

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/20/2010
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OF MID-WILSHIRE			STREET ADDRESS, CITY, STATE, ZIP CODE 3545 WILSHIRE BOULEVARD, SUITE #103 LOS ANGELES, CA 90010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Complaint visit. Complaint Intake Number: CA00234251- Substantiated	V 000		
V 502	494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS 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: Based on interview and record review, the facility failed to include in the medical record a current history and physical examination for Patient 1. Findings: A review of the medical record revealed Patient 1 was admitted to the facility on May 12, 2010, with end stage renal disease, diabetes and hypertension. A copy of a consultation dated December 14, 2009, was faxed to the facility on April 29, 2010 (13 days prior to admission to the facility). The reason for the consultation was for permacath placement and creation of an arteriovenous fistula for dialysis access. There was no current	V 502		9/21/10

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

TITLE

(X6) DATE

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

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V 502	Continued From page 1 history and physical examination that was completed by the physician. During an interview on September 20, 2010 at 11:25 a.m., the facility administrator could not explain why there was no current history and physical examination in Patient 1's medical record. A review of the facility's policy and procedure on Comprehensive Interdisciplinary Assessment and Plan of Care, on the Role of the Interdisciplinary Team section revealed the patient's attending physician prior to admission to the facility will provide documentation including a current (defined as within the last 30 days) history and physical or hospital or clinic discharge summary prior to the patient's first visit at the dialysis facility that can be used to evaluate the patients current health status, medical condition including co-morbidities, immunization history, and medication history).	V 502			
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS 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.	V 541		9/20/10	

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V 541	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a care plan addressing Patient 1's behavior problem. Findings: During an interview on September 20, 2010, at 8 a.m., Staff B stated she wanted to complain about Patient 1. She stated that every treatment day the patient had a lot of issues. She stated he was not respectful to the staff including herself. She further stated the patient did not use the call light to call staff. Instead he snapped his fingers to call staff. During an interview on September 20, 2010, at 8:52 a.m., the social worker stated Patient 1 was rude to staff and other patients have observed. A review of the medical record revealed Patient 1 was admitted to the facility on May 12, 2010. A comprehensive assessment was completed on May 21, 2010. A care plan was developed on May 21, 2010. A review of the interdisciplinary notes from May, 12, 2010- September 8, 2010, revealed documentation of the behavior problems of Patient 1. There was no care plan developed addressing the behavior problems. During an interview on September 20, 2010, at 11:30 a.m., the facility administrator stated the behavior problem should have been addressed in the care plan. A review of the physician notes form May 2010-	V 541			

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V 541	<p>Continued From page 3</p> <p>September 2010 revealed no documentation of the patient's behavior problems.</p> <p>During an interview on September 20, 2010, at 9:37 a.m., the social worker stated she discussed Patient 1's behavior problems with the physician but she did not document the discussions she had with the physician.</p> <p>A review of the facility's policy and procedure on Comprehensive Interdisciplinary assessment and Plan of Care revealed significant change in psychosocial needs/ change in mentation or psychosocial needs severe enough to interfere with the patient's ability to follow aspects of the treatment plan and may include situations related to immediate family members. (Any patient considered at risk for involuntary discharge or transfer must be considered "unstable" under this category.) The plan of care components included the psychosocial status and the description was to provide necessary monitoring and social work interventions, including counseling services and appropriate referrals.</p> <p>The section on plan of care and updates to plan revealed if the patient is stable, but not meeting the plan of care goals in specific areas, then those areas should be reassessed and the plan of care revised for those areas., or changes documented in the progress notes or physician extender orders.</p>	V 541			