

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:  <b>052560</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/20/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAN PABLO DIALYSIS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>14020 SAN PABLO AVE SUITE B</b> <b>SAN PABLO, CA 94806</b>	
(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 reflects the findings of the California Department of Public Health during the investigation of two complaints.  Complaints: CA00233756 and CA00234065  Representing the Department: Nikki Kratt, HFEN  The inspection was limited to the complaints investigated and does not represent a full inspection of the facility.  Complaint CA00233756 was not substantiated.  One deficiency was identified as a result of CA00234065. See V 715	V 000		
V 715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P  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: Based on observation, interview, and record review, the facility failed to ensure staff followed facility policy to perform post treatment assessment to ensure that Patient 1 was stable for discharge.  Findings:  During a telephone interview on 9/16/10 at 2:30	V 715		
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 715	<p>Continued From page 1</p> <p>p.m., Patient 1 stated registered nurse (RN) 1 did not perform a post treatment assessment on him following his dialysis treatment. Patient 1 stated, "She doesn't touch me, no checking my pulse, no listening to my lungs." Patient 1 continued "I had (social worker) watch. RN 1 never touched me. Another nurse had just come in. (Social worker) asked her to do the post treatment assessment." Patient 1 stated, "I asked them if I could just move (to another station where another nurse would be assigned). They said, 'no'."</p> <p>On 9/20/10 at 8:40 a.m., Patient 1 was observed receiving his dialysis treatment at station 1. At approximately 9:30 a.m., Patient 1's treatment was being terminated by certified hemodialysis technician (CHT) 2). After CHT 2 removed the dialysis needles, Patient 1 held pressure on his access sites to prevent bleeding. RN 1 did not come by to assess Patient 1 even after he stopped holding pressure and had dressings applied to his access sites. At 9:55 a.m. RN 1 was observed at another station about 20 feet away. RN 1 then walked past Patient 1 to do catheter care for the patient in adjacent station 2 whose treatment had just ended. At 10:03 a.m., Patient 1 was speaking to the case manager from his health insurer. At 10:05 a.m., RN 1 was observed performing the post treatment assessment for the patient in adjacent station 2 even though Patient 1 had finished his treatment before the patient at station 2. At 10:08 a.m. RN 1 walked by Patient 1 and briefly looked at him and the case manager. The case manager walked away, and RN 1 walked away as well. After a minute, Patient 1 stood up and left the treatment room.</p> <p>At 10:15 a.m., RN 1 was observed performing the</p>	V 715			

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V 715	<p>Continued From page 2</p> <p>post treatment assessment for the patient at station 9. She was asked why Patient 1 did not receive his post-treatment assessment. She placed her hands on the stethoscope around her neck and asked "He left already?" while looking around the treatment room.</p> <p>At 1:40 p.m., the regional clinical services specialist (CSS) was informed that RN 1 did not perform a post-treatment assessment for Patient 1. The CSS stated a post-run assessment was not required if the patient had a stable run. The facility policy for assessment and Patient 1's just completed treatment run were requested. Review of the policy "Post Treatment Patient Assessment" indicated its purpose was, "To ensure that the patient is stable, to determine the patient's discharge status, and to evaluate the effectiveness of the treatment plan."</p> <p>Review of Patient 1's treatment run for 9/20/10 showed RN 1 documented at 5:36 a.m. in Patient 1's Pretreatment Data Collection &amp; Assessment, Patient 1 had diminished breath sounds, a sign of abnormal respiratory function, often from fluid overload. RN 1 documented entering Patient 1's Posttreatment Data Collection and Assessment at 9:45 a.m. Patient 1's respiratory status was documented "No SOB (shortness of breath) No auscultation (no listening to breath sounds to assess Patient 1's breath sounds to determine if were still abnormal)."</p>	V 715			