

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

PRINTED: 10/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052786	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2009
NAME OF PROVIDER OR SUPPLIER EL CERRITO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 10690 SAN PABLO AVENUE EL CERRITO, CA 94530	
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V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 05189 The following reflects the findings of the California Department of Public Health during a recertification survey from 7/20/09 to 7/27/09.</p> <p>Representing the Department of Public Health: Dorothy Rice HFEN, Lutgarda Sturms HFEN, Nikki Kratt HFEN, Stella Tannehill HFEN, and Artemis Jardinero HFEN.</p> <p>The census at the start of the survey was 127 (114 Hemodialysis and 13 Peritoneal) patients.</p> <p>Acronyms and Abbreviations commonly used in this report: AVF arteriovenous fistula AVG arteriovenous graft BP blood pressure CAPD continuous ambulatory peritoneal dialysis CCPD continuous cycling peritoneal dialysis DM diabetes mellitus ESRD end stage renal disease HD hemodialysis Kt/v kinetic modeling for dialysis adequacy reflecting clearance, time and volume MR medical record PCT patient care technician P&P policies and procedures RN registered nurse RU reuse technician UF ultrafiltration UFR ultrafiltration rate</p>	V 000		
V 110	<p>494.30 INFECTION CONTROL</p> <p>This CONDITION is not met as evidenced by: Surveyor: 05189</p>	V 110		

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

TITLE

(X6) DATE

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

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V 110	Continued From page 1 Based on observation of care delivery, interview with staff and patients, and record review, the facility failed to comply with the Condition for Coverage for Infection Control as demonstrated by: Staff's failure to consistently wear gloves when making contact with patients or patient' s equipment, to consistently remove gloves or wash hands between patients, to change gloves during vascular catheter care, and to consistently wash hands after removing gloves (Refer to V113). Failure to clearly separate designated contaminated areas from clean areas (Refer to V117). Failure to appropriately clean and disinfect contaminated equipment and medical devices in between patient care (Refer to V122). Failure to ensure that eight of 13 staff members reviewed were re-educated annually on facility's infection control practices (Refer to V132). Failure to implement the "Medication Policy" when expired medications were found in the medication refrigerator and in the medication storage located in the treatment area. Expired medications were available for use by the licensed clinical staff (V143). The cumulative effect of these failures constituted a severe safety breach that limited the facility's ability to furnish adequate care and had the potential to cause patient harm.	V 110			
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE	V 113			

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V 113	<p>Continued From page 2</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 21174 Based on observation and staff and patient interviews, staff failed to consistently wear gloves when contacting patients or patient ' s equipment, failed to consistently remove gloves or wash hands between patients, failed to change gloves during vascular catheter care, and failed to consistently wash hands after removing gloves, increasing the potential for cross-contamination.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the initial tour on 7/20/09 at 8:28 a.m., Staff M was asked if she could explain a computer screen display for dialysis station 16. She had been at another dialysis station. She removed her gloves, washed her hands, and came over to station 16's computer screen. Without donning new gloves, she typed on the computer keyboard between station 16 and 17. Without washing her hands or donning gloves, she then touched the dialyzing machine's screen for station 17. 2. During the initial tour on 7/20/09 at 8:50 a.m. Staff G prepared to perform catheter care for Patient 6. Staff G was wearing an isolation lab coat, mask, and gloves. Patient 6 wore a mask as well. Staff G removed the catheter dressing and old tape. Without changing gloves and washing his hands, he poured a cleanser onto a 	V 113			

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V 113	<p>Continued From page 3</p> <p>two-inch gauze dressing and placed the dressing behind the catheter and withdrew blood from both ports of the catheter with saline-filled syringes. After discarding the syringes, he removed his gloves and washed his hands.</p> <p>Staff G was subsequently observed performing catheter care on random Patient 17 on 7/22/09 at 10:56 a.m. After removing the old dressing and tape, he removed his gloves and washed his hands. During interview following the catheter care, Staff G was informed that although he was observed performing catheter care correctly for the Patient 17, he did not remove his gloves and wash his hands after removing the old dressing for Patient 6 on 7/20/09. He said "Oh."</p> <p>* On 7/22/09 at 9:05 a.m., Staff X was observed taking a used dialyzer and tubing to the "dirty" sink. The dialyzer and tubing contained bloody residue. She removed the dialyzer from the tubing, placed it in a plastic bag, and then placed it in a large container. She disposed of the tubing in a hazardous waste container. She removed her gloves and immediately grabbed another pair of new gloves, and donned them without first washing her hands. She picked up packages of new tubing and delivered them to Staff J at station 8. During interview, immediately afterward, Staff X was informed she was observed handling contaminated equipment and donning new gloves without washing her hands. She said "Yes?". She was asked what she should have done after removing soiled gloves. She stated "Wash my hands."</p> <p>* On 7/22/09 at 4:05 p.m. Patient 9, an alert and oriented patient, was interviewed and asked if he observed staff changing gloves and washing their</p>	V 113			

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V 113	<p>Continued From page 4</p> <p>hands between caring for other patients and him. He stated, "I never see staff washing their hands after wearing gloves."</p> <p>Surveyor: 26616</p> <p>5. In an observation during initial tour on 7/20/09 at 9:35 a.m., Staff G (a Registered Nurse) was checking the medication refrigerator temperature logbook when the dialysis machine at Station 7 alarmed. Staff G put on clean gloves and touched the dialysis machine screen, held patient's blanket and blood lines. After the machine stopped alarming, he removed his gloves and without disinfecting his hands, continued to check the medication refrigerator temperature logbook.</p> <p>In an interview on 7/20/09 at 9:38 a.m., Staff G said, "I was in a hurry that's why I forgot to wash my hands."</p> <p>6. In an observation on 7/22/09 at 8:45 a.m., Staff H (a Registered Nurse) was giving intravenous medications to a patient at Station 15. After giving the medications, she removed the dirty gloves and without disinfecting her hands, touched the computer keyboard. While Staff H was on the computer, the machine alarmed at Station 15. Staff H put on clean gloves and touched the dialysis machine screen. After the dialysis machine stopped alarming, she removed the dirty gloves and with bare hands touched the patient's skin near the vascular access site. Without disinfecting her hands after removing her dirty gloves on two occasions and touching the patient's skin with her bare hands, Staff H went back to the computer and touched the computer keyboard.</p>	V 113			

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V 113	<p>Continued From page 5</p> <p>In an interview on 7/22/09 at 8:50 a.m., Staff H said, "I did not hold anything contaminated with blood, but yes, I forgot to disinfect my hands after removing my gloves."</p> <p>7. In an observation on 7/22/09 at 2:10 p.m., Staff M (a Certified Hemodialysis Technician) was observed cleaning the dialysis machine and chair at Station 14. Staff M removed the dirty gloves after cleaning the machine and chair, and without disinfecting her hands, touched the computer keyboard. She put on clean gloves and continued preparing for the next patient by putting the dialyzer, blood lines, saline bags on the dialysis machine. Staff M removed the used gloves and without disinfecting her hands, assisted the next patient at Station 14. At 2:50 p.m., Staff M cannulated the fistula of patient treated at Station 14. After she secured the needles with tapes, she removed her dirty gloves and put on another pair of clean gloves, went to a clean preparation area and took 2 syringes and a vial of Heparin (medication to prevent blood clots), without washing or disinfecting her hands after performing an invasive procedure to the patient in Station 14. At 2:53 p.m., Staff M went back to the patient in Station 14, gave the bolus of Heparin and after three minutes initiated the dialysis treatment. After the treatment was initiated, Staff M removed her dirty gloves and, without washing or disinfecting her hands, touched the computer keyboard.</p> <p>Review of the facility's Infection Control policy and procedure stated, "Hand hygiene is to be performed...prior to gloving, after removal of gloves...after patient and dialysis delivery system contact,...before touching clean areas such as supplies and before leaving the patient care</p>	V 113		

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V 113	Continued From page 6 area....The Chairside Snappy (computer system) cart, monitor and keyboard are considered clean areas. Gloves are removed and hands washed or alcohol based hand rubs used before and after touching the keyboard."	V 113			
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 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. 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. This STANDARD is not met as evidenced by: Surveyor: 14545 Based on observation and interview, the facility failed to clearly separate designated contaminated areas from clean areas when: -an unlabeled, open container with clean fistula clamps was placed on the counter next to a container of dirty clamps soaking in a bleach solution and a container of clean wipes soaking in	V 117			

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V 117	<p>Continued From page 7</p> <p>bleach solution, -covered containers of soaking dirty clamps and containers of clean wipes soaking in a bleach solution were placed immediately adjacent to designated "dirty" sinks, and when -clean items were stored below a designated dirty area counter that was 30 1/4 inches from the patient's chair in station 5.</p> <p>This practice placed the patients at risk for cross-contamination and infections.</p> <p>Findings:</p> <p>1. During the initial facility tour of the large treatment room on 7/20/09 at 9:52 a.m., an uncovered, unlabeled, plastic container of approximately 12 fistula clamps was on the counter across from patient station 19. The open container of fistula clamps was placed next to two covered containers with bleach solution that were immediately adjacent to a sink labeled "dirty." At 9:52 a.m. on 7/20/09, the Facility Administrator said the uncovered container of fistula clamps was clean and should be labeled. The Facility Administrator picked up the open container of fistula clamps and moved them to another counter.</p> <p>2. On 7/22/09 at 8:50 a.m., inspection of the designated dirty area next to patient station 5 in the large treatment room was conducted while accompanied by the Facility Administrator and the Clinical Specialist. A cart with bagging supplies and an open container for bagged dialyzers for reuse processing was positioned next to the end of a counter that had two covered containers of bleach solution. One of the covered containers contained clean wipes and behind it, the other</p>	V 117			

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V 117	<p>Continued From page 8</p> <p>covered container held soaking dirty clamps. Between the two containers of bleach solution and the dirty sink on the other end of the counter, was an open package of clean wipes. Behind it was an open, unlabeled, plastic basket with two types of clamps in it. The drawers and cupboards below the counter were labeled for clean supplies, and contained alcohol and Betadine wipes, sterile bags of saline, sterile blood lines and gauze. The distance between the counter and the patient's chair in station 5 was 30 1/4 inches and there was no clear separation between the dirty counter area and the patient area.</p> <p>When interviewed on 7/22/09 at 8:50 a.m., the Facility Administrator looked at the open basket of clamps and said they were dirty.</p> <p>At 9 a.m. on 7/22/09, while accompanied by the Facility Administrator and the Clinical Specialist, inspection of the counter across from patient station 19 again found two containers of bleach solution immediately adjacent to the sink that was labeled "dirty." The one in front had soaking clean wipes and behind it, the other container had soaking dirty clamps. On the other side of the two containers of bleach solution was equipment for testing conductivity. Next to that, three clean bags of sterile solution for intravenous use were laid out on the counter.</p> <p>At approximately 9 a.m. on 7/22/09, the Facility Administrator acknowledged that there was no clear separation of clean and dirty areas surrounding the "dirty" sink across from patient station 19.</p> <p>Review of the facility's policy and procedure for</p>	V 117			

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V 117	Continued From page 9 infection control found on page 5 of 8, number 41: "Clean areas should be clearly designated for the preparation, handling, and storage of ... unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Teammates will not handle and store ... clean supplies in the same or adjacent area to that where used equipment ... is handled..." Surveyor: 21174 * During the tour of the water treatment area on 7/22/09, observation at 3:01 p.m. showed an open storage cart opposite an unlocked doorway containing dressing supplies and an opened package containing 11 50 cc. vials of lidocaine 1%, a topical anesthetic used to lessen pain when injecting needles. Staff R was asked why the lidocaine was stored in an unsecured area. He stated "I'll put this away."	V 117		
V 122	494.30(a)(4)(ii) PROCEDURES FOR INFECTION CONTROL [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: Surveyor: 26616 Based on observation, interview, and record review, the facility failed to implement its infection control policy and procedure when a facility staff did not appropriately clean and disinfect contaminated equipment and medical devices in	V 122		

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V 122	<p>Continued From page 10</p> <p>between patient care. This failure created the potential for cross-contamination and transmission of bloodborne pathogens (e.g. hepatitis B, C...) and other infections from one patient to another.</p> <p>Findings:</p> <p>1. During the initial tour on 7/20/09 at 9:52 a.m., there was blood splattered across the tops of sharps receptacles that were placed at the patient stations 3, 4, 5, 6, 7, 10, 14 and 16.</p> <p>2. In an observation on 7/22/09 at 9:00 a.m., Staff O (Certified Hemodialysis Technician) was cleaning Station 15 after termination of dialysis treatment and after the patient has left the station. Staff O wiped the screen and the front part of the dialysis machine but failed to wipe the top, the sides, the bottom and the internal circuits of the dialysis machine. The staff hung the blood pressure cuff on the side of the machine without disinfecting it. Staff O left the two dialysate bottles, dialysate connector and the used bicarbonate container on the bottom of the machine, without disinfecting them.</p> <p>In an interview on 7/22/09 at 9:10 a.m., Staff O said he cleaned the blood pressure cuff with cloth wipes soaked in hot water because he was not sure if he could clean it with bleach. He acknowledged he did not clean the dialysis machine before he prepared the machine for the next patient in accordance with the facility policy.</p> <p>Review of the facility's Infection Control policy and procedure stated, "Equipment including the dialysis delivery system...blood pressure equipment, outside of sharps containers...as well</p>	V 122			

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V 122	Continued From page 11 as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient...throughout the work day, and after each treatment."	V 122		
V 132	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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. This STANDARD is not met as evidenced by: Surveyor: 26616 Based on interview and record review, the facility failed to ensure that eight (Staff 1, F, G, L, K, P, Q, and R) of 13 staff members reviewed were re-educated on facility's infection control practices. This failure had the potential that staff would not follow the most current infection control practices. Findings: The personnel files of 13 staff members were reviewed on 7/21/08. Eight of the files did not contain evidence of staff re-education on infection control practices during the prior 12 months. Staffs F and R received infection control training in February 2008, Staffs 1, G, K, and P received training in March 2008, Staff Q received education in April 2008, while Staff L's record contained no evidence of training in infection control.	V 132		

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V 132	Continued From page 12	V 132			
V 143	<p>In an interview on 7/23/09 at 1:30 p.m., Staff C (clinical specialist) said the training in infection control practices should be conducted annually.</p> <p>494.30(b)(2) OVERSIGHT</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: Surveyor: 26616 Based on observation, interview, and record review, the facility failed to implement the "Medication Policy" when expired medications were found in the medication refrigerator and in the medication storage located in the treatment area. Expired medications were available for use by the licensed clinical staff. This failure put patients at risk of receiving degraded medications that did not achieve the desired medication effect.</p> <p>Findings:</p> <p>In an observation on 7/23/09 at 9:25 a.m., in the refrigerator for medication storage there were ten vials of Epogen 10,000 units that had expired in September 2008, and eight singleject 60 micrograms pre-filled syringes of Aranesp that had expired in April 2009 (both medications were used to treat anemia). In the medication storage area there was one tube of 15 grams Glucose that had expired in February 2009 (medication to treat low blood sugar)</p>	V 143			

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V 143	Continued From page 13 In an interview on 7/23/09 at 9:30 a.m., Staff F acknowledged the deficient practice and stated that the expired medications should be discarded.	V 143		
V 222	The facility "Medication Policy", reviewed on 7/23/09 stated, "...All medications are checked monthly for expiration dates....Medications are ordered and replaced prior to expiration." 494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4 Concentrate preparation 5.4.3 Bulk storage tanks (acid concentrate): safety controls Procedures should be in place to control the transfer of the acid concentrate from the delivery container to the storage tank to prevent the inadvertent mixing of different concentrate formulations. If possible, the tank and associated plumbing should form an integral system to prevent contamination of the acid concentrate. The storage tanks and inlet and outlet connections, if remote from the tank, should be secure and labeled clearly. This STANDARD is not met as evidenced by: Surveyor: 21174 Based on observation and staff interview, the facility failed to ensure that large volume dialysate concentrate was stored properly. Failure to securely cover three 300 gallon storage tanks increased the possibility of contamination or tampering of the dialysate. Findings: During a tour of the water treatment area on 7/22/09 at 3 p.m, observation showed three large 300 gallon plastic tanks filled with dialysate from	V 222		

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V 222	Continued From page 14 2/3 full to ¾ full in a room that was accessible via an unlocked door during the facility ' s hours of operation. None of the lids completely covered the tanks; rather, they were perched on an edge of the tanks, exposing 20-25 percent of the surface area of the tank. The biomedical technician (Staff R) was present at the time of the observation. When asked why the lids did not cover the tanks, he stated, " I need to talk to the guy who fills it. The tops should be closed. " On 7/23/09 at 4:40 p.m., observation showed the tanks were still incompletely covered. The facility administrator was present and stated, " I ' ve never see the lids on. " On 7/27/09 at 1 p.m., observation showed the tanks had not yet been covered. The facility ' s divisional clinical service specialist confirmed the lids did not fit over the tanks. She stated " Our biomed tech will talk to (supplier) when they deliver, to replace the lids. "	V 222			
V 305	494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE 4 Records: meet req for medical records All records described in this recommended practice shall meet the requirements for medical records, including completeness, legibility, and security. A place should be provided for the signature or other unique mark of identification of the person completing each step of the reprocessing procedure (i.e., the person performing preventive maintenance procedures, the person[s] investigating complaints, and the person[s] conducting quality assurance [QA] and quality control [QC] activities). Maintaining these records is the responsibility of the medical director.	V 305			

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V 305	<p>Continued From page 15</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to have complete reprocessing records for one of three patients sampled for closed record review. (Patient 15) This failure made it difficult to determine when one dialyzer (artificial kidney) was reprocessed.</p> <p>Findings:</p> <p>On 7/22/09, review of the clinical record showed that Patient 15 received treatment at the facility from 3/13/09 to 3/23/09 and utilized a reprocessed/reused dialyzer. According to the "Review of Hemodialysis for Nurses and Dialysis Personnel," reprocess/reuse is the process of cleaning and disinfecting a dialyzer to be used again for that same patient's treatment.</p> <p>The flowsheet dated 3/13/09, showed that Patient 15 received the first treatment and the "Re-Use Number" was documented as "0" (designating the first time usage and no pre-processing being done). On 3/14/09, Patient 15 received the second treatment. However, on this date, the "Re-Use Number" again was "0". Patient 15 received the third treatment on 3/16/09, when the documented "Re-Use Number" was "2".</p> <p>On 7/22/09, Staff R extensively reviewed and researched the computerized reprocessing records and found no documented rationale for the discrepancy. Staff R stated he was not sure what happened, but he assumed that staff used a new (not a pre-processed dialyzer) for the first treatment on 3/13/09 which would account for the Re-use Number "0". Staff R continued to state</p>	V 305		

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V 305	Continued From page 16 that the first dialyzer used on 3/13/09 was then reprocessed, and that the flowsheet dated 3/14/09 should have shown the "Re-Use Number "1", instead of "0".	V 305			
V 401	494.60 PHYSICAL ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Surveyor: 26616 Based on observation and interview, the facility failed to maintain a safe treatment environment when one emergency exit door was blocked with objects that could create a hazard in the event of a fire. Findings: During the initial tour on 7/20/09 at 10:00 a.m., the following items were found blocking an emergency exit corridor: five small oxygen tanks, one visitor's chair, and one intravenous (IV) pole with a medication pump. In an interview on 7/20/09 at 11:00 a.m., Staff D said the chair and IV pole should not be near the exit. She also said that the five oxygen tanks will be stored in another place.	V 401			
V 403	494.60(b) EQUIPMENT MAINTENANCE 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	V 403			

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V 403	<p>Continued From page 17 manufacturer's recommendations.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 26616 Based on observation, interview and record review, the facility failed to consistently monitor the temperature of the refrigerators where temperature sensitive medications were stored, creating the potential that the medications' potency be negatively affected.</p> <p>Findings:</p> <p>During the initial tour on 7/20/09 at 10:30 a.m., there were two medication refrigerators in the medication preparation area which stored Epogen (drug used to treat anemia) vials, flu and pneumococcal vaccines, and insulin.</p> <p>Review of the Refrigerator Temperature Logs (#1 and #4) from February 2009 to the time of survey on July 20, 2009, showed that the staff did not record the temperature daily. The logs showed there were no temperatures recorded on the following dates:</p> <p>For refrigerator #1: February 2, 4, 5, 6, 9, 18, 20, 23, 24, 25 and 26 March 2, 6,9, 11, 14, 16, 18, 23, 24, 25, 28 and 30 April 1, 3, 6, 8, 11, 13, 17, 20, 22, 25 and 27 May 2, 4, 6, 9, 15, 16, 18, 20, 27 and 29 June 12, 15 and 17 July 6 and 20</p> <p>For refrigerator #4: April 1, 3, 6, 8, 11, 13, 17, 20, 22, 25 and 27 May 2, 4, 6, 9, 13, 15, 16, 18, 20, 27 and 29</p>	V 403			

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V 403	Continued From page 18 June 1, 12, 15 and 17 July 6, 13 and 20 In an interview on 7/23/09 at 11:00 a.m., Staff D stated the refrigerators' temperature should be checked daily. The facility's policy and procedure for "Medications Requiring Refrigeration" stated, "The refrigerator is checked daily to ensure that the temperature remains between 36° F to 46°F. The temperature is documented on the Refrigerator Temperature Log."	V 403		
V 407	494.60(c)(4) PATIENT CARE ENVIRONMENT 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: Surveyor: 21174 Based on observation, interview, and document review, the facility failed to ensure patients' dialysis access sites were visible at all times during dialysis, increasing the potential for unobserved needle dislodgement leading to exsanguination (heavy, uncontrolled bleeding) and death. Findings: 1. During the initial tour on 7/20/09 at 8:20 a.m. observation showed random Patient 16 sitting at station 3. She had a blanket covering her body up to her chin. Her access was not visible. At 8:38 a.m., only the bottom tapes of her fistula	V 407		

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V 407	Continued From page 19 showed on her left arm. A sign posted by station 3, as well as all the other dialysis stations indicated "Your Blood Access must remain uncovered at all times!" 2. During the initial tour on 7/20/09 at 8:20 a.m., observation showed random Patient 18 asleep at station 18. He was covered by a blanket and no part of his access could be seen. 3. On 7/21/09 at 2:46 p.m., observation showed Patient 5 asleep with a blanket covering his catheter access. Staff O was near Patient 5 but did not ask Patient 5 to uncover his access site until he was prompted by the evaluator. He then asked Patient 5 to lower his blanket to uncover his catheter. Staff O was informed three patients were observed on 7/20/09 with covered accesses. He stated it can be a problem. Surveyor: 26616 4. In an observation on 7/20/09 at 8:30 a.m., the patient at Station 7 was in a reclining chair and had a blanket covering his face, body, right upper arm access and the bloodlines which were connected to the dialysis machine. The facility policy for "Treatment Initiation", reviewed on 7/21/09, stated, "...Verify that the access and connections are visible at all times during treatment. The access and connections are left visible for ongoing monitoring."	V 407			
V 408	494.60(d) EMERGENCY PREPAREDNESS	V 408			

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V 408	Continued From page 20 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: Surveyor: 26616 Based on observation and interview, the facility failed to develop policies and procedures for the management of medical emergencies, such as hypertension and significant blood loss during dialysis treatment. The lack of policies and procedures to follow during medical emergencies could threaten the life and safety of patients if the facility direct care staffs did not know how to respond in case of such emergencies. Findings: In an interview on 7/22/09 at 10:00 a.m., Staff H (Registered Nurse) said if the patient would have high blood pressure during the treatment, she would call the doctor and would follow the order. In an interview on 7/23/09 at 1:45 p.m., Staff C (Divisional Clinical Service Specialist) stated that the facility did not have policies and procedures for the management of episodes of high blood pressure or significant blood loss through access sites. Staff C also said that if the patient had high blood pressure or significant blood loss, the nurse would assess the patient then call the doctor and	V 408			

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V 408	Continued From page 21	V 408		
V 409	would follow the doctor's order. (Refer to V 494.60(d)(1) EMERGENCY PREPAREDNESS 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 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. This STANDARD is not met as evidenced by: Surveyor: 26616 Based on interview and record review, the facility failed to ensure that staff received training on emergency preparedness and demonstrated knowledge of emergency procedures. Nine of 12 Personnel files did not contain evidence of such training and evaluation. This failure had the potential that staff would not implement the facility's procedures in the event of an emergency.	V 409		

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V 409	Continued From page 22 Findings: On 7/21/09, review of 12 personnel files showed that nine staff members' file did not contain evidence of emergency preparedness training and demonstrated competency within the past 12 month. For example, Staff L's file showed no evidence of such training, Staffs F received training on 2/24/08, and Staffs D, G, K, P, and R, received training in March 2008. In an interview on 7/23/09 at 1:30 p.m., Staff C (Divisional Clinical Service Specialist) said the training should be conducted annually. The facility policy for "Disaster, Fire and Business Continuity Emergency Preparedness Guidelines", reviewed on 7/21/09, stated, "Facility Administrator (FA)/Manager will ensure that: All teammates will be inserviced annually on general disaster procedures."	V 409			
V 416	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency. This STANDARD is not met as evidenced by: Surveyor: 26616 Based on interview and record review, the facility failed to implement its policy and procedure for emergency preparedness when it failed to contact the local disaster management agency. This failure had the potential that, in the event of a disaster, the facility needs would not be met.	V 416			

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V 416	Continued From page 23 Findings: In an interview on 7/23/09 at 1:30 p.m., Staff C (Divisional Clinical Service Specialist) stated that the facility policy for emergency preparedness was created in September 2008, but has not been implemented yet. Staff C also stated that the facility had not contacted the local disaster management agency. Review of the facility policy for "Disaster, Fire and Business Continuity Emergency Preparedness Guidelines", reviewed on 7/23/09 stated, "The facility will: Contact the local disaster and management agency (emergency operations center [EOC]) at least annually to ensure that the disaster agency is aware of the dialysis facility needs in the event of an emergency."	V 416		
V 466	494.70(a)(15) PATIENTS' RIGHTS [The patient has the right to-] (15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency; This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to ensure that four (Patients 7, 13, 14, and 15) of 15 sampled patients received accurate information on how to contact the State survey agency. This failure placed the patients at risk of not being able to contact the State agency in case they had a grievance.	V 466		

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V 466	Continued From page 24 Findings: 1. During a telephone interview on 7/21/09 at approximately 10:30 a.m., Patient 7 stated he was not aware of the facility's grievance procedures. On 7/21/09, during an interview, Staff V said that all patients signed the form about the grievance procedures. When the form was reviewed by Staff V and this surveyor, it was noted that the form was signed by both Patient 7 and Staff V on 6/12/09 but the form contained an incorrect address and phone number for the State survey agency. Surveyor: 05189 2. On 7/22/09 and 7/23/09, record review showed that the "Patient Grievance Procedure" forms, signed by Patients 13, 14, and 15 on 3/12/09, contained an outdated State survey agency address and telephone number . Surveyor: 21174 3. Record review on 7/21/09 for Patients 6 and 10 showed Patient Grievance Procedure forms signed by the patients informing them to contact the State Agency at a long-outdated address and phone number.	V 466			
V 470	494.70(c) POSTING OF RIGHTS 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: Surveyor: 22301 Based on observation, interview, and record review, the facility failed to update the State	V 470			

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V 470	Continued From page 25 agency's address and phone number posted in the facility lobby. This failure placed the patients at risk of not being able to file a grievance with the State agency. Findings: By observation on 7/21/09 at approximately 10:30 a.m., in the presence of Staff V, the State agency's address and phone number posted in the facility's lobby were not current. This was pointed out to Staff C who took the posting down and stated the posting will be update.	V 470			
V 502	494.80(a)(1) ASSESSMENT CRITERIA The patient's comprehensive assessment must include, but is not limited to, the following: (1) Evaluation of current health status and medical condition, including co-morbid conditions. This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and record review, the facility failed to ensure that three (Patients 5, 14, and 15) of 15 sampled patients received an assessment of their current health condition. For Patient 5, the facility failed to assess the dry weight after the patient lost weight during an extended hospitalization and failed to validate the blood pressure reading prior to administering a blood pressure lowering drug. These failures had the potential for negative outcomes related to fluid	V 502			

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V 502	<p>Continued From page 26 and blood pressure management.</p> <p>The facility failed to assess Patient 14's condition after a treatment and to assess Patient 15's limping and painfull leg. These failures placed the patient at risk of unidentified needs.</p> <p>Findings:</p> <p>1. Patient 5 started dialysis in July 2003. On 5/28/09 Patient 5 was admitted in an acute hospital and was transferred to a nursing home for rehabilitation on 6/25/08.</p> <p>a. Review of his treatment flowsheets from 7/7/09 to 7/21/09 indicated that his present weight ranged from 85 kg to 89 kg. The dialysis orders on 7/21/09 had a dry weight order of 101 kg dry weight. Patient 5's pretreatment weight on 7/21/09 was 88.6 kg. There was no documented evidence that Patient 5's dry weight was adjusted to reflect his current weight.</p> <p>b. Patient 5 was observed during dialysis treatment on 7/21/09. His blood pressure at 4:02 p.m. was 256/135. By observation at 4:18 p.m., Staff I gave Patient 5 a dose of Clonidine (drug used to lower the blood pressure) without validating the blood pressure reading, placing Patient 5 at risk of a drop in blood pressure in case the reading was not accurate. Surveyor: 05189</p> <p>3. On 7/23/09, the review of the record showed that Patient 14 was admitted to the facility on 10/14/08 and discharged on 2/15/09.</p> <p>Record review further showed that on 1/1/09, Patient 14 had a prescription for 3 hour and 45 minutes duration. According to the flowsheet, the</p>	V 502			

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V 502	<p>Continued From page 27</p> <p>treatment was initiated at 7:00 a.m. and ended at 9:55 a.m., "per pt [patient]request". There was no documented evidence of a post treatment assessment of patient's condition prior to leaving the facility.</p> <p>4. Patient 15's record was reviewed on 7/22/09 and it showed that Patient 15 was admitted to the facility on 3/19/07. Patient 15 had a current prescription for 195 minute duration (3.25 hours).</p> <p>a. The flowsheet showed that on 3/16/09, the treatment was initiated at 6:14 a.m. and that the patient came in "limping due to leg pain", and that the RN (Staff D) was notified. The treatment was discontinued at 9:32 a.m. There was no documented evidence that Patient 15's condition after the treatment was evaluated. There was no evidence that the nurse assessed the patient's leg pain and decrease in function.</p> <p>On 7/22/09, Staff D acknowledged the deficient practice and stated that she was not sure why staff did not collect the complete post treatment data nor why the RN failed to conduct an assessment of the leg.</p> <p>b. The flowsheet dated 3/18/09, showed that Patient 15's blood pressure at 6:08 a.m., when the treatment was initiated, was 174/93. At 9:28 a.m., the treatment ended. The post-treatment sitting blood pressure was 165/99 and the post-treatment standing blood pressure was 172/103. There was no nursing assessment conducted by the registered nurse to address the elevated blood pressure before Patient 15 left the facility.</p> <p>On 7/22/09, Staff D acknowledged the deficient</p>	V 502			

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V 502	<p>Continued From page 28</p> <p>practice and could not provide an explanation as of why Patient 15's elevated blood pressure was not evaluated.</p> <p>Surveyor: 21174</p> <p>4. Record review on 7/21/09 showed that Patient 10 was admitted to the facility on 3/23/09 and was new to dialysis. There were no nursing assessments of Patient 10's present or pre-existing physical condition, symptoms, physical or sensory deficits, falls risk, immunization status, or dialysis access site. A nurse's progress note on 7/7/09 noted that Patient 10 had come into the facility with shortness of breath, general weakness, and vomiting that morning, so was sent to the emergency department instead of undergoing dialysis. There was no subsequent nursing progress note acknowledging Patient 10's three day hospitalization and no assessment of his condition upon his return to the facility. A review of Post Treatment records indicated nursing documented dialysis could not be performed on 7/18/09, because Patient 10's dialysis access, an AV graft, had clotted. There were no nursing progress notes addressing the clotted access.</p> <p>On 7/21/09 at approximately 9 a.m., the facility's clinical nursing consultant was informed there was no nursing input for the Interdisciplinary Assessment. She stated that the nurses were behind in their nursing assessments and were "trying to catch up."</p> <p>Patient 10 was interviewed at the facility on 7/21/09 at 4:50 p.m. He stated the physician thought his graft clotted because the clamps</p>	V 502			

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V 502	Continued From page 29 facility staff applied to his graft to stop the bleeding once dialysis needles were removed were applied too tightly, causing a clot. There was no evidence that the use of clamps was re-assessed for Patient 10. Patient 10 was interviewed again at the facility on 7/23/09 at 4:55 p.m. He stated he was able to apply his own pressure to his graft after his last dialysis treatment. He stated "It worked very well." He stated "The surgeon said there was too much pressure with the clamps." Observation showed a pair of clamps on the treatment table next to Patient 10. He was asked if he were going to apply pressure himself after the current treatment. He stated "I hope so". Staff W, the nurse caring for Patient 10 was asked if he heard about the results of the venogram (diagnostic test to determine patency of the access) or Patient 10's desire to hold his own pressure. He stated he had not heard about either the venogram or the patient's wishes but he would "mark it in the notes."	V 502		
V 503	494.80(a)(2) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] (2) Evaluation of the appropriateness of the dialysis prescription, This STANDARD is not met as evidenced by: Surveyor: 26616 Based on observation, interview and record review, the facility failed to evaluate the appropriateness of dialysis prescription for one of	V 503		

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V 503	Continued From page 30 15 sampled patients (Patient 2) when the blood flow rate was running between 200 to 500 milliliters/minute during dialysis treatment but the doctor's order stated 250 milliliters/minute. Failure to assess the appropriateness of the dialysis prescription placed the patient at risk for an ineffective treatment regimen. Findings: Patient 2 was admitted to the facility on 12/29/08 with diagnoses including diabetes and end stage renal disease. Patient 2's dialysis access was a left upper arm arteriovenous fistula (AVF). In an observation on 7/22/09 at 8:30 a.m., Patient 2 was having dialysis treatment in Station 15. She was awake and conversant. The dialysis machine screen showed a blood flow rate of 500 ml/min. On 7/22/09, review of the Hemo Treatment Orders, showed that on 4/6/09 the physician ordered, "Blood Flow Rate: 250" Review of Patient 2's Post Treatment records from 7/6/09 to 7/22/09, showed that the blood flow rate ranged from 200 ml/min to 500 ml/min. In an interview on 7/22/09 at 4:00 p.m., Staff C (Divisional Clinical Service Specialist) said the prescription for the blood flow rate of 250 was when the fistula was new, and they(meaning the registered nurses and the physician) missed to change it when Patient 2's fistula matured.	V 503		
V 504	494.80(a)(2) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] Blood pressure, and fluid management needs.	V 504		

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V 504	Continued From page 31 This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and record review, the facility failed to manage the blood pressure of two (Patients 5 and 11) of 15 sampled patients. This failure placed the patients at risk for a medical emergency, such as a stroke, related to high blood pressure. Findings: a. Patient 5 started dialysis in July 2003 because of kidney complications from high blood pressure(b/p). On 7/21/09 review of the flowsheet showed that at 2:58 p.m. Patient 5 presented with no edema, with a weight gain of 2.8 kg, and had a blood pressure of 233/165. At 3 p.m. the treatment was initiated. Patient 5's blood pressure was then recorded at 3:01 p.m. as 243/142, and according to the technician's documentation, the nurse was made aware of the high values. At 3:31 p.m. the blood pressure was 244/129 and at 4:02 p.m. it was 256/135. During an interview with the patient on 7/21/09 shortly after 4 p.m., the dialysis machine started alarming. Patient 5's blood pressure was still 256/135 mmHg. One liter of fluid had been removed. Staff O came and reset the machine to say that the alarm was acknowledged. Further record review showed that Patient 5's physician orders for blood pressure management included an order for Clonidine (drug used to lower the blood pressure) 0.10 mg orally if systolic	V 504		

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V 504	<p>Continued From page 32</p> <p>b/p > (higher then) 190 mmHg and diastolic b/p >110 mmHg. The dose was to be repeated twice if needed at one hour interval and the physician was to be notified for persistent systolic b/p >180 and diastolic >100. There was no documented evidence that Patient 5 was given Clonidine as ordered, despite the fact that his blood pressure was higher then the parameters dictated by the physician for drug administration. It was only at 4:18 p.m. that Staff I gave Patient 5 a dose of Clonidine, more then one hour after the treatment was started and the patient's blood pressure known.</p> <p>Patient 5's flowsheets were further reviewed and showed that the patient presented with high blood pressure in more than one occasion. For example, on 7/16/09 at 2:36 p.m., when the treatment was initiated, Patient 5 presented with generalized edema and the b/p was 188/104. By 3:36 p.m. the b/p increased to 223/119 and remained over 200/100 until the conclusion of the treatment, despite the fact that 4.3 kg of fluid were removed. According to nurse's documentation, Clonidine was given at 6:08 p.m. after the treatment was terminated and patient's blood pressure was 206/112. There was no dose of Clonidine given during treatment.</p> <p>On 7/14/09, Patient 5's blood pressure on arrival was 198/131 and at 3:17 p.m. was 210/105. A dose of Clonidine was given at 3:28 p.m. An hour later at 5: 17 p.m. the b/p was 246/115 and at 5:54 p.m. when the treatment ws discontinues it was 192/100 (two liters of fluid were removed). There was no evidence that a second dose of Clonidine was given as ordered when the b/p remained above the prescribing parameters.</p>	V 504			

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V 504	<p>Continued From page 33</p> <p>On 7/7/09, Patient 5's blood pressure at initiation was 192/115 and went up to 255/111 by 3:30 p.m. When the treatment was discontinued at 6:05 p.m. the b/p was 218/111. There was no documented evidence that Patient 5 was given any Clonidine.</p> <p>There was no notifications to the physician documented in the progress notes or in the post treatment flowsheets.</p> <p>b. Patient 11's first hemodialysis treatment was on 4/14/08 and was transferred to this facility on 5/15/08. Patient 11's kidneys failed secondary to complications of high blood pressure and diabetes.</p> <p>On 7/23/09, Patient's 11 treatment flowsheets from 7/7/09 to 7/21/09 were reviewed and showed that Patient 1's blood pressure was persistently and remarkably high. For instance, on 7/9/09, Patient 11's b/p was 204/89 at 10:48 a.m., one hour after the treatment was initiated and after 1 liter of fluid was removed. The patient was discharged after dialysis with a blood pressure of 228/119. There was no evidence that interventions were taken to address the high blood pressure.</p> <p>On 7/18/09 the patient's pretreatment blood pressure was 208/122 and the post treatment b/p was 184/118. There was no documented evidence that the patients vital signs (especially the b/p) were monitored during the dialysis treatment.</p> <p>On 7/27/09, Staff D was interviewed about Patient 11's high blood pressure. Staff D said Patient 11 had difficulty following the treatment regimen. She</p>	V 504			

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V 504	Continued From page 34 further said, "I agree, I don't know why the nurses did not call the doctor. I don't know why they did not give the standing order medications for high blood pressure. No, we don't have a policy on high blood pressure parameters, except the doctor's orders." Patient 11's medication orders were reviewed by this surveyor and Staff D. Patient 11 had PRN (as needed) orders for high blood pressure. The order was to give Clonidine 0.10 mg orally if the systolic b/p was >190 and the diastolic b/p>110. The dose could be repeated in one hour if needed and the physician was to be notified for persistent b/p systolic >180 and diastolic >100. The Clonidine was not administered to Patient 11 on 7/9 and on 7/18/09.	V 504		
V 540	494.90 PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Surveyor: 05189 Based on observation of care delivery, interview with staff and patients, and record review, the facility failed to comply with the Condition for Coverage for Patient Plan of Care as demonstrated by: Failure to develop comprehensive plans of care for three (Patients 2, 6, and 10) of 15 sampled patients (Refer to V541). Failure to implement the plan of care for three (Patients 1, 5, and 11) of 15 sampled patients, placing the patients at risk for a medical emergency, such as a stroke, related to high blood pressure (Refer to V541).	V 540		

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V 540	Continued From page 35 Failure to monitor the status of Patient 5, who was on the transplant list and failure to communicate with the transplant center at least annually, resulting in Patient 5 losing the place on the list of one transplant center (Refer to V561).	V 540			
V 541	494.90 PATIENT PLAN OF CARE The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by: Surveyor: 21174 Based on interview and record review, the facility failed to develop comprehensive plans of care for three (Patients 2, 6, and 10) of 15 sampled patients, and failed to implement the plan of care for three (Patients 1, 5, and 11) of 15 sampled patients. This failures increased the possibility that Patients 2's, 6's, and 10's needs would not be met, and placed Patients 1, 5 and 11, at risk for a medical emergency, such as a stroke, related to lack of management of high blood pressure.	V 541			

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V 541	<p>Continued From page 36</p> <p>Findings:</p> <p>1. Record review on 7/21/09 showed that Patient 6 was admitted to the facility on 8/22/08 after moving from another state, where she had been on chronic dialysis since 2002. Patient 6 received three treatments/week and had a catheter access because of her poor vasculature in her arms. She had a history of failed grafts. Because of the continued need for a catheter for dialysis access, the physician had requested that Patient 6 be moved up on the transplant list.</p> <p>Review of the clinical record on 7/21/09 indicated Patient 6 requested to end dialysis treatments early 21 times since she began dialysis at the facility. There was no documentation noted by any member of the health care team or no evidence of an interdisciplinary care plan developed to address Patient 6's lack of adherence to the dialysis regimen. The facility's clinical nurse consultant was interviewed on 7/23/09 at 1:35 p.m. and informed of the numerous early terminations. She stated "This could affect her chances for transplant." Looking through the record, she acknowledged there were quite a few requests and confirmed there was no documentation in the patient's records indicating staff's addressing the problem.</p> <p>The registered dietitian was interviewed on 7/23/09 at 3:35 p.m. She stated "It would have been helpful to having nursing's input (regarding the numerous early terminations)."</p> <p>2. Record review on 7/21/09 showed that Patient 10 was admitted to the facility on 3/23/09 and was new to dialysis. The record contained no</p>	V 541			

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V 541	<p>Continued From page 37</p> <p>evidence that a nursing assessment was conducted for Patient 10 and consequently, the patient care plan did not contain any nursing input. A nurse's progress note on 7/7/09 noted that Patient 10 had come into the facility with shortness of breath, general weakness, and vomiting that morning, so was sent to the emergency department instead of undergoing dialysis. There was no subsequent nursing progress note acknowledging Patient 10's three day hospitalization, what his condition was, or what the plan of care might entail. A review of Post Treatment records indicated nursing documented dialysis could not be performed on 7/18/09, because Patient 10's dialysis access, an AV graft, had clotted. There were no nursing progress notes addressing the clotted access, what procedure was done by the vascular surgeon to clear the clot, and what the plan of care might entail to ensure patency of the graft.</p> <p>On 7/21/09 at approximately 9 a.m., the facility's clinical nursing consultant was informed there was no nursing input for the Interdisciplinary Assessment nor any nursing plans of care for Patient 10 identified. She stated that the nurses were behind in their nursing assessments and development of care plans and were "trying to catch up." She stated that the facility's priority was to get the plans of care for those patients admitted after November 2008 caught up first, then work on the plans of care for the rest of the patients. She was informed that Patient 10 was recently admitted, yet had no comprehensive or nursing specific plans of care.</p> <p>Patient 10 was interviewed at the facility on 7/21/09 at 4:50 p.m. He stated the physician thought his graft clotted because the clamps</p>	V 541			

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V 541	<p>Continued From page 38</p> <p>facility staff applied to his graft to stop the bleeding once dialysis needles were removed were applied too tightly, causing a clot. He stated he wanted to apply pressure to the graft himself and he knew how to do it.</p> <p>Patient 10 was interviewed again at the facility on 7/23/09 at 4:55 p.m. He stated he was able to apply his own pressure to his graft after his last dialysis treatment. He stated "It worked very well." He stated "The surgeon said there was too much pressure with the clamps." Observation showed a pair of clamps on the treatment table next to Patient 10. He was asked if he were going to apply pressure himself after the current treatment. He stated "I hope so". Staff W, the nurse caring for Patient 10 was asked if he heard about the results of the venogram (diagnostic test to determine patency of the access) or Patient 10's desire to hold his own pressure. He stated he had not heard about either the venogram or the patient's wishes but he would "mark it in the notes."</p> <p>Surveyor: 26616</p> <p>3. Record review on 7/21/09 showed that Patient 2 was admitted to the facility on 12/29/08 with diagnoses including diabetes, end stage renal disease, and anemia. The patient received in center hemodialysis treatments on Mondays, Wednesdays and Fridays via an arteriovenous fistula (AVF- access) placed on the left upper arm. Patient 2 had low albumin levels (blood test to check nutritional status), ranging from 2.7 to 3.3 (Normal - > 4.0 g/dl (grams per deciliter) from March 2009 to July 2009. Further record review showed that Patient 2 had history of falls at home and at the facility.</p>	V 541			

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V 541	<p>Continued From page 39</p> <p>The Nurse's assessment, dated 4/23/09, indicated, "...lower extremity edema...Pt (patient) had some bruising on access area noted even w/o (without) any apparent infiltration (accumulation of blood in the tissue or bruise when needle was displaced out of vein or artery during dialysis)...Pt. had a few reported episode of falling however reports that she continues to manage well w/ (with) walker instead of cane."</p> <p>On 6/29/09 the dietitian documented in a progress note, "Patient is currently mildly protein malnourished, her weight however has remained stable and she reports a good appetite....Patient has not tolerated a variety of supplement samples she has been given to try. Provided education on improving HBV (high biologic value) protein intake and encouraged patient to continue to work on the same. Will continue to monitor nutritional parameters and to follow-up with patient when necessary."</p> <p>Further record review showed no evidence that a comprehensive and individualized plan of care, based on the multi-disciplinary assessment, was developed for Patient 2. There were no documented interventions and treatment goals that were individualized to Patient 2's needs, and that were measurable.</p> <p>In an interview on 7/22/09 at 11:00 a.m., Staff C (Divisional Clinical Service Specialist) stated that the facility staff have started developing comprehensive care plans for newly admitted patients, but none was developed Patient 2. Surveyor: 22301</p> <p>4. Patient 5 started dialysis in July 2003 because of kidney complications from high blood pressure (b/p).</p>	V 541			

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V 541	Continued From page 40 On 7/21/09 review of the flowsheet showed that at 2:58 p.m., Patient 5 presented with no edema, with a weight gain of 2.8 kg, and had a blood pressure of 233/165. At 3 p.m. the treatment was initiated. Patient 5's blood pressure was then recorded at 3:01 p.m. as 243/142, and according to the technician's documentation, the nurse was made aware of the high values. At 3:31 p.m. the blood pressure was 244/129 and at 4:02 p.m. it was 256/135. During an interview with the patient on 7/21/09 shortly after 4 p.m., the dialysis machine started alarming. Patient 5's blood pressure was still 256/135 mmHg. One liter of fluid had been removed. Staff O came and reset the machine to display that the alarm was acknowledged. Further record review showed that Patient 5's plan of care included physician orders for Clonidine (drug used to lower the blood pressure) 0.10 mg orally if systolic b/p > (higher then) 190 mmHg and diastolic b/p >110 mmHg. The dose was to be repeated twice if needed at one hour interval and the physician was to be notified for persistent systolic b/p >180 and diastolic >100. There was no documented evidence that Patient 5 was given Clonidine as ordered/planned, despite the fact that his blood pressure was higher then the parameters dictated by the physician for drug administration. It was only at 4:18 p.m. that Staff I gave Patient 5 a dose of Clonidine, more then one hour after the treatment was started and the patient's blood pressure known. Patient 5's flowsheets were further reviewed and showed that the patient presented with high blood pressure in more than one occasion. For	V 541			

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V 541	<p>Continued From page 41</p> <p>example, on 7/16/09 at 2:36 p.m., when the treatment was initiated, Patient 5 presented with generalized edema and the b/p was 188/104. By 3:36 p.m. the b/p increased to 223/119 and remained over 200/110 until the conclusion of the treatment, despite the fact that 4.3 kg of fluid were removed. According to nurse's documentation, Clonidine was given at 6:08 p.m. after the treatment was terminated and patient's blood pressure was 206/112. There was no dose of Clonidine given during treatment.</p> <p>On 7/14/09, Patient 5's blood pressure on arrival at 2:08 p.m. was 198/131 and at 3:17 p.m. was 210/105. Clonidine was not given until 3:28 p.m. An hour later at 5: 17 p.m. the b/p was 246/115 and at 5:54 p.m., when the treatment was discontinued, it was 192/100 (two liters of fluid had been removed). There was no evidence that a second dose of Clonidine was given as ordered and in accordance with the plan of care, when the b/p remained above the prescribing parameters.</p> <p>On 7/7/09, Patient 5's blood pressure at initiation was 192/115 and went up to 255/111 by 3:30 p.m. When the treatment was discontinued at 6:05 p.m. the b/p was 218/111. There was no documented evidence that Patient 5 was given any Clonidine.</p> <p>There was no notifications to the physician documented in the progress notes or in the post treatment flowsheets.</p> <p>5. Patient 11's first hemodialysis treatment was on 4/14/08 and was transferred to this facility on 5/15/08. Patient 11's kidneys had failed secondary to complications of high blood pressure and diabetes.</p>	V 541			

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V 541	Continued From page 42 On 7/23/09, Patient's 11 treatment flowsheets from 7/7/09 to 7/21/09 were reviewed and showed that Patient 1's blood pressure was persistently and remarkably high. For instance, on 7/9/09, Patient 11's b/p was 204/89 at 10:48 a.m., one hour after the treatment was initiated and after 1 liter of fluid had been removed. The patient was discharged after dialysis with a blood pressure of 228/119. There was no evidence that interventions were taken to address the high blood pressure in accordance with the plan of care. On 7/27/09, Staff D was interviewed about Patient 11's high blood pressure. Staff D said, "I don't know why the nurses did not call the doctor. I don't know why they did not give the standing order medications for high blood pressure. No, we don't have a policy on high blood pressure parameters, except the doctor's orders." Patient 11's medication orders were reviewed by this surveyor and Staff D. Patient 11 had PRN (as needed) orders for high blood pressure. The order was to give Clonidine 0.10 mg orally if the systolic b/p was >190 and the diastolic b/p>110. The dose could be repeated in one hour if needed and the physician was to be notified for persistent b/p systolic >180 and diastolic >100. The plan of care was not implemented when Clonidine was not administered to Patient 11 on 7/9 and on 7/18/09.	V 541			
V 542	494.90(a) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient.	V 542			

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V 542	<p>Continued From page 43</p> <p>This STANDARD is not met as evidenced by: Surveyor: 21174</p> <p>Based on interview and record review, the facility failed to develop comprehensive plans of care for three (Patients 2, 6, and 10) of 15 sampled patients. This failure increased the possibility that Patients 2, 6, and 10's needs would not be met.</p> <p>Findings:</p> <p>1. Record review on 7/21/09 showed that Patient 6 was admitted to the facility on 8/22/08 after moving from another state, where she had been on chronic dialysis since 2002. Patient 6 had a catheter access because of her poor vasculature in her arms. She had a history of failed grafts. Because of the continued need for a catheter for dialysis access, her physician had requested that Patient 6 be moved up on the transplant list.</p> <p>Review of Patient 6's record on 7/21/09 indicated she requested to end dialysis treatments early 21 times since she began dialysis at the facility. There was no documentation noted by any member of the health care team or no evidence of an interdisciplinary care plan developed to address Patient 6's lack of adherence to the dialysis regimen. The facility's clinical nurse consultant was interviewed on 7/23/09 at 1:35 p.m. and informed of the numerous early terminations. She stated "This could affect her chances for transplant." Looking through the record, she acknowledged there were quite a few requests and confirmed there was no documentation in the patient's records indicating staff's addressing the problem.</p> <p>The registered dietitian was interviewed on 7/23/09 at 3:35 p.m. She stated "It would have</p>	V 542			

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V 542	<p>Continued From page 44</p> <p>been helpful to having nursing's input (regarding the numerous early terminations)." "I'm not on the floor when she terminates her treatment. Part of the problem may be that she feels so good."</p> <p>2. Record review on 7/21/09 showed that Patient 10 was admitted to the facility on 3/23/09 and was new to dialysis. Review of the Interdisciplinary Assessment for Patient 10 indicated assessment findings and condition management issues by the registered dietitian and social worker, but no nursing assessment or identified management issues, despite Patient 10's admission almost four months ago. There were no nursing assessments of Patient 10's present or pre-existing physical condition, symptoms, physical or sensory deficits, falls risk, immunization status, or dialysis access site. A nurse's progress note on 7/7/09 noted that Patient 10 had come into the facility with shortness of breath, general weakness, and vomiting that morning, so was sent to the emergency department instead of undergoing dialysis. There was no subsequent nursing progress note acknowledging Patient 10's three day hospitalization, what his condition was, or what the plan of care might entail. A review of Post Treatment records indicated nursing documented dialysis could not be performed on 7/18/09, because Patient 10's dialysis access, an AV graft, had clotted. There were no nursing progress notes addressing the clotting access, what procedure was done by the vascular surgeon to clear the clot, and what the plan of care might entail to ensure patency of the graft.</p> <p>On 7/21/09 at approximately 9 a.m., the facility's clinical nursing consultant was informed there was no nursing input for the Interdisciplinary</p>	V 542			

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V 542	Continued From page 45 Assessment nor any nursing plans of care for Patient 10 identified. She stated that the nurses were behind in their nursing assessments and development of care plans and were "trying to catch up." She stated that the facility's priority was to get the plans of care for those patients admitted after November 2008 caught up first, then work on the plans of care for the rest of the patients. She was informed that Patient 10 was recently admitted, yet had no comprehensive or nursing specific plans of care. Patient 10 was interviewed at the facility on 7/21/09 at 4:50 p.m. He stated the physician thought his graft clotted because the clamps facility staff applied to his graft to stop the bleeding once dialysis needles were removed were applied too tightly, causing a clot. He stated he wanted to apply pressure to the graft himself and he knew how to do it. Patient 10 was interviewed again at the facility on 7/23/09 at 4:55 p.m. He stated he was able to apply his own pressure to his graft after his last dialysis treatment. He stated "It worked very well." He stated "The surgeon said there was too much pressure with the clamps." Observation showed a pair of clamps on the treatment table next to Patient 10. He was asked if he were going to apply pressure himself after the current treatment. He stated "I hope so". Staff W, the nurse caring for Patient 10 was asked if he heard about the results of the venogram (diagnostic test to determine patency of the access) or Patient 10's desire to hold his own pressure. He stated he had not heard about either the venogram or the patient's wishes but he would "mark it in the notes."	V 542			
V 554	494.90(a)(7)(ii) DEVELOPMENT OF PATIENT	V 554			

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V 554	<p>Continued From page 46 PLAN OF CARE</p> <p>When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the-</p> <p>(A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with §494.80(a)(10).</p> <p>This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to maintain the transplant status of one from thirteen patients sampled. This failure resulted in the patient losing his place in the list of one transplant center.</p> <p>Findings:</p> <p>Patient 5's first dialysis started back on 7/2003. His kidneys failed secondary to his high blood pressure. Patient 5 was admitted to the facility on 12/2006.</p> <p>On 7/21/09 at approximately 11 a.m., Patient 5's medical record was reviewed. In the long term</p>	V 554		

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V 554	<p>Continued From page 47</p> <p>program dated 8/2/07, Patient 5 checked the transplant and the cadaver donor portion referring to his continued choice to eventually get a kidney transplant. Again on 7/3/08, the transplant portion was checked. Upon further review of the patient's record, this surveyor found a letter from a Transplant Center 1 dated 4/23/09 stating that the transplant center will close the patient's case with the transplant center because the patient or the dialysis facility did not respond or reply to the letter and phone calls the transplant center made regarding some requirements in order to update transplant status of Patient 5. The letter stated, "On 1/27/09, we sent you a letter asking you to contact our office within 30days to discuss your transplant evaluation at the _____ Transplant Center. We have also called your dialysis unit on 3/18/09 and 3/23/09 and not received a response. Because we have not heard from you, we are left to assume that you are not interested in pursuing a transplant at this time and we have closed your case with our Center."</p> <p>The letter from Transplant Center 1 referred to in the previous paragraph was also in the patient's record. The letter dated 1/26/09 stated that the transplant center needed updated chest Xray, echocardiogram, EKG and laboratory results. It also stated to contact the transplant center within 30 days from the date of the letter.</p> <p>This was brought to the attention of Staff D and Staff S. Staff D said the social worker who follow Patient 5 will be available 7/23/09. Staff S acknowledged that the social workers are expected to do the coordination with the transplant centers and it is the social workers's responsibility to follow up the transplant status of the patient.</p>	V 554			

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V 554	<p>Continued From page 48</p> <p>The transplant history of Patient 5 was reviewed with Staff S since Staff T was not available at the time. The facilities tracking list indicated that Patient 5 was listed in two transplant centers. Transplant Center 1 had referred date as 6/6/08 and evaluated date as 6/12/08. Transplant Center 2 referred date was 9/20/04 and evaluated date was 10/07/04. Under the June and July 2009 Transplant List for Davita East Bay Nephology, Patient 5 was blank under comments. Staff S said Staff T was supposed to fill that up. Tranplant Center 2's Kidney waiting list dated 7/13/09 was reviewed and it indicated Patient 5 as "active (6/08) seen for re-eval, remain med cleared but needs upd cxr, ekg & echo. (7/05) Med cleared 6/08) SW re cleared. Excellent candidate."</p> <p>Another letter dated 6/9/08 from the Outreach Nurse Practitioner indicated that Patient 5 was found to be an excellent transplant candidate after a re-evaluation done by a physician and the nurse practitioner.</p> <p>There was no documentation found referring to the telephone calls made by Transplant Center 1.</p> <p>On 7/23/09, Staff T acknowledged she did not get any messages and denied having any knowledge of the letter dated 4/23/09 from Transplant Center 1.</p> <p>There was no mention of addressing the present transplant status of Patient 5 found in the plan of care.</p> <p>Legend: Transplant Center 1 - UC Davis Transplant Center 2 - California Pacific Medical</p>	V 554		

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V 554	Continued From page 49 Center	V 554		
V 561	494.90(c) TRANSPLANTATION REFERRAL TRACKING The interdisciplinary team must- (1) Track the results of each kidney transplant center referral; (2) Monitor the status of any facility patients who are on the transplant wait list; and (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status. This STANDARD is not met as evidenced by: Surveyor: 22301 Based on interview and record review, the facility failed to monitor one patient's transplant status. This failure resulted in the patient getting off the waiting list of one transplant center. Findings: Refer to Vtag 554. At approximately 9 a.m. on 7/23/09, Staff T (Patient 5's assigned social worker) was interviewed and asked about the transplant status of Patient 5. Staff T immediately responded, "It's taken cared of". After this surveyor discussed with Staff T the result of Staff S and this surveyor's review, she said, "He is taken off the list? Now that, I don't know anything about, What did you say , he was on Transplant Center 1 , I know he was listed at Transplant Center 2. I don't have knowledge of this letter. I'll find his letter with Transplant Center 2, it's in the print out usually. He was in the hospital and is in a nursing home now. I saw him yesterday. No, I did not get any	V 561		

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V 561	Continued From page 50 telephone messages. I only work here part time." Patient 5 was interviewed on 7/23/09 at 3:35 p.m. while he was getting his dialysis treatment. When asked where he is right now with the transplant list he said, " I don't know right now, my social worker came to see me today and said I'm not even on the list, how can that be I went to my appointments,sent everything they asked for, they sent me tubes for labs and I had them draw it here. I don't know what happened to that. Yes, I remember getting a letter but I was in and out of the hospital then, I was so sick to take care of it, I did not feel well most of the time so I probably put it aside." Patient 5 was in the hospital from 5/28/09 to 6/25/09. There was definitely a change of status for the patient. He now resides temporarily in a skilled nursing facility, his dry weight before he was in the hospital was 101 kg, his recent post dialysis weights ranges from 85 kg to 89 kg, a weight loss of approximately 15 kg. He now have central venous catheter as his dialysis access. These changes do not have documentation of coordinating or notification to the transplant center.	V 561			
V 587	494.100(b)(2),(3) HOME DIALYSIS MONITORING [The dialysis facility must -] (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient's medical record.	V 587			

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V 587	<p>Continued From page 51</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14545 Based on record review and interview, the facility failed to retrieve and review the home treatment records for peritoneal dialysis from 2/8/09 through 7/21/09 for one of 15 sampled patients, Patient 8. The failure to retrieve and to review the home treatment records had the potential that staff would not monitor the patients' status to determine if the patients follow the treatment regimen or have problems with their home dialysis.</p> <p>Findings:</p> <p>Patient 8 was admitted to the facility on 9/13/05 with diagnoses including chronic renal failure and diabetes, type 2.</p> <p>During interview on 7/21/09 at 1 p.m., Patient 8 said she forgot to bring in her self-monitoring CCPD treatment records from home.</p> <p>Record review on 7/21/09 found Patient 8 had current physician orders for peritoneal dialysis with cyclor (CCPD). The most current records of Patient 8's home CCPD treatments were dated 2/6, 2/7, and 2/8/09.</p> <p>Review of interdisciplinary progress notes from February 2009 to the date (7/21/09) found only one entry that addressed the need for Patient 8 to bring in home CCPD records. The nurse wrote on 4/23/09: "asked patient to bring inher flow sheet to see how much fluid she is taking off. Verbalized understanding."</p> <p>There was no evidence the facility consistently</p>	V 587		

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V 587	Continued From page 52	V 587			
V 715	<p>educated and reinforced the need for Patient 8 to bring in self monitoring data for home treatments.</p> <p>494.150(c)(2)(i) POLICIES AND PROCEDURES</p> <p>The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on record review and staff interview, the facility failed to implement its medication administration policies/procedures for three of seven treatments provided to one (Patient 15) of 15 sampled patients. The staff failed to document the use of saline flushes prior and after medication administration. This failure increased the risk of medication mixing and possible potential risk of drug interaction.</p> <p>Findings:</p> <p>On 7/22/09, the review of the closed record showed that Patient 15 received treatment at the facility from 3/13/09 to 3/23/09 and had a prescription for four treatments per week. On 3/13/09 the physician ordered for Patient 15 Epogen (red blood cell production enhancer), 5500 unites, IV (intravenous) push, and Zemplar (synthetic Vitamin D medication that reduces parathyroid hormone levels), 2 mcg (micrograms), IV push.</p> <p>On 7/22/09, review of the facility policy for</p>	V 715			

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V 715	Continued From page 53 "Administration Of Intravenous Epogen" showed that the policy instructed the staff to: "a. Open...saline clamps and flush line with 50 ml [cc] saline (prevents backup of medication into saline bag). b. After administering Epogen..., flush 50 ml of saline...(ensures Epogen is flushed into system). c. Document administration of medication and saline flush, including dose, route, time,..." The facility policy for "Administration of Parental Medications (Non-Epogen)", reviewed on 7/22/09, instructed the staff to: "a. Open...saline clamps and flush line with 50 ml saline. b. After administering the medication..., flush 50 ml of saline... c. If more than one (1) medication is being administered, flush the saline line with 50 ml of saline between each medication. (Ensures medications are not mixed) d. Document administration of medication and saline flush, including dose, route, time..." Patient 15's flowsheets dated 3/13/09, 3/16/09, and 3/21/09 showed that the patient was given Epogen and Zemplar, and received a flush of only 100 ml of saline, instead of the 150 ml as instructed by the policy. On 7/22/09, Staff C acknowledged the deficient practice and stated she was not sure why staff failed to document and follow the above medication administration policies and procedures.	V 715		
V 726	494.170 MEDICAL RECORDS The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive	V 726		

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V 726	<p>Continued From page 54</p> <p>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: Surveyor: 05189 Based on record review and interview, the facility failed to maintain accurate and complete records for four of 15 sampled patients (Patients 6, 10, 13 and 14).</p> <p>1. The facility failed to document blood glucose results, thirty-minute checks, and responses to interventions for Patient 13. These failures placed the patient at risk that potential complications would not be promptly identified and addressed by staff.</p> <p>2. The facility failed to document accurate numerical post-treatment weight in relationship to fluid loss, complete the patient early treatment termination form, complete the post assessment data format, complete and accurately document medication administration, and complete the rationale for prolonged treatment for Patient 14. These failures did not ensure that Patient 14 received the care and services to attain or maintain the highest practicable physical well-being.</p> <p>3. The facility provided Patients 6 and 10 with incorrect information for contacting the State Agency, potentially hindering grievance resolution.</p> <p>Findings:</p> <p>1. On 7/23/09, review of the closed medical</p>	V 726			

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V 726	<p>Continued From page 55</p> <p>record showed that Patient 13 was admitted to the facility on 12/12/06 with end stage kidney disease and diabetes and was discharged from the facility on 2/6/09.</p> <p>a. The "Order Inquiry Report", dated 1/12/09, showed that Patient 13 had a physician order for Blood Glucose (sugar) Testing, every treatment. However, the flowsheet dated 2/6/09, showed no blood sugar test results documented. Moreover, the "Medication & Ancillaries Administered" section of the 2/6/09 dated flow sheet showed that the Blood Glucose Testing was "missed".</p> <p>b. The flowsheet, dated 2/2/09, showed that Patient 13 had a prescription for 180 minute (3 hour) duration. The treatment was initiated at 6:05 a.m., the patient was asymptomatic and had a blood pressure of 114/60. At 6:35 am, Patient 13 was asymptomatic and "awake" with a blood pressure of 105/63.</p> <p>The next entry on the flowsheet was documented at 7:25 am (approximately an hour later), when Patient 13 was found to be "hypotensive" (low blood pressure) at 97/59. At this time, 200 ml (milliliter) of NS (normal saline) was administered. There was no documentation of Patient 13's response to the intervention.</p> <p>At 8:51 a.m. Patient 13 continued to have a low blood pressure (90/52), and the UF was decreased. At 9:05 am Patient 13's treatment ended.</p> <p>On 7/23/09, review of the facility policy for "Intradialytic Monitoring" showed the following: "a. Treatment checks should be completed at least every thirty [30] minutes."</p>	V 726			

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V 726	<p>Continued From page 56</p> <p>b. All findings, interventions and patient response will be documented in the patient's medical record."</p> <p>On 7/23/09, Staff C acknowledged the deficient practice and stated she was unsure why the ordered blood glucose test, thirty minute checks, the patient response to the interventions were not documented.</p> <p>2. Record review on 7/23/09, showed that Patient 14 was admitted to the facility on 10/14/08 and was discharged from the facility on 2/6/09.</p> <p>a) The flowsheet dated 1/1/09, showed that Patient 14 had a prescription for:</p> <ul style="list-style-type: none"> - Dry Weight of 128.5 kilograms. - 2000 unit Heparin (anti-clotting medication) Bolus; - Zemplar (synthetic Vitamin D medication that reduces parathyroid hormone levels), 1.5 mcg (micrograms); - Epogen (red blood cell production enhancer medication) and, - 225 minute (3 hours and 45 minutes) treatment duration. <p>According to the flowsheet dated 1/1/09, Patient 14's pre-treatment weight was 131.6 kg., indicating the need to remove 3.1 kg to meet the patient's dry weight of 128.5 kg. The treatment was ended at 9:32 a.m., approximately one hour early and only 2.4 kg of fluid were removed as documented in the "Intradialytics" section of the flowsheet. Further review showed that the "Post Treatment" section of the flowsheet showed only a 1.5 kg fluid removal.</p> <p>On 7/23/09, Staff C stated that she was not sure</p>	V 726			

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V 726	<p>Continued From page 57</p> <p>why there were discrepancies in Patient 14's clinical documentation.</p> <p>The "Early Termination Of Treatment" form utilized by the facility for patient early termination of treatment was incomplete. For example, the "Reason", "Patient Signature", and other designated sections were blank. On 7/23/09, Staff C stated the form should have been completed, or the staff should have documented why it was not completed.</p> <p>Further review showed that section for "Post treatment Data Collection & Assessment" was not complete to include Patient 14's clinical condition at the end of treatment.</p> <p>According to the same flowsheet, Patient 14 received only 14 units of Heparin, instead of the 2000 units prescribed by the physician. On 7/23/09 at approximately 12:30 p.m., Staff W stated (and demonstrated) that the only heparin vials used in the facility for Heparin Bolus administration were the 1,000 unit/ml vials where it would be almost impossible for a nurse to prepare only 14 units. Staff W did not explain the discrepancy in documentation.</p> <p>b) Review of the flowsheet dated 1/6/09, showed that Patient 14 had a prescription for 225 minute (3 hours and 45 minutes) duration. The treatment was started at 6:26 a.m. and was to last until 10:11 am. However, the flowsheet showed that the treatment was prolonged until 10:25 am. There was no documentation explaining why the treatment was extended.</p> <p>On 7/23/09, Staff C acknowledged the deficient practice and stated she was not sure why the</p>	V 726			

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V 726	Continued From page 58 treatment was prolonged beyond the prescribed duration.	V 726		
V 729	Surveyor: 21174 3. Record review on 7/21/09 for Patients 6 and 10 showed Patient Grievance Procedure forms signed by the patients informing them to contact the State Agency at a long-outdated address and phone number. 494.170(b)(1) COMPLETION OF RECORDS/CENTRALIZATION OF INFO Current medical records and those of discharged patients must be completed promptly. This STANDARD is not met as evidenced by: Surveyor: 22301 Based on observation, interview, and record review, the facility failed to complete promptly one (Patient 5) of 15 sampled patients' medical record. The staff failed to promptly document the administration of a blood pressure lowering drug to Patient 5. This failure had the potential that the interdisciplinary team members would not have an up-to-date image of the patient at all times. Findings: By observation on 7/21/09 at approximately 4:10 p.m., Patient 5's blood pressure recorded during treatment 256/135 mmHg and the pulse was 87 beats/minute. At 4:18 p.m. Staff I gave Patient 5 a dose of Clonidine (drug used to lower blood pressure).	V 729		

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V 729	Continued From page 59 The flowsheet for the dialysis treatment provided on 7/21/09 was reviewed on 7/24/09 and showed that administration of Clonidine was not documented by Staff I. Staff D confirmed the findings.	V 729		