

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: 052597	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2009
NAME OF PROVIDER OR SUPPLIER MISSION VIEJO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 27640 MARGUERITE PARKWAY MISSION VIEJO, CA 92692	
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V 000	<p>INITIAL COMMENTS</p> <p>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 111 patients and the patient sampled consisted of 9 hemodialysis patients and 2 home peritoneal dialysis patients.</p> <p>Representing the Department of Public Health were Teri Spencer, HFEN, Phyllis Weaver, HFEN and Raul Reyes, HFEN.</p> <p>Abbreviations used in this document:</p> <p>cc cubic centimeter CDC Centers for Disease Control and Prevention CHT certified hemodialysis technician CVC central venous catheter CN charge nurse FA facility administrator IDT interdisciplinary team LVN licensed vocational nurse psi pounds per square inch RN registered nurse RT reuse technician</p>	V 000		
V 113	<p>494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE</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:</p>	V 113		3/24/09

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>Surveyor: 14724</p> <p>Based on observation and interview, the facility failed to ensure all staff changed gloves, and washed or sanitized their hands as indicated.</p> <p>Findings:</p> <p>On 2/24/09, during continuous observations of direct care staff delivering care to the hemodialysis patients between 12:45 P.M. and 2:30 P.M., 3 staff members did not follow CDC guidelines for changing gloves, and washing or sanitizing hands as follows:</p> <ol style="list-style-type: none"> At 2:20 P.M., a staff member terminated the dialysis treatment for the patient at station 10. The staff member, gloved, disconnected the patient's CVC, then, without removing the gloves, walked to the nurses station and obtained supplies from the common CVC supply tray. This action potentially contaminated the supplies on the CVC tray. <p>When interviewed on 2/27/09 at 8:15 A.M., the FA stated that staff were never to obtain supplies from common supply trays or carts while wearing contaminated gloves.</p> <ol style="list-style-type: none"> At 2:00 P.M., a gloved staff member initiated the dialysis for the patient at station 13. The staff member removed the gloves but did not wash or sanitize her hands, then typed on the data entry keyboard. This action potentially contaminated the keyboard used for 2 patient stations. At 2:28 P.M., a gloved staff member initiated the dialysis for the patient at station 18. The staff member removed the gloves but did not wash or sanitize her hands before typing on the data entry 	V 113			

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V 113	Continued From page 2 keyboard used for 2 patient stations.	V 113			
V 116	When interviewed on 2/27/09 at 8:15 A.M., the FA stated that staff were to always wash or sanitize their hands after removing gloves and before typing on the data entry keyboards. 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, the facility failed to ensure items taken to 1 of 20 dialysis stations were disinfected before being returned to a clean area. Findings: During observation of the hemodialysis patient treatment area on 2/24/09 at 2:20 P.M., a bottle of Ex-Sept antiseptic was on the chair-side table at station 5, while a patient received dialysis. After completion of the patient's treatment at 3:20 P.M.,	V 116		3/24/09	

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V 116	Continued From page 3 an RN removed the bottle of Ex-Sept from the chair-side table and without disinfecting the bottle, placed it back on the clean supply cart between the stations.	V 116		
V 119	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation and interview, the facility failed to ensure common supply carts and dialysis supplies were kept sufficient distance from 19 of 20 hemodialysis patient stations to prevent contamination of the supplies. Findings: On 2/24/09 at 8:30 A.M., during the initial tour of the hemodialysis patient treatment area, common supply carts were located between every 2 patient stations, with the exception of the isolation station. The supply carts were approximately 6 to 9 inches from the dialysis machines and patient chairs. The supply carts had multiple plastic drawers containing hemodialysis supplies. Numerous open boxes of gloves and bagged dialyzers for the next shift of patients were stored on the top of the supply carts. The close proximity of the supply carts and supplies to the dialysis	V 119		3/24/09

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V 119	Continued From page 4 stations exposed the carts and supplies to splashes, splatters or sprays of blood, and created the potential for cross-contamination with blood borne pathogens via the supplies. On 2/24/09 at 10:30 A.M., the FA stated that staff were not to keep the dialyzers and supplies for the next shift of patients on top of the supply carts. The FA acknowledged that doing so exposed those supplies to potential contamination. The FA stated that the drawers of supplies on the carts were to be closed at all times. The FA stated she had not considered that the drawer fronts themselves may be contaminated with blood and staff touching the drawers to obtain supplies could spread that contamination via their gloves or hands.	V 119			
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. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance 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.	V 147		3/24/09	

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V 147	<p>Continued From page 5</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 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 policy and procedure review, the facility failed to ensure CVC care was provided to 7 randomly observed patients in accordance with facility procedures.</p> <p>Findings:</p> <p>1. Continuous observations of direct care staff providing care to 6 hemodialysis patients with CVCs were conducted on 2/24/09 from 12:50 P.M. to 3:20 P.M. at stations 6,7,24,and 25, at station 13 on 2/26/09 at 2:05 P.M. and at station 23 on 2/27/09 at 10:35 A.M. In each case, the patients sat upright in their chairs when the blood lines were connected prior to the start of treatment, when dressing changes were done, and when the blood lines were disconnected after completion of treatment.</p> <p>Review of the facility's central venous catheter care Policy 1-04-02A, Item 5, showed that patients should be in a comfortable supine (lying on the back with the face upward) position. Policy</p>	V 147			

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V 147	Continued From page 6 1-04-02D, Item 7, specified that the patient was to be in a comfortable, reclining position. The rationale listed for placing the patients in this position when accessing a CVC was that the supine position increased blood flow through the catheter and diminished the risk of air embolism.	V 147			
V 332	2. On 2/24/09 at 2:28 P.M., an RN initiated the hemodialysis treatment for the patient at station 18. The RN removed the patient's old CVC dressing, and then, without changing gloves, proceeded to cleanse the CVC exit site. When reviewed on 4/25/09, the facility procedure "Central Venous Catheter (CVC) Cleaning and Dressing Change" required staff to remove their gloves and wash hands after removing the old CVC dressing and before cleansing the CVC exit site. The rationale listed for this step was "Hand washing protects patient and teammate from cross contamination". 494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE 11.2 Rinsing/cleaning: precleaning equipment/pressures 11.2.1 When precleaning is done, it is part of the reprocessing procedures. All applicable requirements for design and maintenance of equipment included in this document should be adhered to for precleaning of equipment. The maximum pressures for the dialyzer, or other limits set by the manufacturer, should be adhered to. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on observation, interview and policy and	V 332		3/24/09	

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V 332	Continued From page 7 procedure review, the facility failed to ensure 1 of 1 Reuse Technicians was aware of maximum allowable pressure limits and how to monitor water pressures when pre-rinsing dialyzers. Findings: The facility dialyzer reprocessing system included a pre-rinse sink where the blood compartments of the used dialyzers were flushed and reverse ultrafiltration of the dialyzers performed. On 2/24/09 at 11:00 A.M., during observation of dialyzer reprocessing procedures, the RT stated he thought the maximum water pressure for the pre-rinse procedures was 55 psi. The RT stated he did not routinely monitor the water pressures at the pre-rinse sink and was not aware of where the pressure gauge was located. When reviewed on 2/24/09, the facility policy "Manual Reverse Ultrafiltration (RF) Without Header Removal" identified the maximum water pressures for flushing the dialyzer blood compartment as 20 psi, and 15 psi for the reverse ultrafiltration procedure. On 2/24/09 at 2:30 P.M., the Reuse Training Coordinator explained that the pressure gauge for the pre-rinse sink was located under the sink. The Training Coordinator stated that all RTs should know the maximum water pressures for pre-rinsing dialyzers, and where the pressure gauge is located for monitoring.	V 332		
V 455	494.70(a)(4) PATIENTS' RIGHTS [The patient has the right to-] (4) Privacy and confidentiality in personal medical records;	V 455		3/24/09

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V 455	Continued From page 8 This STANDARD is not met as evidenced by: Surveyor: 14724 Based on record review and interview, the facility failed to ensure medical information privacy for 1 non-sampled patient (12). Findings: When the medical record for Patient 7 was reviewed on 2/26/09, an electronic progress note, dated 8/30/08 described an incident when Patient 7 was splattered with blood after another patient pulled out their fistula needle. The first and last names of the other patient (Patient 12) appeared in the progress note in Patient 7's record. This clearly identified Patient 12 as the one who pulled out her needles. The progress note included an explanation of Patient 12's hepatitis status, as related to Patient 7's blood exposure. Documentation of Patient 12's name and medical information entered into Patient 7's medical record violated Patient 12's right to privacy. When interviewed on 2/27/09 at 11:00 A.M., the FA stated that Patient 12's name and medical information should not have been entered into Patient 7's medical record.	V 455			
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		3/24/09	

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V 504	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14724</p> <p>Based on medical record review and interview, the facility failed to ensure patient assessments were completed post dialysis, after symptoms of significant hypotension, severe cramping and elevated heart rates greater than 120 were experienced during dialysis for 2 of 9 sampled hemodialysis patients (2, 5).</p> <p>Findings:</p> <p>1. A 2/26/09 review of the medical record for Patient 5, showed the following:</p> <p>a. The 2/25/09 dialysis treatment record showed that the patient complained of muscle cramps, was feeling dizzy and had a blood pressure of 102/83 at 5:45 P.M. The patient received 200 cc of normal saline and the ultrafiltration (fluid removal) on the dialysis machine was turned down to minimum. At 5:53 P.M., Patient 5's blood pressure was 116/44, the patient reported feeling better, but was still having severe cramps. The patient received another 300 cc of normal saline. At 6:01 P.M. the patient ' s blood pressure was 151/96 and the treatment was terminated because of severe cramping.</p> <p>Further review of the treatment record and progress notes showed no evidence of additional patient assessment regarding the severe cramping to indicate whether the cramping had resolved or if any further treatment was provided.</p> <p>b. The 2/12/09 dialysis treatment record showed that the patient had a blood pressure of 146/68 with a pulse of 119 when the treatment was terminated at 6:15 P.M. Prior to discharge at 6:23</p>	V 504			

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V 504	<p>Continued From page 10</p> <p>P.M., the patient's blood pressure was 137/70 with a pulse of 130. The post treatment data collection and assessment area of the treatment record specified the patient had an irregular heart beat after dialysis.</p> <p>Further review of the treatment record and progress notes showed no evidence that staff conducted additional patient assessment regarding the high pulse rate or the irregular heart beat.</p> <p>c. The 1/22/09 dialysis treatment record showed that the patient had a blood pressure of 118/81 with a pulse of 121 when the treatment was terminated at 6:15 P.M. Prior to discharge at 6:25 P.M. the patient's standing blood pressure was 132/72 with a pulse of 127.</p> <p>Further review of the treatment record and progress notes showed no evidence that staff conducted additional patient assessment regarding the high pulse rate.</p> <p>On 2/27/09 at 11:00 A.M. RN 3 stated the RNs would report a patient's heart rate greater than 120 to the physician and would document it on the flow sheet or in the progress notes.</p> <p>2. When Patient 2's medical record was reviewed on 2/25/09, the 2/13/09 dialysis treatment record showed the patient's blood pressure was 143/87 at 9:31 A.M. A subsequent entry at 9:41 A.M. did not have a blood pressure, but indicated the patient received 300 cc of normal saline after dialysis because of " faint out " while standing.</p> <p>A review of the treatment record and progress notes showed no evidence that additional</p>	V 504			

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V 504	Continued From page 11 assessments of the patient's blood pressure or condition was conducted.	V 504		
V 517	494.80(b)(2) FREQUENCY OF ASSESSMENT A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. This STANDARD is not met as evidenced by: Surveyor: 14724 Based on medical record review and staff interview, the facility failed to complete the comprehensive reassessment for 1 of 12 sampled patients (5). Findings: A review of the medical record for Patient 5 on 2/26/09, showed the patient was admitted to the facility on 10/23/08. The initial comprehensive assessment was completed within 30 days. The record did not contain a follow up comprehensive reassessment of the patient.	V 517		

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V 517	Continued From page 12 During an interview with RN 4 on 2/27/09 at 08:20 A.M., the RN stated the staff were unable to locate Patient 5's follow up comprehensive reassessment that was to be completed within three months after completion of the initial assessment.	V 517		
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: 14724 Based on medical record review and interview, the facility failed to ensure a pre-dialysis assessment was integrated into the patient's plan of care/treatment interventions for 1 of 12 sampled patients (5). Findings: During medical record review on 2/26/09, a 2/21/09 progress note described that, when Patient 5 returned from vacation, she reported to the nurse that she felt very tired and had a nose bleed the prior day. The progress note indicated that the plan for Patient 5's care was for the	V 541		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052597	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2009
NAME OF PROVIDER OR SUPPLIER MISSION VIEJO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 27640 MARGUERITE PARKWAY MISSION VIEJO, CA 92692		
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V 541	Continued From page 13 dialysis treatment to be delivered without heparin and that the heparin would be stopped until the patient's nose bleed was relieved. A STAT hemoglobin was drawn and reported. Contrary to the progress note, the 2/21/09 dialysis treatment record showed that a heparin bolus of 1,500 units was administered to Patient 5 at 7:13 A.M., and the heparin bolus/infusion of 1,500 units was administered at 8:49 A.M. When interviewed on 2/27/09 at 11:00 A.M., the CN confirmed that the 2/21/09 treatment record indicated heparin was administered to Patient 5, instead of being withheld.	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: 14724 Based on interview and record review, the facility failed to ensure 2 of 2 home peritoneal dialysis patients (10, 11) were seen monthly by a physician and progress notes reflecting such visits were included in the patients' medical records. Findings: 1. A 2/27/09 medical record review showed that	V 560			

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V 560	Continued From page 14 Patient 10 was a home peritoneal dialysis patient of the facility since 12/13/07. Patient 10's medical record lacked evidence of monthly evaluations by a physician or other medical practitioner. There was a progress note, dated 8/11/08, showing a physician's examination and evaluation of the patient. There was a 5 month interval until the next physician progress note on 1/27/09. On 2/27/09 at 8:50 A.M., the Home Training RN stated she was aware of the requirement for patients to be seen at least monthly by a physician, and explained that, although he was informed about the requirement, Patient 10 refused to go to the physician's office every month. The Home Training RN stated that the facility IDT had not discussed the patient's non-adherence with the requirement, or revised Patient 10's plan of care to address the barriers to his compliance. 2. A 2/27/09 medical record review showed that Patient 11 was a home peritoneal dialysis patient at the facility since 4/28/08. During a 2/27/09 interview, Patient 11 stated he was seen at his physician's office every month. When reviewed on 2/27/09, Patient 11's medical record lacked evidence of monthly physician evaluations. The most recent physician progress note in the record was dated 10/28/08. On 2/27/09 at 8:55 A.M., the Home Training RN confirmed that Patient 11 was seen monthly at the physician's office. The Home Training RN stated that she periodically called the physician's office to request the monthly progress note, but was not aware it had been 4 months since one was sent.	V 560			
V 715	494.150(c)(2)(i) POLICIES AND PROCEDURES	V 715			

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V 715	<p>Continued From page 15</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: 14724 Based on observation, interview and policy review, the facility medical director failed to ensure staff followed written procedures for termination of dialysis for 3 of 4 randomly observed patients, and for patient monitoring during dialysis for 2 of 9 sampled hemodialysis patients (7, 8).</p> <p>Findings:</p> <p>1. On 2/24/09, when terminating the dialysis treatments for the second shift patients at station 16 at 12:53 P.M., station 15 at 1:24 P.M., and station 10 at 2:28 P.M., the staff members terminated the treatments, removed the patients' needles and removed the bloodlines and dialyzers from the dialysis machines before taking the patients' temperatures.</p> <p>The facility procedure "Termination of Dialysis" required staff to obtain the patients' vital signs prior to terminating their dialysis treatments. The policy "Suspected Pyrogen Reactions" described actions staff were to take if a patient developed a fever, or other symptoms of a pyrogen reaction (occur when patients' blood is exposed to contaminants in the dialysate) during dialysis. If a</p>	V 715			

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V 715	Continued From page 16 patient developed a fever, staff were to collect dialysate and water samples, preserve the dialyzer and bloodlines for possible testing, and call the patient's physician for orders to draw blood cultures, to aid in further investigation into the causes for the patient's febrile reaction. When interviewed on 2/27/09 at 8:15 A.M., the FA stated that staff were to take the patient's temperature prior to terminating their dialysis treatment, to determine if the patient had an adverse reaction to the treatment which may require intervention. 2. On 2/24/09 at 9:15 A.M., during the initial tour of the hemodialysis patient treatment area, CHT 1 stated that patients were to be monitored by staff every 30 minutes during their dialysis treatments. The monitoring included looking at the patient's vascular access, and evaluating their blood pressure, pulse rate and dialysis machine parameters, as recorded by the interactive medical record system. A 2/26/09 review of the medical records for Patients 7 and 8 showed intervals of 60 minutes between monitoring recorded on the treatment records. The 2/4/09 treatment record for Patient 7 showed a 60 minute interval between monitoring at 8:42 A.M. and 9:42 A.M.. The 2/4/09 treatment record for Patient 8 showed a 64 minute interval between monitoring at 6:06 P.M. and 7:10 P.M. During a 2/27/09 interview, the FA confirmed that staff were to monitor the patients every 30 minutes during dialysis.	V 715		
V 726	494.170 MEDICAL RECORDS The dialysis facility must maintain complete,	V 726		

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V 726	<p>Continued From page 17</p> <p>accurate, and accessible records on all patients, including home patients who elect to receive 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: 14724 Based on record review and interview, the facility failed to ensure the electronic dialysis treatment records for 3 of 9 sampled hemodialysis patients (3,7,8) accurately reflected the treatments and care provided.</p> <p>Findings:</p> <p>The facility medical record system was a combination of manual and electronic documentation. The hemodialysis treatment records were electronically documented via an interactive system with the dialysis machines. Review of the medical records for Patients 3, 7, and 8 on 2/26/09 demonstrated examples of inaccurate documentation on the treatment records of the treatments and care provided:</p> <p>1. The 1/22/09 treatment record for Patient 3 showed that, although a reprocessed dialyzer was used for the treatment, the required germicide tests and patient/dialyzer identification were not recorded on the treatment record. The fields for recording the germicide and identification all contained the words "Non-reuse".</p> <p>When interviewed on 2/27/09 at 11:00 A.M., the CN and FA confirmed the dialyzer used for Patient 3 on 1/22/09 was reprocessed, and explained that the electronic record system had</p>	V 726			

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V 726	<p>Continued From page 18</p> <p>not been changed to enable recording the germicide tests and identification when the patient's dialysis prescription changed from non-reuse to a reprocessed dialyzer.</p> <p>2. The 2/2/09 and 2/6/09 treatment records for Patient 7 lacked post dialysis assessment information. The fields on the electronic treatment records for "Posttreatment Data Collection & Assessment" had "No Data" in them.</p> <p>During the 2/27/09 11:00 A.M. interview, the FA stated that the missing post dialysis assessments were due to a problem in the electronic record system.</p> <p>3. The 1/22/09 treatment record for Patient 8 showed an interval of 2 hours between patient and machine monitoring at 11:36 A.M. and 1:35 P.M.</p> <p>During the 2/27/09 11:00 A.M. interview, the FA explained that the 2 hour interval was a "glitch" in the electronic record system. The FA pointed out that the corresponding machine parameter entries for Patient 8 at those times showed a machine dialysate flow rate of 230, which was lower than the minimum flow rate the machine could deliver, indicating that the interactive system was not functioning properly at that time.</p>	V 726			