

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

PRINTED: 02/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>552533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/31/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYSVILLE DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 8TH STREET MARYSVILLE, CA 95901</b>	
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V 000	INITIAL COMMENTS  The following represents the findings of the California Department of Public Health during a recertification survey from 8/24/10 to 8/31/10.  Representing the Department: Glenn Ingo, HFEN Steven Gardner, HFEN  Census - 76 Sample Size - 7	V 000		
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS  The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements.  This STANDARD is not met as evidenced by: Based on interview and observation, the facility registered nurses (RNs) failed to follow Section 2725.3 (a) (5) of the California Nurse Practice Act which stipulates that the registered nurse can not delegate certain responsibilities, one of these being patient assessment. During random observations, 18 patients were observed having dialysis treatment (a procedure that cleans impurities from the blood of people whose kidneys can no longer perform that function) initiated or terminated. At no time was a registered nurse observed performing pre or post treatment assessments.  Findings:  On 8/24/10, a review of the facility policy titled,	V 101		10/1/10

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

TITLE

(X6) DATE

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

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V 101	<p>Continued From page 1</p> <p>"Treatment Initiation Patient Assessment" dated 09/07, indicated that the patient care technicians (PCT) assessed the patient and would notify the RN if they detected a problem. The policy indicated that it was the PCT's decision to initiate treatment and the RN "should" see the patient within the first hour of treatment.</p> <p>On 8/24/10, a review of the facility policy titled, "Post Treatment Patient Assessment," dated 09/07, indicated that the PCT performed the post treatment assessment and reported the "findings that may preclude discharge" to the RN.</p> <p>On 8/25/10 at 3 pm in a concurrent interview with Administration Staff (Admin) 2 and RN 3, RN 3 stated that she performed pre-dialysis treatment assessments by looking at and talking to the patient after they arrive to the treatment floor. She stated that she looks for shortness of breath, jugular vein distension (bulging neck veins), obvious swelling in the lower legs, and how the patient was walking. She would also ask them if they were having any difficulties.</p> <p>On 8/31/10 at 2 pm, the Medical Director stated that he expected pre and post treatments to be done. He stated that a pre-treatment assessment should be done before the dialysis treatment was initiated. He further stated that in order to assess respiratory, cardiac and fluid status, the nurse must listen to lung and heart sounds and check for peripheral edema.</p> <p>RN 3 stated she did try to see the patients within the first hour of treatment. RN 3 and Admin 2 agreed that an assessment on a patient who, for example, was 58 minutes into a 180 minute treatment could not be considered a</p>	V 101			

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V 101	Continued From page 2 pre-treatment assessment. RN 3 and Admin 2 also acknowledged that PCTs were not qualified or trained to do assessments, they could only to collect and record data.	V 101			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL  [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: Based on observation and interview, facility staff failed to properly disinfect equipment (all surfaces) used in treatment stations. This failure had the potential to result in the transmission of blood borne pathogens to other patients.  Findings:  1. On 8/25/10 at 9:35 pm, 9:40 pm, 10:42 pm and 11:43 pm, Patient Care Technician (PCT) 6 was observed cleaning treatment chairs after use. PCT 6 did not clean the crevice between the seat and back of the chair or between the lower seat and footrest.  On 8/25/10 at 1:10 pm, PCT 6 stated, "That's the way I was trained." PCT 6 acknowledged that these areas could not be adequately cleaned without reclining the chair.  2. On 8/25/10, during random observations in the	V 122		9/17/10	

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V 122	<p>Continued From page 3</p> <p>treatment area, then following was noted:</p> <p>a. Staff were not disinfecting the plastic bags on the side of all the dialysis machines, containing emergency disconnection equipment, between treatments.</p> <p>b. Blood pressure cuffs attached to all of the dialysis machines had an accumulation of lint from patient blankets adhered to the Velcro (hook and latch closure device). These were used on multiple patients without cleaning the Velcro fasteners between patients.</p> <p>On 5/14/10 at 2 pm, Admin 1 agreed that the plastic bags should be disinfected between treatments, and that that the blood pressure cuffs were a source of possible cross contamination and should be cleaned between patients or isolated from the patients.</p> <p>3. During observations on 8/25/10 at 9:55 am and 10:15 am, PCT 6 did not clean the televisions, blood pressure cuffs, or emergency kits on the sides of two dialysis machines nor did PCT 4 clean the in the crevices between the arms and seats and the backrests and seats of two chairs between patients.</p> <p>4. During an observation on 8/25/10 at 1:40 pm, PCT 5 did not clean the TV or emergency kit on the side of the dialysis machine nor did he clean the crevices between the arms and the seat and the backrest and the seat of the chair between patients.</p> <p>During an interview on 8/25/10 at 1:50 pm, PCT 5 stated that everything in the station was supposed to be cleaned between patients including the</p>	V 122			

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V 122	Continued From page 4 television, chair and crevices. He stated that the emergency kits were cleaned every Friday. He confirmed that the cleaning of the stations between patients was not always performed correctly.	V 122		
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE 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: Based on observation, interview, the facility failed to ensure a safe environment when supplies available for use in one emergency evacuation kit were found to be expired. This had the potential for expired supplies to be used for patient care.  Findings:  During an observation of the emergency evacuation kit on 8/24/10 at 11 am, the following supplies were expired:  * Two bottles of waterless hand antiseptic * Five butterfly needles (fine needles for accessing a vein) * Two 30 milliliter syringes * 15 three milliliter syringes	V 401		9/17/10
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU  During an interview on 8/24/10 at 11:15 am, RN 3 confirmed that the supplies (found in the emergency evacuation kit) were expired.	V 403		9/16/10

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V 403	<p>Continued From page 5</p> <p>The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the facility did not record the temperature of one medication refrigerator for 9 days. This failure had the potential for the effectiveness of temperature sensitive medications to be compromised.</p> <p>Findings:</p> <p>The facility policy and procedure titled, "Medications Requiring Refrigeration," dated 9/07, indicated that medication refrigerators temperatures were to be checked at the beginning and end of the day.</p> <p>During the initial tour of the peritoneal dialysis (a procedure to correct a fluid imbalance or remove wastes from the blood normally done by the kidneys) room on 8/24/10 at 2 pm, the medication refrigerator temperature log for "Refrigerator One," dated 7/10, was reviewed. Documentation indicated that the temperature had not been recorded twice a day for nine days from 8/12 to 8/24/10.</p> <p>During an interview on 8/24/10 at 2:35 pm, Registered Nurse 7 confirmed that the temperatures had not been documented in the log. She stated that the refrigerator log had not</p>	V 403			

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V 403	Continued From page 6 kept up, because she had been "too busy and forgot."	V 403			
V 415	494.60(d)(4)(ii) PE-ANNUAL EVAL-EMERGENCY/DISASTER PLANS  The facility must- Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary;  This STANDARD is not met as evidenced by: Based on interview and facility document review, the facility failed to evaluate the expected actions of the staff and patients in an emergency situation, when it did not perform emergency drills for the past year, which had the potential to affect the health and safety of the staff, patients, and the public.  Findings:  On 8/30/10, the facility policy and procedure titled, "Disaster and Emergency Preparedness Training Drills," dated 4/10, was reviewed. Documentation indicated that emergency drills were to be performed quarterly.  The "Drill Evaluation Forms" from 8/09 to 8/10 were reviewed on 8/30/10. There was no documentation that indicated the facility had performed any quarterly emergency drills for the time period between 8/09 and 8/10.  During an interview on 8/30/10 at 3:55 pm, PCT 8 stated the facility had not performed any emergency drills.  During an interview on 8/31/10 at 11:40 am,	V 415		9/17/10	

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V 415	Continued From page 7 Admin 1 confirmed that quarterly emergency drills were not being performed by the facility, as indicated by the facility policy.	V 415		
V 500	494.80 CFC-PATIENT ASSESSMENT  This CONDITION is not met as evidenced by: Based on observation, interview and facility document review, the facility failed to ensure that a comprehensive pre and post treatment assessment was performed on each patient prior to and after dialysis treatment (a procedure that cleans impurities from the blood of people whose kidneys can no longer perform that function). This Condition is not met as evidenced by:  On 8/25/10 from 9:30 am to 12 pm and from 1 pm to 3 pm, 18 random patients were observed having dialysis treatment initiated or terminated. At no time was a registered nurse observed listening to lung sounds, heart sounds, or feeling the legs for signs of edema (fluid buildup in the tissue) before or after treatment.  The omission of the pre-treatment assessment could result in acute respiratory, cardiac, fluid status and dialysis access problems being unrecognized. These indicators are used, in consultation with the patient, along with blood pressure and the presence/absence of peripheral edema to formulate a treatment plan to determine dialysis machine settings such as, amount of fluid to be removed, the rate at which it should be removed, and ensure that the patient is stable enough to tolerate the treatment.  Post treatment assessments are used to evaluate the effectiveness of the dialysis treatment plan	V 500		10/1/10

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V 500	Continued From page 8 and to ensure the patient is stable enough for discharge. Post treatment assessment findings are also referred to before the next treatment to establish a history for the patient, making it possible to minimize the dangerous and unpleasant effects dialysis treatment. (See V-504)	V 500			
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS  The patient's comprehensive assessment must include, but is not limited to, the following:  Blood pressure, and fluid management needs.  This STANDARD is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to ensure that comprehensive pre and post treatment assessments were performed on each patient prior to initiation and after termination of dialysis treatment.  Findings:  1. On 8/25/10 from 9:30 am to 12 pm and from 1 pm to 3 pm, during random observations in the treatment area, 15 patients were observed having dialysis treatment initiated or terminated. At no time was a registered nurse observed listening to patients' lung sounds, heart sounds, or feeling the legs for signs of edema (fluid buildup in the tissue).  On 8/25/10 at 2 pm, Patient 4 stated that no staff ever listened to his heart and lungs prior to treatment.	V 504		10/1/10	

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V 504	<p>Continued From page 9</p> <p>On 8/25/10, the facility policy and procedure titled, "Treatment Initiation Patient Assessment," dated 9/07 was reviewed. the policy indicated that a registered nurse should assess the patient within the first hour of dialysis. The assessment included heart and lung status and the presence or absence of edema.</p> <p>On 8/25/10, the facility policy and procedure titled, "Post Treatment Patient Assessment," dated 9/07, was reviewed. The policy indicated that a licensed nurse should assess the patient and notify the physician of any changes.</p> <p>On 8/25/10 at 3 pm in a concurrent interview with Administration Staff (Admin) 2 and Registered Nurse (RN) 3, RN 3 stated that she performed pre-dialysis treatment assessments by looking at and talking to the patient after they arrive to the treatment floor. She stated that she looks for shortness of breath, jugular vein distension (bulging neck veins), obvious swelling in the lower legs, and how the patient was walking. She would also ask them if they were having any difficulties. She stated that she did not use a stethoscope to listen to the patient's lungs and heart. RN 3 further stated that if there was a problem, the patient care technician (PCT) would tell her, and she would go see the patient. RN 3 stated "I don't have enough time to always assess the patient." Admin 2 and RN 3 were then asked if, this was an adequate pre-treatment assessment. Both indicated it was not.</p> <p>Admin 2 stated that a pre-treatment assessment should include listening to lung and heart sounds with a stethoscope. She further stated that the pre treatment assessment should be performed as soon as possible upon the arrival of a patient</p>	V 504			

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V 504	<p>Continued From page 10 to the treatment floor.</p> <p>RN 3 stated she did try to see the patients within the first hour of treatment. RN 3 and Admin 2 agreed that an assessment on a patient who, for example, was 58 minutes into a 180 minute treatment could not be considered a pre-treatment assessment.</p> <p>When asked how the post treatment assessment was completed, RN 3 stated the PCT would tell her if there were any problems, and she would see the patient. RN 3 and Admin 2 agreed that without an adequate pre-treatment assessment, the post treatment assessment, even if performed, would be of little use in determining the effectiveness of the treatment and the status of the patient. RN 3 and Admin 2 also agreed that PCTs were not qualified or trained to do assessments, only to collect data.</p> <p>2. During observations in the treatment area on 8/30/10 between 2:45 and 3 pm, patients were observed arriving for dialysis. The patients walked within five to six feet from the desk where RN 3 was working. RN 3 did not look up or talk to the three patients. RN 4 was attending to patients and working at chair-side computers. She was not observed performing patient assessments at any time.</p> <p>On 8/30/10 between 2:45 and 3:09 pm, The following was observed:</p> <p>a. At 2:45 pm, Patient 9 had her weight recorded and was assisted into the treatment chair.</p> <p>b. At 2:48 pm, her blood pressure was taken by a PCT.</p> <p>c. At 2:50 pm, her temperature was taken by a</p>	V 504			

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V 504	<p>Continued From page 11</p> <p>PCT</p> <p>d. At 2:56 pm, the PCT inserted the needles connected to the inflow and outflow tubing into the patient's access site on her arm.</p> <p>e. At 3:09 pm, the patient's dialysis treatment was started.</p> <p>No pre-treatment assessment was performed on the patient.</p> <p>On 8/30/10 at between 2:46 and 3:06 pm The following was observed:</p> <p>a. At 2:46 pm, Patient 10 had her weight recorded and was assisted into a treatment chair.</p> <p>b. At 2:49 pm, her blood pressure and temperature were taken by a PCT.</p> <p>c. At 2:35 pm, the PCT inserted the needles connected to the inflow and outflow tubing into the patient's access site on her arm.</p> <p>d. At 3:06 pm, the patient's dialysis treatment was started.</p> <p>No pre-treatment assessment was performed on the patient.</p> <p>During an observation on 8/30/10 between 3 and 3:16 pm, The following was observed:</p> <p>a. At 3 pm, Patient 11 had her weight recorded and was assisted into a treatment chair.</p> <p>b. At 3:03 pm, her blood pressure and temperature were taken by a PCT.</p> <p>c. At 3:10 pm, the PCT inserted the needles connected to the inflow and outflow tubing into the patient's access site on her arm.</p> <p>d. At 3:16 pm, the patient's dialysis treatment was started.</p>	V 504			

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NAME OF PROVIDER OR SUPPLIER  <b>MARYSVILLE DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 8TH STREET MARYSVILLE, CA 95901</b>		
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V 504	Continued From page 12 No pre-treatment assessment was performed on the patient.  On 8/31/10 at 2 pm, the Medical Director stated that he expected pre and post treatments to be done. He stated that a pre-treatment assessment should be done before the dialysis treatment was initiated. He further stated that in order to assess respiratory, cardiac and fluid status, the licensed nurse must listen to lung and heart sounds and check for peripheral edema.	V 504			
V 684	494.140(b)(1) PQ-NURSE MANAGER-12 MO RN+6 MO DIALYSIS  (1) Nurse manager. The facility must have a nurse manager responsible for nursing services in the facility who must- (i) Be a full time employee of the facility; (ii) Be a registered nurse; and (iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have a designated nurse manager responsible for the supervision of dialysis and nursing care provided by direct care staff which had the potential for unsafe practice during the delivery of patient care.  Findings:  On 8/30/10, the personnel file for Registered Nurse (RN) 9 was reviewed. The job description titled, "Registered Nurse-Chronic," dated 10/08 signed on 2/17/10 by RN 9 indicated that the RN 9 did not have any supervisory responsibilities.	V 684		10/8/10	

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V 684	Continued From page 13	V 684			
V 714	<p>On 8/30/10, the personnel file for RN 3 was reviewed . The job description titled, "Clinical Coordinator-Chronic," dated 9/08 and signed on 11/20/09 by RN 3, indicated that the RN 3 did not have any supervisory responsibilities.</p> <p>During an interview on 8/31/10 at 1:45 pm, Admin 1 confirmed that no RN was designated as nurse manager, and that no RN had any direct input into the hiring, evaluating, or termination of staff as stipulated by regulation.</p> <p>494.150(c)(1) MD RESP-DEVELOP, REVIEW &amp; APPROVE P&amp;P</p> <p>The medical director must-</p> <p>(1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility;</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to establish a policy and procedure that reflected the regulation and current standards of practice to ensure patients were assessed by a registered nurse prior to and after dialysis treatment.</p> <p>Findings:</p> <p>On 8/24/10, a review of the facility policy titled, "Treatment Initiation Patient Assessment" dated 09/07, indicated that the patient care technicians (PCT) assessed the patient and would notify the RN if they detected a problem. The policy indicated that it was the PCT's decision to initiate treatment and the RN "should" see the patient within the first hour of treatment. (See V101)</p>	V 714		10/31/10	

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V 714	Continued From page 14  On 8/24/10, a review of the facility policy titled, "Post Treatment Patient Assessment," dated 09/07, indicated that the PCT performed the post treatment assessment and reported the "findings that may preclude discharge" to the RN. (See V101)  On 8/25/10, during observations in the dialysis treatment area, no pre or post treatment assessments were witnessed. (See V504)  On 8/25/10 at 3 pm in a concurrent interview, Administration Staff (Admin) 2 and Registered Nurse (RN) 3, agreed that pre/post treatment assessments were not being performed. (See V504)  On 8/31/10 at 2 pm, the Medical Director stated that he expected pre and post treatments to be done. He stated that a pre-treatment assessment should be done before the dialysis treatment was initiated. (See V504)	V 714			
V 750	494.180 CFC-GOVERNANCE  This CONDITION is not met as evidenced by: Based on observation, staff interview, policy and procedure review, the governing body failed oversee the overall management of the facility. This condition was not met as evidenced by:  The governing body has full legal authority and responsibility for the governance and operation of the facility. The ability of the health care team to provide a safe level of care to patients cannot be ensured as evidenced by the seriousness of the deficiencies cited throughout this document as follows:	V 750		10/31/10	

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V 750	<p>Continued From page 15</p> <p>The facility failed to ensure patient assessments were being performed by a registered nurse as stipulated in the California Nurse Practice Act. (See V101)</p> <ol style="list-style-type: none"> <li>The facility failed to ensure that staff cleaned and disinfected treatment chairs and emergency kits on the machines after each patient's treatment. (See V122)</li> <li>The facility had expired needles, syringes and antiseptic hand cleaner available for use in emergency medical kits. (See V401)</li> <li>The facility failed to monitor the temperature of one medication refrigerator. (See V403)</li> <li>There was no evidence that the facility had performed quarterly disaster preparedness drills for the previous year. (See V415)</li> <li>The facility failed to ensure that pre and post treatment assessments were being performed. (See V504)</li> <li>The facility failed to ensure that there was an RN designated to be responsible for nursing services. (See V-684)</li> <li>The governing body failed to ensure the medical director provided adequate oversight of facility policies to ensure the safety of patients. (See V714)</li> </ol> <p>The cumulative effects of these systemic problems resulted in the inability of the governing body to ensure the provision of quality care in a clean, safe, and sanitary environment, and that</p>	V 750			

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V 750	Continued From page 16 necessary care and services were provided by qualified staff to manage the patients' medical status.	V 750			