

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

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052883	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2010
NAME OF PROVIDER OR SUPPLIER SAN DIEGO EAST DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 292 EUCLID AVENUE SAN DIEGO, CA 92114	
(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 visit. The facility census at the time of the visit was 57 hemodialysis patients and 15 peritoneal dialysis patients. The sample size was 7 patients. Representing the Department were, HFEN 22383 and HFEN 15930. On 8/25/10 at 8:56 A.M., an immediate jeopardy was called related to one staff member providing care to 3 hepatitis B susceptible (non-immune) patients at the same time as providing care to 2 hepatitis B positive patients. The immediate jeopardy was abated on 8/25/10 at 2:30 P.M. Glossary of Abbreviations: CCHT Certified Clinical Hemodialysis Technician P&P Policy and Procedure RN Registered Nurse	V 000		
V 110	494.30 CFC-INFECTION CONTROL This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff who cared for hepatitis B positive patients did not simultaneously care for patients who were susceptible (non-immune) to hepatitis B (refer to V131). The facility also failed to clean and disinfect equipment and contaminated surfaces of patient treatment chairs, dialysis machines, biohazardous trash cans, sharps containers, and computer stations (refer to V122).	V 110		9/30/10

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 110	Continued From page 1	V 110		
V 122	<p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</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, interview and record review, the facility failed to clean and disinfect equipment and contaminated surfaces as it related to the cleaning of the 9 of 21 treatment chairs (3, 4, 7, 9, 10, 11, 12, 13 and the isolation room), 5 of 21 dialysis machines (9, 10, 11, 12, 13), biohazardous trash cans, sharp containers, and 3 computer stations, increasing the potential for cross-contamination of pathogens (disease producing organisms).</p> <p>Findings:</p> <p>On 8/24/10 at 2:58 P.M., the initial tour of the patient treatment area was conducted with the Administrator. He stated that the treatment chairs and machines were clean and ready for use for the patients scheduled for the following morning. The following was observed during the tour:</p>	V 122		9/30/10

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V 122	<p>Continued From page 2</p> <p>a. At stations 9, 10, 11, 12 and 13 , the wells at the bottom of the dialysis machines that hold individual jugs of dialysate, contained clear standing liquid. The sides of the machines had splashes of white crystallized material and the BiCart holders (a bicarbonate cartridge) on the front of the machines were covered with a white crystallized material and were moist to the touch.</p> <p>b. The treatment chairs at stations 9, 10, 11, and 12 had splatters of white crystallized material and dark red fluid on the outside and the inside surfaces of the arm rests. The treatment chair at station 13 was soiled with large long dark red drips on the inside surfaces of the right arm rest, which extended beneath the seat cushion.</p> <p>c. The biohazard trash cans and disposal sharps containers had numerous dark red splatters on the outer surfaces.</p> <p>d. The shared computers at stations 9, 10, 11, 12, and had dusty keyboards and white crystallized material splattered on the computer carts. The computer at station 9 had an uncovered, used needle next to the computer keyboard.</p> <p>e. On 8/24/10 at 3:27 P.M., the facility's isolation room contained 2 large biohazard garbage cans, 2 trash cans, 2 chairs and a stool. There was no dedicated thermometer for the isolation room. The treatment chair had dried blood on the outside surfaces of both arms. There were 2 stethoscopes hanging inside the room on a hook and 1 hanging on the dialysis machine.</p> <p>The Administrator was interviewed on 8/24/10 at 3:15 P.M. He acknowledged that the cleaning of the chairs and equipment needed to improve. He</p>	V 122			

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V 122	Continued From page 3 stated the shared computers and the carts that they sat on, were considered a clean area. On 8/31/10, the facility provided the P&P titled Infection Control for Dialysis Facilities, that read in part, "45. Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammate, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. 46. Teammates will give special attention to cleaning control panels on the dialysis delivery system and other surfaces that are frequently touched and potentially contaminated with patient's blood..."	V 122			
V 131	494.30(a)(1)(i) IC-HBV-ISOLATION-STAFFING Isolation of HBV+ Patients Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during the period when dialysis is terminated on one patient and initiated on another. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff caring for 2 patients who were hepatitis B positive, did not concurrently care for 3 of 57 patients (1, 2, 3) who were susceptible (non-immune) to hepatitis B.	V 131		9/30/10	

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V 131	<p>Continued From page 4</p> <p>Findings: The facility provided their hepatitis tracking information on 8/25/10. The facility records indicated that they had 2 of 57 patients were hepatitis B positive, and 29 of 57 patients remained susceptible to Hepatitis B.</p> <p>The facility provided the patient seating schedule, indicating the assigned appointment times and where each patient sat during treatments. The seating schedule also included the staff assignments. The seating schedule indicated that an isolation station was used for 2 patients that were hepatitis B positive.</p> <p>Comparison of the seating schedule with the hepatitis B tracking information identified that 3 patients susceptible (non-immune) to hepatitis B sat in the same pod as the isolation station. One staff member was assigned to care for that pod of patients, which included the 3 patients susceptible (non-immune) to hepatitis B and 2 patients that were in isolation for hepatitis B.</p> <p>The CCHT responsible for the seating schedule stated on 8/25/10 at 9:37 A.M., that the patients' hepatitis B status was not taken into consideration when she made the seating schedule and staff assignments.</p> <p>The Charge Nurse stated on 8/25/10 at 9:37 A.M., that she responsible for monitoring patients hepatitis titers. She stated she was unaware that the same staff that cared for the 2 hepatitis B positive patients patients, also cared for 3 susceptible (non-immune) patients.</p> <p>This oversight placed the 3 susceptible patients at greater risk for contracting hepatitis B during their hemodialysis treatments.</p> <p>The facility P&P titled Infection Control and Isolation Measures for the Known or Suspected Hepatitis B Surface Antigen Positive Patients, last</p>	V 131			

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V 131	Continued From page 5 revised 12/08, read in part, "29. Teammates caring for confirmed or suspected hepatitis B surface antigen positive (HBsAg) positive Patient(s) do not care for surface antibody negative (susceptible) patients simultaneously." The survey team called Immediate Jeopardy and informed the Facility Administrator on 8/25/10 at 9:56 A.M. The survey team discussed the requirements for the Plan of Correction to abate the Immediate Jeopardy with the Facility Administrator. The immediate jeopardy was abated after the facility provided an acceptable Plan of Correction on 8/25/10 at 2:30 P.M.	V 131			
V 403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU 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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 3 of 21 treatment chairs (9, 11, 12) had intact surfaces to enable effective disinfection and cleaning. The facility failed to maintain mechanical lift in a clean manner. Findings: On 8/24/10 at 2:54 P.M., the initial tour of the patient treatment area was conducted with the Administrator. The following was observed:	V 403		9/30/10	

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V 403	<p>Continued From page 6</p> <p>a. The treatment chairs at stations 9, 11 and 12 were observed with small tears in the upholstery on the arm rests and/or foot rests. The side table on treatment chair 11 had two areas of approximately 1 inch in length where the laminate (outer covering of the table) was missing and exposed the fiber board beneath. These surfaces prevented appropriate disinfection/cleaning and increased the possibility for cross-contamination with infectious pathogens.</p> <p>b. The mechanical lift (a lift with a sling used to assist patients in or out of a bed or a chair) was dusty and the mechanism that controlled the movement of the legs was completely rusted over. The mechanism itself consisted of a 2 foot long handle with an attached cogged wheel. When the handle was moved to the left or right, it caused the hinged legs of the lift to either widen or narrow its base. The hinged portion of the mechanical lift legs were wrapped with a clear plastic wrap. The rusted condition and plastic wrap prevented appropriate disinfection.</p> <p>On 8/24/10 at 3:15 P.M., the Administrator stated that the chairs needed repair and the mechanical lift needed some attention.</p> <p>On 8/31/10, the facility provided the P&P titled Infection Control for Dialysis Facilities, read in part, "45. Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility chairs, outside of sharps contained, IV poles, as well as all work surfaces will be wiped clean with</p>	V 403			

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V 403	Continued From page 7 a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment..."	V 403			
V 413	494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that emergency suction equipment was accessible and ready to use at all times on 1 of 1 crash carts. Findings: On 8/24/10 at 2:53 P.M., the initial tour of the facility was conducted with the Administrator. The suction canister on top of the emergency crash cart (emergency supplies necessary for assistance with resuscitation) did not have suction tubing or a suction catheter attached to the suction machine. The crash cart was opened and the contents were examined. The crash cart contained suction tubing, but was without appropriate suction catheters. On 8/24/10 at 3:15 P.M., the Administrator stated that the emergency suction equipment on the crash cart should have had the suction tubing and suction catheter attached and ready for use.	V 413		9/30/10	
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS	V 543		9/30/10	

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V 543	Continued From page 8 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 interview and record review, the facility failed to ensure that staff completed a post dialysis assessment for 1 of 7 sampled patients (11). Findings: Patient 11's record was reviewed on 8/27/10. On the 8/26/10 treatment sheet, the Post Treatment Data Collection & Assessment section was left blank. On 8/27/10 at 3:00 P.M., the Clinic Manager stated that the nurses were required to complete an assessment of the patients before they left. He was unaware that Patient 11's post dialysis assessment was not completed prior to the patient leaving the facility.	V 543			
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the staff accurately documented heparin dosages that were administered during	V 544		9/30/10	

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V 544	<p>Continued From page 9</p> <p>hemodialysis treatments for 2 of 7 sampled patients (10, 11).</p> <p>Findings:</p> <p>1. Patient 10's record was reviewed on 8/26/10. Documentation on the treatment sheets for 8/11/10 and 8/20/10 indicated the heparin dosages given during the treatment was "1 unit," instead of the actual dosages given. The physician's orders were for 600 units/hour.</p> <p>The Clinic Manager was interviewed on 8/27/10 at 3:00 P.M. He acknowledged the administered heparin dosages were not accurately documented on the treatment sheets.</p> <p>2. Patient 11's record was reviewed on 8/26/10. Documentation on the treatment sheets for 8/16/10 and 8/20/10 indicated the heparin dosages given during the treatments were "1 unit," instead of the actual dosages given. The physician's orders were for 800 units/hour.</p> <p>The Clinic Manager was interviewed on 8/27/10 at 3:00 P.M. He acknowledged the administered heparin dosages were not accurately documented on the treatment sheets.</p>	V 544			