

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: 052863	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2009
NAME OF PROVIDER OR SUPPLIER RAI - NORTH RIVERSIDE - RIALTO			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 NORTH RIVERSIDE AVENUE, SUITE 150 RIALTO, CA 92376	
(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: 14909 The following reflects the findings of the California Department of Public Health during the investigation of one complaint. Complaint number: CA00153077 Representing the Department of Public Health: Donna Dolgovin HFEN The inspection was limited to the specific complaint reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number: CA00153077	V 000		
V 412	494.60(d)(2) EMERGENCY PREPAREDNESS The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Surveyor: 14909 Based on record review and interview the facility failed to ensure that a dialysis patient (Patient 1) had received adequate patient training regarding how to handle emergencies at home, including uncontrolled bleeding from the access site used for dialysis, after the patient had to be transported to an emergency department when the patient suffered uncontrollable bleeding from the access site on 11/2/07. On 12/5/07, the patient again suffered uncontrolled bleeding from the access site, and expired at home. Findings:	V 412		

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 412	<p>Continued From page 1</p> <p>On 9/24/08 a visit was made to a local hospital to review Patient 1's medical record. Record review revealed the patient had been brought into the emergency department on 11/1/07, by paramedics after the patient's access site had been bleeding for several hours. The patient was treated and released back home after it had been determined that the bleeding had stopped and the patient was stable.</p> <p>The patient was referred back to the dialysis unit for further routine care.</p> <p>On 2/13/09, a visit was made to the patient's dialysis center. Record review revealed Patient 1 was an 84 year old who had end-stage renal disease and required dialysis three times a week. The patient lived alone and had a care-giver who came during the day only. The patient was alone after the care-giver left.</p> <p>Record review revealed that on 12/4/07, the patient received dialysis as the physician had ordered. There were no problems noted during the treatment and no excessive bleeding was documented after the treatment was completed. The patient was discharged home in stable condition.</p> <p>On 12/5/07, the patient was found dead on the front porch of the house, with signs of uncontrolled bleeding from the access site.</p> <p>Interview with the center director was conducted on 2/13/09, at 1:40 p.m. She was questioned on the facility's policy regarding patient teaching. The center director revealed that there was no specific policy dictating how often and what specific topics</p>	V 412			

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V 412	<p>Continued From page 2</p> <p>were to be taught to the patients. The center director further stated that all of the patients receive training through out the year on various topics, including how to handle bleeding from their access sites.</p> <p>Further record review revealed that the last time there was any documented patient teaching regarding how to handle emergency bleeding was dated 2/06, almost two years before the patient expired. The center director stated that "we try to do annual updates with our education program, but it does not always happen that way."</p> <p>The facility failed to ensure that Patient 1 was reeducated on how to handle emergencies at home, including uncontrollable bleeding, after the patient had suffered the first bleeding episode on 11/1/07, one month prior to the patient's death at home.</p>	V 412			