

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052549</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/23/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRESENIUS MEDICAL CARE BURBANK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2031 WEST ALAMEDA AVE SUITE 202 BURBANK, CA 91506</b>	
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V 000	INITIAL COMMENTS  Surveyor: 11683 The following reflects the findings of the Department of Public Health during a Recertification Survey.  Representing the Department of Public Health: Marcelyn Cypert, REHS, HFE II Rosalinda Ramos, RN, HFE I Sylvia Villaflores, REHS, HFE I	V 000		
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE  Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.  This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility staff members failed to wash their hands in between caring for patient and/or touching patient equipment when gloves were changed.  Findings:  a. On January 21, 2009, at 12:50 p.m., Employee A was observed with gloved hands administering normal saline and attaching the blood pressure cuff to Patient 9 in Station 15. Employee A then changed gloved to terminate treatment for the patient in Station 14. Employee A was observed in between gloved changes attending to patients in stations 14 and 15. Employee A was also observed touching the hemodialysis machine with	V 113		5/15/09

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 113	<p>Continued From page 1</p> <p>gloved hands and working on the computer with bare hands for both stations.</p> <p>On January 23, 2009, at 2 p.m., during an interview with Employee A, he stated that he should have washed his hands in between patient care as well as when touching the equipment after each glove change.</p> <p>A review of the facility's policy on Hand Hygiene stipulated that hands should be washed with antimicrobial soap and water before direct contact with a patient after removing gloves and after contact with equipment, computers, furniture or other items near the patient.</p> <p>b. On January 21, 2009, at 1:50 pm., Employee B was observed wearing complete personal protective equipment while providing catheter care to Patient 13. Employee B had clean supplies gauzes, tape, "Exsept" antibacterial solution, heparin/normal saline filled syringes and hemostats on top of a blue disposable chux by the armchair. The employee wiped and wrapped the two port lumen catheter with Exsept soaked gauze, disposed the soiled gauzes on top of the syringes, and then pulled the syringes under the piles of soiled gauzes, and administered normal saline and heparin. The patient was then hooked up to the hemodialysis machine and started treatment. A hemostat (plastic locking device to prevent dislodgement) was then taken from amongst the pile of clean and used supplies and was applied to the tubing.</p> <p>On the same day, at 2 p.m., during an interview with Employee B, she agreed that the clean and soiled supplies used for Patient 13 should have been separated to prevent cross contamination.</p>	V 113			

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V 113	Continued From page 2  Surveyor: 06616 c. On January 22, 2009, at 9:30 A.M., during the morning observation, Patient 6 was observed receiving dialysis. Employee G was observed adjusting the treatment prescription on the dialysis machine with the right hand only and with the left hand, extending the left index finger of the clean and hand touching the computer to complete the delivery of prescribed treatment orders. In an interview at 9:40 a.m., Employee H stated, "staff do not want to contaminate the computer so they adjust the patient parameters on the dialysis machine with one hand and input treatment information into the computer with their other hand. It eliminates having to wash their hands." A review of the infection control policy and procedure FMS-CS-IC-II-155-080A, entitled, "Gloves", stipulates, "Employees are to wear gloves when touching any part of the dialysis machine or equipment at the dialysis station while a patient is connected. Gloves must be worn appropriately. Change gloves and practice hand hygiene for each patient and /or station to prevent cross-contamination. Remove gloves and wash hands in-between patients."	V 113		
V 130	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE  Isolation of HBV+ Patients  To isolate HBsAg positive patients, ... dedicate machines, equipment, instruments, supplies, and medications that will not be used by HBV susceptible patients.  This STANDARD is not met as evidenced by:	V 130		5/15/09

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V 130	Continued From page 3 Surveyor: 11683 Based on observation, interview and record review, the facility failed to ensure that anyone entering the isolation area of Patient 5, during hemodialysis treatment, must dispose of their personal protective equipment when they leave the isolation room.  Findings:  According to Patient 5's clinical record, he was admitted to the facility on September 1, 2008, with diagnoses that included end stage renal disease, diabetes with renal manifestations type 2 and positive for Hepatitis B.  On January 21, 2009, at 9:05 a.m., Patient 5 was observed in the isolation room waiting for the facility staff to start him on the hemodialysis machine to receive treatment. Employee C went into the room to speak with Patient 5 and failed to remove his personal protective equipment ( gown, glove and mask) when he went back to the nurse's station.  At approximately 9:15 a.m., Employee D went into the isolation room wearing a white gown underneath the yellow gown, gloves and face shield and started the patient on hemodialysis treatment. The employee took off the yellow gown, gloves and mask and left the room wearing the white gown.  On the same day, at 10 a.m., during an interview with Employee C, he stated that he was not aware that he did not remove his Personal Protective Equipment when he went out of the isolation room.	V 130		
V 190	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED	V 190		2/25/09

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V 190	<p>Continued From page 4 BY REFERENCE</p> <p>5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution.</p> <p>5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration.</p> <p>The face of the timers used to control the regeneration cycle should be visible to the user.</p> <p>6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated.</p> <p>The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and pistons and clog orifices in the softener control head.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727</p>	V 190			

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V 190	Continued From page 5 Based on observation, interview and record review, the facility failed to maintain the salt pellets half full in the brine tank. Findings: During an observation on January 21, 2009, at 1:02 p.m., the brine tank was ¼ full of salt pellets and the salt pellets were below the water level. During an observation on January 22, 2009, at 7:08 a.m., the brine tank was 1/3 full of salt pellets. A portion of the salt pellets were above the water level and a portion was below the water level. During an interview on January 22, 2009, at 8:45 a.m., the chief technician stated the facility's policy and procedure did not stipulate the amount of the salt pellets in the brine tank. A review of the facility's policy and procedure entitled "Water Treatment Equipment" stipulated the top level of the salt pellets in the brine tank must be maintained above the level of the brine solution in the tank.	V 190		
V 213	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE  6.3.3 Water distribution systems: culture/LAL sample sites/frequency (new)/log Water distribution piping systems should be monitored for bacteria and endotoxin levels. Bacteria and endotoxins shall not exceed the levels specified in [AAMI] 4.1.2. [(i.e., bacteria <200 CFU/mL and endotoxin <2 EU/mL]  Bacteria and endotoxin testing should be conducted at least monthly. For a newly-installed water distribution piping system, or when a change has been made to an existing system, it is recommended that weekly testing be conducted for 1 month to verify that bacteria or endotoxin levels are consistently within the allowed limits.	V 213		4/11/09





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V 402	Continued From page 8  This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain the building to ensure the safety of the patients, the staff and the public.  Findings: During an observation tour of the facility on January 21, 2009, from 7:10 a.m.- 12:40 p.m., the following was observed: Water Treatment Room 1. Sections of the wall were damaged. 2. The reverse osmosis (RO) membrane was supported by a block of concrete and a piece of wood. 3. The drain pipe was within the floor sink. A one inch air gap was not maintained. Bicarbonate Room 4. The drain pipe was within the floor sink. A one inch air gap was not maintained. Treatment Area 5. The ports behind the chairs, in all the dialysis stations located along the wall, had an accumulation of brown deposits. 6. There were brown spots in the ceiling tiles above station 18. 7. The door to the isolation room (station 9) was missing. 8. The sink faucet next to station 1 had an aerator device. 9. The sink faucet between station 11 and 12 had an aerator device. 10. There was peeling wall paint near station 14 and outside station 9. Janitorial Supply Room 11. The room did not have a vent. Chemicals were stored in the room.	V 402		

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V 402	Continued From page 9 12. The floor was dusty. Janitor Room 13. The janitorial sink was clogged. 14. The room had no vent. 15. There was peeling wall paint above the janitorial sink. Clean Utility Room 16. The sink faucet had an aerator device. 17. There was no vent. 18. There were 7 oxygen tanks and 4 portable tanks stored in the room. 19. The faucet had an aerator screen. Supply Room 20. The ceiling vent was covered with dust. Technician Room 21. Under the fire extinguisher, a section of the wall was damaged. The base coving was detached. During an interview on January 21, 2009, at 9:00 a.m., the chief technician stated they were in the process of changing the walls in the water treatment room. He stated the oxygen tanks should not be stored in the clean utility room. During an interview on January 22, 2009, at 8:50 a.m., the chief technician stated the room used to be the soiled utility room. He further stated the ice machine used to be in the clean utility room and not oxygen tanks. In an interview that same day, at 10:30 a.m., the chief technician stated there was a door at the entrance of the isolation room but was removed and was never replaced.	V 402		
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).	V 407		5/15/09

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V 407	Continued From page 10  This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility failed to ensure the patients access sites were visible during hemodialysis treatment.  Findings:  On January 21, 2009, at 7:05 a.m., during the tour of the treatment area, patients' access sites were not visible in stations 13, 14, 15 and 17. At 9:00 a.m. observation rounds, it was noted that the patient's access site in station 20 was not visible. At the 11:00 a.m. observation rounds, it was noted that patients' access site were not visible in stations 4, 10, 19 and 21.  On January 22, 2009, at 7 a.m., it was observed that patients' access sites were not visible in stations 3, 6, 7, 8, 15, 17 and 20. The facility staff members were passing by the patients without reminding the patients about their access sites not being visible while receiving treatment.  On January 23, 2009, at 10 a.m., during an interview with the clinical manager, she stated that access sites should be visible during treatment.	V 407			
V 454	494.70(a)(3) PATIENTS' RIGHTS  [The patient has the right to-] (3) Privacy and confidentiality in all aspects of treatment;  This STANDARD is not met as evidenced by: Surveyor: 11683	V 454		5/15/09	

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V 454	Continued From page 11 Based on observation and interview, the facility failed to provide privacy for 1 of 15 sampled patients (Patient 12).  Findings:  During an observation on January 22, 2009, at 7:50 a.m., Patient 12 was lying on the floor with the paramedics providing cardio-pulmonary resuscitation (CPR). The patient was observed exposed from the waist up, all the time that CPR was being administered by paramedics. Meanwhile, facility staff members were observed providing care to their assigned patients and failed to provide privacy for Patient 12. Patient 12 was in full view of patients in stations 3, 20 and 21.  During an interview on January 22, 2009, at 9 a.m., the clinical manager stated that a privacy curtain should have been provided for Patient 12 when the paramedics had taken over the resuscitation activity from facility staff members. Upon further investigation, it was determined that the portable privacy curtain was stored in a locked supply room which was 35 feet away from station 2.	V 454			
V 501	494.80 PATIENT ASSESSMENT  The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for	V 501		2/27/09	

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V 501	Continued From page 12 care.  This STANDARD is not met as evidenced by: Surveyor: 06616 Based on record review and interview of staff, the facility failed to ensure all members of the interdisciplinary team be responsible for providing each patient with an individualized and comprehensive assessment of needs for Patient 6.  Findings:  During a review of patient records on January 22, 2009, it was noted that the comprehensive assessment dated January 8, 2009, was not completed and signed by the treating physician for Patient 6. In an interview with the interdisciplinary team, the social worker stated the physician was not clear on the procedure for completing the form. She further stated the treating physician had the form but had not completed the history and physical or physician assessment, as stipulated in the Comprehensive Interdisciplinary Assessment policy and procedure (FMS-CS-IC-I 110-125D1).	V 501			
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,	V 503		5/20/09	

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V 503	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility failed to follow the physician's order for dialysis prescription (blood rate, medications, oxygen) for 8 of 10 sampled patients (Patients 2, 3, 4, 5, 9, 11,12 and 13).</p> <p>Findings:</p> <p>a. According to the admission facesheet, Patient 2 started dialysis at the facility on June 5, 2007, with diagnoses of end stage renal disease and diabetes with renal manifestations type 2.</p> <p>On January 22, 2009, at 10:30 a.m., Patient 2 was observed receiving hemodialysis treatment via left arm fistula. The blood flow rate was 350 and the dialysate flow rate was 800.</p> <p>A review of the clinical record revealed a physician's order dated July 27, 2007, 3 times a week treatment, 3 1/2 hours, blood flow rate of 350 and dialysate flow rate of 800. Further review of the clinical record, specifically the treatment data on January 17, 2009, documented the blood flow rate was 346 -357. On January 8, 2009, the documented blood flow rate was 327- 335. On December 23, 2008, the documented blood flow rate was 325.</p> <p>On December 9, 2008, the physician ordered to restart Zemplar at 6 mcg every treatment if calcium was &lt;10.5 and phosphorous was &lt; 7. The laboratory result dated December 11, 2008, revealed a lab result for calcium of 6.8 and phosphorous for 7.5. On December 18, 2008, lab result for calcium was 7.4 and phosphorous was 6.3.</p>	V 503		

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V 503	<p>Continued From page 14</p> <p>A review of the hemodialysis treatment record revealed that on December 13, 20, 22, 23 and 31, 2008, the patient was not administered Zemplar as ordered.</p> <p>b. According to the admission facesheet, Patient 5 started dialysis at the facility on September 1, 2008, with diagnoses of end stage renal disease and diabetes with renal manifestations type 2.</p> <p>On January 21, 2009, at 10:50 a.m., Patient 5 was observed receiving hemodialysis treatment in the isolation room via left upper arm fistula. The blood flow rate was 450 and the dialysate flow rate was 800.</p> <p>A review of the clinical record revealed a physician's order dated September 15, 2008, 3 times a week treatment for 4 hours, blood flow rate of 450 and dialysate flow rate of 800. Further review of the clinical record specifically the treatment data on January 19, 2009, documented the blood flow rate was 400-475. On January 16, 2009, the documented blood flow rate was 475-481. On January 14, 2009, the documented blood flow rate was 373-481.</p> <p>c. According to the admission facesheet, Patient 9 started dialysis at the facility on January 1, 2007, with diagnoses that included end stage renal disease and hypertension.</p> <p>On January 21, 2009, at 12:50 a.m., Patient 9 was observed receiving hemodialysis treatment via left lower arm fistula. The blood flow rate was 450 and the dialysate flow rate was 800.</p> <p>A review of the clinical record revealed a physician's order dated November 1, 2008, 3</p>	V 503			

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V 503	<p>Continued From page 15</p> <p>times a week treatment for 3 hours, blood flow rate of 450 and dialysate flow rate of 800. Further review of the clinical record specifically the treatment data on December 28, 2008, documented the blood flow rate was 405-443. On January 2, 2009, the documented blood flow rate was 454-462. On January 9, 2009, the documented blood flow rate was 451-456. On January 14, 2009, , the documented blood flow rate was 402-459. On January 21, 2009, the documented blood flow rate was 405-456.</p> <p>On December 26, 2008, the physician ordered Epogen 2,000 units to be administered intravenously every treatment. A review of the hemodialysis treatment record revealed that on December 28 and 30, 2008, and January 2, 5 and 7, 2009, the patient received Epogen 4,000 units.</p> <p>d. On January 21, 2009, at approximately 1:50 p.m., Patient 13 was observed being prepped by the licensed nurse to start treatment. The patient was receiving oxygen 3 liters via nasal cannula.</p> <p>A review of the clinical record revealed that the patient started treatment at the facility on January 21, 2008, with diagnoses that included end stage renal disease, vasculitis and diabetes with renal manifestation type 2. Further review of the clinical record failed to show a physician's order for oxygen administration.</p> <p>On January 23, 2009, at 10 a.m., during an interview with Employee E, she stated that the patient comes with her own oxygen and then switches to the facility's oxygen while receiving treatment. Surveyor: 15727 Findings:</p>	V 503			

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V 503	Continued From page 16 e. During an observation on January 21, 2009, at 12:52 p.m., Patient 11 was observed during dialysis treatment with oxygen administered by nasal cannula at 2.5 liters per minute. A review of the PRN protocol revealed oxygen 2 liters/minute for dyspnea. This was not followed by staff. f. During an observation on January 22, 2009, at 7:15 a.m., Patient 12 was occupying station 2 during dialysis treatment. Oxygen was administered by nasal cannula at 3 liters/minute. During an interview on January 22, 2009, at 7:15 a.m., the licensed nurse after checking the flow meter of the oxygen concentrator stated oxygen was administered at 3 liters/ minute. A review of the PRN protocol revealed oxygen 2 liters/minute for dyspnea. This was not followed by staff. g. A review of the treatment records of Patient 3, from January 3-17, 2009, revealed a blood flow rate between 347-355. A review of the physician's order revealed the blood flow rate was to be 400. h. A review of the treatment records of Patient 4 from December 9-January 17, 2009 revealed a blood flow rate between 349-354. A review of the physician's order revealed the blood flow rate was to be 400.	V 503			
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	V 541		5/15/09	

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V 541	<p>Continued From page 17</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and staff interview, the interdisciplinary team failed to develop and involved the patient in the development of an individualized plan of care that addressed the patient's needs based on comprehensive assessment.</p> <p>Findings:</p> <p>a. On January 22, 2009, during record review of Patient 5's clinical record, it was noted that the patient started dialysis at the facility on September 1, 2008. On September 8, 2008, the interdisciplinary team, who was comprised of the physician, licensed nurse, dietitian and social worker, developed a plan of care addressing patient's identified needs. However, the care plan failed to show written evidence that the patient signed the plan of care.</p> <p>b. On January 22, 2009, during record review of Patient 8's clinical record, it was noted that the patient was admitted to the facility on January 8, 2008, as a peritoneal dialysis patient. His diagnoses on admission was end stage renal disease, diabetes mellitus, anemia, hypertension and coronary artery disease.</p>	V 541			

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V 541	Continued From page 18 On March 11, 2008, the interdisciplinary team developed a care plan addressing the patient's needs and concerns. However, the care plan failed to show written evidence to indicate that the patient was involved in the development of the plan of care.  On January 23, 2009, at 10 a.m., during an interview with the clinical manager, she stated that the interdisciplinary team members would make sure there was written evidence that the patient was involved in the development of the plan of care.	V 541		
V 560	494.90(b)(4) IMPLEMENTATION OF THE PATIENT PLAN OF CARE  The dialysis facility must ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly, as evidenced by a monthly progress note placed in the medical record, and periodically while the hemodialysis patient is receiving in-facility dialysis.  This STANDARD is not met as evidenced by: Surveyor: 06616 Based on interview and medical record review, the facility failed to ensure all dialysis patients were seen by a physician, nurse practitioner, clinical nurse specialist or physician's assistant providing ESRD care at least monthly for one patient (Patient 1), as evidenced by a monthly progress note placed in the medical record, and periodically while the patient was receiving in-facility hemodialysis.  Findings:	V 560		3/31/09

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V 560	Continued From page 19 During an interview on January 19, 2008, at 10:15 AM, Patient 1 stated that she has not see her physician while receiving dialysis at the facility. She stated, that she sees the physician during "clinic" visits only. A review of the medical record for Patient 1 revealed there was no documentation of a monthly progress note, to indicate a physician visit was made for the months of July, August, September, October and December '2008, as required.	V 560		
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: 11683 Based on observation, interview and record review, the interdisciplinary team failed to keep a tracking system to monitor the status of a patient (Patient 8) who was on a transplant waiting list.  Findings:  On January 22, 2009, at 1 p.m., Patient 8 came to the center for his monthly clinic appointment. During an interview, the patient stated that he was on the waiting list for kidney transplant in a transplant center. He also stated that every month he has blood drawn in the hemodialysis center that was sent to the transplant center.	V 561		3/1/09

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V 561	Continued From page 20	V 561			
V 586	<p>On the same day, at 2:00 p.m., while reviewing Patient 8's clinical record with Employee E, there was no written documentation of a monthly blood test, who or where to send the blood and communications to and from the hemodialysis and transplant centers regarding Patient 8's status on the waiting list.</p> <p>494.100(b)(1) HOME DIALYSIS MONITORING</p> <p>The dialysis facility must -</p> <p>(1) Document in the medical record that the patient, the caregiver, or both received and demonstrated adequate comprehension of the training;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the dialysis staff failed to show written documentation in the medical record that Patient 8 demonstrated adequate comprehension of the training provided prior to starting self-dialysis at home.</p> <p>Findings:</p> <p>On January 22, 2009, at 11 a.m., during review of Patient 8's clinical record, it was noted that Peritoneal Dialysis Training was started on January 8, 2008, in the facility. The Training Core Curriculum was reviewed and it was disclosed that both the patient (Trainee) and registered nurse (RN-Trainor) failed to sign.</p> <p>At 10:30 a.m., during an interview with Employee F, she stated that the patient was trained however both the patient and the RN failed to sign the form when the training had concluded.</p>	V 586		5/15/09	
V 587	494.100(b)(2),(3) HOME DIALYSIS	V 587		5/15/09	

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V 587	<p>Continued From page 21 MONITORING</p> <p>[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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the facility staff failed to ensure that Daily Flow Sheets for a home patient were reviewed for completeness and accuracy for Patient 8.</p> <p>Findings:</p> <p>A review of Patient 8's medical record revealed that he was admitted to the facility on January 8, 2008, for continuous cycler peritoneal dialysis (PD) in a home setting. The daily peritoneal physician order dated September 9, 2008, indicated 3 exchanges of a 6 liter bag with 1.50% dextrose and one 6 liter bag with 2.50% dextrose, a total of 4 exchanges daily and exit site care daily. On October 14, 2008, the physician ordered 10,000 units of Epogen to be administered subcutaneously every week by the patient.</p> <p>Further review of the PD daily flow sheet record from October 22, 2008 through January 6, 2009, revealed that the number of exchanges performed by the patient did not reflect the physician's order. The Epogen was administered</p>	V 587			

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V 587	Continued From page 22 every two weeks contrary to the physician order and the record also documented that the exit site care was done every other day.  On January 22, 2009, at 1:00 p.m., during an interview with Employee F, she acknowledged the above findings. She also indicated that the issues/concerns that were brought to her attention would be addressed in the monthly clinic visit of the four PD patients.	V 587			