

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>052727</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAI - INDIANA COURT - REDLANDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1210 INDIANA COURT REDLANDS, CA 92373</b>		
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V 000	INITIAL COMMENTS  The following reflects the findings of the California Department of Public Health during a recertification survey.  Representing the Department: Octavio Relopez, HFEN Rumia Sagala, HFEN  Census: 136 Sample size: 13  Abbreviations and Acronyms:  ESRD- End Stage Renal Disease HD- Hemodialysis UFR- Ultrafiltration Rate CHT- Certified Hemodialysis Technician QAPI- Quality Assessment and Performance Improvement RN- Registered Nurse CC- Clinical Coordinator FA- Facility Administrator SW- Social Worker	V 000			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE  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: Based on observation, interview and record review, the facility staff failed to wear disposable gloves when touching the dialysis machine and dialyzer which had the potential for exposure to	V 113		12/22/10	

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 113	<p>Continued From page 1</p> <p>and the transmission of potentially infectious substances between patients and staff.</p> <p>Findings:</p> <p>On 11/8/10, at 10 AM, during an observation on the treatment floor, HCT (Hemodialysis Certified Technician) 1 was observed touching the hemodialysis (HD) machine and the dialyzer (a cylindrical equipment used as an artificial kidney) on station 15 with bare hands, then moved to another station and typed on the computer keyboard with bare hands. HCT 1 did not perform hand hygiene prior to touching the keyboard.</p> <p>During an interview with HCT 1 on 11/8/10, at 10 AM, he stated that the HD machine was considered dirty and the computer keyboard clean. HCT 1 acknowledged that he should have worn gloves before touching the HD machine and the dialyzer and performed hand hygiene prior to touching the computer keyboard.</p> <p>During an interview with RN (Registered Nurse) 1 on 10/8/10, at 10: 03 AM, he stated that the HD machine and the dialyzer were considered dirty and staff should wear gloves before touching them. RN 1 explained that after touching the HD machine, staff should remove the gloves and perform hand hygiene prior to touching the computer keyboard.</p> <p>A review of the facility ' s infection control policy and procedure with a revised date of July 2010, the following was noted:</p> <p>" Gloves are required whenever ... touching the patient ' s equipment or supplies. Hands are always washed after gloves are removed between</p>	V 113			

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V 113	Continued From page 2 patient contacts as well as after touching ... contaminated items. "	V 113			
V 236	494.40(a) ADDITIVES-LABEL SPIKED JUGS/LABEL SPECIFIC PT  5.4.5 Additives: labeling spiked jugs/labeling if for specific pt (5.4.4.1 Concentrate jugs): If a chemical spike is added to an individual container to increase the concentration of an electrolyte, the label should show the added electrolyte, the date and time added, and the name of the person making the addition.  Containers should be labeled to indicate the final concentration of the added electrolyte ...This information should also be recorded in a permanent record. Labels should be affixed to the containers when the mixing process begins.  6.4.2 Additives When additives are prescribed for a specific patient, the container holding the prescribed acid concentrate should be labeled with the name of the patient, the final concentration of the added electrolyte, the date on which the prescribed concentrate was made, and the name of the person who mixed the additive.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that spiked jugs were appropriately labeled with complete information by failing to include the specific name of the patient on each individual jug which had the potential to result in the patients' exposure during dialysis treatment to an electrolyte concentration different from what the physician had ordered.	V 236		12/22/10	

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V 236	<p>Continued From page 3</p> <p>Findings:</p> <p>During an observation in the treatment floor on 11/15/10, at 11:15 AM, multiple acid bath concentrate jugs were on top of a cart in a hallway close to the treatment area. Two (2) acid concentrate jugs had a written label, "Special Bath" and a green sticker label. The green sticker label did not include the name of the specific patient and contained the following information:</p> <p># 1 Special Bath jug- 11/10/10, 3K/ CA 3.0 (Final concentration of potassium and calcium electrolytes) and staff signature.</p> <p># 2 Special Bath jug- 11/10/10, 1K/ CA 3.0 and staff signature.</p> <p>During an interview with the RN Clinical Coordinator (CC) on 11/15/10, at 11:15 AM, the RN CC stated that the facility had been using pre-mixed acid concentrate from the manufacturer with standard concentrations of 1K/ 2.5 CA; 2K/ 2.5 CA; and 3K/ 2.5 CA.</p> <p>When asked about the concentration of the special bath jugs, and why the patient's name was not included in the label, the RN CC stated, "It is our policy that as long as the concentration and the date it was prepared is there, we don't need to specify the patient's name." The RN CC further explained that special bath jugs had a concentration different from the standard pre-mixed acid concentrate and had to be mixed with added electrolytes as ordered by the physician.</p> <p>During a review of the facility's policy and</p>	V 236			

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V 236	Continued From page 4 procedure titled, "Dialysate Concentrate: Mixing/Use in individual Containers," dated April 2007, the following were noted:  "When dialysate concentrate is altered and mixed for a specific patient's needs, the container will be clearly labeled with all the following information:  Original (base) solution concentration of potassium and calcium Date and time of mix Specific additive used Final concentration of potassium and calcium Initials of person mixing the concentrate."  The above policy and procedure for labeling altered and mixed acid concentrates did not include labeling the specific name of the patient.	V 236			
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 and interview, the facility failed to ensure that the facility was maintained to provide dialysis patients, staff and visitors a safe environment by allowing an annex front door unlocked without personnel present allowing easy public entry and access to the treatment areas, storage supplies and dialysis equipment. This had the potential to create hazard risks and danger to all dialysis patients, staff and visitors.	V 401		11/22/10	

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V 401	Continued From page 5 Findings:  On 11/8/10, at 9:15 AM, during the initial tour, an annex front door of the facility was observed unlocked. The door was directly opposite a public parking area and would allow easy entry by the public inside the facility. The unlocked front door would lead straight into unlocked supply storage room and dialysis equipment, and to the dialysis treatment area.  On 11/9/10, at 8:45 AM, the facility's Social Worker (SW) was observed entering the facility from the parking area thru the unlocked annex front door.  In an interview with the SW and the acting Facility Administrator (FA) on 11/9/10, at 8:45 AM, the SW stated, "Only the dietician and me use this door when we come in." The acting FA acknowledged that the unlocked door would provide easy access of unauthorized individuals into the storage supply, dialysis equipment and treatment areas and could pose a danger to dialysis patients, staff and visitors. The acting FA immediately instructed the staff to lock the door.	V 401			
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX  The patient's comprehensive assessment must include, but is not limited to, the following:  (2) Evaluation of the appropriateness of the dialysis prescription,  This STANDARD is not met as evidenced by: Based on interview and record review, facility staff	V 503		12/28/10	

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V 503	<p>Continued From page 6</p> <p>failed to ensure that appropriate dose of heparin (a medication used to help prevent clotting of blood) was administered as prescribed to 1 of 13 sampled patients (Patient 12) which had the potential to result in dialyzer failure, and may have resulted in multiple dialyzer failures due to patients' clotted dialyzers.</p> <p>Findings:</p> <p>On 11/10/10, Patient 12's medical record was reviewed. Patient 12 was 73 years of age and had diagnoses that included End Stage Renal Disease (ESRD) and hypertension (high blood pressure). The dialysis treatment prescription order dated 9/23/10 included, "Heparin 7,000 units- bolus; Maintenance- 1,500 units; Total heparin (dose) of 13,000 units."</p> <p>Review of the dialysis treatment records dated from 10/26/10 to 11/8/10, indicated that the heparin was not administered according to the prescribed dose during dialysis treatment. The following records documented that the total amount of heparin administered was below the prescribed dose of 13,000 units.</p> <p>10/26/10 Heparin bolus given- 7,000 units; heparin maintenance total- 4,400 units; (Total amount administered= 11,400 units).</p> <p>10/30/10 Heparin bolus- 7,000; heparin maintenance total- 5,000; (Total amount administered= 12,000 units).</p> <p>11/1/10 Heparin bolus- 7,000; heparin maintenance total- 0; (Total amount administered= 7,000 units).</p>	V 503			

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V 503	<p>Continued From page 7</p> <p>11/2/10 Heparin bolus- 7,000; heparin maintenance total- 4,500; (Total amount administered= 11,500 units).</p> <p>11/4/10 Heparin bolus- 7,000; heparin maintenance total- 4,500; (Total amount administered= 11,500 units).</p> <p>11/6/10 Heparin bolus- 7,000; heparin maintenance total- 5,100; (Total amount administered= 12,100 units).</p> <p>11/8/10 Heparin bolus- 7,000; heparin maintenance total- 2,300; (Total amount administered= 9,300 units).</p> <p>In an interview with RN 3 on 11/10/10, at 10:35 AM, RN 3 reviewed Patient 12's treatment records and stated that he could not understand why the heparin orders were not administered as prescribed. RN 3 acknowledged that the total amount of heparin administered during dialysis treatment was below the prescribed total dose of 13,000 units.</p> <p>During an interview with the facility administrator (FA) on 11/10/10, at 2:50 PM, the FA reviewed Patient 12's dialysis treatment records and acknowledged that Patient 12 was not administered the prescribed total amount of heparin of 13,000 units during dialysis treatment.</p> <p>In another interview with the FA and the Quality Assurance (QA) nurse on 11/15/10, at 2:05 PM, the facility's Quality Assessment and Performance Improvement (QAPI) log for dialyzer reuse was reviewed. The QAPI guidelines documented that an action plan will be required if there was a sustained increase in the number of</p>	V 503			

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V 503	Continued From page 8 dialyzer failures noted for any reason over the 3 month period being evaluated.  The number of failed dialyzers due to clotted dialyzers for the past 6 months, from January 2010 to July 2010 included the following:  January- 5 clotted dialyzers February- 3 March- 7 April- 12 May- 5 June- 4 July- 6  No documentation was found to indicate that an action plan for clotted dialyzers had been developed. The FA and the QA nurse confirmed the above findings.	V 503			
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS  The plan of care must address, but not be limited to, the following: (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: Based on observation, interview and record review, facility staff failed to implement the plan of care to manage the volume status for 3 of 13 sampled patients (Patients 10, 11, 12) by failing to consistently implement the physician's orders in managing excessively low blood pressure (hypotension) during dialysis treatment which resulted in further treatment complications and had the potential to result in a serious medical condition.	V 543		12/28/10	

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V 543	<p>Continued From page 9</p> <p>Findings:</p> <p>1. On 11/11/10, Patient 12's medical record was reviewed. Patient 12 was 73 years of age and had diagnoses that included ESRD, hypertension and congestive heart failure (CHF). Patient 12 had been receiving hemodialysis treatment 4 times a week on every Tuesday, Thursday, Saturday and Monday.</p> <p>Review of Patient 12's hemodialysis treatment records dated from 10/26/10 to 11/8/10, showed that Patient 12 had experienced signs and symptoms of excessively low blood pressure during dialysis treatment. Patient 12's dialysis prescription orders included treatment duration of 240 minutes (4 hours). Patient 12's PRN (as needed) orders dated 7/19/10 for hypotension included the following:</p> <p>"If patient demonstrates signs or symptoms of hypotension - Place in Trendelenberg (head lower than heart) position, decrease the UFR, normal saline bolus (a large amount of medication to be administered) 200 milliliters (ml), may repeat up to 5 times (compare vital signs to normal baseline values), administer oxygen 2-4 liters per minute."</p> <p>a. The treatment record dated 11/8/10 showed that Patient 12 had been experiencing signs of hypotension during the course of dialysis treatment. The patient's blood pressure was abnormally low at a range from 93/53 to 81/53. The treatment record interdialytic documentation included the following:</p> <p>13:37 (1:37 PM) - 136/64 (B/P); UFR- 1.67; Treatment (tx) started.</p>	V 543			

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V 543	<p>Continued From page 10</p> <p>15:01 (3:01 PM) - 106/60; UFR- 1.67</p> <p>15:31 (3:31 PM) - 93/53; UFR- 1.67</p> <p>16:01 (4:01 PM) - 81/53; UFR- 1.67; b/p low cuff (equipment used to check blood pressure) adjusted and rechecked.</p> <p>16:04 (4:04 PM) - 81/53; tx ended 30 minutes early due to hypotension, RN aware.</p> <p>The above documentation in the patient's treatment record indicated that facility staff had failed to implement the treatment protocol for hypotension and the patient's prescribed PRN orders for hypotension when Patient 12's blood pressure dropped to an abnormally low blood pressure.</p> <p>There was no documentation found in the treatment record to indicate that Patient 12 was administered normal saline solution, UFR decreased, patient placed on Trendelenberg position, and oxygen administered as prescribed in the PRN orders. No documentation was found to indicate that the physician had been notified regarding the patient's persistent hypotension and that the treatment had been stopped 30 minutes earlier due to hypotension.</p> <p>b. The treatment record dated 11/6/10, documented that Patient 12 had experienced persistent signs of hypotension. Interdialytic documentation included the following:</p> <p>10:18 AM - BP 199/67; UFR- 1.25; Treatment initiated with out difficulty.</p> <p>12:38 PM - BP 97/60; UFR- 1.25; Patient resting</p>	V 543			

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V 543	<p>Continued From page 11 quietly. Voices no complaints.</p> <p>12:41 PM - BP- 102/45; UFR- 1.25; Resting quietly.</p> <p>12:43 PM - BP- 99/50; UFR- 1.25; Resting quietly, rechecked BP still low.</p> <p>12:59 PM - BP- 96/59; UFR- 1.25; 200 ml normal saline (NS) given; BP rechecked improved 114/59.</p> <p>1:38 PM - BP- 68/14; UFR- 1.25; Hypotensive, BP cuff repositioned. Keep feet up and BP rechecked.</p> <p>1:52 PM - BP- 74/38; UFR- 1.25; BP remains low, NS bolus (200 ml) given. Patient alert and oriented.</p> <p>2:08 PM - BP- 81/41; UFR- 1.25; Treatment ended per RAI policy, patient stable, discharged ambulatory (able to walk).</p> <p>A review of the facility's policy and procedure titled, "Complications of Treatment: Blood Pressure Problems ... " dated September 2009, the following were noted:</p> <p>"Actions: Hypotension- If the patient demonstrates signs or symptoms of hypotension, decrease the ultrafiltration rate and obtain vital signs ...</p> <p>Notify the nurse and place the patient in Trendelenberg position. Administer saline bolus ... per approved protocol, standing order or specific physician order.</p>	V 543			

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V 543	<p>Continued From page 12</p> <p>Administer oxygen as indicated per physician order.</p> <p>... If the patient remains hypotensive and/or symptomatic (showing signs) after interventions, discontinue dialysis and notify the physician.</p> <p>Collaborate with physician/care team to determine possible causes for hypotension ... "</p> <p>During an interview with RN 1 who was the acting FA on 11/10/10, at 9:35 AM, she stated that the facility's protocol for hypotension was to give normal saline as ordered, decrease the UF rate and if the patient's hypotension persists, call the physician. RN 1 reviewed Patient 12's treatment records and the PRN orders for hypotension and confirmed the findings. RN 1 acknowledged that the prescribed PRN orders and facility protocol for hypotension was not carried out by staff when Patient 12 experienced signs of hypotension.</p> <p>2. A review of Patient 11's medical record on 11/15/10 revealed that Patient 11 was 65 years old and had diagnosis that included ESRD and hypertension. Patient 11 had been receiving hemodialysis treatment 3 times a week.</p> <p>A review of the hemodialysis flow sheets, dated 11/2/10 and 11/11/10, revealed that Patient 11's blood pressure was abnormally low and had experienced signs of hypotension during the hemodialysis treatment.</p> <p>The treatment record interdialytic documentation dated 11/9/10 included the following:</p> <p>1:56 PM - BP 141/71; UFR- 1.2; Tx started 3:35 PM - BP 101/43; UFR- 1.12; Patient resting</p>	V 543			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052727</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAI - INDIANA COURT - REDLANDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1210 INDIANA COURT REDLANDS, CA 92373</b>		
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V 543	<p>Continued From page 13</p> <p>5:05 PM - BP 115/41; UFR- 1.12 5:35 PM - BP 86/47; UFR 1.12; Rechecked BP improved 103/47. 5:36 PM - BP 103/47; UFR 1.12 5:56 PM - BP 99/51; UFR 1.12; Tx completed ... BP low, no complaint, BP rechecked. 6:28 PM - discharged via wheelchair.</p> <p>Further review of the hemodialysis flow sheets revealed that there was no documented evidence that the licensed nurse had implemented the physician's PRN order to manage the patient ' s abnormally low blood pressure. No documentation was found to indicate that normal saline had been administered, patient placed in a Trendelenberg position, UFR was decreased, and oxygen administered to the patient.</p> <p>3. On 11/10/10, Patient 10's medical record was reviewed. Patient 11 was 56 years of age and had diagnoses that included End Stage Renal Disease (ESRD, Diabetes and hypertension (high blood pressure). Patient 10 had been receiving hemodialysis (the use of machine to clean the blood) treatment 3 times per week on every Tuesday, Thursday and Saturday.</p> <p>Review of Patient 10's hemodialysis treatment records dated from 10/23/10 to 11/9/10, the dialysis prescription orders included a treatment duration of 210 minutes (3.5 hours). Patient 10's PRN orders for hypotension dated 7/19/10, included the following:</p> <p>"If patient demonstrates signs or symptoms of hypotension - Place in Trendelenberg position, decrease the UFR, normal saline bolus of 200 ml, may repeat up to 5 times (compare vital signs to normal baseline values), administer oxygen 2-4</p>	V 543			

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V 543	Continued From page 14 liters per minute."  a. A review of the treatment record dated 10/23/10 showed that during the course of the treatment, Patient 10 had experienced signs and symptoms of hypotension. Patient 10's blood pressure had dropped to an abnormally low range of 92/49 (adult normal blood pressure= 120/80) and had shown signs and symptoms of discomfort. The treatment record interdialytic (during dialysis treatment) documentation included the following:  10:09 AM - With scattered rales (crackling sounds heard in the lungs). Patient denies shortness of breath (SOB). Will try to challenge weight if tolerated.  10:14 AM - BP 139/42; UFR- 1.29; Treatment (Tx) started.  11:55 AM - BP 92/49; UFR- 1.29; Patient moaning, normal saline (NS) bolus given, goal lowered to 4.0 kg.  12:25 PM - BP 109/56; UFR- 0.  1:44 PM - BP 98/61; UFR- 0; Tx completed. Blood returned without difficulty.  3:06 PM - Post BP, patient noted lethargic, hypotensive. NS bolus 500 ml given but patient remains slow to response. Another 500 ml given and placed patient on oxygen at 2 liters/ minute per nasal cannula (2 prong plastic tubing to the nose). Patient responded well and BP improved after 30 minutes. Patient discharged to home alert/oriented and ambulatory (able to walk). Patient 10 ' s recorded post treatment BP was	V 543			

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V 543	<p>Continued From page 15</p> <p>109/57 and a post weight (dry weight) of 65.7 kg.</p> <p>A review of the facility's policy and procedure titled, "Complications of Treatment: Blood Pressure Problems ... " dated September 2009, the following were noted:</p> <p>"Actions: Hypotension- If the patient demonstrates signs or symptoms of hypotension, decrease the ultrafiltration rate and obtain vital signs ...</p> <p>Notify the nurse and place the patient in Trendelenberg position. Administer saline bolus ... per approved protocol, standing order or specific physician order.</p> <p>Administer oxygen as indicated per physician order.</p> <p>... If the patient remains hypotensive and/or symptomatic (showing signs) after interventions, discontinue dialysis and notify the physician.</p> <p>Collaborate with physician/care team to determine possible causes for hypotension ... "</p> <p>Staff had failed to implement the facility's treatment protocol for hypotension and the prescribed PRN orders for hypotension when Patient 10's blood pressure dropped to an abnormally low level and showed persistent signs and symptoms of hypotension.</p> <p>There was no documentation found in the treatment record to indicate that the physician had been notified regarding the patient ' s persistent signs and symptoms of hypotension. No order was found to challenge (to take more</p>	V 543			

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V 543	<p>Continued From page 16</p> <p>fluids out during the treatment) the patient's weight and the UFR was stopped and not decreased as prescribed when the patient's BP dropped to an abnormally low level.</p> <p>b. A review of the treatment record dated 11/9/10 indicated that Patient 10 had experienced signs of hypotension. The interdialytic documentation included the following:</p> <p>10:01 AM - BP 115/65; UFR- 0; Tx started.</p> <p>11:32 AM - BP 93/81; UFR- .14; Patient resting quietly, voices no complaints.</p> <p>1:01 PM - BP 43/28; UFR- .14; BP low, offers no complaints, BP retaken.</p> <p>1:03 PM - BP 106/53; UFR- .14; vital signs stable offers no complaints.</p> <p>1:38 PM - BP 99/53; Tx completed. (300 ml of NS given at 1:38 PM.)</p> <p>The above documentation in the patient's treatment records showed that staff had failed to implement the facility's treatment protocol for hypotension and the prescribed PRN orders for hypotension when Patient 10's blood pressure dropped to an abnormally low level and showed persistent signs and symptoms of hypotension.</p> <p>There was no documentation found in the treatment record to indicate that the UFR was decreased, patient was placed in Trendelenberg position and that oxygen was administered when the patient's BP dropped to an abnormally low.</p> <p>During an interview with RN 1 who was the acting</p>	V 543			

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V 543	Continued From page 17 FA on 11/10/10, at 9:35 AM, she stated that the facility's protocol for hypotension was to give normal saline as ordered, decrease the UF rate and if the patient's hypotension persists, call the physician. RN 1 reviewed Patient 10's treatment records and the PRN orders for hypotension and confirmed the findings. RN 1 acknowledged that the prescribed PRN orders and facility protocol for hypotension was not carried out by staff when Patient 10 had experienced signs of hypotension.	V 543			