

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: 552575	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2009
NAME OF PROVIDER OR SUPPLIER KIDNEY DIALYSIS CENTER OF VENTURA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 LOMA VISTA ROAD, #101 VENTURA, CA 93003	
(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 Surveyor: 14724 the following represents the findings of the Department of Public Health during a recertification visit. the facility census at the time of the visit was 80 patients and the patient sample consisted of 7 hemodialysis patients and 1 home peritoneal dialysis patient. Representing the Department of Public Health were Teri Spencer, HFEN and Linda Mosel, HFEN. Abbreviations used in this document: BP blood pressure CC Clinical Coordinator CDC Centers for Disease Control and Prevention CHT Certified Hemodialysis Technician CVC central venous catheter DON Director of Nurses HBV hepatitis B virus PCT Patient Care Technician	V 000		
V 110	494.30 INFECTION CONTROL This CONDITION is not met as evidenced by: Surveyor: 14724 Based on observation, interview, and record review, the facility failed to ensure the provision of a sanitary environment in accordance with infection control guidelines outlined by the Centers for Disease Control and Prevention, by failing to conduct surveillance of patients for hepatitis B (refer to V124), and failing to ensure the dialysis chairs were disinfected and free of	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 blood contamination (refer to V122). The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	V 110		
V 115	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurring or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation and interview, the facility failed to ensure 1 of 3 staff (PCT 1) wore facial personal protective equipment when conducting activities which could result in splashes, splatters or sprays of potentially infectious materials. Findings: On 6/16/09, direct care staff were continuously observed during the turnover between the first and second shifts of hemodialysis patients. While working at station 4, at 9:00 A.M., PCT 1 did not wear personal protective equipment over the eyes, nose or mouth when removing ("stripping") the blood lines and dialyzer from the hemodialysis machine, after the first shift patient's treatment. PCT 1 wore eyeglasses without side panels, and no mask or visor during the procedure.	V 115		

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V 115	Continued From page 2 On 6/17/09 at 11:15 A.M., the CC stated that staff were to wear full facial protective equipment whenever stripping hemodialysis machines, to protect them from splashes of blood.	V 115			
V 116	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation and interview, the facility failed to ensure red plastic bags kept on top of 19 of 19 hemodialysis machines during patients' treatments were not discarded after each treatment, resulting in potential for the transmission of blood borne pathogens between patients. Findings: On 6/15/09, during initial tour of the facility patient treatment area, each of the 19 hemodialysis machines was equipped with a built-in plastic	V 116			

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V 116	Continued From page 3 "bin" on the top of the machine. The bins were filled with a supply of red plastic bags, which remained there throughout patients' treatments. On 6/16/09, direct care staff were continuously observed during the turnover between the first and second shifts of hemodialysis patients. After terminating patients' treatments, staff would obtain one red plastic bag from that machine's bin, for disposing the used blood lines and dialyzers. The remainder of the supply of red bags were left in the bin. The location of the red bags on top of the hemodialysis machines meant they were presumed contaminated with patients' blood. Leaving the contaminated bags on top of the machines throughout multiple subsequent patient treatments created the potential for transmission of blood borne pathogens. During an interview on 6/17/09 at 11:15 A.M., the DON stated that the machine manufacturer indicated that the bins on top of the machines could be used to hold supplies. The DON stated she questioned whether this was in accordance with CDC infection control guidelines.	V 116			
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.	V 122			

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V 122	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation and interview, the facility failed to ensure 6 of 7 dialysis chairs were disinfected between patients, resulting in the potential for transmission of blood borne pathogens between patients, via the dialysis chairs.</p> <p>Findings:</p> <p>1. On 6/16/09 direct care staff were continuously observed during the turnover between the first and second shifts of hemodialysis patients.</p> <p>At 9:24 A.M., CHT 1 terminated the dialysis treatment for the first shift patient at station 14, and proceeded to strip and wipe down/disinfect the outer surfaces of the dialysis machine. At 9:36 A.M., the first shift patient was discharged from station 14, and CHT 2 discarded the excess supplies from the dialysis chair, but did not wipe down/disinfect the chair. At 10:36 A.M. CHT 1 admitted and initiated the dialysis treatment for the second shift patient at station 14, without wiping down/disinfecting the chair.</p> <p>When interviewed on 6/16/09 at 11:35 A.M., CHT 1 stated that she thought CHT 2 wiped down/disinfected the chair at station 14 after the first shift patient was discharged.</p> <p>2. During the 6/16/09 turnover observations, direct care staff wiped/disinfected the dialysis chairs while in the upright position and did not recline the chairs to access the inner surfaces for disinfection.</p>	V 122		

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V 122	Continued From page 5 On 6/18/09 at 8:30 A.M., six dialysis chairs, which were cleaned and ready for use by patients, were reclined and inspected. When reclined, 5 of the 6 chairs had exposed dried red-brown liquid dripping down the inner surfaces of the chairs, alongside the cushions. When interviewed on 6/18/09 at 8:45 A.M., the CC stated that staff were to recline the chairs and disinfect the chair surfaces between patients, with careful attention to this when a patient bled from their vascular access sites.	V 122			
V 124	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on interview and record review, the facility failed to ensure 37 of 37 patients who were susceptible to hepatitis B were tested for the presence of hepatitis B monthly, resulting in the potential for the undetected spread of the hepatitis B virus among the susceptible patients. Findings: On 6/17/09 and 6/18/09, during review of the	V 124			

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V 124	Continued From page 6 medical records for patients 1, 4, 6, and 8, it was noted that they lacked immunity (surface antibody titer less than 10), and were susceptible to the hepatitis B virus. The laboratory results indicated that the patients were not tested for the presence of hepatitis B (surface antigen test) every month, as required by the CDC. The results indicated the patients were tested every 3 months. On 6/18/09, the facility hepatitis B testing report between March, 2008 and June, 2009 was reviewed. Patients who were susceptible to hepatitis B were tested for the presence of the virus every 3 months during the 15 month period. As of 6/18/09, there were 37 patients who were susceptible to hepatitis B. When interviewed on 6/18/09 at _____, the CC confirmed that the susceptible patients were tested for hepatitis B every 3 months in error. The CC stated she was confused about the CDC requirements for surveillance of patients for hepatitis B. The failure to conduct monthly surveillance of susceptible patients for the presence of hepatitis B created the potential for the undetected spread of hepatitis B, and risked the health and safety of the susceptible patients.	V 124			
V 147	494.30(a)(2) CDC RR-10 AS ADOPTED BY REFERENCE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections.	V 147			

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V 147	<p>Continued From page 7</p> <p>B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance</p> <p>A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation and interview, the facility failed to ensure appropriate infection control measures were implemented for 1 of 1 patient (6) whose CVC was accessed, resulting in potential for contamination of the CVC.</p> <p>Findings:</p> <p>On 6/16/09 at 10:56 A.M., Patient 6 was admitted and his hemodialysis treatment was initiated, via a CVC. Patient 6 had a full beard, which hung</p>	V 147			

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V 147	Continued From page 8 down within 3 inches of the CVC exit site. When the staff member accessed Patient 6's CVC, the patient wore a mask over his nose and mouth, but the full beard was not covered, exposing the open CVC ports to potential contamination from the beard.	V 147			
V 407	When interviewed on 6/17/09 at 11:15 A.M., the CC stated that she had not considered covering Patient 6's beard when accessing the CVC. 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: 14724 Based on observation and interview, the facility failed to ensure 3 of 11 patients' vascular access sites were visible at all times during their hemodialysis treatments, resulting in the potential for undetected needle dislodgement and loss of blood. Findings: On 6/18/09 at 9:08 A.M., eleven patients were receiving hemodialysis in the patient treatment area. Three of the patients had blankets and/or clothing covering their vascular access sites and blood tubing connections, obscuring view of the access sites. At 9:10 A.M. on 6/18/09, RN 1 explained that all patients' vascular access sites were to remain	V 407			

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V 407	Continued From page 9 visible at all times during dialysis.	V 407			
V 543	494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Surveyor: 17130 Based on observation, interview and record review, the facility failed to ensure that ?? of 7 sampled hemodialysis patients (2,3,5,) received complete assessments pre, during, or post dialysis treatment. Findings: 1. Patient 2 was admitted to the facility on 5/28/09. The patient dialysed three times a week through a fistula in the right arm. During an interview on 6/17/09 at 9:40 A.M., Patient 2 stated that he was a diabetic and had a stroke in the past from high blood pressure. On 6/17/09, the medical record was reviewed. On 5/28/09, the physician ordered Clonidine 0.1mg by mouth as needed for a systolic (top number) blood pressure greater than 180mm/Hg. Clonidine is a medication given to reduce high blood pressure. The Dialysis Flowsheet dated 5/28/09 specified that on arrival to the facility Patient 2's standing blood pressure was 223/126 (systolic=223;	V 543			

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V 543	<p>Continued From page 10</p> <p>diastolic=126). For a period of one hour and five minutes from 4:15 P.M. through 5:20 P.M., Patient 2's blood pressure ranged from 189/113 to 190/113. Patient 2 was discharged home at 5:30 P.M. with a blood pressure of 190/95. There was no evidence that a standing blood pressure was taken post treatment. There was no indication in the medical record that the RN assessed Patient 2 regarding the high blood pressure. There was no indication in the medical record that Clonidine was given as ordered to decrease the blood pressure.</p> <p>The Dialysis Flowsheet dated 6/01/09 indicated that on arrival the patient's sitting blood pressure was 186/104 (systolic=186). There was no evidence that the standing blood pressure was taken pre-treatment. At the start of dialysis at 6:15A.M., Patient 2's blood pressure was 205/123 (systolic=205). From 9:09 A.M. until the end of the treatment at 9:45 A.M., the patient's blood pressure ranged from 188/102 (systolic=188) to 195/101 (systolic=195). There was no indication that the RN assessed the patient regarding the high blood pressure or that the Clonidine was given.</p> <p>The Dialysis Flowsheet dated 6/03/09 indicated that on arrival the patient's blood pressure was 210/110 (sitting). There was no evidence that the standing blood pressure was taken pre-treatment. From 6:20A.M. through 9:35A.M., a period of three hours and 15 minutes, Patient 2's blood pressure ranged from 188/97(systolic=188) to 203/113(systolic=203). There was no evidence that the RN assessed Patient regarding the high blood pressure or that the Clonidine was given as ordered. Patient 2 was discharged home with a sitting blood pressure of 190/103 (systolic 190).</p>	V 543			

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V 543	<p>Continued From page 11</p> <p>The Dialysis Flowsheet dated 6/05/09 indicated that on arrival Patient 2's standing blood pressure was 205/114 (systolic=205). From 6:00A.M. through 9:30A.M., a period of 3 and 1/2 hours, the patient's blood pressure ranged from 182/101 (systolic=182) to 208/103(systolic=208). There was no indication that the RN assessed Patient 2 regarding the high blood pressure or that the Clonidine was given.</p> <p>During an interview on 6/18/09 at 11:35A.M., RN 1 was interviewed. RN 1 stated, "I should have given the Clonidine per the policy." The RN stated that the facility policy differed from the physician's standing order. The RN said that according to the policy, Clonidine was given for a systolic blood pressure greater than 190(mm/Hg) and a diastolic greater than 90(mmHg).</p> <p>On 6/18/09, the facility P & P for General Guidelines for Treatment of Nausea and Vomiting, Itching, and Hypertension adopted by the Governing Body on 2/01/09 specified that "Hypertension requiring immediate treatment is defined as a systolic pressure of at or greater than 190mmHg or a diastolic pressure of or greater then (than) 90mmHg. Treat by administering Clonidine 0.1mg PO."</p> <p>During an interview on 6/18/09 at 1:00 P.M., the Clinical Coordinator stated that the P&P did not coincide with the physician's standing orders. The CC stated that both should be the same.</p> <p>2. On 6/17/09 at 9:45A.M., Patient 2 was observed while direct care staff completed his dialysis treatment and disconnected the machine. At 9:55A.M., Patient 2 walked to the scale to be</p>	V 543			

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(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 543	Continued From page 12 weighed prior to leaving the facility. At 10:00A.M., RN 2 listened to the patient's lungs and checked his feet for edema. RN 2 did not listen to the Patient 2's heart or check the radial pulse to determine if the heart rate was regular. At 10:02A.M., Patient 2 left the facility. During an interview on 6/17/09 at 10:05A.M., RN 2 stated that she did not listen to Patient 2's heart for irregularity. RN 2 stated, "Auscultating (listening) was part of the post-assessment and should have been done." On 6/17/09, the facility policy on Dialysis Patient Assessment and taking Vital signs.	V 543		
V 546	494.90(a)(3) DEVELOPMENT OF PATIENT PLAN OF CARE [The plan of care must address, but not be limited to, the following:] Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on interview and record review, the facility failed to ensure the implementation of the mineral metabolism patient plan of care for 1 of 8 sampled patients (4). Findings: Patient 4 was admitted to the facility on 1/2/08 and was receiving hemodialysis treatments 4	V 546		

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

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V 546	Continued From page 13 times a week. When reviewed on 6/17/09, Patient 4's medical record included a written physicians's order, dated 1/15/09, calling for Zemplar (a medication for the management of mineral metabolism) to be administered every dialysis. A review of the 10 dialysis treatment records from the treatments delivered between 5/28/09 and 6/15/09 showed that the Zemplar was not administered to Patient 4 as ordered during the treatments on 5/28/09 and 6/11/09. During a 6/18/09, 10:20 A.M. interview, the CC confirmed that the medication was ordered every dialysis, and stated it would need to be clarified with Patient 4's physician, since the patient had 4 treatments per week.	V 546			