

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: 052729	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2009
NAME OF PROVIDER OR SUPPLIER OAKLAND DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 5354 CLAREMONT AVENUE OAKLAND, CA 94618	
(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: 05189 The following represents the findings of the Department of Public Health during an investigation of one complaint and one entity reported incident. Entity Self-Report Number: CA00180446. Complaint Intake Number: CA00181996. Representing the Department of Public Health: Dorothy Rice, HFEN. The inspection was limited to the specific entity reported incident and complaint being investigated and does not represent the findings of a full inspection of the facility. The entity report incident and the complaint were substantiated. Four deficiencies were issued.	V 000		
V 468	494.70(b)(1) RIGHT: INFORMED OF DISCHARGE/TRANSFER POLICY The patient has the right to- (1) Be informed of the facility's policies for transfer, routine or involuntary discharge, and discontinuation of services to patients; This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to ensure one patient's right to be informed of the facility's involuntary discharge policy. (Patient 1) This failure resulted in one patient being involuntarily transferred without the patient having full and clear acknowledgement of the procedure.	V 468		

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 468	Continued From page 1 Findings: On 4/1/09 record review showed that Patient 1 was admitted to the facility on 11/16/05 with a diagnosis of end stage renal (kidney) disease for tri-weekly dialysis treatments. Further record review showed Patient 1 was involuntarily discharged from the facility on 3/2/09 for "missed treatments". However, during the record review, the surveyor found no documentation that the facility gave Patient 1 information about the facility policies regarding the involuntary discharge. Moreover, Staff B stated on 4/1/09 that she thought Staff C provided the information while Staff B stated that she thought Staff C provided Patient 1 the information regarding involuntary discharge. In summary, neither staff provided information about the facility policies regarding the involuntary discharge to Patient 1 and neither was aware that any other staff provided the information.	V 468			
V 469	494.70(b)(2) RIGHT: INFORMED OF DISCHARGE/TRANSFER POLICY [The patient has the right to-] (2) Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in §494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed. This STANDARD is not met as evidenced by: Surveyor: 05189	V 469			

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V 469	Continued From page 2 Based on staff interview and record review, the facility failed to ensure one resident's right to receive a written notice 30 days in advance of an involuntary discharge (Patient 1). This failure increased the risk of a disorderly transfer and possible inconsistent treatments for Patient 1. Findings: On 4/1/09 record review showed that Patient 1 was admitted to the facility on 11/16/05 with a diagnosis of end stage renal (kidney) disease for tri-weekly dialysis treatments. On 2/19/09 the medical director/patient physician signed a letter addressed to Patient 1 stating that the facility could no longer care for Patient 1, and that the involuntary transfer was effective "as of March 1, 2009". On 4/1/09 at approximately 1:00 PM, Staff B acknowledged that the time interval from 2/19/09 to 3/1/09 did not constitute a 30 day notice provision to Patient 1 allowing sufficient time for an effective and orderly involuntary transfer.	V 469			
V 559	494.90(b)(3) IMPLEMENTATION OF THE PATIENT PLAN OF CARE If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must- (i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.	V 559			

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V 559	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to adjust the care plan of one (Patient 1) of one patient reviewed when the patient repeatedly missed treatments. This failure placed Patient 1 at risk of not achieving expected treatment outcome goals. Findings: According to record review on 4/1/09, Patient 1 was admitted to the facility on 11/16/05 with a diagnosis of end stage renal (kidney) disease. Subsequent record review showed that Patient 1 had a prescription for tri-weekly dialysis treatments and that the patient "missed treatments" the latter part of year 2008, due to non-compliance with the scheduled treatments. For example, during December 2008, the patient missed treatments on 12/1/08, 12/3/08, 12/5/08, 12/8/08, 12/10/08, 12/12/08, 12/15/08, 12/17/08, and 12/29/08. The "Summary/Assessment" section of the annual 12/29/08 updated comprehensive care plan for Patient 1 showed the following:" Pt [patient]...non compliant with TX[treatment], unable to reach-left message on cell phone." The review of the "Plan, Intervention, and Education" section of the same dated care plan included the following "Cont [continue] to try to reach by telephone ..." There was no comprehensive intervention nor measurable timetable goals identified by the team. Further record review showed that Patient 1	V 559			

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V 559	Continued From page 4 missed 9 treatments during January 2009, and 11 treatments during February 2009. Patient 1's clinical record contained no subsequent revised care plans with attempted interventions and measurable timetable goals. On 4/1/09 at approximately 1:20 p.m., Staff C acknowledged that the annual updated care plan contained only information and not adequate interventions and goals for the identified "missed treatment" problem. Additionally, Staff C stated that no additional revised, adjusted care plan for this identified problem was developed for Patient 1.	V 559		
V 766	494.180(f) INVOL DISCHARGE/TRANSFER POLICY/PROCEDURE The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless - (1) The patient or payer no longer reimburses the facility for the ordered services; (2) The facility ceases to operate; (3) The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs; This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to implement its discharge policy and procedure for one (Patient 1) of one patient reviewed. This failure increased the risk of not allowing Patient 1 sufficient time for an orderly	V 766		

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V 766	<p>Continued From page 5 discharge and transfer.</p> <p>Findings:</p> <p>On 4/1/09 during a visit to the facility, the record review showed that Patient 1 was admitted to the facility on 11/16/05 with a diagnosis of end stage renal (kidney) disease. Further record review showed that Patient 1 had a prescription for tri-weekly dialysis treatments and was involuntarily discharged from the facility on 3/2/09 for "missed treatments" due to non-compliance. For example,</p> <ul style="list-style-type: none"> -During November 2008, the patient missed 2 treatments; -During December 2008, the patient missed 13 treatments; -During January 2009, the patient missed 9 treatments; -During February 2009, the patient missed 11 treatments. <p>On 4/1/09, the review of the facility's "Patient Behavior Agreement, 30 Day Discharge, Involuntary Discharge or Involuntary Transfer" showed that, "a. When it is necessary to discharge a patient from the facility, the Facility Administrator, (ROD) Regional Operation Director, Divisional Vice President (DVP), Medical Director, and Renal Network must be notified...to discuss the event and determine if there are other viable options..." and "b. The patient will be given a list of alternate dialysis providers and is requested to provide the facility the name of the provider within 30 days. "</p> <p>On 4/1/09, the review of a progress note dated 1/7/09 showed that Patient 1 requested a transfer to another hemodialysis facility. The voluntary</p>	V 766			

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V 766	<p>Continued From page 6</p> <p>transfer was not accomplished.</p> <p>On 2/19/09 the medical director/patient physician addressed a letter to Patient 1 stating that the facility could no longer care for Patient 1 "due to your lack of commitment to remain consistent with your dialysis treatments..." The involuntary transfer was effective "as of March 1, 2009".</p> <p>On 4/1/09 at approximately 1:00 p.m., Staff B stated that she was not sure if the DVP was notified of the involuntary transfer and included into a discussion to determine other viable options. Additionally, Staff B acknowledged that the time interval from 2/19/09 to 3/1/09 did not constitute a 30 day notice provision to Patient 1 allowing the patient ample time upon completing the involuntary transfer that included the prospective provider name ensuring an orderly transfer.</p>	V 766			