

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

PRINTED: 10/02/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER SAN DIMAS DIALYSIS CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1335 CYPRESS STREET SAN DIMAS, CA 91773	
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V 000	INITIAL COMMENTS Surveyor: 19582 The following reflects the findings of the Department of Public Health during a Recertification survey. Representing the Department of Public Health: Belinda Rarela, RN- HFEN Sir Lin Chang, RN-HFEN Elizabeth Arenas, REHS-HFE I	V 000		
V 101	494.20 COMPLIANCE W/FED, STATE, & LOCAL LAWS The facility and its staff must operate and furnish services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements. This STANDARD is not met as evidenced by: Surveyor: 14041 a. 2001 California Building Code, 422.18 Chronic Dialysis Clinics. A chronic dialysis clinic shall provide the following: 1. A minimum of 100 square feet of floor space, inclusive of aisles, per bed or station. Based on observation, record review, and interview the facility failed to provide a minimum of 100 square feet for a dialysis station that was section off, as a isolation area, from the surrounding dialysis stations. Finding: On June 24, 2009, during the inspection of the facility, a review of the emergency evacuation	V 101		

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 101	<p>Continued From page 1</p> <p>floor plan posted on the wall stipulated the facility had one isolation room. However, during the survey, it was observed the isolation room was now the director of nurse's office.</p> <p>In addition, the evaluator observed there were a total of three isolation areas (Stations 1, 2 and 3) which were labeled or marked with red tapes on the floor. The evaluator observed that one of the three isolation areas (Station 3) measured approximately 64 square feet. A dirty sink was observed located between Station 2 and Station 3. The three staff were observed crossing the red lines between Station 2 and Station 3 to go to the sink to wash their hands.</p> <p>An interview was held with the Administrator and he stated that he would remove one of the isolation stations (Station 3) as soon as possible.</p> <p>b. Based on observation, interview, and record review, the facility failed to adhere to the approved building plans for the Dialysis Facility.</p> <p>Finding:</p> <p>On June 24, 2009, the evaluator conducted an inspection of the facility and reviewed the emergency evacuation plan posted on the wall. The posted emergency plan indicated that the facility had one isolation room which was observed during the survey to now be the director of nurses' office.</p> <p>In addition, the evaluator observed there were a total of three isolation areas (Stations 1, 2 and 3) which were labeled or marked with red tapes on the floor.</p> <p>A review of the approved construction plans for</p>	V 101			

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V 101	Continued From page 2 the facility showed an Isolation Room, however, the name of the area was crossed out by a pencil and it was handwritten as "DON."	V 101			
V 110	494.30 INFECTION CONTROL This CONDITION is not met as evidenced by: Surveyor: 19582 Based on observation, interview, and record review, it was determined that the facility did not meet the Conditions of Participations (COP) for infections control by failing to: 1. Ensure the staff consistently removed gloves and washed hands between each patient or station. The facility staff failed to remove gown used in the isolation area before leaving the isolation area (refer to V113). 2. Implement their Visiting Policy during initiation of treatment. A visitor without protective clothing was observed sitting with Patient 6 during the initiation of dialysis treatment (refer to V115). 3. Ensure the staff cleaned and disinfected a blood pressure cuff and call light/ television control between each patient use, ensure the dialysis stations were cleaned and disinfected while patient was in the waiting area (refer to V122). 4. Ensure that isolation areas for HBsAg patients	V 110			

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V 110	Continued From page 3 were removed from the mainstream of activity (refer to V128). 5. Ensure the staff member caring for an HBsAg positive patients should not care for HBV susceptible patients at one time (refer to V131). The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 110		
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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: Surveyor: 19582 Based on observation, interview and record review, the facility failed to ensure the staff consistently removed gloves and washed hands between each patient or station. The facility staff failed to remove gown used in an isolation area before leaving the isolation area. Findings: On June 26, 2009, between 9:35 a.m. to 9:50 a.m., the patient care technician (PCT 1) was observed in Station 1 (Isolation area). PCT 1 was wearing a white gown open in the front and gloves, holding a clipboard and taking the vital signs while the patient was standing. After taking the patient's vital signs, PCT 1 removed his	V 113		

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V 113	<p>Continued From page 4</p> <p>gloves, put on another pair of gloves, and with the white gown still open in front, removed the linen covering the treatment chair in Station 2 (Isolation area), placed it in the large yellow bin, removed the used dialyzer and tubing and discarded them into the large Biohazard bin. Wearing the same pair of gloves with the white gown open in the front, PCT 1 removed the linen covering the treatment chair in Station 1, placed it into a large yellow bin, removed the used dialyzer and tubing, and discarded them into the large Biohazard bin. PCT 1 changed gloves then proceeded to clean Stations 1 and 2 with cloth wet with bleach solution.</p> <p>After cleaning Stations 1 and 2 (Isolation areas), PCT 1 removed his gloves, washed his hands, still wearing the same white gown open in the front, went to Station 6 and proceeded to remove the linen covering the treatment chair, discarded it in the large yellow bin, removed the dialyzer, and bloodline tubing, then while holding the tubing, he walked several feet from Station 6 towards the large Biohazard bin.</p> <p>During an interview with PCT 1 on June 26, 2009 at 10:20 a.m., he stated he was taking care of the patients in the Isolation area. PCT 1 stated he must remove gloves and wash hands before leaving the isolation area. PCT 1 stated the gown was open in front because it was hot and he was not aware he had to change the gown.</p> <p>During an interview with the director of nursing (DON), she stated the staff must wear the yellow isolation gown in the isolation area. The DON stated the PCT did not have to walk towards the large Biohazard bin, the tubing must be discarded in the Biohazard container in each station.</p>	V 113			

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V 113	Continued From page 5	V 113		
V 115	<p>A review of the Protocol for Hepatitis B indicated, "Yellow isolation gown will be utilized."</p> <p>494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE</p> <p>Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 19582 Based on observation, interview and record review, the facility failed to implement their Visiting Policy during initiation of treatment by failing to ensure that a visitor, who was seated next to Patient 6, wore protective clothing during the initiation of dialysis treatment.</p> <p>Findings:</p> <p>On June 24, 2009 at approximately 9:10 a.m., during a tour observation, Patient 6 was observed in Station 29 with a visitor sitting next to the treatment chair. The PCT, who was wearing a white gown, face shield and gloves, initiated the dialysis treatment via the right arm arterio-venous graft in the presence of the visitor, who was wearing no protective equipment (gown, gloves, face shields), to protect her from potential spurting or spattering of blood.</p> <p>During an interview with the director of nursing on</p>	V 115		

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V 115	Continued From page 6 June 25, 2009 at 11:30 a.m., she stated no visitor during initiation of treatment.	V 115		
V 122	<p>A review of the Visiting Policy indicated, "No visitor is allowed in the treatment area when dialysis is being initiated or terminated."</p> <p>494.30(a)(4)(ii) PROCEDURES FOR INFECTION CONTROL</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: Surveyor: 19582 Based on observation, interview and record review, the facility staff to demonstrate that they follow standard infection control precautions by failing to:</p> <ol style="list-style-type: none"> Clean and disinfect a blood pressure cuff and call light/ television control between each patient use. Ensure the dialysis stations were cleaned and disinfected while the patient was in the waiting area. Ensure equipments such as Dialyzer Machines 6, 7, 16, 17, 26, 29, and 32, were kept clean. <p>Findings:</p> <ol style="list-style-type: none"> On June 26, 2009 at approximately 9:40 a.m., Station 6 was unoccupied. A patient care technician removed the used linen covering the 	V 122		

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V 122	<p>Continued From page 7</p> <p>treatment chair, dialyzer and bloodline tubing, then cleaned the chair and machine with a cloth wet with bleach solution. The technician did not clean and disinfect the blood pressure (BP) cuff and the call light/ television control used by the previous patient.</p> <p>During an interview with the PCT on June 26, 2009 at 10:20 a.m., he stated the BP cuff and call light must be cleaned between each patient.</p> <p>A review of the Dialysis Policy and Procedure on Environmental Surfaces indicated, "Equipment and chairs will be cleaned with bleach solution between each treatment."</p> <p>2. On June 24, 2009 at approximately 9:20 a.m., a PCT was observed cleaning Station 8 after the treatment. A patient walked into Station 8, touched the chair then put his bag on the chair. The PCT stopped the patient and proceeded to clean the chair while the patient remained standing by the treatment chair.</p> <p>A review of the Traffic Control Policy indicated to, "Remain in waiting area until it is time for Dialysis treatment."</p> <p>During an interview with the medical director on June 26, 2009 at 3 p.m., he stated the letters were sent to patients indicating not to come to the treatment area until time for dialysis treatment. Surveyor: 14041</p> <p>3. On June 25, 2009, at 10:02 a.m., the evaluator inspected the dialyzers and observed the following:</p> <p>1. Dialyzer Machines 6, 7, 16, 17, 26, 29, and 32 had dark reddish-brown substances at the base of the IV pole.</p>	V 122			

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V 122	Continued From page 8 2. Dialyzer Machine 32 had red spots adjacent to the bicarbonate inlet plug. 3. Dialyzer Machine 7 had red spots on the Venous Chamber holder and Machine 26 had two red spots under the rotor shield. An interview was held with the staff member and he stated that the machines are cleaned after every patient. These dialyzers were supposed to be clean and ready for use by the patients. The evaluator asked for a policy and procedure regarding how to clean the dialyzer machines and the staff stated that there was no written procedure.	V 122			
V 131	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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: Surveyor: 14041 Based on observation and interview, the facility failed to ensure that a staff member caring for an HBsAg positive patients should not care for HBV susceptible patients at the same time. Finding: On June 26, 2009, at approximately 2:58 p.m., the evaluator observed a staff member entered Station 3, an isolation area, which was marked with red tape on the floor, for the HBsAG positive patient. The staff member was wearing the same	V 131			

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V 131	Continued From page 9 open smock and exposed scrubs while being observed working with five patients in Stations 1, 2, 3, 4, and 5. Stations 1, 2, and 3 were observed with red tapes on the floor to identify as isolation areas. There was a sink located between Stations 2 and 3. The evaluator observed the staff member going between the two stations and crossing over the red marked areas in Station 2 and Station 3 to wash hands. An interview was held with the director of nursing and she stated that the staff should only worked with the HBsAG positive patient and cannot enter and exit the isolation area without changing his covering at all times.	V 131		
V 411	494.60(d)(1) EMERGENCY PREPAREDNESS [Staff training must be provided and evaluated at least annually and include the following:] (iii) Ensuring that nursing staff are properly trained in the use of emergency equipment and emergency drugs. This STANDARD is not met as evidenced by: Surveyor: 19582 Based on observation and interview, the facility failed to ensure the nursing staff was properly trained in the use of emergency equipment. Findings: On June 25, 2009 at 7:40 a.m., the licensed nurse checked the automated external defibrillator and suction located on top of the crash cart. The licensed nurse turned on the suction machine. When asked to demonstrate if	V 411		

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V 411	Continued From page 10 the machine was functioning, the licensed nurse attached the tubing to the cannister, then turned the suction on. After ten (10) minutes, the licensed nurse stated the machine was not functioning. During concurrent interview, the licensed nurse stated to check the suction the practice was to turn the switch to on position. The licensed nurse stated she would ask someone to check the machine. At 8:30 a.m., the licensed nurse, stated she had to remove the plastic cap at the end of the suction tubing for the suction to work.	V 411			
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: 19582 Based on record review, observation and interview, the facility failed to "flag" patients who needed assistance during an emergency in accordance with the Emergency Evacuation Plan policy and procedure. Findings: A review of the facility Emergency Evacuation Plan policy and procedure indicated that, "Patients requiring assistance (identified by a red flag "Patient Needs Assistance") should be assisted by the staff to clamp and cut the lines." On June 26, 2009 at 8:05 a.m., during an interview, the licensed nurse (RN 1) stated she	V 412			

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V 412	<p>Continued From page 11</p> <p>knew which patient would need assistance in an emergency.</p> <p>On June 26, 2009 at 8:15 a.m., during an interview, the licensed nurse (RN 2) stated the facility did not have an actual evacuation or emergency drill. The licensed nurse stated he knew which patient would need assistance and pointed to the patient in the station across from the Medication Room. However, the station (Patient 7) was not "flagged."</p> <p>A review of Patient 2's medical record indicated the patient, "Needs assistance with clamp and cut procedure." and unable to execute hand-crank procedure.</p> <p>A review of Patient 6's medical record indicated the patient, "Needs assistance with clamp and cut procedure." and unable to execute hand-crank procedure.</p> <p>A review of Patient 5's medical record indicated the patient refused training/education of clamp and cut procedure.</p> <p>During an interview on June 26, 2009 at 9:30 a.m., Patient 5 stated he would like the staff to disconnect him from the machine during an emergency.</p> <p>A review of Patient 7's medical record, indicated the patient needed assistance with clamp and cut procedure.</p> <p>On June 26, 2009 at 10:05 a.m., during tour observation, the patients' stations did not have red flags to indicate the patients needed assistance in "clamp and cut procedure" in case</p>	V 412			

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V 412	Continued From page 12 of emergency.	V 412			
V 415	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary; This STANDARD is not met as evidenced by: Surveyor: 14041 Based on observation and interview, the facility failed to evaluate the effectiveness of the emergency and disaster plans and update them as often as necessary. Finding: The evaluator requested for documentation regarding emergency and disaster plans including the drills. An interview with the director of nursing and she stated that there was no evidence or documentation of actual emergency drills conducted with the facility staff. She stated, "I only been working here for two months and I am working on this requirement."	V 415			
V 503	494.80(a)(2) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] (2) Evaluation of the appropriateness of the dialysis prescription,	V 503			

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V 503	Continued From page 13 This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility staff failed to evaluate the appropriateness of the dialysis prescription for one sampled patient (Patient 1). Findings: Patient 1's record revealed the patient was admitted to the facility on October 25, 2004 with diagnosis of end stage renal disease (ESRD). The patient expired on May 7, 2009. An interview with the director of nursing (DON) on June 25, 2009 at 2:15 p.m., as well as a review of the hemodialysis record dated February 8, 2006, disclosed the patient was provided hemodialysis treatment for two and half hours (from 11 a.m to 1:30 p.m.). According to the dialysis prescription, the length of treatment time should be three hours.	V 503		
V 506	494.80(a)(3) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] Immunization history, and medication history. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility failed to ensure the patient's comprehensive assessment included immunization history and medication history for four sampled patients	V 506		

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V 506	<p>Continued From page 14 (Patient 1, 3, 4, and 6).</p> <p>Findings:</p> <p>1. Patient 1's record revealed the patient was admitted to the facility on October 25, 2004 with diagnosis of end stage renal disease (ESRD). The patient expired on May 7, 2009.</p> <p>An interview with the director of nursing (DON) on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that the immunization history and medication history were completed.</p> <p>2. Patient 3's record revealed the patient was admitted to the facility on March 31, 2008 with diagnosis of ESRD.</p> <p>An interview with the DON on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that the immunization history was completed. There was no documented evidence to indicate the home medication history was completed from April 2008 to June 2009.</p> <p>3. Patient 4's record revealed the patient was admitted to the facility on November 5, 2008 with diagnosis of ESRD.</p> <p>An interview with the DON on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence the immunization history and home medication were completed.</p>	V 506			

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V 506	Continued From page 15 Surveyor: 19582 4. On June 25, 2009, Patient 6's medical record was reviewed. According to the medical record, the patient was admitted to the dialysis facility with end stage renal disease with primary diagnosis of hypertension. A review of the Annual Interdisciplinary Assessment and Plan of Care (IDT) dated June 5, 2009, revealed no documentation on Health Maintenance (Vaccination) and the Immunization Record was blank. During an interview with the DON on June 25, 2009 at 11:30 a.m., she acknowledged the IDT and Immunization Record were not completed. The DON stated she had been trying to review patients' record.	V 506			
V 513	494.80(a)(10) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] (10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility staff failed to ensure the evaluation of suitability	V 513			

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V 513	<p>Continued From page 16</p> <p>for a transplantation referral, based on the criteria developed by the prospective transplantation center and its surgeons, were documented in the medical records for 3 sampled patients (Patient 1, 3, and 4).</p> <p>Findings:</p> <p>1. Patient 1's record disclosed the patient was admitted to the facility on October 25, 2004 with diagnosis of end stage renal disease (ESRD). The patient expired on May 7, 2009.</p> <p>An interview with the director of nursing (DON) on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that an evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation, had been done.</p> <p>2. Patient 3's record disclosed the patient was admitted to the facility on March 31, 2008 with diagnosis of ESRD.</p> <p>An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the interdisciplinary assessment and plan of care, indicated the patient had been placed on the transplant list. However, according to the DON, there was no documented evidence that an evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation, had been done.</p> <p>3. Patient 4's record disclosed the patient was admitted to the facility on November 5, 2008 with diagnosis of ESRD.</p>	V 513			

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V 513	Continued From page 17 An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the interdisciplinary assessment and plan of care, disclosed the patient had not been placed on the transplant list. However, according to the DON, there was no documented evidence that an evaluation of suitability for a transplantation non-referral, based on criteria developed by the prospective transplantation, had been done.	V 513		
V 516	494.80(b)(1) FREQUENCY OF ASSESSMENT An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility failed to conduct an initial comprehensive assessment within the latter of 30 calendar days for 3 sampled patients (Patients 1, 3, and 4). Findings: 1. Patient 1's record revealed the patient was admitted to the facility on October 25, 2004 with diagnosis of end stage renal disease (ESRD). The patient expired on May 7, 2009. An interview with the director of nursing (DON) on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that the initial comprehensive assessment had been done within the latter of 30 calendar days.	V 516		

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V 516	Continued From page 18 2. Patient 3's record revealed the patient was admitted to the facility on March 31, 2008 with diagnosis of ESRD. An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the entire clinical record, revealed no documented evidence that the initial comprehensive assessment had been done within the latter of 30 calendar days . 3. Patient 4's record revealed the patient was admitted to the facility on November 5, 2008 with diagnosis of ESRD. An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that the initial comprehensive assessment had been done within the latter of 30 calendar days. According to the DON, the initial comprehensive assessment may be misplaced.	V 516			
V 517	494.80(b)(2) FREQUENCY OF ASSESSMENT A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility staff failed to conduct a follow up comprehensive reassessment within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care for 3 sampled patients (Patients 1, 3, and 4).	V 517			

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V 517	<p>Continued From page 19</p> <p>Findings:</p> <p>1. Patient 1's record revealed the patient was admitted to the facility on October 25, 2004 with diagnosis of end stage renal disease (ESRD). The patient expired on May 7, 2009.</p> <p>An interview with the director of nursing (DON) on June 25, 2009 at 2:15 p.m., as well as a review of the entire clinical record, disclosed no documented evidence a follow up nursing assessment had been done after January 8, 2007. There was no documented evidence to indicate a follow up nutritional assessment had been done after December 26, 2008 and a follow up psychosocial assessment had been done after December 30, 2008.</p> <p>2. Patient 3's record revealed the patient was admitted to the facility on March 31, 2008 with diagnosis of ESRD (end stage renal disease).</p> <p>An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that a follow up comprehensive assessment had been done before June 5, 2009.</p> <p>3. Patient 4's record revealed the patient was admitted to the facility on November 5, 2008 with diagnosis of ESRD.</p> <p>An interview with the DON on June 25, 2009 at 2:25 p.m., as well as a review of the entire clinical record, disclosed no documented evidence that a follow up comprehensive assessment had been done before June 5, 2009.</p>	V 517			

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V 517	Continued From page 20 During an interview with the registered dietitian on June 26, 2009 at 9:55 a.m., the registered dietitian stated a follow up nutritional assessment was misplaced after December 26, 2008.	V 517			
V 544	During an interview with the social worker on June 26, 2009 at 11:45 a.m., the social worker stated a follow up psychosocial assessment was misplaced after December 30, 2008. 494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE [The plan of care must address, but not be limited to, the following:] 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: Surveyor: 19582 Based on observation, interview and record review, the facility failed to administer dialysis treatment as prescribed by the physician. Patient 6's prescribed blood flow rate (BFR) was not consistently followed. Findings: On June 24, 2009 at 9:15 a.m., Patient 6 was observed undergoing dialysis treatment. A patient care technician (PCT) stated she started the	V 544			

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V 544	Continued From page 21 patient's blood flow rate (BFR) at 200, checked the venous pressure resistance and read 90, then increased the blood flow rate to 400 as prescribed, and verified the prescription on the Hemodialysis Record was BFR of 400. On June 24, 2009 at 9:45 a.m., Patient 6 was observed undergoing dialysis treatment with a BFR of 400. A review of the Hemodialysis Record dated May 4, 9, 18, 20,, 25, 29 & 30, 2009 and June 5, 10 & 20, 2009, indicated the prescribed BFR was 400 as documented in the "Prescription Verification and Safety Check." However, a review of the documented BFR during "Dialysis Monitoring" for the above dates revealed the actual BFR during the dialysis treatments ranges from 300 to 350 while the patient was either resting or stable. During an interview with the medical director on June 26, 2009 at 3 p.m., he stated the technician would notify the staff nurse if the prescribed BFR was unable to achieve and the licensed nurse would notify the physician.	V 544		
V 547	494.90(a)(4) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level. The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.	V 547		

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V 547	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Surveyor: 19582</p> <p>Based on observation, interview and record review, the facility failed to administer the correct loading dose for heparin and hourly dose as prescribed to Patient 2 for a total of six (6) hemodialysis treatments. In addition, the facility failed to administer the correct Epogen dose as prescribed to Patient 2 during one hemodialysis treatment.</p> <p>Findings:</p> <p>On June 24, 2009 at 2:45 p.m., Patient 2 was observed undergoing hemodialysis treatment. During concurrent interview, the patient stated she was on dialysis treatment three times a week.</p> <p>A review of Patient 2's medical record on June 25, 2009, revealed the following:</p> <p>a. The Physician Hemodialysis Orders dated January 2, 2009, indicated a heparin loading dose of 1000 units and hourly dose of 500 units. The Hemodialysis Record dated June 12, 15, 17, 19, 22 & 24, 2009, revealed the patient received heparin loading dose of 2000 units and hourly dose of 1000 units.</p> <p>b. The Physician's Order sheet dated May 27, 2009, and noted at 12:15 p.m., indicated to increase Epogen to 8000 units by intravenous route every treatment. The Hemodialysis Record dated May 29, 2009, revealed the patient received Epogen 6000 units.</p>	V 547			

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V 547	Continued From page 23 During an interview with the director of nursing (DON) on June 25, 2009 at 1p.m., she reviewed the record and acknowledged the heparin and Epogen orders and the documentation in the Hemodialysis Record. The DON was not able to find a physician's order for 2000 units Heparin loading dose and Heparin 1000 units hourly dose. During an interview with the medical director on June 26, 2009 at 3 p.m., he reviewed the medical record, stated the patient received 1000 units of heparin loading dose and 500 units hourly dose on June 10, 2009 and acknowledged the patient received 2000 units heparin loading dose and 1000 units hourly dose the following hemodialysis treatments.	V 547		
V 550	494.90(a)(5) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on observation, interview and record review, the facility staff failed to ensure two sampled patients (Patients 2 and 3) were evaluated for the appropriate vascular access type, taking into consideration co-morbid	V 550		

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V 550	<p>Continued From page 24</p> <p>conditions, other risk factors, and whether the patients were potential candidates for arteriovenous fistula (AV) placements. For Patients 2 and 3, the facility failed to document an action plan for permanent vascular access.</p> <p>Findings:</p> <p>1. Patient 3's record revealed the patient was admitted to the facility on March 31, 2008, with diagnosis of ESRD.</p> <p>A review of the vascular access incidence and prevalence log revealed the patient had a central venous catheter for more than 90 days. However, a review of the interdisciplinary (ID) assessment and plan of care for access management dated May 11, 2009, disclosed no documented evidence there was an active plan in process for the placement of a more permanent vascular access. A more permanent vascular access such as AV fistula was not addressed in the goal or the action plan in the plan of care.</p> <p>In an interview with the director of nursing on June 25, 2009 at 2:25 p.m., she stated the patient had not been evaluated for the placement of a more permanent vascular access in the ID assessment and plan of care since she was admitted.</p> <p>Surveyor: 19582</p> <p>2. On June 24, 2009 at 2:45 p.m., Patient 2 was observed undergoing hemodialysis treatment via catheter over the right chest area.</p>	V 550			

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V 550	Continued From page 25 A review of the admission sheet indicated the patient was admitted to the facility on December 24, 2008 with end stage renal disease and primary diagnosis of hypertension. A review of the facility Vascular Access Incidence and Prevalence log revealed Patient 2 had a catheter (only access) in use equal to or more than ninety (90) days. However, a review of the Interdisciplinary Assessment and Plan of Care for Vascular Access dated June 6, 2009, indicated to monitor and maintain. There was no documented evidence in the action plan for a more permanent vascular access. The action plan was blank and the listed action plan interventions such as surgical consult, vascular access study referral and value of permanent access were not checked off. During an interview with the medical director on June 26, 2009 at 3 p.m., he reviewed Patient 2's medical record and indicated the documentation dated May 29, 2009 regarding "vascular surgeon for vein mapping." The medical director acknowledged the patient had a catheter for more than ninety days.	V 550			
V 554	494.90(a)(7)(ii) DEVELOPMENT OF PATIENT PLAN OF CARE When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the- (A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or	V 554			

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V 554	<p>Continued From page 26</p> <p>(C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with §494.80(a)(10).</p> <p>This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview and record review, the facility failed to ensure the interdisciplinary (ID) team develop plans for pursuing transplantation or declining transplantation for two sampled patients (Patients 3 and 4) when the patient was a transplant referral candidate or had declined the transplantation referral.</p> <p>Findings:</p> <p>1. Patient 3's record revealed the patient was admitted to the facility on March 31, 2008 with diagnosis of ESRD (end stage renal disease).</p> <p>A review of the interdisciplinary (ID) assessment and plan of care for transplant status dated June 5, 2009, revealed no documented evidence the patient's plan of care reflected the information from the interdisciplinary team's evaluation of the patient's suitability for transplantation referral.</p> <p>In an interview on June 26, 2009 at 2:30 p.m., the administrator stated the patient had agreed to be placed on the kidney transplant list. However, there was no documented evidence that the patient was informed about transplantation was an option, living and deceased kidney donation,</p>	V 554			

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V 554	Continued From page 27 area transplant center(s), and the transplant facility's selection criteria. 2. Patient 4's record revealed the patient was admitted to the facility on November 5, 2008 with diagnosis of ESRD. A review of the interdisciplinary (ID) assessment and plan of care for transplant status dated June 25, 2009, revealed no documented evidence the patient's plan of care reflected the information from the interdisciplinary team's evaluation of the patient's suitability for transplantation referral. In an interview on June 26, 2009 at 2:30 p.m., the administrator stated the patient had disagreed to be placed on the kidney transplant list. However, there was no documented evidence that the patient was informed about transplantation was an option.	V 554		
V 625	494.110 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT This CONDITION is not met as evidenced by: Surveyor: 19582 Based on record review and staff interviews, it was determined that the dialysis facility did not meet the Conditions of Participation (COP) for Quality Assurance and Improvement Program by failing to: 1. To develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team and to demonstrate evidence of its quality improvement and	V 625		

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V 625	Continued From page 28 performance improvement program for review (refer to V626). 2. To maintain an ongoing program that achieved measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors (refer to V627). 3. To measure, analyze, and track quality indicators or other aspects of performance that the facility adopted or developed that reflected the processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves (refer to V628). The cumulative effects of these systemic problems resulted in the dialysis center's inability to ensure the provision of quality health care in a safe environment.	V 625			
V 626	494.110 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by	V 626			

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V 626	Continued From page 29 CMS. This STANDARD is not met as evidenced by: Surveyor: 19582 Based on record review and interview, the dialysis facility failed to maintain and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The facility also failed to demonstrate evidence of its quality improvement and performance improvement program for review by CMS. Findings: 1. A review of the Board Meeting/CQI minutes dated March 26, 2009, February 5, 2009, November 20, 2008 and August 14, 2008 indicated the attendees included the medical director, administrator, director of nursing (former) and the chief financial officer. The masters-prepared social worker and registered dietitian were not included in the attendees. The minutes included the current census, new admits, transfer-in, walk-in, deaths, transfer-out, transplants, number of patients hospitalized, total number of hospital days for the month, patients per shift for Monday/Wednesday/Friday and for Tuesday/Thursday/Saturday treatment. However, the number of patients hospitalized and the total numbers of hospital days for the month were not consistently documented. There were no documented indicators related to improved health outcomes and the prevention and reduction of medical errors.	V 626			

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V 626	<p>Continued From page 30</p> <p>A review of the section for Monthly Clinical CQI Review indicated the following pre-printed indicators: % Hemoglobin greater or equal to 11 and equal or less than 10.9, Kt/v greater or equal to 1.2 and equal or greater than 1.4, % albumin, % URR greater or equal to 6.5 or equal to 73.5, % patients with fistula, % patients with catheters, % patients with catheter over 90 days. However, there was no documented evidence to indicate ongoing monitoring, trending outcomes, prioritizing areas for improvement, developing action plans, implementing, evaluating and revising plans when indicated.</p> <p>During an interview on June 26, 2009 at 1:05 p.m., the director of nursing (DON) stated she had not attended any committee meeting since she started on April 13, 2009. The DON stated she started the infection control log but was not able to find infection control committee minutes.</p> <p>During an interview with the administrator and the medical director on June 26, 2009 at 3 p.m., they stated the former DON had the quality assessment and performance improvement data. Surveyor: 17030</p> <p>2. During an interview with the director of nursing on June 25, 2009 at 2:15 p.m., she never participated in the QAPI (quality assurance and performance improvement) activities.</p> <p>In an interview with the registered dietitian (RD) on June 26, 2009 at 9:55 a.m., the RD stated she never participated in the QAPI activities.</p> <p>During an interview with masters-prepared social worker on June 26, 2009 at 11:45 a.m., she stated she participated in the QAPI activities.</p>	V 626			

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V 626	Continued From page 31 During an interview with the administrator on June 26, 2009 at 3 p.m. as well as the medical director, he (Administrator) stated there was no trending of data to be measured, analyzed, and tracked because all records for patients data were misplaced by the former DON. According to the administrator, all QAPI activity records including minutes and patients data were misplaced by the former DON.	V 626			
V 627	494.110(a)(1) PROGRAM SCOPE The program must include, but not be limited to, an ongoing program that achieves measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview with the facility staff, the facility failed to maintain an ongoing program that achieved measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. Findings: During an interview with the administrator and medical director on June 26, 2009 at 3 p.m., they stated there was no documented evidence to indicate an ongoing program that achieved measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved	V 627			

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V 627	Continued From page 32 health outcomes and with the identification and reduction of medical errors. According to the administrator, there was no trending of data for patients because all records for patients data were misplaced by the former DON.	V 627			
V 628	494.110(a)(2) PROGRAM SCOPE The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Surveyor: 17030 Based on interview with facility staff, the facility failed to measure, analyze, and track quality indicators or other aspects of performance that the facility adopted or developed that reflected the processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. Findings: During an interview with the administrator and medical director on June 26, 2009 at 3 p.m., they stated there was no documented evidence to indicate an ongoing program that achieved measurable improvement in health outcomes and reduction of medical errors by using indicators or performance measures associated with improved health outcomes and with the identification and reduction of medical errors. According to the administrator, there was no trending of data to be	V 628			

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V 628	Continued From page 33 measured, analyzed, and tracked because all records for patients data were misplaced by the former DON.	V 628			
V 715	494.150(c)(2)(i) POLICIES AND PROCEDURES The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; This STANDARD is not met as evidenced by: Surveyor: 17030 Based on observation, interview, and record review, the medical director failed to ensure that the policies relative to drug discard were adhered to by the licensed nursing staff in the facility. The facility staff failed to label the opened heparin vials and to use a plastic breakable lock to secure the crash cart. Findings: During the initial tour in the facility on June 24, 2009 between 8:35 a.m. and 9 a.m., two 30 ml- (milliliter) vials of heparin (1000 units/ml) and one 10 ml -vial of heparin (5000 units/ml) by the dirty sink were observed opened but not dated. An interview with a registered nurse revealed those vials should be labeled after opened. During the same tour with the director of nursing (DON), the crash cart, located by the scale where the patients and family members passed by, was observed opened with emergency medications in the first drawer. The DON then locked the crash	V 715			

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V 715	Continued From page 34 cart with a key attached by the cart. According to the DON, the crash cart should be locked. A review of the policy for drug discard disclosed any opened multiple dose vials needed should be dated when opened and initialed. A review of the policy for the crash cart disclosed a plastic breakable crash cart lock should be used to secure the cart.	V 715			