry under Nutrition/Metabolic read "Late entry for May (no day charted) 2010. . . ." signed by RD 1 and noted on July 12, 2010.</p> <p>The clinical record for Patient 10 was reviewed on August 11, 2010. The patient progress notes entry under Nutrition/Metabolic read "Late entry for December (no day charted) 2009. . . ." signed by RD 1 and noted on February 11, 2010. Late entry for November (no day charted) 2009. . . ." signed by RD 1 and noted on February 11, 2010. Also, the last entry under this heading was May 21, 2010 and signed by RD 1.</p> <p>The clinical record for Patient 4 was reviewed on August 16, 2010. The patient progress notes entry under Nutrition/Metabolic read "Late entry for January (no day) 2010. . . ." signed by RD 1 and noted on July 14, 2010. "Late entry for February (no day) 2010. . . ." signed by RD 1 and also noted on July 14, 2010. "Late entry for March (no day) 2010. . . ." signed by RD 1 and also noted on July 14, 2010. "Late entry for April (no day) 2010. . . ." signed by RD 1 and also noted on July 14, 2010. "Late entry for May (no day) 2010. . . ." signed by RD 1 and also noted on July 14, 2010. A total of five months of late entries all noted on July 14, 2010.</p>	V 729			

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V 729	Continued From page 22 The clinical record for Patient 2 was reviewed on August 16, 2010. The patient progress notes entry under Nutrition/Metabolic read "Late entry for January (no day) 2010. . . ." signed by RD 1 and noted on July 15, 2010. "Late entry for February (no day) 2010. . . ." signed by RD 1 and also noted on July 15, 2010. "Late entry for March (no day) 2010. . . ." signed by RD 1 and also noted on July 15, 2010. "Late entry for April (no day) 2010. . . ." signed by RD 1 and also noted on July 15, 2010. "Late entry for May (no day) 2010. . . ." signed by RD 1 and also noted on July 15, 2010. For total of five months of late entries all noted on July 15, 2010. During an interview with the RD 1, while reviewing the above clinical records, on August 16, 2010 at 2:20 PM, she stated before December 2009 she was responsible for doing assessments, teaching, and laboratory review for 210 patients. She stated from December 2009 and March 2010, she was responsible for 227 patients from three prisons and one dialysis center. She stated it was very hard to keep up and during that time she was four months behind in charting. She stated she was supposed to chart in the clinical records at least once a month. She stated a reasonable patient load would be about 130 patients with 150 patient load being the maximum. The facility policy and procedure titled "Provision of ESRD Dietitian" revised September 2008 read "The services provided will include: Charting the patient's dietary progress monthly or more frequently as needed in the medical record."	V 729			
V 757	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS The governing body or designated person	V 757		10/14/10	

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V 757	<p>Continued From page 23</p> <p>responsible must ensure that-</p> <p>(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients;</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an adequate number of personnel were available to perform patient care which caused eight of 12 (1,2,3,4,5,6,7,8) sampled patients to experience increased complications from hemodialysis treatments and had a potential to affect a universe of 95 patients health and well-being.</p> <p>Findings:</p> <p>During a confidential interview on August 11, 2010 at 7:50 AM, a patient was asked if adequate staff was on duty. The patient stated, "Just between you and me, they run short sometimes. They need more people."</p> <p>1. During a record review on August 11, 2010, Patient 1's hemodialysis flowsheet dated July 30, 2010 indicated no post treatment assessment had been performed by a Registered Nurse (RN).</p> <p>During a record review on August 12, 2010, Patient 7's hemodialysis flowsheet dated July 27, 2010 indicated no post treatment assessment had been performed by an RN.</p> <p>During a record review on August 12, 2010, Patient 5's hemodialysis flowsheet dated July 27, 2010 indicated no post treatment assessment</p>	V 757			

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V 757	<p>Continued From page 24 had been performed by an RN.</p> <p>During a record review on August 16, 2010, Patient 4's hemodialysis flowsheet dated July 31, 2010 indicated no post treatment assessment was charted by the RN.</p> <p>Nephrology Nursing Standards of Practice and Guidelines for Care by the American Nephrology Nurse's Associate dated 2005 indicate the nurse will "Assess the patient predialysis, during treatment, and after treatment" and"Notify the physician or advanced practice nurse of any assessment findings that might require modification of the hemodialysis prescription."</p> <p>2. Patients 1, 2, 3, 4, 6, 7, 8 had episodes of blood pressures outside of the normal range (120/80) and physician standing orders were not followed as indicated:</p> <p>a. The clinical record for Patient 1 was reviewed on August 11, 2010 and the hemodialysis flowsheets indicated on July 30, 2010, Patient 1's BP (blood pressure) was 97/64 at 11:43 AM (no interventions) and no repeat BP until 12:45 (1 hour later). Also, this record indicated no post treatment assessment had been performed by an RN.</p> <p>On August 4, 2010, Patient 1's BP was 71/45 at 11:39 AM and next BP of 95/62 was at 1:09 PM, (90 minutes later).</p> <p>On August 16, 2010 at 11:50 AM, the clinical record for Patient 1 was reviewed with CC 1 and she verified the low BPs were not followed by another BP reading within 15 minutes. She also stated the patient's BP should be taken every 30</p>	V 757			

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V 757	<p>Continued From page 25</p> <p>minutes during dialysis treatment and every 15 minutes if there was a doctor's order and the patient's pressure was low. She also stated a post treatment assessment should always be completed and charted.</p> <p>b. During a record review on August 11, 2010, Patient 3's medical record contained physician standing orders dated November 12, 2009 which read "Hypotension (low blood pressure) -Decrease/Discontinue UFR (ultrafiltration rate), position patient in Trendelenburg (lay patient straight back with head below level of feet), and give 200 ml (milliliters) of NSS (normal saline solution), monitor bp (blood pressure) every 15 minutes, when bp stabilizes, gradually increase UFR." and "Hypertension (high blood pressure): Clonidine (a blood pressure lowering medication) 0.1 mg (milligram) po (by mouth) and may repeat x1 if bp still uncontrolled. . . ."</p> <p>On July 29, 2010, a BP of 98/58 at 3:05 PM (no interventions performed) and the next BP was taken at 4:41 PM (one and one half hours later).</p> <p>On August 3, 2010, a BP of 107/30 at 3:11 PM (no interventions performed) and the next BP was taken at 4:18 PM (over one hour later).</p> <p>On August 5, 2010, a BP of 170/70 at 4:32 PM and the next BP of 183/92 was 5:21 PM (50 minutes later) and no interventions performed.</p> <p>c. During a record review on August 11, 2010, Patient 6's hemodialysis flowsheets indicated: On July 26, 2010, BP was 91/60 at 5:08 PM, the RN was notified and the fluid removal rate was decreased; however, no repeat BP was documented until 6:22 PM (over one hour later)</p>	V 757			

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V 757	<p>Continued From page 26 when he had a BP of 96/57.</p> <p>d. During a record review on August 12, 2010, Patient 7's hemodialysis flowsheets indicated: On August 3, 2010 a BP at 2:06 PM of 174/77 and the next BP of 168/78 was over one hour later at 3:12 PM with no interventions performed.</p> <p>e. The clinical record for Patient 4 was reviewed on August 16, 2010. The Standing Orders dated November 12, 2009 read "Hypotension: Decrease/discontinue UFR, position patient in Trendelenburg, and give 200 ml NSS, monitor BP every 15 minutes, when BP stabilizes, gradually increase UFR."</p> <p>Patient 4's hemodialysis flowsheets indicated:</p> <p>On July 29, 2010, the BP taken at 12 PM was 93/54 (no interventions or RN assessment performed) and the next BP of 102/54 was 39 minutes later at 12:39 AM.</p> <p>On July 31, 2010, BP at 11:34 was 96/69, and at 11:58 AM (24 minutes later) the BP was 94/69. No intervention was performed.</p> <p>On August 5, 2010, BP at 1:35 PM was 81/44. Patient Care Technician (PCT) 2 documented "BP low" and that the patient was stable and the RN was aware. No assessment by the RN was documented and no intervention was performed. The next BP was taken 25 minutes later at 2 PM.</p> <p>f. The clinical record for Patient 2 was reviewed on August 16, 2010 at 11:15 AM and the hemodialysis flowsheet indicated:</p> <p>On August 3, 2010, BP of 96/74, was taken at</p>	V 757			

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V 757	<p>Continued From page 27</p> <p>1:45 PM and the next BP taken was at 2:35 PM, which was 50 minutes later.</p> <p>On August 4, 2010, Patient 2's BP at 10 AM was 83/47. The next BP was taken at 10:41 AM, which was 41 minutes later and his BP was 85/48.</p> <p>During an interview on August 16, 2010 at 11:25 AM, Clinical Coordinator (CC) 1 stated two RN's were on the unit for 17 patients. She stated when one nurse went to lunch, the other was left with 17 patients. CC 1 stated she was also the anemia manager, adequacy manager, completed nursing care plans and physician orders for all the patients.</p> <p>g. The clinical record for Patient 8 was reviewed on August 11, 2010 at 9:30 AM and contained standing orders dated November 17, 2009 which read "Hypotension: Decrease/discontinue UFR , position patient in Trendelenburg, and give 200 ml NSS, monitor BP every 15 minutes, when BP stabilizes, gradually increase UFR." No BP parameters were written with the order and his hemodialysis flowsheets indicated:</p> <p>On July 30, 2010, when Patient 8's dialysis treatment was completed his BP was 202/120 and his post treatment assessment by CC 1 indicated his BP was 188/120. (No interventions were performed or physician notified.)</p> <p>On August 2, 2010, BP was 188/107 and his post treatment assessment by CC 1 indicated his BP was 179/110. (No interventions were performed or physician notified.)</p> <p>On August 4, 2010, Patient 8's BP was 171/103</p>	V 757			

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V 757	<p>Continued From page 28</p> <p>and his post treatment assessment by CC 1 indicated his BP was 181/104. (No interventions were performed or physician notified.)</p> <p>During an interview and record review of Patient 8's clinical record with CC 1 on August 16, 2010 at 11:50 AM, she stated Patient 8 was incarcerated and his clinical problems were reported to the doctor who takes care of him there. She stated Patient 8's high BPs should have been reported to his doctor, but she verified no documentation of reporting them was in the chart. She also stated the patient's BP should be taken every 30 minutes during dialysis treatment and every 15 minutes if there was a doctor's order and the patient's pressure was low. She also stated a post treatment assessment should always be completed and charted.</p> <p>The clinical record for Patient 10 was reviewed on August 11, 2010 at 11 AM. The patient progress notes dated July 28, 2010 read, "Tx (treatment) was initiated with 250 BFR (blood flow rate) and ran for 5 min (minutes) and Arterial (blood) pressure began to elevate." The post treatment record dated July 28, 2010 under Machine Setup the following areas were blank: Area, station, machine #, manual conductivity, machine conductivity, manual pH, machine pH, air detector on pass, alarm test machine temperature, UF system, and dialysate verified. The Post Treatment record for July 29, 2010 indicated Patient 10's BP was taken during his dialysis treatment at 10:36 AM and the next BP was taken at 11:26, which was 50 minutes between readings.</p> <p>During an interview and record review of Patient 10's chart with CC 1 on August 16, 2010 at 11:45</p>	V 757			

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

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V 757	Continued From page 29 AM, she verified Patient 10 had been on the machine and the record indicated the above machine setup was not done according to Patient 10's clinical record. During an interview and record review of Patient 8's clinical record with the CC 1, she stated Patient 8 was incarcerated and his clinical problems were reported to the doctor who takes care of him there. She stated Patient 8's high BPs should have been reported to his doctor, but she verified no documentation of reporting them was in the chart. During this time, the clinical record for Patient 1 was reviewed with CC 1 and she verified the above low BPs were not followed by another BP reading within 15 minutes. She also stated the patient's BP should be taken every 30 minutes during dialysis treatment and every 15 minutes if there was a doctor's order and the patient's pressure was low. She also stated a post treatment assessment should always be completed and charted.	V 757			