

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: 052678	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2010
NAME OF PROVIDER OR SUPPLIER SAN DIEGO DIALYSIS SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 720 GATEWAY CENTER DRIVE SAN DIEGO, CA 92102	
(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 The following represents the findings of the Department of Public Health during a recertification survey. The facility census at the time of the survey there was 126 hemodialysis patients. Representing the Department were: HFEN 22383 and HFEN 15930. CCHT Certified Clinical Hemodialysis Technician CD Clinic Director kg Kilogram P&P Policy and Procedure RN Registered Nurse	V 000		
V 111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Based on observation, interview and P&P review, the facility failed to ensure staff used aseptic technique when drawing up 1% lidocaine from an open multidose vial. Findings: On 10/12/10 at 2:15 P.M., RN 1 was observed drawing up 1% lidocaine from a multidose vial. She did not cleanse the top of the opened multidose vial of lidocaine prior to drawing up the medication. When asked what she used to clean the top of the vial, she said, "nothing". RN 1 replaced the vial on to the clean supply cart and	V 111		12/2/10

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 111	Continued From page 1 continued to the patient treatment area with the syringe of 1% lidocaine. RN 1 entered patient treatment station 3 and began to cleanse the patient's access site. RN 1 was stopped just prior to injecting the patient with the lidocaine. RN 1 was asked about the lidocaine, she stated, "I should have discarded it and drawn up new lidocaine and thrown away the vial." On 10/12/10, the facility provided a P&P titled, "Administration of Local Anesthetic". "Step 3." read, "Clean the top of the medication vial with alcohol swab." The Association for Professionals in Infection Control and Epidemiology (APIC) discussed in a paper titled, "Safe Injection, Infusion and Medication Vial Practices in Healthcare" dated 7/30/09, "...Vials...", "...Cleanse the access diaphragm of vials using friction and 70% alcohol..."	V 111			
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT 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.	V 116		12/2/10	

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V 116	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff did not cross contaminate 2 rolls of paper tape and a thermometer. Findings: 1. On 10/13/10 at 9:45 A.M., During observation of the patient treatment area; CCHT 1 obtained a roll of paper tape from the clean supply cart. He took roll of tape into the patient care area. CCHT 1 removed strips of the tape for use on a patient's dressing, placing the strips of tape on the patient's treatment chair. CCHT 1 took the remaining roll of tape and placed it back onto the clean supply cart. When asked if that was his usual practice, he stated, "no, the tape should have been dedicated to that patient, or strips pulled off of the roll at the clean supply cart and then only take the strips of tape into the patient treatment area." 2. On 10/13/10 at 9:02 A.M., RN 3 was observed providing care. RN 3 placed a roll of tape and a thermometer on patient's chair side table. After the patient's treatment was complete, RN 3 took the thermometer and the tape from chair side table, placed the roll of tape in her pocket, and placed the thermometer on the supply cart without cleaning it. On 10/13/10 at 9:28 A.M., RN 3 acknowledged that she should not have put the tape in her pocket and should have disinfected the thermometer before placing it back on the supply cart.	V 116			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL	V 122		12/2/10	

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V 122	<p>Continued From page 3</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure the cleaning and disinfection of 24 of 24 treatment chairs, one Hoyer lift, one prime bucket and 1 of 27 dialysis machines.</p> <p>Findings:</p> <p>1. On 10/13/10 at 10:18 A.M., during the observation of the patient treatment area, patient treatment chairs were noted to have reddish brown stains on them. All 24 treatment chairs had evidence of dried blood beneath the armrest tables, on either the right, left, or both sides of the chairs. The CD acknowledged that the treatment chairs needed cleaning.</p> <p>2. During the observation of the patient treatment area on 10/12/10 at 3:00 P.M., a Hoyer lift located against the wall on the east end of the clinic was dusty, and had reddish brown stains on the metal hanger which supported the seat. The Clinical Director and the Educational Coordinator acknowledged that the Hoyer lift needed to be cleaned after every use and stated that it did not look as if it had been cleaned recently.</p> <p>3. On 10/13/10 at 9:10 A.M., during the turn-over</p>	V 122			

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V 122	Continued From page 4 between patient shifts, at treatment station 4, CCHT 1 took the prime bucket off of the machine and dumped the prime buckets contents into the laboratory sink. He then walked past a biohazard container and placed the prime bucket on the top of the biohazard container. When CCHT 1 returned to collect the prime bucket he did not disinfect the bottom of the prime bucket prior to placing it back on the machine. When asked about his practice, CCHT 1 stated, "I should have wiped down the entire bucket." 4. On 10/13/10 at 9:02 A.M., Machine F at station 9 had a piece of clear packing tape at the bottom of the blood pump segment. The tape was lifting at the ends. RN 3 wiped the machine after the treatment wiping over the tape. The tape on the front of the machine prevented the disinfection of the machine between patients. On 10/13/10 at 10:56 A.M., the technical staff were asked about the tape on Machine F. They stated that the screw threads for the blood pump segment had been stripped and the tape was securing the segment. Machine F's repair log's last entry dated 8/10 did not address the tape on the blood pump segment. On 10/14/10 at 2:17 P.M., the CD stated the patient care staff did not see the tape on the machine as a problem or as an infection control issue.	V 122			
V 187	494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves,	V 187		12/2/10	

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V 187	Continued From page 5 sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range. This STANDARD is not met as evidenced by: Based on observations the facility failed to provide a schematic diagrams of their water system that identified the components, valves, sample ports, and flow direction. Findings: On 10/13/10 at 10:47 A.M., the facility's water room was inspected with the technical department staff, the tech acknowledged there was a sheet that indicated the components of the water room, but there was no schematic to indicate how they were linked to indicate the flow of water.	V 187			
V 255	494.40(a) MICROB MONITOR-REPEAT CULTURES 7.2 Microbial monitoring methods 7.2.1 General: repeat cultures Cultures should be repeated when bacterial counts exceed the allowable levels. If culture growth exceeds permissible standards, the water system and dialysis machines should be cultured weekly until acceptable results are obtained. Additional samples should be collected when	V 255		12/2/10	

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V 255	<p>Continued From page 6</p> <p>there is a clinical indication of a pyrogenic reaction or septicemia, and following a specific request by the clinician or the infection control practitioner.</p> <p>If repeat cultures are performed after the system has been disinfected (e.g., with formaldehyde, hydrogen peroxide, chlorine, or peracetic acid), the system should be flushed completely before collecting samples. Drain and flush storage tanks and the distribution system until residual disinfectant is no longer detected before collecting samples.</p> <p>This STANDARD is not met as evidenced by: Based on interview, water testing logs and P&P review, the facility failed to implement their P&P for weekly water testing for 4 weeks, when the bacterial counts in pre-disinfection exceeded the acceptable levels.</p> <p>Findings:</p> <p>On 10/19/10 at 1:49 P.M., The Central Technical Program Manager was interviewed concerning endotoxin and AAMI chemical testing. He stated, the P&P indicated, "If any pre disinfection test results met or exceeds action levels or allowable limits, the water treatment systems, or individual components, well be validated by testing the aforementioned sites weekly for a minimum of 4 weeks."</p> <p>On 10/19/10 at 2:15 P.M., The laboratory results for 2/19/10, indicated that the bacteria colony count was greater than 200 in the "distil loop return before clinic" and the "techst outlet before 1". The follow-up testing was within limits, however the facility failed to continue testing for</p>	V 255			

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V 255	Continued From page 7 another 3 weeks.	V 255			
V 403	<p>On 10/19/10 at 2:10 P.M., The Central Technical Program Manager acknowledged, the water testing should have continued for 3 more weeks.</p> <p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU</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 observation, interview and record review the facility failed to maintain one flash light and replace an outdated backup Ambu bag on the emergency cart. The facility failed to follow the Manufactures guidelines for the testing of the AED (automated external defibrillator).</p> <p>Findings:</p> <p>On 10/12/10 at 11:00 A.M., the emergency cart and it's contents were inspected with the CD. There was one flashlight that was non functional and the replacement Ambu bag had an expiration date of 2008. The CD acknowledged that the flashlight and Ambu bag had to be replaced.</p> <p>On 10/12/10 at 11:15 A.M., the logs for the emergency cart were inspected. The logs indicated that the AED was tested daily and monthly. The Manufacture's guidelines indicated testing to be conducted daily, weekly, monthly and annually. The CD acknowledged the AED</p>	V 403		12/2/10	

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V 403	Continued From page 8 needed further testing as indicated in the manufactures guidelines and that the staff need to be more vigilant with the testing of the AED.	V 403			
V 453	494.70(a)(2) PR-RECEIVE UNDERSTANDABLE INFORMATION The patient has the right to- (2) Receive all information in a way that he or she can understand; This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that the non-Spanish speaking staff knew the DNR wishes for 4 of 12 sampled patients (3, 4, 7, 10). Findings: On 10/14/10, Patients 3,4,7 and 10's records were reviewed. There was paperwork entitled Declaración de Resucitación (Statement of resuscitation) in Spanish. This document in each of the patient's records (3,4,7, 10) indicated the patient's wishes regarding resuscitation (also know as a DNR form). There was no English translation of the form in any of the patient's record. On 10/14/10 at 9:33 A.M., the CD and the charge nurse were asked about the DNR form. The CD and the charge nurse stated that most of the staff was non-Spanish speaking. The unit secretary translated and assisted the patients in filling out the forms. The CD and the charge nurse acknowledged that the staff needs to be able to have each patient's DNR wishes available for staff in English.	V 453		12/2/10	

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V 503	<p>494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(2) Evaluation of the appropriateness of the dialysis prescription,</p> <p>This STANDARD is not met as evidenced by: Based on interview and medical record review, the facility failed to act on a high potassium level for 1 of 12 sampled patients (11). The facility failed to ensure a physician's order for a 3.0 calcium bath was implemented for 1 of 12 sampled patients (8).</p> <p>Findings:</p> <p>1. On 10/19/10 at 10:30 A.M., The facility provided Patient 11's medical record for review. On 10/11/10, Patient 11 had a lab result of a 6.5 potassium level (normal levels 3.5-5.1 per the lab conducting the testing) The nursing and physician's progress notes did not address the high potassium level and there were no orders to change Patient 11's dialysis prescription.</p> <p>On 10/19/10 at 10:45 A.M., RN 2 stated, she spoke to the physician and the patient was to "have his potassium level drawn next week." The physician's orders were reviewed with RN 2 and she acknowledged there was no written order for a potassium draw. The repeat lab should have been drawn on 10/18/10. The daily lab log for 10/18/10 did not included Patient 11's name to have his potassium level redrawn.</p>	V 503		12/2/10	

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V 503	Continued From page 10 2. On 10/14/10 at 11:20 A.M., the facility provided Patient 8's medical record for review. On 7/13/10 a physician's order was written for a 3.0 calcium bath. Review of the patient's treatment sheets from 8/17/10 through 10/14/10, indicated that Patient 8 received a 2.5 calcium bath contrary to the physician's order for a 3.0 calcium bath. On 10/14/10 at 11:30 A.M., Patient 8's dialysis prescription was reviewed with CCHT 2 while the patient was receiving his dialysis treatment. The prescription set in the dialysis machine was a 2.0 potassium with a 2.5 calcium bath. CCHT 2 acknowledged that Patient 8 was receiving the wrong dialysis bath and should have been on a 3.0 calcium bath.	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 record review the facility failed to ensure that 2 of 12 sampled patients (7, 10) vital signs were monitored every 30 min as per protocol and failed to achieve 2 of 12 sampled patients (1, 10) dry weights. Findings: 1. Patient 7's treatment record documentation for 9/30/10 indicated, Patient 7's vital signs between 11:20 A.M. and 12:26 P.M., contained a gap greater than an hour. Patient 10's treatment record documentation for	V 543		12/2/10	

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V 543	Continued From page 11 10/8/10 indicated, Patient 10's vital signs between 10:03 A.M. and 11:04 A.M., contained a gap greater than an hour. On 10/14/10 at 11:25 A.M., the Charge Nurse stated that all patients were to be monitored every 30 minutes unless sooner if the patient had symptoms of distress. 2. Patient 1's target weight of 68kg was not achieved on 10/6, 10/8, 10/11, 10/13/10. There was no indication that the staff notified the physician that the patient's target weights were not being met. Patient 10's target weight of 78.5kg was not met on the following dates: 9/24, 9/27, 9/29, 10/1, 10/4, 10/6, 10/8, 10/11, and 10/13/10. There was no indication that the staff notified the physician that the patient's target weights were not being met. On 10/14/10 at 11:25 A.M., the charge nurse stated she was unaware the patients were not achieving their target weights. She stated the staff had not communicated that information to her. She did not have that information to tell the physician.	V 543			
V 545	494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate.	V 545		12/2/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052678	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/19/2010
NAME OF PROVIDER OR SUPPLIER SAN DIEGO DIALYSIS SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 720 GATEWAY CENTER DRIVE SAN DIEGO, CA 92102		
(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 545	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that the social worker informed the dietitian of 1 patients' inability to purchase protein sources due to monetary problems (14). Findings: On 10/13/10 at 9:00 A.M., Patient 14 stated during an interview, she was having problems buying enough meat products, that money was tight. When asked if she had talked to someone about that, Patient 14 stated, "Yes, I talked to the social worker a couple weeks ago." On 10/13/10 at 9:45 A.M., the facility provided Patient 14's medical record for review. According to Patient 14's medical record, she was admitted to the clinic on 2/24/10. A plan of care dated 3/22/10, that was signed by both the dietitian and the social worker contained no documentation connecting the patient's low albumin (a measurement of protein) level, which at that time was 2.8 (the facility's target goal is 4.0) and her inability to purchase enough meat. The Interdisciplinary Team met in May 2010, to review Patient 14's treatment plan. The dietitian and the social worker both attended the May meeting, Patient 14's albumin was documented as 3.4 at that time. In reviewing the comprehensive assessment and plan of care for dietary, the dietitian started the patient on Prostat (a high protein supplement) 1-3 tbs on admission and continued the protein supplement. The Interdisciplinary Progress Notes were reviewed from the patients admission until 10/13/10, The	V 545			

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V 545	Continued From page 13 progress notes contained no information in the social worker's notes pertaining to the patients' monetary problems. Patient 14's medical record did not reflect a discussion between the dietitian and the social worker, concerning the continued low albumin and the patient's inability to purchase meats. On 10/13/10 at 10:50 A.M., the dietitian and social worker were interviewed. The dietitian stated, she had no idea that the patient was having problems with money. The social worker stated, she knew of the problem and had placed the patient on a voucher list. The dietitian and social worker acknowledged it would have been helpful if they both knew of Patients 14's monetary problems.	V 545			
V 549	494.90(a)(4) POC-MONITOR ESA RESPONSE The patient's response to erythropoiesis-stimulating agent(s), including blood pressure levels and utilization of iron stores, must be monitored on a routine basis. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the facility staff followed a physician's order to discontinue an order for Epogen (a medication given to increase the development of red blood cells) for 1 of 12 sampled patients (12). Findings: On 10/19/10 at 11:00 A.M., the facility provided Patient 12's medical record for review. A physician's order dated 9/15/10, was to discontinue the Epogen. Review of the patient's dialysis treatment sheets, Patient 12 continued to receive Epogen for 3 dialysis treatments after the	V 549		12/2/10	

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V 549	Continued From page 14 physician ordered the medication discontinued (9/17, 9/20, 9/22/2010).	V 549		
V 560	On 10/19/10 at 11:15 A.M., the CD reviewed patient 12's medical record and acknowledged that the patient should not have received the Epogen after 9/15/10. 494.90(b)(4) POC-PTS SEEN BY MED STAFF 1X/MO 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: Based on observation, interview and record review, the facility failed to ensure the physician's progress notes were accessible to the facility staff and in the patient's medical records for 1 of 12 sampled patients (11). Findings: On 10/15/10 at 2:00 P.M., the facility provided patient 11's medical record for review. The admission date for Patient 11 was 1/29/10, per the Patient Report Sheet. The medical record for Patient 11 was without physician progress notes. On 10/15/10 at 2:30 P.M., the CD was asked for the progress notes for Patient 11. The CD stated the unit secretary was the only one with the computer code to retrieve the physician's progress notes and she was off today.	V 560		12/2/10

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V 560	Continued From page 15	V 560			
V 637	<p>On 10/15/10 at 3:00 P.M., The CD stated, "This system is not good."</p> <p>494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT</p> <p>The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must- (A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents.</p> <p>This STANDARD is not met as evidenced by: Based on record review the facility failed to have a system in place to track the Hepatitis B status ao all patients in the facility.</p> <p>Findings:</p> <p>On 10/12/10 11:53 A.M., the facility's Hepatitis Vaccine Record was provided. Three of the 126 patients were not listed on the tracking log. The tracking record was inconsistent in documenting the current antibody status of 18 of 126 patients related to when the patients were tested last and where the patients were regarding their course of vaccination.</p>	V 637		12/2/10	