

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060	
(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	<p>INITIAL COMMENTS</p> <p>The following represents the findings of the Department of Public Health during a Recertification Survey.</p> <p>The facility census at the time of the survey was 48 patients. The patient sample was 5 hemodialysis patients.</p> <p>Representing the Department of Public Health: Barbara Carbajal, HFEN Yolanda Mowad, HFEN</p> <p>The following Conditions for Coverage were not met: 494.30 Infection Control 494.40 Water and Dialysate Quality 494.80 Patient Assessment 494.90 Patient Plan of Care 494.110 Quality Assessment and Performance Improvement</p> <p>Abbreviations and glossary used in this document:</p> <p>BFR - blood flow rate BMT - Biomedical Technician B/P - Blood Pressure Catheter - plastic tube that can be placed in a large, central vein for temporary or longer-term access for hemodialysis or in the abdomen for peritoneal dialysis. CSS - ChairSideSnappy - computerized chairside charting system. DCS - Director of Clinical Services DFU - Manufacturers directions for use Dialysate - precise mixture of treated water and chemicals to create a concentration gradient so</p>	V 000		

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.

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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	Continued From page 1 wastes can be removed from the blood. Dialysis - process of removing waste and excess fluid from the blood. DFR - dialysate flow rate EDW - Estimated dry weight, the weight without the excess fluid that builds up between dialysis treatments. The EDW is similar to what a person with normal kidney function would weigh after urinating. ESRD - End stage renal disease, the failure of kidney function when life can not be supported without dialysis treatments. FA - Facility Administrator/Nurse Manager Geri-chair - large wheeled recliner chair which has three positions HBV - Hepatitis serological status (HBsAG, total anti-HBc, anti-HBs) Hemodialysis - Cleans the blood of excess water and wastes by passing it through an artificial kidney or dialyzer. kg -kilogram. A kilogram equals 2.2 pounds. mg -milligram, a metric measurement of weight ml - milliliter, a metric measurement of fluid volume PCT - Patient Care Technician Phoenix meter - A hand-held, syringe-style meter for quick and accurate measurement of conductivity and pH. PPE - Personal protective equipment. Items facility/family members wear to protect themselves from possible blood borne contaminants. The items can include face masks, face shields, gloves, and impervious gowns. QAPI - Quality Assessment and Performance Improvement RBMT - Regional Biomedical Technician, responsible for an assigned geographical area of BMT's.	V 000			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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	Continued From page 2 RN - Registered Nurse ROM - Regional Operations Manager, responsible for the county area facilities. Trendelenburg position - body is laid flat on the back with the feet higher than the head. UF - Ultrafiltration. The process of fluid removal during the dialysis treatment. URR - Urea reduction ratio is a way of measuring effectiveness of dialysis treatments. URR reveals how much waste is removed by hemodialysis treatments. 65 represents an adequate dialysis treatment. Vascular access-A way to gain repeated entry to the patient's bloodstream for hemodialysis.	V 000			
V 110	494.30 CFC-INFECTION CONTROL This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Condition of Participation (COP) for Infection Control by failing to: Provide a sanitary environment to minimize the transmission of infectious agents. (refer to V 111) Ensure that staff implemented standard precautions for glove use and hand hygiene in the dialysis treatment area to prevent transmission of infectious agents among patients and staff. (refer to V 113) Ensure items taken into dialysis stations were either disposable, dedicated for use only by a single patient or cleaned and disinfected before taken to a common area or used on another patient. (refer to V 116)	V 110		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 110	Continued From page 3 Ensure the clean area designated for preparation of medications was only used for preparation of medications and that blood samples were not handled or stored in this area. (refer to V 117) Ensure that accepted public health procedures for cleaning and disinfection of contaminated surfaces, medical devices and equipment were implemented. (refer to V 122) Ensure that the HBV serological status of all patients was known upon admission or within 7 days of admission; that patients were routinely tested in accordance with the facility's policy and the CDC's schedule for Hepatitis B testing, and that patients were appropriately managed based on the test results. (refer to V 124) Ensure all susceptible patients were vaccinated and that vaccinations were initiated and completed according to the vaccine manufacturer's timeline. (refer to V 126)	V 110			
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, review of facility policy and procedure, and interview, the facility failed to monitor infection control practices and ensure	V 111		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 111	<p>Continued From page 4</p> <p>that a sanitary environment was provided to minimize the transmission of infectious agents within and outside the dialysis unit. Four staff (PCT 1, 2, 3 and RN 1) failed to remove protective gowns potentially soiled with with blood and body fluids/dialysate prior to leaving the treatment area. A geri-chair was used by one of 5 sample patients during dialysis and likely contaminated with blood, was not cleaned and disinfected before the patient left the dialysis station in the chair and returned to a skilled nursing facility. A suitcase used to store emergency supplies in the treatment area was made of a cloth material that could be adequately cleaned and disinfected.</p> <p>Findings:</p> <p>1. The facility policy and procedure titled, "Infection Control for Dialysis Facilities", last revised 3/10, was reviewed and states, "Appropriate PPE will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces, for example, reuse room, patient care areas. PPE is to be removed prior to leaving the treatment area. PPE is not to be worn in non-treatment areas...". The policy and procedure also states, "The outside surfaces of all equipment will be wiped with a bleach solution prior to removal from the treatment area."</p> <p>During the initial tour of the facility starting at 8:18 a.m. on 8/23/10, staff were observed leaving the treatment floor wearing protective gowns (PPE) and walking through a corridor to obtain supplies from the supply room or items from the water treatment area. There were hooks where staff could hang their gowns on before leaving the</p>	V 111			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 111	<p>Continued From page 5 treatment area.</p> <p>a. PCT 1 was observed leaving the treatment area wearing a gown and going into the water treatment area on 8/23/10 at 8:22 a.m.</p> <p>b. PCT 2 was observed leaving the treatment wearing a gown and going into the water treatment area on 8/23/10 at 9:56 a.m.</p> <p>c. During an observation on 8/25/10 at 3:09 p.m., RN 1 left the treatment area wearing a gown and walked into the employee break room.</p> <p>d. PCT 3 was observed on 8/31/10 at 9:01 a.m. leaving the treatment area wearing a protective gown and walked into the water treatment area.</p> <p>The FA was interviewed at the time of the observations and concurred staff failed to remove their gowns (PPE) when leaving the treatment area.</p> <p>2. During initial tour of the facility on 8/23/10 starting at 8:18 a.m., a red cloth suitcase was observed on the treatment floor area. The FA was interviewed and indicated the suitcase was used to store supplies used during emergencies. The FA confirmed the suitcase was made of cloth and could not be adequately disinfected with a bleach wipe.</p> <p>3. On 8/25/10 at 12:30 p.m., Patient 1 was wheeled to the facility in her geri-chair from a skilled nursing facility located across the parking lot. Patient 1 was wheeled to the treatment floor in her geri-chair, was not transferred to a treatment chair and received her dialysis treatment in the geri-chair. After completion of the</p>	V 111			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 111	Continued From page 6 dialysis treatment, staff did not clean and disinfect the patient's geri-chair and she left the unit and returned to the skilled nursing facility in the geri-chair.	V 111			
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE 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: Based on observation, review of facility policy and procedure, and interview, the facility failed to ensure that four staff (PCT 1, PCT 2, RN 1 and RN 2) and two patients, implemented infection control precautions for glove use and/or hand hygiene in the dialysis treatment area to prevent transmission of infectious agents among patients and staff. Staff failed to wear gloves when touching patients' equipment at dialysis stations, failed to change gloves and sanitize hands between patients and/or dialysis stations, and failed to implement the facility's handwashing procedure. The facility also failed to ensure that two patients wore gloves when assisting with care by holding their access sites post treatment. Findings: The facility's policy and procedure, "Infection Control for Dialysis Facilities", last revised 3/10,	V 113		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 113	<p>Continued From page 7</p> <p>was reviewed and indicates, "The Centers of Disease Control (CDC) Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients will be followed when caring for all patients. Hand hygiene is to be performed upon entering the facility, prior to going, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area. Gloves should be worn when touching the blood lines, dialyzer or dialysis delivery system during or after a dialysis treatment. Gloves should be changed when after touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system. Gloves should be provided to patients and gloves and gown to visitors if these individuals assist with procedures such as self-cannulation or holding access sites."</p> <p>Hand hygiene includes washing hands with soap and water or using a waterless alcohol-based antiseptic hand rub with 60-90% alcohol. The CDC recommends vigorously rubbing hands together for 15 seconds when washing the hands, and covering all surfaces of the hands and fingers until hands are dry when using an alcohol based hand rub. The facility's "Handwashing" procedure dated 9/07, states, "...Wet hands and apply antiseptic liquid soap. cover hands and wrists with lather and wash vigorously for a minimum of 15 seconds..."</p> <p>1. During an observation at station 2 on 8/23/10 at 8:30 a.m., RN 1 touched the patient's dialyzer without wearing gloves. Shortly thereafter PCT 2,</p>	V 113			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 113	<p>Continued From page 8</p> <p>who was caring for the patient at station 2, entered information in the computer then proceed to care for another patient wearing the same pair of gloves.</p> <p>2. On 8/23/10 at 8:31 a.m., PCT 1 walked up to treatment station 7 while a patient was receiving treatment, talked to the patient and touched the dialysis treatment machine without wearing gloves. At the completion of the conversation, PCT 1 walked away from station 7 without washing or sanitizing her hands and proceeded to station 6 where another patient was receiving a dialysis treatment. PCT 1 touched the dialysis machine at station 6 without wearing gloves, and again failed to wash or sanitize her hands after touching the dialysis machine. In an interview at the time of the observation, the FA concurred PCT 1 did not use gloves or perform hand hygiene.</p> <p>3. On 8/23/10 at 8:48 a.m., PCT 1 was observed washing her hands at a sink in the treatment area. PCT 1 passed her hands under running water, did not use soap and washed her hands for a total of 8 seconds. On 8/25/10 at 9:42 a.m., PCT 2 was also observed while washing hands at a sink on the treatment floor and washed his hands for six seconds. In an interview at the time of the observation, the FA concurred the procedure for handwashing was not followed by PCT 1 and PCT 2.</p> <p>4. During observations on 8/23/10 beginning at 10 a.m. accompanied by PCT 2, PCT 2 went from stations 1 to 2, 2 to 3 and 3 to 4 wearing the same pair of gloves. PCT 2 touched the dialysis machines, the patients and the computerized chairside charting system (CSS) at each dialysis</p>	V 113			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 113	Continued From page 9 treatment station. 5. On 8/23/10 at 2:12 p.m., PCT 2 was observed on the treatment floor area, replacing fluid jugs at each dialysis machine. PCT 2 exchanged the plastic jugs at stations 4, 5, 6 and 7 without changing gloves and sanitizing hands between stations. In an interview at the time of the observation, the FA concurred PCT 2 wore the same pair of gloves in stations 4, 5, 6, and 7. 6. On 8/23/10 at 3:22 p.m., the patient at station 7 was observed holding his access site after completing his dialysis treatment. The patient was not wearing gloves. The FA concurred the patient was not wearing gloves while holding his access site. 7. During observations on 8/24/10 at 8:31 a.m. and 8:48 a.m., RN 2 used the CSS while wearing the same gloves worn while caring for the patient on station 9. After using the CSS, RN 2 returned to care for the patient, without removing the gloves, washing or sanitizing hands and putting on clean gloves. 8. On 8/31/10 at 1:00 p.m., the patient at station 4 was observed holding her access site after completing her dialysis treatment, and was not wearing gloves. RN 3 confirmed the observation.	V 113			
V 114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing. This STANDARD is not met as evidenced by:	V 114		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 114	Continued From page 10 Based on observation, review of facility policy and procedure and interview, the facility failed to ensure that soap was available at a staff handwashing sink and that the paper towel dispenser for the sink was mounted high enough to keep the towels dry and free from contact with water on the sink and contamination. The facility also failed to ensure there was a supply of paper towels at the sink used by patients to wash their access sites prior to dialysis to prevent infection. Findings: The facility's policy and procedure, "Infection Control for Dialysis Facilities", last revised date 3/10, was reviewed and indicates, "Hand washing sinks should be dedicated only for hand washing purposes and remain clean. Soap and a supply of paper towels protected from contamination must be available at each sink." 1. During the initial tour of the facility starting on 8/23/10 at 8:18 a.m., there was no soap at a sink utilized for hand washing by facility staff. In addition, the paper towel dispenser was not mounted at a sufficient height above the sink to keep the towels dry and free from contamination due to contact with water on the sink. The sink also had tubing draining into the sink. 2. A sink utilized by facility staff and by patients for washing their access sites had no supply of paper towels in the vicinity of the sink. The FA was interviewed at the time of the observations and concurred with the findings.	V 114			
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT	V 116		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 116	<p>Continued From page 11</p> <p>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.</p> <p>-- 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.</p> <p>-- 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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that items taken into dialysis stations were either disposed of, dedicated for use on a single patient, or cleaned and disinfected before being taken to a common area or used on another patient, to prevent transmission of infectious agents.</p> <p>The facility used cloth (non-disposable) blood pressure cuffs for patients during dialysis. The cuffs were not dedicated for single patient use, however, the facility failed to clean and disinfect the cuffs according to the manufacturer's directions, before use on another patient. The facility also failed to ensure that paper treatment sheets that were brought into the treatment area were disposed of. The sheets of paper could not be disinfected, and were taken to a common area to be filed in the patients' charts. An arm board covered with a wrap and taped with paper tape that could not be cleaned and disinfected, was</p>	V 116			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 116	<p>Continued From page 12</p> <p>also stored in a shelf area behind stations 5 and 6.</p> <p>Findings:</p> <p>The facility's policy and procedure titled "Infection Control for Dialysis Facilities", last revised 3/10, was reviewed and indicated, "Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or use on another patient.... 40. Non-disposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) will be dedicated for use only on a single patient."</p> <p>1. On 8/23/10 starting at 8:18 a.m., a piece of paper was placed on the side of the CSS computer monitor screen between stations 1 and 2, stations 3 and 4, stations 5 and 6, stations 7 and 8, and stations 9 and 10. When asked what the sheets of paper were, PCT 1 and PCT 2 indicated they were treatment sheets, similar to a "Kardex", and listed all of a patient's treatment orders. The sheets of paper were not covered in plastic or a material with a wipeable surface and could not be adequately disinfected.</p> <p>When asked what happened to the sheet of paper after a patient's treatment was complete, PCT 1 and PCT 2 reported, "We make changes on it if needed, place it on the desk at the nurses' station, and it is filed in the patient's chart." In an interview concurrent with the observation, the FA confirmed this practice.</p> <p>2. During observations on 8/23/10 starting at 8:18 a.m., an arm board covered in a wrap and taped</p>	V 116			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 116	<p>Continued From page 13</p> <p>with paper tape was stored on a shelf behind stations 5 and 6. When asked about the arm board, the FA indicated it was used by a patient to help control his arm. In an interview concurrent with the observation, the FA agreed that the arm board could not be adequately disinfected, due to the cover and the paper tape.</p> <p>3. On 8/24/10 beginning at 8:32 a.m., PCT 6 was observed cleaning station 3. PCT 6 cleaned and disinfected the patient chair with a disposable wipe dampened with a bleach solution, but did not clean and disinfect the non-disposable (cloth) blood pressure cuff. When asked about the blood pressure cuff, PCT stated "I forgot".</p> <p>At 8:46 a.m. on 8/24/10, RN 3 was observed cleaning station 6 with a disposable wipe dampened with a bleach solution. RN 3 rolled up the non-disposable (cloth) blood pressure cuff and placed it on the dialysis machine. When questioned about the observation, RN 3 confirmed she did not clean and disinfect the blood pressure cuff.</p> <p>In an interview concurrent with the observations, the DCS indicated the blood pressure cuffs used in the facility are made of a material called Sontara, a synthetic fiber similar to rayon. The DCS stated "They are the same ones we used at our other facility with same instructions for cleaning."</p> <p>The manufacturer's "Low-Level Disinfection Procedure" for the blood pressure cuffs was reviewed and states, "Prepare Enzol enzymatic detergent according to the manufacturer's instructions. Apply port-cap to cuff and use a sterile brush to agitate the detergent solution over</p>	V 116			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 116	Continued From page 14 entire cuff surface for five minutes. Rinse continuously with distilled water for five minutes. To disinfect, first follow the cleaning steps above, then spray cuff with 10% bleach solution until saturated, agitate with a sterile brush over entire cuff surface for five minutes. Rinse continuously with distilled water for five minutes. Wipe off excess water with sterile cloth and allow cuff to air dry."	V 116			
V 117	In an interview concurrent with the review, the ACS confirmed the facility was using non-disposable blood pressure cuffs, the cuffs were not dedicated for use only on a single patient and was not following the manufacturer's procedure for cleaning and disinfecting blood pressure cuffs between patients. 494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to	V 117		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 117	<p>Continued From page 15</p> <p>deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation, facility document review, and interview, the facility failed to ensure the clean area designated for preparation of medications was used only for the preparation of medications and that blood samples were not handled or stored in this area.</p> <p>Findings:</p> <p>The facility's "Medication Policy", last revised 9/09 was reviewed. The purpose of the policy is to provide guidelines for the safe and aseptic preparation of all medications, and the policy states in part, "An aseptic environment and aseptic technique is used when preparing medications."</p> <p>During the initial tour of the facility starting on 8/23/10 at 8:18 a.m., there was a space marked on a desk in the treatment area and a sign posted at the back of the desk which indicated, "Medication preparation area". The area was covered with a calendar, and there was a patient chart and other pieces of paper on top the desk. In an interview concurrent with the observation, the FA confirmed that this area is the location where intravenous medications are prepared for patients.</p> <p>On 8/26/10 at 11:43 a.m., PCT 5 was observed loading a syringe with heparin in the medication preparation area. Three lab tubes containing blood were observed next to the bottle of heparin. The FA was interviewed at the time of the observation and confirmed the observation.</p>	V 117			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 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 observations and interview the facility failed to implement standard infection control precautions for the cleaning and disinfecting of contaminated surfaces, medical devices and equipment between patient use. Treatment chairs were not cleaned and disinfected between patient use, and visible dried blood was observed on four of ten dialysis chairs. Four of 10 dialysis chairs also had torn upholstery, could not be adequately disinfected and had not been removed from use. Cloth (non-disposable) blood pressure cuffs used by multiple patients during dialysis, were not disinfected per the manufacturer's guidance between patient use, and the counter, CSS and television extension arms, bicarb jugs and biohazard containers located in the "splash zone" of one dialysis station was not cleaned between patients during patient changeover.</p> <p>Findings:</p> <p>The facility's policy and procedure titled "Infection Control for Dialysis Facilities" last revised 3/10 was reviewed. Item 21 states "Non-disposable items, such as stethoscopes, are not be shared</p>	V 122		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 122	<p>Continued From page 17</p> <p>unless disinfected between patients." Item 38 states, "Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or use on another patient." Item 40 states, "Non-disposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) will be dedicated for use only on a single patient." Item 45 states, "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 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."</p> <p>1. On 8/23/10 at 8:30 a.m. during the initial tour , a dried blood smear was observed on the left arm of the treatment chair in station 2 near the patient's access site. At the time of the observation, there was a patient seated in the chair receiving treatment. Blood was also observed on the floor by the treatment chair. The observations were confirmed by the FA.</p> <p>2. On 8/23/10 starting at 10 a.m. accompanied by the FA, the following was observed:</p> <p>a. Four treatment chairs ready for patient use in stations 1, 2, 5 and 6 were observed to have tears in the upholstery (wipeable surface)</p>	V 122			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 122	<p>Continued From page 18</p> <p>exposing the fabric content/stuffing of the chairs. Due to the torn upholstery, the chairs could not be adequately disinfected, but had not been removed from use.</p> <p>b. Dried blood was observed on the right and left sides of the the treatment chair at station 7 and on the right side of the treatment chair at station 9.</p> <p>c. Two bloody fistula pressure clamps (used for the patient at station 3) were observed in a sink located next to the patient in station 10. There was a wet blood smear on the edge of the sink.</p> <p>3. On 8/23/10 at 4:25 p.m., the dried blood observed on the treatment chairs in stations 7 and 9 at 10 a.m. was still present. Dried blood was also observed on the foot rest of the treatment chair in station 2 and along the right and left seam creases of the arm rests.</p> <p>4. On 8/24/10 starting at 8:15 a.m., direct care staff were observed during the changeover between the first and second shift of patients.</p> <p>a. At 8:30 a.m., PCT 6 proceeded to wipe down/disinfect the outer surfaces of the dialysis machine at station 3 with a bleach solution. PCT 6 wiped/disinfected the dialysis chair while it was in an upright position and did not recline the chair to access the inner surface/crevices. PCT 6 did not did not clean/disinfect the non-disposable (cloth) blood pressure cuff, did not wipe the station 6 counter, television extension arm, the CSS extension arm, the sides, top and bottom of the acid/bicarb plastic jugs, the shelf on the front of the dialysis machine that holds the jugs, and the biohazard container which were all located in</p>	V 122			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 122	<p>Continued From page 19</p> <p>the "splash zone" of the treatment area.</p> <p>As PCT 6 walked away from station 3, he was asked if station 3 was clean and ready for use by a patient and reported he was finished cleaning and the station was ready for a patient. When asked to put on a pair of gloves, recline the chair and push the cushion away from the side arm to expose the inner surface/crevices, dried blood was observed on the right inner surface of the chair alongside the cushion.</p> <p>When questioned regarding the procedure for cleaning and disinfecting the dialysis station following treatment, PCT 6 stated, "I clean all sides of dialysis machine, the jugs, the TV and computer arms, the blood pressure cuff and the chair." When questioned further, PCT 6 stated, "I forgot to clean those areas."</p> <p>b. At 8:46 a.m. on 8/24/10, RN 3 was observed cleaning station 6 with a disposable wipe dampened with a bleach solution. RN 3 rolled up the non-disposable (cloth) blood pressure cuff and placed it on the dialysis machine. When questioned about the observation, RN 3 confirmed she did not clean and disinfect the blood pressure cuff.</p> <p>In an interview concurrent with the observations, the DCS indicated the blood pressure cuffs used in the facility are made of a material called Sontara, a synthetic fiber similar to rayon.</p> <p>The manufacturer's "Low-Level Disinfection Procedure" for the blood pressure cuffs was reviewed and states, "Prepare Enzol enzymatic detergent according to the manufacturer's instructions. Apply port-cap to cuff and use a</p>	V 122			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 122	Continued From page 20 sterile brush to agitate the detergent solution over entire cuff surface for five minutes. Rinse continuously with distilled water for five minutes. To disinfect, first follow the cleaning steps above, then spray cuff with 10% bleach solution until saturated, agitate with a sterile brush over entire cuff surface for five minutes. Rinse continuously with distilled water for five minutes. Wipe off excess water with sterile cloth and allow cuff to air dry."	V 122			
V 124	In an interview concurrent with the review, the ACS confirmed the facility was using non-disposable blood pressure cuffs, the cuffs were not dedicated for use only on a single patient and was not following the manufacturer's procedure for cleaning and disinfecting blood pressure cuffs between patients. 494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to test the HBV serological status of one sampled and one unsampled patients (Patients 2 and 6) upon admission and ensure results were known within 7 days of admission, failed to	V 124		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 124	Continued From page 21 ensure the serological status of 11 chronic hemodialysis patients was know and failed to ensure that ten patients identified as "HBV susceptible" were tested for the presence of hepatitis B on a monthly basis. The failure to implement measures to prevent transmission of HBV through prompt detection and appropriate management, placed patients at risk for infection. Findings: Review of facility policy titled "Hepatitis Surveillance, Vaccination and Infection Control Measures" indicated in the section "Hepatitis B Testing" that "In order to prevent the transmission of Hepatitis B among patients, all new patiens should be tested and their HBV serologic status (i.e., Hepatitis B Surface antigen [BSA], total Hepatitis B Core Antibody [total anti-HBc or HBcAb], and Hepatitis B surface Antibody [anti-HBs or HBsAb]) results should be know prior to admission for treatment. If the results of this testing are not known at admission and the Medical Director determines that the patient needs to be admitted for treatment before prior testing can be completed, then the patient should be tested immediately upon intake and result known within seven (7) days of admission. If the hepatitis B surface antigen (HBsAg) status is unknown, the facility Medical Director will be notified and the patient treated as a suspect patient for hepatitis B infection." The policy further indicated "Monthly hepatitis B surface antigen (HBsAg) testing will be completed on patients who are susceptible or not immune to hepatitis B infection, including non-responders to the vaccine."	V 124			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 124	Continued From page 22 1. On 8/31/10 at 9 a.m. , the "Hepatitis Audit Report" dated 8/31/10 was reviewed, and indicated the HBV status of Patient 2 was unknown. Patient 2 was admitted on 7/07/10 and had a dialysis treatment on 7/12/10, and treatments on Monday, Wednesday and Friday (MWF) thereafter. Interview with the DCS confirmed that the facility could not provide any evidence that testing had been done or that the Medical Director had been notified. 2. The "Hepatitis Audit Report" dated 8/31/10 also indicated the HBV status of Patient 6 was unknown. Patient 6 was admitted on 4/14/10, had a dialysis treatment on 4/20/10 and treatments on Tuesday, Thursday and Saturday (TTS) thereafter. Interview with the DCS confirmed that the facility could not provide any evidence that the patient had been tested or that the Medical Director had been notified. 3. Review of the "Hepatitis Audit Report" dated 8/31/10 noted the status of 10 patients as "susceptible" to hepatitis B. Further review revealed that none of the 10 patients identified as "susceptible" had been tested monthly. In an interview concurrent with the review, the DCS confirmed that the facility did not have any evidence the ten patients were monitored monthly according to facility policy. 4. The "Hepatitis Audit Report" dated 8/31/10 noted the status of 11 chronic hemodialysis patients as "unknown". The admission dates of the 11 patients ranged from 2/06 through 2/10. The facility was not able to provide evidence of the patients' hepatitis status.	V 124			
V 126	494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF	V 126		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 126	<p>Continued From page 23</p> <p>Hepatitis B Vaccination</p> <p>Vaccinate all susceptible patients and staff members against hepatitis B.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that susceptible patients were offered the hepatitis B vaccination and that vaccinations were initiated and completed according to the vaccine manufacturer's timeline for two of 5 sample patients and 6 unsampled patients (Patients 1, 3, 7, 8, 9, 10, 11 and 12). There was no evidence Patients 7, 8 and 9 were offered or declined the hepatitis vaccination. Vaccinations for Patients 10, 11, 12 and 13 were not initiated timely and Patient 3 did not complete the vaccination series. There was no evidence Patients 11, 12, and 13 were offered or declined a second series of the vaccination or that Patient 1 was offered or declined a second booster.</p> <p>Findings:</p> <p>The facility's policy titled "Hepatitis Surveillance, Vaccination and Infection Control Measures" was reviewed. The section "Vaccination" states, "Hepatitis B vaccination is recommended for all susceptible chronic dialysis patients and should be offered upon admission with physician order. The dose, schedule and number of doses may vary depending upon the vaccine used."</p> <p>The vaccine schedule recommended for adult hemodialysis patients by the manufacturer of the vaccine used in the facility (Engerix-B) is: first dose, at elected date; second dose, 1 month</p>	V 126			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 126	Continued From page 24 later; third dose, 2 months after first dose, and fourth dose, 6 months after first dose. Review of the facility's "Hepatitis Audit Report" dated 8/31/10 and review of the "Adult Vaccine Administration Records" (AVAR) revealed the following: 1. Patient 7 was admitted on 11/14/07, and her hepatitis B status was identified as susceptible, however, there was no evidence (AVAR) she was offered or had declined the hepatitis B vaccine. 2. Patient 8 was admitted on 9/25/09, and her hepatitis B status was identified as susceptible, however, there was no evidence (AVAR) she was offered or had declined the hepatitis B vaccine. 3. Patient 9 was admitted on 5/14/10, and her hepatitis B status was identified as susceptible, however, there was no evidence (AVAR) she was offered or declined the hepatitis B vaccine. 4. Patient 10 was admitted on 2/18/09 and identified as susceptible. The AVAR was reviewed and noted the patient did not receive his first dose of vaccine until 4/6/09. 5. Patient 11 was admitted on 4/24/08 and identified as susceptible. Review of AVAR indicated the patient did not receive his first dose of vaccine until 1/21/09. Patient 11's status remains susceptible, however, there was no evidence that he was offered or declined a second series of the vaccine. 6. Patient 12 was admitted on 3/11/09 and identified as susceptible. Review of the AVAR noted the patient did not receive his first dose of	V 126			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 126	Continued From page 25 vaccine until 7/3/09. Patient 12's status remains susceptible, however, there was no evidence that he was offered or declined a second series of the vaccine. 7. Patient 1 was admitted on 5/1/08 and identified as susceptible. Review of the AVAR revealed she completed a second series of vaccine on 5/12/09 and received a booster on 10/17/09. The patient's status remains susceptible, however, there was no evidence that she was offered or declined another booster. 8. Patient 3 was admitted on 2/2/10 and review of AVAR revealed he received his first, second and third doses of vaccine at appropriate times, but did not receive the fourth vaccination. In an interview concurrent with the reviews, the FA and DCS confirmed that hepatitis B vaccinations were not initiated upon admission and the course completed in accordance with the manufacturer's suggested timelines. They also indicated the facility did not currently have a system to track vaccination administration to assure completion of the ordered course.	V 126			
V 132	494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	V 132		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 132	Continued From page 26 failed to ensure that two of 12 staff members (PCT 3 and PCT 7) were provided with annual infection control training. The personnel records for PCT 3 and PCT 7 were missing documentation that the employees were provided with annual infection control training. Findings: On 8/31/10 starting at 9:00 a.m., employee for 12 staff were reviewed. There was no evidence that PCT 3 and PCT received annual infection control training in their records. In an interview concurrent with the review, the DCS verified there was no documentation the employees were provided with infection control training in their records.	V 132			
V 143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Based on observation and review of the facility's medication policy, the facility failed to ensure that medication prepared for IV administration to patients during dialysis was properly labeled to prevent medication errors and ensure that administration of the medication did not exceed safe/acceptable timelines. The facility also failed to ensure that two opened vials of injectable medication were dated when opened to ensure the medications were used an discarded within	V 143		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 143	Continued From page 27 acceptable timelines. Findings: The facility's "Medication Policy", last revised 9/09 was reviewed. The purpose of the policy is to provide guidelines for the safe and aseptic preparation of all medications. According to the policy, "medications administered during the hemodialysis treatment are given via the medication infusion line whenever possible." The policy also states that "medication preparation should be performed only for the current shift of patients", that medications prepared and administered immediately by the same licensed nurse do not need to be labeled, and states that "if the medication is not immediately administered or is to be administered by another teammate, the medication must be labeled with the patient name, name of medication, date, time prepared, dose and initials of teammate preparing the medication." The policy and procedure also indicates "Each vial is labeled with the date, time and initials of the person opening the vial and the discard date." 1. On 8/23/10 at 11:52 a.m., two heparin syringes were observed on the counter top in the nurses station area. The syringes were labeled but the label did not include the date or time that the heparin solution was prepared. The FA was present during the observation and concurred. 2. On 8/23/10 at 12:05 p.m., an opened 30 ml vial of Heparin sodium and a 2 ml vial of Hectoral were observed in the medication refrigerator. The vials were not labeled with the date, time and initials of the person opening the vials and the discard date.	V 143			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 143	Continued From page 28	V 143			
V 147	<p>3. On 8/31/10 at 11:09 a.m., RN 2 was sitting at the nurses' desk with his back to the medication preparation area. Two one cc syringes with fluid and one three cc syringe with fluid were observed laying on a protective cover in the medication preparation area. The syringes were not labeled with the patient name, name of medication, date, time prepared, dose and initials of the nurse that prepared the medication. The FA was present and concurred with the findings.</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE</p> <p>Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care</p>	V 147		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 147	Continued From page 29 B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to implement National Kidney Foundation guidance and ensure a patient wore a surgical mask when the patient's catheter was exposed to minimize exposure to airborne contaminants and prevent infection. Findings: During an observation on 8/24/10 at 8:19 a.m., RN 2 and RN 3 were preparing to initiate the dialysis treatment for the patient at station 7 via the patient's central line catheter. During the observation, the catheter was exposed, but the patient was not wearing a surgical mask to cover his nose and mouth. The FA was present during the observation and confirmed the patient was not wearing a mask.	V 147			
V 175	494.40 CFC-WATER & DIALYSATE QUALITY This CONDITION is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not meet the Condition of Participation (COP) for Water and Dialysate Quality by failing to: Ensure the water treatment area was secure from access by unauthorized persons. (refer to V 184)	V 175		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 175	<p>Continued From page 30</p> <p>Ensure the water system included schematic diagrams that labeled major components and identified the device, described its function, how performance is verified and the actions to take int he event performance is not within an acceptable range (refer to V 187)</p> <p>Measure and record the total hardness of the water exiting the water softener at the end of each treatment day. (refer to V 191)</p> <p>Test and record results of monitoring total chlorine every 4 hours each dialysis day until activities that require use of dialysis quality water are completed. (refer to V 196)</p> <p>Complete and record measurements of the reverse osmosis system to monitor performance and detect problems affecting the system (refer to V 199)</p> <p>Follow the manufacturer's DFU for storing dry acid concentrate, mixing bicarbonate and recording pertinent information regarding concentrate preparation. (refer to V 226)</p> <p>Label mixing tanks, storage tanks and concentrate jugs with information including the date of preparation and the composition of the mixture. refer to V 228)</p> <p>Record pertinent information regarding the mixing of acid concentrate. (refer to V 229)</p> <p>Maintain documentation regarding the cleaning and disinfection of the bicarbonate mixing system and the individual jugs (refer to V 230, V 239, V 244)</p>	V 175			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 175	Continued From page 31 Implement a system to ensure bicarbonate was not used beyond the time specified by the manufacturer and facility policy. (refer to V 233) Ensure staff measured the pH/conductivity before starting each patients dialysis treatment. (refer to V 250)	V 175			
V 184	494.40(a) ENVIRONMENT-SECURE & RESTRICTED 8 Environment: secure & restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the water treatment area was secure. An outside door located near the water treatment area was left open and unattended allowing potential access to the restricted area by unauthorized persons. Findings: During an observation on 8/31/10 from 10:56 to 11:05 a.m., the outside door leading to water treatment area was propped open and was unattended. There were no staff in the immediate	V 184		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060	
(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 184	Continued From page 32 area. The facility is located in a office complex with various medical specialities. There is a parking lot that encompasses the complex, and multiple housing units in front of and behind the complex.	V 184		
V 187	494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, 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 observation and interview it was determined the facility did not have schematic diagrams of the water system and did not label major components in a manner that identified the device, described its function, how to verify performance and what actions to take in the event performance is not within an acceptable range. Findings: During the initial tour of the water treatment area of the facility on 8/23/10 at 11:48 a.m., accompanied by the RBMT and BMT, no	V 187		11/8/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 187	Continued From page 33 schematic diagrams or labels of the water system were observed. The RBMT and BMT confirmed there were no schematic diagrams of the facility's water system.	V 187			
V 191	494.40(a) SOFTENERS: TESTING HARDNESS/LOG 6.2.4 Softeners: Testing hardness/log Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total hardness monitoring requirements of the reverse osmosis machine manufacturer. Total hardness of the water exiting the water softener should be measured at the end of each treatment day. Water hardness test results should be recorded in a water softener log. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to test the total hardness of the water at the end of each treatment day to monitor the effectiveness of the water softener and ensure that limits established by the manufacturer of the reverse osmosis machine were not exceeded. Findings: The facility's "Routine Total Chlorine Testing Log 2-07-04A", was reviewed on 8/25/10 starting at 11:20 a.m. and revealed that the total hardness of the water was not tested at the end of the day for 15 of the 20 days between 8/2/10 and 8/24/10. In an interview concurrent with the review, the BMT agreed there was no documentation that testing was completed as required.	V 191		11/8/10	
V 196	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY	V 196		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 196	<p>Continued From page 34</p> <p>6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L].</p> <p>Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>This STANDARD is not met as evidenced by: Based on document review, policy and procedure review, and interview, the facility failed to test dialysis water for safe levels of chlorine/chloramine every four hours. Testing for total chlorine was not completed or not completed every four hours. Chlorine/chloramine destroys red blood cells and failure to monitor and ensure dialysis water did not exceed safe levels, placed</p>	V 196			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 196	<p>Continued From page 35 patients at risk for harm.</p> <p>Findings:</p> <p>Review of facility policy and procedure titled "Daily Water System Total Chlorine Monitoring" dated 2/7/04, indicated, "Total chlorine testing is done on a daily basis prior to the first patient treatment and every four hours until all activities that require use of dialysis quality water are completed."</p> <p>In an interview on 8/23/10 at 8:18 a.m., the FA indicated there are three patient shifts Monday through Saturday with the first patients going on treatment at 4:30 a.m. and the last patients of the day coming off the dialysis treatment machines usually no later than 4:30 p.m.</p> <p>On 8/25/10 at 11:20 a.m., the facility's "Routine total chlorine testing log 2-07-04A" was reviewed for 18 dialysis days from 8/2/10 through 8/21/10, with the BMT, and revealed that total chlorine testing was not completed or not completed every four hours on 17 of 20 days.</p> <p>8/2/10 more than four hours between tests 8/3/10 more than four hours between tests 8/4/10 last test at 12:30 p.m. 8/5/10 more than four hours between tests 8/6/10 last test at 8:30 a.m. 8/7/10 more than four hours between tests 8/9/10 last test at 12:30 p.m. 8/10/10 more than four hours between tests 8/11/10 last test at 12:30 p.m. 8/13/10 last test at 11:30 a.m. 8/14/10 no results logged for test 8/16/10 last test at 12:00 p.m. 8/17/10 no results logged for test 8/18/10 last testing at 12:40 p.m.</p>	V 196			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 196	Continued From page 36 8/19/10 no results logged for test 8/20/10 last test at 12:30 p.m. 8/21/10 no results logged for test In an interview concurrent with the review, the BMT acknowledged the facility was not checking the dialysis water quality as directed by facility policy and procedure.	V 196			
V 199	494.40(a) RO-MEETS AAMI/MONITORED, RECORDED ON LOG 5.2.7 Reverse osmosis: meets AAMI/monitored/recorded on log Refer to RD62:2001, 4.3.7 Reverse osmosis: When used to prepare water for hemodialysis applications, either alone or as the last stage in a purification cascade, reverse osmosis systems shall be shown to be capable, at installation, of meeting the requirements of Table 1, when tested with the typical feed water of the user, in accordance with the methods of [AAMI] 5.2.2. 5.2.7 Reverse osmosis Users should carefully follow the manufacturer's instructions for feed water treatment and monitoring to ensure that the RO is operated within its design parameters. 6.2.7 Reverse osmosis All results of measurements of RO performance should be recorded daily in an operating log that permits trending and historical review. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that the results of measurements of RO performance were	V 199		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 199	<p>Continued From page 37</p> <p>complete and recorded daily to permit trending of RO fuction and detect problems.</p> <p>Findings:</p> <p>The facility's "Water Treatment Log" was reviewed on 8/25/10 starting at 11:20 a.m. Log entries for measurements of reverse osmosis performance were incomplete for 14 of the 20 days reviewed from 8/2/10 through 8/24/10.</p> <p>8/2/10-RO product water flow rate missing,final product water quality missing, end of day hardness test result missing</p> <p>8/3/10-RO pre-filter inlet pressure missing, RO product water flow rate missing</p> <p>8/4/10-RO pre-filter inlet pressure missing, RO product water flow rate missing, final product water quality missing, end of day hardness test result missing</p> <p>8/5/10-RO product water flow rate missing</p> <p>8/6/10-Primary carbon pressure missing, end of day hardness test result missing</p> <p>8/7/10-Final product water quality missing</p> <p>8/9/10-End of day harness test result missing</p> <p>8/11/10-Start of day hardness test result missing, end of day hardness test results missing</p> <p>8/12/10-End of day hardness test results missing</p> <p>8/13/10-Start of day hardness test result missing, end of day hardness test results missing</p>	V 199			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060	
(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 199	Continued From page 38	V 199		
	8/14/10-Salt level in brine tank missing			
	8/20/10-Start of day hardness test results missing			
	8/21/10-End of day hardness test result missing			
	8/23/10-End of day hardness test result missing			
	In an interview concurrent with the review, BMT agreed that information was missing.			
V 224	494.40(a) MIXING SYSTEMS-H2O/DRAIN/ELECTRIC	V 224		11/8/10
	5.4.4.1 Mixing systems: water/drain/electric Concentrate mixing systems require a purified water source, a suitable drain, and a ground fault protected electrical outlet.			
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have a suitable drain for the bicarb mixing system. The bicarb mixing system did not empty into a floor drain, causing liquid to pool on the floor of the bicarb/acid mixing area.			
	Findings:			
	On 8/23/10 at 11:48 a.m., accompanied by the BMT, standing fluid was observed on the floor of the bicarb/acid mixing room. The drain on the bicarb mixing tank did not empty into a floor drain. The BMT confirmed the drain on the bicarb tank had to drain onto the floor instead of into a floor drain, causing the standing liquid puddle on the tile floor.			
V 226	494.40(a) MIX SYS-DFU/MONITOR/PM/LOG/SANITIZE	V 226		11/8/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 226	<p>Continued From page 39</p> <p>5.4.4.1 Mixing systems: follow DFU/monitor/PM/log/sanitization If a concentrate mixing system is used, the preparer should follow the manufacturer's instructions for mixing the powder with the correct amount of water.</p> <p>If a concentrate mixing system is used, the number of bags or the weight of powder added should be determined and recorded.</p> <p>Manufacturer's recommendations should be followed regarding any preventive maintenance and sanitization procedures. Records should be maintained indicating the date, time, person performing the procedure, and results (if applicable).</p> <p>6.4.1 Mixing systems: Systems for preparing either bicarbonate or acid concentrate from powder should be monitored according to the manufacturer's instructions.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, review of the manufacturer's DFU, and policy and procedure review, the facility failed follow the manufacturer's instructions for storing dry acid concentrate and mixing bicarbonate and failed to record pertinent information regarding preparation of concentrates mixed.</p> <p>Findings:</p> <p>1. Review of manufacturer's DFU of dry pack for bicarbonate dialysis indicated in part, "...add 90 liters of purified water". Water temperature should be 24 degrees +/- 2 degrees Centigrade.</p>	V 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 226	<p>Continued From page 40</p> <p>Empty entire dry pack into the water gradually while gently mixing the solution. Mix for one minute after the powder has been added. Add water for a total volume of 96 liters. Mix again for approximately ten minutes. The bicarbonate base concentrate should be used within 24 hours of mixing. Protect from excessive heat."</p> <p>The facility's policy and procedure, "Bicarbonate Concentrate System Mixing", revised 9/09, was reviewed and indicated, "All bicarbonate mixing will be performed in accordance with the bicarbonate manufacturer's recommendations."</p> <p>In an interview on 8/23/10 at 2:12 p.m., PCT 2 indicated that he takes care of the water treatment area and bicarbonate mixing area, and usually works Monday, Wednesday and Friday. When asked about his training, PCT 2 indicated that he was taught by the former owners of the facility.</p> <p>In an interview on 8/25/10 at 9:11 a.m., PCT 2 was questioned regarding the procedure for mixing bicarbonate and stated, "I dump the stuff in and turn on the timer." In an interview on the same date at 4:02 p.m., the BMT was also questioned regarding the procedure and stated, "The timer cycle is five minutes." The BMT confirmed that the bicarbonate mixing time was five minutes less than the manufacturer's DFU, with the use of the current mixing tank.</p> <p>2. The facility's "Bicarb Mixing Log" was reviewed and did not contain information regarding the test results for any of the batches of bicarb made in the facility for the months of 6/10, 7/10 or 8/10. Additionally, the form did not contain the required second team verification four of six times for the</p>	V 226			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 226	Continued From page 41 month of 8/10, 18 times for the month of 7/10, and 20 times during the month of 6/10. During the month of 7/10, the facility did not mix bicarb on 1 of 27 treatment days. 3. Review of manufacturers DFU for Dry Acid Concentrate for Bicarbonate Dialysis indicates, "Avoid excessive temperature." During an inspection on 8/31/10 at 8:24 a.m., accompanied by the FA, an outside metal storage container, located in the parking lot behind the facility, was observed to contain supplies including 23 boxes of 1K acid, 18 boxes of 2K acid, and two boxes of IV normal saline solution. The FA stated, "It was 101 degrees last week when I was working out here in the shed." The RBMT and BMT called the manufacturer of the acid product, and according to the manufacturer, storing items at any more or less than room temperature (59-86 degrees F) is considered excessive heat.	V 226			
V 228	494.40(a) MIXING SYSTEMS-LABELING 5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine. Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until the tank has been emptied. Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their	V 228		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 228	Continued From page 42 contents. Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that mixing tanks, storage tanks and concentrate jugs were properly labeled with the date of preparation and the composition of the mixture. Findings: 1. During on observation, on 8/25/10 at 4:02 p.m., accompanied by the BMT, the acid mixing container was labeled with a cut-out of the formula mixture, however, the date of preparation was not indicated on the label. The expiration date and lot number on the cut out, which applied only to the dry powder and not the concentrate, was not marked out. 2. The bicarbonate mixing tank, which contained fluid, did not have a label identifying the chemical formulation and date the concentrate was mixed. 3. An acid concentrate jug with three different labels was also observed. Each of the labels contained different information regarding the contents. The BMT concurred with the findings.	V 228			
V 229	494.40(a) MIXING SYSTEMS-PERM RECORD/VERIF TEST 5.4.4.1 Mixing systems: perm record/verification	V 229		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 229	<p>Continued From page 43</p> <p>testing</p> <p>In addition to container labeling, there should be permanent records of batches produced. These records should include the concentrate formula produced, the volume of the batch, the lot numbers of powdered concentrate packages, the manufacturer of the powdered concentrate, the date and time of mixing, any test results, the person performing the mixing, the person verifying mixing and test results, and the expiration date (if applicable).</p> <p>6.4.1 Mixing systems</p> <p>Acid and bicarbonate concentrates may be tested by using conductivity or by using a hydrometer. Concentrates should not be used or transferred to holding tanks or distribution systems until all tests are completed. The test results and verification that they meet all applicable criteria should be recorded and signed by the individuals performing the tests.</p> <p>This STANDARD is not met as evidenced by: Based on facility document review, policy and procedure review, and interview, the facility failed to record pertinent information regarding the mixing of acid concentrate in the facility, including test results, the person verifying mixing and test results, batch volume and the manufacturer of the powdered concentrate.</p> <p>Findings:</p> <p>The facility's policy and procedure, "Bicarbonate Concentrate Mixing System", revised 9/09 was reviewed and indicates, "Preparation of bicarbonate concentrate is documented on a log at the time of preparation and verified by a second teammate. The log should include the</p>	V 229			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 229	Continued From page 44 concentrate formula produced, the volume of the batch, the lot numbers of powdered concentrate packages, the manufacturer of the powdered concentrate, the date and time of mixing, any verification test results and the expiration date." The facility's "Bicarb Mixing Log", was reviewed and did not contain information regarding the test results of the mixed bicarbonate solution or expiration dates for any of the 85 batches of bicarbonate that were made in the facility for the months of 6/10, 7/10 and 8/10. The form did not contain the required second team verification four of six times for the month of 8/10, 18 times for the month of 7/10, and 20 times for the month of 6/10. Additionally, the log did not include the volume of the batch four times and did not list the manufacturer of the powdered concentrate five times for the month of 6/10. In an interview concurrent with the review, the BMT, confirmed the missing information.	V 229			
V 230	494.40(a) MIXING SYSTEMS-CLEANING 6.4.1 Mixing systems: cleaning Concentrate mixing equipment should be either: (1) completely emptied, cleaned, and disinfected according to the manufacturer's instructions; or (2) cleaned and disinfected using a procedure demonstrated by the facility to be effective in routinely producing concentrate meeting [these regulations related to allowable bacterial and endotoxin levels]. The disinfection data should be recorded for each ...disinfection cycle using a dedicated log. This STANDARD is not met as evidenced by: Based on policy and procedure review and interview, the facility failed to maintain a log and	V 230		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060	
(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 230	Continued From page 45 record data regarding the cleaning and disinfection of the bicarbonate mixing system and the individual jugs. Findings: The facility's policy and procedure, "Bicarbonate Concentrate System Mixing", dated 9/09 was reviewed and indicates, "Small refillable containers used to mix and store bicarbonate concentrate are rinsed daily and disinfected at a minimum weekly." In an interview on 8/25/10 at 4:02 p.m., the BMT indicated that facility logs relating to the disinfection of the bicarbonate mixing tank and the individual jugs could not be found.	V 230		
V 231	494.40(a) ACID CONC MIX SYS-EMPTY ALL/PREV CORROSION 5.4.4.2 Acid concentrate mixing systems: empty completely/prevent corrosion Acid concentrate mixing tanks should be designed to allow the inside of the tank to be completely emptied and rinsed according to the manufacturer's instructions when concentrate formulas are changed. Acid concentrate mixing tanks should be emptied completely before mixing another batch of concentrate. Because concentrate solutions are highly corrosive, mixing systems should be designed and maintained to prevent corrosion. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	V 231		11/8/10

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 231	Continued From page 46 failed to maintain the acid concentrate mixing system in a manner which prevented acid crystals from growing on the outside of the unit. Findings: During an inspection on 8/23/10 at 11:48 a.m., accompanied by the BMT and the RBMT, the acid concentrate mixing system was observed to have white crystal like growth on the outside of the housing unit. The size of the crystal growth was about one-quarter inch in length and the circumference of the cylindrical container. The BMT and RBMT concurred the crystal growth on the housing unit of the acid concentrate mixing system unit.	V 231			
V 233	494.40(a) BICARB MIX SYS-STOR/USE TIME/MIN COMBINE 5.4.4.3 Bicarbonate concentrate mixing systems: storage/use time limits/min combine Once mixed, bicarbonate concentrate should be used within the time specified by the manufacturer of the concentrate. 7 Strategies for bacterial control 7.1 General Storage times for bicarbonate concentrate should be minimized, as well as the mixing of fresh bicarbonate concentrate with unused portions of concentrate from a previous batch. The manufacturer's instructions should be followed if they are available. This STANDARD is not met as evidenced by: Based on observation, interview, policy and procedure review and review of the manufacturer's DFU, the facility failed to	V 233		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 233	<p>Continued From page 47</p> <p>implement it's policy and procedure and ensure that bicarbonate concentrate was used the same day it was mixed or discarded at the end of the treatment day, to limit bacterial growth.</p> <p>Findings:</p> <p>The bicarbonate manufacturer's DFU indicates, "This bicarbonate base concentrate should be used within 24 hours of mixing." The facility's policy and procedure, "Bicarbonate Concentrate System Mixing", revised 9/09 was reviewed and indicates, "All bicarbonate concentrate mixing will be performed in accordance with the bicarbonate manufacturer's recommendations. Bicarbonate concentrate is to be used the same day that it is mixed. Any bicarbonate concentrate left over at the end of the treatment day is to be discarded."</p> <p>1. During an observation on 8/23/10 at 2:12 p.m., PCT 2 stopped at station 4 and replaced the existing bicarbonate jug in use with another bicarbonate jug. PCT 2 took the original bicarbonate jug and poured the remaining bicarbonate solution into a jug on the top of a supply cart. PCT 2 repeated the same procedure at stations 5, 6, and 7.</p> <p>PCT was interviewed at the time of the observation and indicated that he was pouring the remaining bicarbonate solution from each jug into a common jug with the intent of using the left over bicarbonate solution the following day. There was no information on any of the bicarbonate jugs regarding the date and time the bicarbonate solution was made, to ensure it was used within 24 hours of mixing in accordance with the manufacturer's DFU. The FA concurred with the findings.</p>	V 233			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 233	Continued From page 48 2. During an observation on 8/25/10 at 9:09 a.m., PCT 1 stopped at station 3 and replaced the existing bicarbonate jug with another bicarbonate jug. PCT 1 took the original bicarbonate jug and poured the remaining bicarbonate solution into a jug on the top of a supply cart. PCT 1 repeated the same procedure at stations 4, 5, 6, and 7. In an interview at the time of the observations, PCT 1 indicated that she was pouring the remaining bicarbonate solution from each jug into a common jug with the intent of using the left over bicarbonate solution the following day. PCT 1 indicated that she was not aware that she should not combine and fill other bicarbonate jugs with existing fluid. There was no information on any of the bicarbonate jugs regarding the date and time the bicarbonate solution was made to ensure it was used within 24 hours of mixing. The FA concurred with the findings.	V 233			
V 239	494.40(a) BICARB CONC DISTRIB-WKLY DISINFECT/DWELL/CONC 5.5.4 Bicarbonate concentrate distribution systems: weekly disinfection/dwell times/conc Bicarbonate concentrate delivery systems should be disinfected on a regular basis to ensure that the dialysate routinely achieves the level of bacteriological purity [required by these regulations]. For piped distribution systems, the entire system, including patient station ports, should be purged of bicarbonate concentrate before disinfection. Each patient station port should be opened and flushed with disinfectant and then rinsed; otherwise, it would be a "dead leg" in the system.	V 239		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 239	Continued From page 49 Appropriate dwell times and concentrations should be used as recommended by the manufacturer of the concentrate system. If this information is not available, bleach may be used at a dilution of 1:100 and proprietary disinfectants at the concentration recommended by the manufacturer for disinfecting piping systems. 6.5 Concentrate distribution: The interval between disinfection should not exceed 1 week. If the manufacturer does not supply disinfection procedures, the user must develop and validate a disinfection protocol. This STANDARD is not met as evidenced by: Based on interview, the facility failed to maintain logs to monitor weekly disinfection of the bicarbonate mixing system. Findings: During an interview with the BMT on 8/25/10 at 4:02 p.m., the BMT could not find any documentation regarding the weekly disinfection of the bicarbonate mixing system.	V 239			
V 243	494.40(a) BICARB JUGS RINSED DAILY/STORED DRY 6.5 Concentrate distribution: bicarb jugs rinsed daily/stored dry Bicarbonate concentrate jugs should be rinsed with treated water and stored inverted at the end of each treatment day. Pick-up tubes should also be rinsed with treated water and allowed to air dry at the end of each treatment day. This STANDARD is not met as evidenced by: Based on observation, policy and procedure	V 243		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 243	Continued From page 50 review and interview, the facility failed to ensure bicarbonate jugs were rinsed at the end of the day and stored inverted, to facilitate drying and limit the growth of bacteria. Findings: The facility's policy and procedure, "Bicarbonate Concentrate System Mixing", revised 9/09, indicates, "Small refillable containers used to mix and store bicarbonate concentrate are rinsed daily and disinfected at a minimum weekly." During the initial tour of the water treatment area of the facility, accompanied by the RBMT and BMT, starting on 8/23/10 at 11:48 a.m., six bicarbonate jugs were observed in the water treatment area, sitting on the floor in a puddle of liquid. When picked up and inverted, there was water in the bottom of the containers. The RBMT and BMT concurred with the findings. On 8/26/10 at 9:08 a.m., accompanied by the BMT, the floor of the acid/bicarbonate mixing room was observed to be covered in approximately one-half inch of water. Hoses used to transfer acid to tanks, the feet of the wooden frame supporting the bicarb tanks, and three bicarbonate jugs were sitting in the water. when picked up and inverted, there was water in the bottom of the jugs.	V 243			
V 244	494.40(a) BICARB JUG MAINTENANCE/DISINFECTION 5.5.4 Bicarbonate concentrate distribution systems: jug disinfection When reusable concentrate jugs are used to distribute bicarbonate concentrate, they should be rinsed free of residual concentrate before	V 244		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 244	Continued From page 51 disinfection. 6.5 Concentrate distribution When reusable concentrate jugs are used to distribute bicarbonate concentrate, they should be disinfected at least weekly. 7 Strategies for bacterial control 7.1 General Following disinfection, jugs should be drained, rinsed, and inverted to dry. This STANDARD is not met as evidenced by: Based on review of facility policy and procedure and interview, the facility failed to maintain logs relating to the weekly disinfection of the bicarbonate jugs. Findings: Review of facility policy and procedure, "Bicarbonate Concentrate System Mixing", revised 9/09 was reviewed and indicates, "Small refillable containers used to mix and store bicarbonate concentrate are rinsed daily and disinfected at a minimum weekly." During an interview with the BMT on 8/25/10 at 4:02 p.m., the BMT could not find any documentation regarding the weekly disinfection of the bicarbonate jugs.	V 244			
V 250	494.40(a) DIALYS PROPOR-T-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with	V 250		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 250	Continued From page 52 an independent method before starting the treatment of the next patient. This STANDARD is not met as evidenced by: Based on observation,interview, and review of the manufacturer's DFU, the facility failed to ensure dialysate conductivity and pH were measured prior to the start of a dialysis treatment, to prevent injury from improper dialysate use. Findings: The bicarbonate manufacturer's DFU were reviewed and indicate, "Check conductivity and pH of dialyzing fluid before starting treatment and each time solution is added." Review of manufacture's DFU for the acid indicate, "Check conductivity and pH of dialysate just prior to dialysis treatment and each time new concentrate is supplied to the machine." During the initial tour of the facility starting on 8/23/10 at 8:31 a.m., the patient in station 7 was observed receiving dialysis treatment. During the observation, PCT 1 obtained the Phoenix meter, and when asked what she was going to do, PCT 1 stated that she was going to check the pH and conductivity of the dialysate. PCT 1 acknowledged she had not performed the test prior to the starting the patient's treatment. The FA confirmed the observation in an interview concurrent with the observation.	V 250			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed,	V 401		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 401	<p>Continued From page 53</p> <p>constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a safe treatment environment for patients. A door to the outside was left open and unattended allowing potential access to restricted areas of the facility by unauthorized persons, the oxygen tank on the emergency cart was not equipped with a regulator and could not be used in the event of an emergency, and boxes of medical supplies including IV fluids and dialysis tubing sets were stored on the floor and not protected from potential contamination.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the initial tour of the facility starting on 8/23/10 at 8:18 a.m., no regulator was observed on the oxygen tank attached to the emergency crash cart, and no regulator was found in the cart. The FA was interviewed at the time of the observation, indicated that a regulator had been ordered, and acknowledged the oxygen tank could not be used without a regulator. 2. During an observation on 8/31/10 between 10:56 a.m. and 11:05 a.m., the outside door leading to water treatment area was open and unattended. During the observation, no facility staff were in the immediate area of the water treatment area. The facility is located in a office complex which contains offices of various medical specialities. Vehicle parking encompasses the entire complex. In front and in back of the complex are multiple housing units. 	V 401			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 401	Continued From page 54	V 401			
V 403	<p>3. On 8/23/10 at 11:48 a.m., seven boxes of medical supplies including IV fluids and dialysis treatment tubing sets were stored on the floor in the water treatment area. During an observation of 8/31/10 at 11:05, a total of 23 boxes of medical supplies were stored on the floor in the water treatment area. The supplies included sterile sponges, normal saline solution, and tubing sets.</p> <p>4. During the initial tour on 8/23/10 at 8:18 a.m., there was a floor tile missing in station 1.</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, record review and interview, the facility failed to maintain a program to ensure that equipment used in the facility was safe and functioning properly.</p> <p>A log for monitoring the temperature of the medication refrigerator was missing entries. Records regarding the daily cleaning, testing and calibration of conductivity and pH meters used to test dialysate were not available. Quality control testing to ensure proper function of a glucose monitor was not performed in accordance with facility procedures. There was no record that a dialysis machine with a broken bracket to hold</p>	V 403		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 403	<p>Continued From page 55</p> <p>treatment lines was inspected and repaired. Five patient treatment chairs with torn upholstery were observed in dialysis stations and had not been repaired or replaced, and there were no records that the eye wash station was flushed and cleaned regularly.</p> <p>Findings:</p> <p>1. The "Medication Refrigerator Temperature Log", was reviewed and no temperatures were recorded on 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, 8/14, 8/19, 8/20 and 8/21/10. The FA concurred with the findings.</p> <p>The facility's policy and procedure titled "Medications Requiring Refrigeration" dated 9/07, was reviewed and indicates that the refrigerator will be checked daily to ensure that the temperature remains between 36 degrees Fahrenheit (F) and 46 degrees F. The policy also states that the temperature will be documented on the "Refrigerator Temperature Log", and that refrigerators that do not maintain temperatures in the stated range, will be repaired or replaced as soon as possible.</p> <p>2. The facility's policy and procedure, "Phoenix Meter Disinfection and Calibration Verification", revision date 9/09 was reviewed and indicates, "The Phoenix meter is disinfected and verified prior to daily use. After disinfection, calibration of the Phoenix meter is verified prior to daily use or whenever inaccurate readings are suspected."</p> <p>The "Phoenix Meter Log" was reviewed for 71 treatment days between 6/10 and 8/23/10. Daily testing was not performed as indicated nor data entered on the form as directed 9 of the 71 days.</p>	V 403			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 403	Continued From page 56 3. The facility's policy and procedure, "Precision Xtra Blood Glucose Monitor: Quality Control", revised 9/07 was reviewed and indicated that the blood glucose monitor is to be checked daily with the quality control solutions (high and low). The policy and procedure further states, "Document result of low control solution test and the range for each control level on the Precision Xtra Quality Control Log Quality control records for the glucose meter were reviewed on 8/26/10 at 2:28 p.m. with the BMT, and there were no records that the blood glucose monitor was checked daily with the quality control solutions. In an interview concurrent with the review, the BMT acknowledged staff have not been performing the tests. 4. In an interview on 8/26/10 at 2:28 p.m., the BMT indicated the facility did not document testing of the eye wash station. The water at eye wash stations can contain contaminants such as rust, scale and chemicals, and should be flushed and cleaned regularly to ensure proper function. The BMT indicated the previous eye wash station did not work properly and the eye wash station was new. 5. During an inspection on 8/23/10 starting at 8:26 a.m., five treatment chairs were observed to have torn upholstery exposing the internal padding. Because their wipeable surface was no longer intact, the chairs could not be adequately disinfected, but had not been repaired or removed from use. The treatment chair at station 1 had a tear on the right side of the foot rest. Station 2's chair had a tear on the left side of the foot rest. Station 5's chair had a tear on the right side of the	V 403			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 403	Continued From page 57 foot rest. Station 6's chair had a tear on the right side of the foot rest. Station 9's chair had a tear on the right side of the foot rest. In an interview at the time of the observations, the FA and DCS concurred with the findings. 6. The facility policy titled, "Documentation of Repairs on Equipment" was reviewed and indicates, "All repairs and calibrations performed on dialysis equipment systems will be documented with a complete work order filled out and signed by the technician performing the repairs. One copy of this work order will be placed in the Machine Maintenance Log in the section indicated by the serial number of the equipment." On 8/23/10 at 10:42 a.m., accompanied by the BMT, the dialysis treatment machine at station 5 was observed to have tape holding the treatment lines in place while a patient was receiving treatment. PCT 2 was questioned regarding the observation and indicated a bracket was broken on the machine and that the tape was needed to hold the tubing in place. PCT 2 stated, "It has been like this for months" and indicated that he had reported the problem to the Biomed department. In an interview concurrent with the observation, the BMT was not able to locate a work order or other documentation for the machine and indicated he was not aware of the broken bracket.	V 403			
V 404	494.60(c)(1) PE-PT CARE ENVIRONMENT-SUFFICIENT SPACE The space for treating each patient must be sufficient to provide needed care and services, prevent cross-contamination, and to accommodate medical emergency equipment	V 404		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 404	<p>Continued From page 58 and staff.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was sufficient space at seven of 10 dialysis stations (stations 3, 4, 5, 6, 7, 8 and 10) to accommodate emergency equipment and prevent cross contamination.</p> <p>Findings:</p> <p>1. On 8/23/10 starting at 8:26 a.m., the left side of the treatment chair in station 3 was observed to be positioned against the wall, and the the right side of the treatment chair was positioned against the wall in station 8. The treatment chairs at stations 4 and 5 and the treatment chairs in stations 6 and 7 were located next to each other, and when the side tables between the chairs were raised, they met. The side tables accommodated supplies and patients' personal belongings.</p> <p>In and interview on 8/23/10 at 3:27 p.m., PCT 1 indicated that items would have to be moved around in order to get emergency equipment and supplies close to the patients in stations 3, 4, 5, 6, 7 and 8.</p> <p>2. During an observation on 8/23/10 at 4:28 p.m., a patient was receiving a dialysis treatment in station 10. The patient's treatment chair was extended and the edge of the foot rest was butted up to a sink labeled "Dirty Sink". There were two bloody fistula pressure clamps in the sink and a wet bloody smear on the edge of the sink. RN 1 was interviewed at the time of the observation, asked how the facility prevented cross contamination between the dirty items in the sink and the patient receiving dialysis treatment and</p>	V 404			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 404	Continued From page 59	V 404			
V 407	was not able to provide an answer. 494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the access of 1 patient remained visible to staff while the patient was receiving treatment to ensure that complications, such as accidental needle dislodgement were promptly detected. Findings: During an observation on 8/25/10 at 9:03 a.m., the access site of the patient receiving treatment at station 2 was covered with a blanket and not visible. In an interview at the time of the observation, the FA concurred with the finding.	V 407		11/8/10	
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;	V 409		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 409	Continued From page 60 (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two of 12 staff were provided with training in emergency preparedness. Findings: Twelve employee records were reviewed on 8/31/10 at 9:00 a.m. with the ACS. The records of PCT 3 and PCT 7 did not include documentation verifying that the employees were provided with annual emergency training. The ACS concurred the paper work was missing.	V 409			
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 oxygen was immediately available in the event of an emergency. The	V 413		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 413	Continued From page 61 oxygen tank on the emergency cart was not equipped with a regulator and could not be used if needed. Findings: During the initial tour of the facility starting on 8/23/10 at 8:18 a.m., it was noted that the oxygen tank attached to the emergency crash cart did not have a regulator, and no regulator was found in the cart supplies. In an interview concurrent with the observation, the FA indicated that a regulator had been ordered, and acknowledged that the tank could not be used without a regulator.	V 413			
V 455	494.70(a)(4) PR-PRIVACY & CONFIDENTIALITY-RECORDS The patient has the right to- (4) Privacy and confidentiality in personal medical records; This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect patient information from casual access. A sign in sheet with information including patient names and pre and post dialysis weights was displayed near the patient scale, and computer screens with patient specific information displayed were left open and visible to others in the area. Finding: 1. On 8/23/10 at 8:18 a.m., a paper sign in sheet was observed directly above the patient weight scale. The sign in sheet contained information including patient names and patient pre and post	V 455		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 455	Continued From page 62 treatment weights. The FA was interviewed at the time of the observation and concurred with the finding.	V 455			
V 500	2. During observations starting 8/23/10 at 8:18 a.m., the CSS computer screen between stations 1 and 2, stations 3 and 4, stations 5 and 6, stations 7 and 8, and stations 9 and 10 were left open and information on the screens was visible to anyone walking by, including other patients and family members. Patient specific information including vital signs, medications, and the name and age of patients was displayed on the screens. The monitors were not equipped with privacy screens or an automated time out feature to protect the privacy and confidentiality of patients' medical information. 494.80 CFC-PATIENT ASSESSMENT This CONDITION is not met as evidenced by: Based on observation, interviews and record reviews, it was determined that the facility did not meet the Condition of Participation (COP) for Patient Assessment by failing to: Evaluate the appropriateness of dialysis prescriptions to meet the individual needs of patients. (refer to V 503) Evaluate the blood pressure and fluid management needs of patients to develop and effective plan of care to manage the volume status of patients (refer to V 504) The cumulative effects of these systemic deficiencies resulted in the facility's inability to ensure that dialysis patients were provided with	V 500		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 500	Continued From page 63 quality health care that met their individualized needs.	V 500			
V 503	494.80(a)(2) PA-APPROPRIATENESS OF DIALYSIS RX The patient's comprehensive assessment must include, but is not limited to, the following: (2) Evaluation of the appropriateness of the dialysis prescription, This STANDARD is not met as evidenced by: Based on record review, review of facility policy and procedure, and interview, the facility failed to evaluate the appropriateness of the hemodialysis prescription for five of 5 sample patients (Patients 1, 2, 3, 4 and 5) and two unsampled patients (Patients 15 and 16) to ensure the dialysis prescription was individualized to meet their needs. For Patients 1, 2, 3, 4, and 5, estimated dry weights were not met and were not evaluated to determine the appropriateness of the hemodialysis prescription. Patients 1, 2, 3, 4, and 15 had low and high blood pressures while receiving dialysis treatment that were not evaluated or treated, and the dialysis prescription for Patient 16 was not re-evaluated when he experienced vomiting and abdominal cramping during dialysis. Findings: In an interview on 8/23/10 at 2 p.m., the FA indicated that the facility definition of hypertension was anything greater than 180 systolic (the top number of a blood pressure reading), and the definition of hypotension was anything 100 or less	V 503		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 64</p> <p>systolic.</p> <p>The facility's policy and procedure titled, "Hypotension" dated 9/07 was reviewed and indicates, "Place patient in modified Trendelenburg position (head is lower than the rest of the body). Open saline line, clamp arterial blood line. Administer a saline bolus of approximately 200 ml. Discontinue UF. Reassess patient. Continue infusing saline up to one liter until patient's blood pressure is restored. If blood pressure is not restored, discontinue dialysis and notify physician. If patient remains hypotensive after discontinuing dialysis, follow physician order. Document treatment and patient response."</p> <p>The facility's policy and procedure title, "Intradialytic Treatment Monitoring" dated 9/08 was also reviewed and indicated, "Treatment checks should be completed at least every 30 minutes. Significant changes are reported to the licensed nurse and documented. Appropriate action is taken and documented, including patient response. The licensed nurse notifies the physician as needed of changes in patient status. All finding, interventions and patient response will be documented in the patient's medical record. Additional documentation may include the following: Indication and patient response to PRN medications."</p> <p>1. On 8/23/10 at 2 p.m., Patient 2's record was reviewed and indicated an EDW had been established at 83.5 kg. Review of twelve treatment records from 7/28/10 through 8/23/10 indicated Patient 2 left the facility after each treatment weighing in the high 80 kg range, with a weight ranging from three to six kg above the</p>	V 503			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 65</p> <p>EDW. There was no assessment why the EDW was not being met to determine appropriateness of the dialysis order.</p> <p>The BFR was ordered at 350. However, Patient 2 did not achieve the BFR during 12 of the 12 treatments with no notation of being evaluated by the charge nurse or physician. Patient 2's BFR ranged from 250 to 300.</p> <p>During 11 of 12 treatments Patient 2 experienced hypertension during dialysis with no notations of intervention by the charge nurse or physician advisement. Patient 2's blood pressure ranged from 170/115, 176/144, 180/122, 185/121 to 216/128. Patient 2 had an order for a medication (Clonidine) to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. However, Patient 2 received the medication only twice, on 7/28/10 for a blood pressure of 169/115 and on 7/30 for a blood pressure of 165/113. Both times there were no notations/assessments by the charge nurse.</p> <p>2. On 8/25/10 at 4 p.m., Patient 3's record was reviewed and indicated an EDW had been established at 125.0 kg. Twelve treatment records were reviewed from 7/19/10 through 8/25/10, and after eight of the 12 treatments, Patient 3 left the facility weighing from one to three kg above the EDW. There was no assessment why the EDW was not being met to determine appropriateness of the dialysis prescription.</p> <p>The BFR was ordered at 300. However, Patient 3 did not achieve the BFR during 10 of the 12 treatments. Patient 3's BFR was consistently at</p>	V 503			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 66</p> <p>350 for the 10 treatments with no notation of being evaluated by the charge nurse or physician.</p> <p>During three of 12 treatments Patient 3 experienced hypertension during dialysis with no notations of intervention by the charge nurse or physician advisement. Patient 3's blood pressure ranged from 186/95, 187/93, 189/105, 190/98 to 227/117. Patient 3 had an order for the medication Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. There was no documentation to support the medication was administered as an intervention or assessment of the patient's hypertension by the charge nurse.</p> <p>Review of Patient 3's heparin order indicated the patient was to receive 1000 units of heparin every hour during his three hour treatment time (a total of 3000 units). Review of treatment records dated 7/21/10, 8/6/10, 8/11/10, and 8/20/10 indicated Patient 3 received only 2500 units of heparin during his three hour treatment, however, RN 1 documented she administered 3000 units of heparin. Review of the 8/4/10 treatment record revealed Patient 3 received only 1500 units of heparin during his three hour treatment however, RN 1 documented she administered 3000 units of heparin.</p> <p>3. On 8/24/10 at 9 a.m., Patient 5's record indicated an EDW had been established at 59.5 kg. Twelve treatment records were reviewed from 7/29/10 through 8/24/10, and Patient 5 left the facility after six treatments weighing between 60.1 to 60.5 kg. There was no assessment why the EDW was not being met to determine appropriateness of the dialysis prescription.</p>	V 503			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 67</p> <p>The BFR was ordered at 400, however, Patient 5 did not achieve the BFR during 11 of the 12 treatments with no notation of being evaluated by the charge nurse or physician. Patient 5's BFR ranged from 300 to 350.</p> <p>4. Patient 15 was interviewed during his treatment on 8/31/10 at 9:05 a.m. during his treatment, complained of a headache, and the screen on his dialysis machine indicated his blood pressure was 193/96. A review of Patient 15's treatment record at 10 a.m., indicated that Patient 15 was hypertensive for 3.5 hours of his 4 hour treatment.</p> <p>Patient 15 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. The order indicated the medication could be repeated in 30 minutes if still unchanged. Patient 15 started his dialysis treatment at 5:30 a.m. with a blood pressure of 154/89 and at 6:10 a.m. it was 169/87. Patient 15's blood pressure was 180/89 at 6:45 a.m. however, there was no documentation that he received the medication at this time. At 7:20 a.m. Patient 15's blood pressure was 188/93, at 8:08 a.m. it was 190/95, at 8:26 a.m. it was 204/97, at 9:03 a.m. it was 199/99 and at 9:14 a.m. it was 193/96. Despite continued hypertension for 3 hours, the medication was not administered until 9:35 a.m. Review of the treatment record revealed no assessment by RN 2 for the patient's continuing hypertensive state, other than the notation "htn" documented at 9:35 a.m.</p> <p>Patient 15's BFR was ordered at 400, however, he did not achieve the BFR during the treatment with no notation of being evaluated by the charge</p>	V 503			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 68</p> <p>nurse or physician. Patient 15's orders also indicated that after his treatment he was to receive 2100 units of heparin in his right jugular CVC catheter arterial line, and 2200 units of heparin in his venous line after his treatment, however, review of the patient's medication administration record indicated he did not receive the heparin.</p> <p>In an interview concurrent with the review, on 8/31/10 at 1:30 p.m., the FA and confirmed the above findings.</p> <p>5. On 8/23/10 at 2:01 p.m., Patient 1's record was reviewed and indicated an EDW had been established at 45 kg. Twelve treatment records reviewed from 7/26/10 through 8/20/10 revealed Patient 1 left the facility after each treatment weighing from 44 to 68 kg, a difference ranging from 1 to 23 kg above the EDW. There was no assessment why the EDW was not being met to determine appropriateness of the dialysis order.</p> <p>The patient's BFR was ordered at 400, however, Patient 1 did not achieve the BFR during 12 of the 12 treatments with no notation of being evaluated by the charge nurse or physician. Patient 1's BFR ranged from 160 to 450. Patient 1's dialysis prescription also indicated she was to receive a total of hourly heparin during treatment in the amount of 1000 units. However, on 8/2 she received 500 units, on 8/6 she received 700 units and on 8/9/10 she received 1500.</p> <p>During two of 12 treatments, Patient 1 experienced hypotension during dialysis with no notation of intervention by the charge nurse or physician advisement. The hypotensive episode on 8/6/10 lasted for a period of two hours without</p>	V 503			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	<p>Continued From page 69</p> <p>assessment or intervention. Patient 1 had an order for normal saline solution that could be administered for hypotension.</p> <p>During the period reviewed, Patient 1 also had two episodes of hypertension during dialysis without assessment, intervention by the charge nurse or physician advisement. Patient 1 had an order for a Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 1 met the criteria for administration of the medication, the medication was not administered.</p> <p>Patient 1 was brought to the facility from a skilled nursing facility in a geri-chair. During an observation on 8/23/10 at 3:00 p.m., Patient 1 was observed sitting in the chair receiving her dialysis treatment. Patient 1 was moaning loudly and could be heard throughout the building. During observations from 3:08 p.m. to 3:54 p.m., Patient 1 continued to moan loudly. During a review of the patient's record post treatment, there was no assessment or notation regarding the moaning.</p> <p>6. On 8/24/10 at 2:57 p.m., Patient 4's record was reviewed and indicated an EDW had been established at 107.5 kg. Twelve treatment records were reviewed from 7/29/10 through 8/24/10, and Patient 4 left the facility after each treatment weighing up to 3.5 kg above the EDW. There was no assessment regarding the reason the EDW was not being met to determine appropriateness of the dialysis prescription.</p> <p>The patient's BFR was ordered at 350, however, Patient 4 did not achieve the BFR during six of</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 503	Continued From page 70 the 12 treatments with no notation of an evaluated by the charge nurse or physician. Patient 4's dialysis prescription indicated he was to receive a total of hourly heparin during treatment in the amount of 1750 units, however, he did not receive the hourly heparin on 7/29, 7/31, 8/5, 8/7, 8/10, 8/12, 8/17 or 8/24/10 and received only 1100 units on 8/14/10. During seven of 12 treatments Patient 4 experienced hypertension during dialysis without an assessment, intervention or physician advisement. Patient 4 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 4 met the criteria for administration of the medication, the medication was not administered. 7. On 8/23/10 at 12:15 p.m., Patient 16 was receiving a dialysis treatment at station 3, and was vomiting and complaining of abdominal cramping. The FA was present during the observation. During a review of the patient's treatment record on 8/24/10 at 1:01 p.m., however, there was no assessment of the patient or notation regarding the vomiting or abdominal cramps.	V 503			
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. This STANDARD is not met as evidenced by:	V 504		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 504	<p>Continued From page 71</p> <p>Based on record review, policy and procedure review, and interview, the facility failed to evaluate the blood pressure and fluid management needs for five of 5 sample patients (Patients 1, 2, 3, and 4) and one unsampled patient (Patient 15) to develop an effective plan of care to manage the patients' volume status and meet their individual needs. For Patients 1, 2, 3 and 4, estimated dry weights were not met and were not evaluated. Patients 1, 2, 3, 4, and 15 had low and high blood pressures while receiving dialysis treatment that were not evaluated and treated.</p> <p>Findings:</p> <p>In an interview on 8/23/10 at 2 p.m., the FA indicated that the facility's definition of hypertension is a blood pressure greater than 180 systolic (the top number of a blood pressure reading), and the facility's definition of hypotension is 100 or less systolic.</p> <p>Review of facility policy and procedure title, "Intradialytic Treatment Monitoring" dated 9/08 indicated, "Treatment checks should be completed at least every 30 minutes. Significant changes are reported to the licensed nurse and documented. Appropriate action is taken and documented, including patient response. The licensed nurse notifies the physician as needed of changes in patient status. All finding, interventions and patient response will be documented in the patient's medical record. Additional documentation may include the following: Indication and patient response to PRN medications."</p> <p>1. On 8/23/10 at 2 p.m., Patient 2's record was reviewed and indicated an EDW had been</p>	V 504			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 504	<p>Continued From page 72</p> <p>established at 83.5 kg. Twelve treatment records reviewed from 7/28/10 through 8/23/10 revealed Patient 2 left the facility after each treatment weighing from 3 to 6 kg above the EDW, without an assessment of why the EDW was not being met.</p> <p>During 11 of 12 treatments Patient 2 experienced hypertension during dialysis with no notation of assessment or intervention by the charge nurse or physician advisement. Patient 2's blood pressure ranged from 170/115, 176/144, 180/122, 185/121 to 216/128. Patient 2 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although the patient met the criteria for receiving the medication, the medication was administered only twice, on 7/28/10 for a blood pressure of 169/115 and on 7/30 for a blood pressure of 165/113.</p> <p>Patient 2's vital signs were not monitored every 30 minutes during dialysis according to facility policy. During 6 of 12 treatments, on 7/28, 7/30, 8/5, 8/11, 8/16 and 8/18, the time between monitoring ranged from 38 minutes to 220 minutes. The FA concurred with the findings.</p> <p>2. On 8/25/10 at 4 p.m., Patient 3's record was reviewed and indicated an EDW had been established at 125.0 kg. Twelve treatment records reviewed from 7/19/10 through 8/25/10 revealed Patient 3 left the facility after eight treatments weighing from 1 to 3 kg above the EDW, without an assessment of why the EDW was not being met.</p> <p>During three of 12 treatments Patient 3 experienced hypertension during dialysis. Patient</p>	V 504			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 504	<p>Continued From page 73</p> <p>3's blood pressures ranged from 186/95, 187/93, 189/105, 190/98 to 227/117. Patient 3 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110, however, the medication was not administered and there was no assessment by the charge nurse or physician advisement.</p> <p>Review of the treatment records revealed that three pre-treatment assessments were initiated from 5 to 10 minutes after the patient's treatment was started and one post treatment assessment was completed 19 minutes prior to completion of the dialysis treatment. In an interview concurrent with the review, the DCS confirmed the findings.</p> <p>3. During an interview with Patient 15 during his treatment on 8/31/10 at 9:05 a.m., the patient complained of a headache. The screen on his dialysis machine indicated his blood pressure was 193/96. During a review of the patient's treatment record at 10 a.m., the patient was noted to be hypertensive during 3.5 hours of his 4 hours treatment.</p> <p>Patient 15 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110, and the order indicated the medication could be repeated in 30 minutes if still unchanged. Patient 15 started his dialysis treatment at 5:30 a.m. with a blood pressure of 154/89 and at 6:10 a.m. it was 169/87. At 6:45 a.m., the patient's blood pressure was 180/89, at 7:20 a.m. it was 188/93, at 8:08 a.m. it was 190/95, at 8:26 a.m. it was 204/97, at 9:03 a.m. it was 199/99 and at 9:14 a.m. it was 193/96. Despite continued hypertension for 3 hours, there</p>	V 504			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 504	<p>Continued From page 74</p> <p>was no assessment of the patient and no treatment for hypertension until 9:35 a.m. when RN 2 administered a dose of Clonidine and documented "htn" in the notes section of the treatment record. In an interview concurrent with the review, the FA concurred with the findings.</p> <p>4. On 8/23/10 at 2:01 p.m., Patient 1's record was reviewed and indicated an EDW had been established at 45 kg. Twelve treatment records were reviewed from 7/26/10 through 8/20/10 and Patient 1 left the facility after each treatment weighing from 1 to 23 kg above the EDW, without an assessment of why the EDW was not being met.</p> <p>During two of 12 treatments Patient 1 experienced hypotension during dialysis without assessment, intervention or physician advisement. The hypotensive episode on 8/6/10 lasted for a period of two hours. During the same review period Patient 1 also had two episodes of hypertension during dialysis without evaluation or intervention by the charge nurse or physician advisement. Patient 1 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 1 met the criteria for the receiving the medication, the medication was not administered.</p> <p>Patient 1's vital signs were not monitored every 30 minutes during treatment according to facility policy for any of the 12 treatment records reviewed. Times between monitoring varied by as much as 45 to 120 minutes. In an interview concurrent with the review, the FA concurred with the findings.</p>	V 504			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 504	Continued From page 75 5. On 8/24/10 at 2:57 p.m., Patient 4's record was reviewed and indicated an EDW had been established at 107.5 kg. Twelve treatment records were reviewed from 7/29/10 through 8/24/10 and revealed Patient 4 left the facility after each treatment weighing up to 3.5 kg above the EDW, without an assessment of why the EDW was not being met. During seven of 12 treatments Patient 4 experienced hypertension during dialysis with no notation of assessment or intervention by the charge nurse or physician advisement. Patient 4's blood pressures included a high systolic reading of 209/110 and a high diastolic reading of 203/125. Patient 4 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 4 met criteria to receive the medication, the medication was not administered. During the review period, Patient 4's vital signs were not monitored every 30 minutes during treatment in accordance with facility policy for any of the 12 treatments. Times between monitoring varied by as much as 72 minutes.	V 504			
V 510	494.80(a)(7) PA-MSW-PSYCHOSOCIAL NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: (7) Evaluation of psychosocial needs by a social worker. This STANDARD is not met as evidenced by:	V 510		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 510	<p>Continued From page 76</p> <p>Based on record review and interview, the facility failed to ensure that psychosocial assessments were completed timely for two of 5 sample patients (Patients 3 and 4) and one unsampled patient (Patient 15). Patient 4's comprehensive assessment did not include an evaluation of the patient's psychosocial needs by a social worker, and psychosocial assessments were not completed timely for Patients 3 and 15.</p> <p>Findings:</p> <p>Review of facility policy and procedure titled, "Social Work Intervention and Documentation Requirements" revealed in item "4. Social workers will document patient records consistent with the parameters set forth in the following table: Plan of care: Within 30 days of admission, monthly on unstable patients, annual on stable patients. Social Work Assessment: Within 30 days of admission, transfer to facility, within 30 days of initiation of training for home therapy, or change in modality with a reassessment to be conducted 90 days after the initial assessment, complete a Quality of Life assessment on all patients at 90 days and annually. Social Work Progress Note: Quarterly or more frequently as needed. Annual social Work Assessment: Annually."</p> <p>1. Patient 3's record was reviewed on 8/25/10 at 4 p.m., and indicated that the patient was admitted on 1/28/10 with diagnoses that included ESRD, hypertension diabetes mellitus and anemia. Review of the record revealed the initial psychosocial assessment was not completed within 30 days of admission, and was completed on 4/13/10, 2 and 1/2 months after it was due. The 90 day psychosocial assessment was</p>	V 510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 510	Continued From page 77 completed on 7/20/10. 2. Patient 15's record was reviewed on 8/31/10 at 10 a.m., and indicated the patient was admitted on 11/9/09 with diagnoses that included ESRD, hypertension, and diabetes mellitus. Record review revealed the 90 day psychosocial assessment was completed on 3/23/10, 1 and 1/2 months after it was due. 3. Patient 4's record was reviewed on 8/24/10 at 2:57 p.m. and indicated the patient was admitted on 1/28/10. Further review revealed a psychosocial assessment had not been completed as of the date of the survey. In an interview concurrent with the review, the FA confirmed the documentation was not present in the medical record.	V 510			
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility did not meet the Condition of Participation (COP) for Patient Plan of Care by failing to: Ensure the plan of care included necessary care and services to manage patients' volume status. (refer to V 543) The cumulative effects of this systemic problem resulted in the dialysis facility's inability to ensure patients were provided with quality health care that met their individualized needs.	V 540		11/8/10	
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited	V 543		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	<p>Continued From page 78</p> <p>to, the following:</p> <p>(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy and procedure review and interview, the facility failed to ensure the plan of care for five of 5 sample patients (Patients 1, 2, 3, 4, and 5) and one unsampled patient (Patient 15) included necessary care and services to manage their volume status. For Patients 1, 2, 3, 4, and 5 the EDW was not being met, but there was no assessment of the reasons for not attaining the target weight and no plan to correct the problem. Patients 1, 2, 4, and 15 had high and/or low blood pressures during treatment without evidence of an assessment or action to address the abnormal values. In addition, blood pressures were not monitored during treatment at the frequency required by facility's policy for Patients 1 and 4.</p> <p>Findings:</p> <p>In an interview on 8/23/10 at 2 p.m., the FA indicated that the facility definition of hypertension was anything greater than 180 systolic (the top number of a blood pressure reading), and the definition of hypotension was anything 100 or less systolic.</p> <p>The facility's policy and procedure titled, "Hypotension" dated 9/07 was reviewed and indicates, "Place patient in modified Trendelenburg position (head is lower than the rest of the body). Open saline line, clamp arterial blood line. Administer a saline bolus of approximately 200 ml. Discontinue UF.</p>	V 543			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	<p>Continued From page 79</p> <p>Reassess patient. Continue infusing saline up to one liter until patient's blood pressure is restored. If blood pressure is not restored, discontinue dialysis and notify physician. If patient remains hypotensive after discontinuing dialysis, follow physician order. Document treatment and patient response."</p> <p>The facility's policy and procedure title, "Intradialytic Treatment Monitoring" dated 9/08 was also reviewed and indicated, "Treatment checks should be completed at least every 30 minutes. Significant changes are reported to the licensed nurse and documented. Appropriate action is taken and documented, including patient response. The licensed nurse notifies the physician as needed of changes in patient status. All finding, interventions and patient response will be documented in the patient's medical record. Additional documentation may include the following: Indication and patient response to PRN medications."</p> <p>1. On 8/23/10 at 2:01 p.m., Patient 1's record was reviewed and indicated an EDW had been established at 45 kg. Twelve treatment records reviewed from 7/26/10 through 8/20/10 revealed Patient 1 left the facility after each treatment weighing from 44 to 68 kg, a difference ranging from 1 to 23 kg above the EDW. There was no assessment regarding the reasons the EDW was not being met or plan to correct the problem.</p> <p>During two of 12 treatments, Patient 1 experienced hypotension during dialysis with no assessment or intervention. The hypotensive episode on 8/6/10 lasted for a period of two hours. Patient 1 had an order for normal saline solution that could be given for hypotension,</p>	V 543			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	<p>Continued From page 80</p> <p>however, Patient 1 did not receive the normal saline. During the period reviewed, Patient 1 also had two episodes of hypertension during dialysis with no assessment or intervention. Patient 1 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 1 met the criteria for receiving the medication, the medication was not administered.</p> <p>Patient 1's vital signs were not monitored every 30 minutes during treatment according to facility policy for any of the 12 treatment records reviewed. Times between monitoring varied by as much as 45 to 120 minutes. In an interview concurrent with the review, the FA concurred with the findings.</p> <p>2. On 8/23/10 at 2 p.m., Patient 2's record was reviewed and indicated an EDW had been established at 83.5 kg. Review of twelve treatment records from 7/28/10 through 8/23/10 indicated Patient 2 left the facility after each treatment weighing in the high 80 kg range, with a weight ranging from three to six kg above the EDW. There was no assessment why the EDW was not being met or plan to correct the issue.</p> <p>During 11 of the 12 treatments Patient 2 experienced hypertension during dialysis without an assessment or action to address the abnormal values. Patient 2's blood pressure ranged from 170/115, 176/144, 180/122, 185/121 to 216/128. Although Patient 2 had an order for a medication (Clonidine) to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110, the medication was administered only twice, on 7/28/10 for a</p>	V 543			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	<p>Continued From page 81</p> <p>blood pressure of 169/115 and on 7/30 for a blood pressure of 165/113.</p> <p>3. On 8/25/10 at 4 p.m., Patient 3's record was reviewed and indicated an EDW had been established at 125.0 kg. Twelve treatment records were reviewed from 7/19/10 through 8/25/10, and after eight of the treatments treatments, Patient 3 left the facility weighing from one to three kg above the EDW. There was no assessment regarding why the EDW was not being met or plan to address the issue.</p> <p>4. On 8/24/10 at 2:57 p.m., Patient 4's record was reviewed and indicated an EDW had been established at 107.5 kg. Twelve treatment records reviewed from 7/29/10 through 8/24/10 revealed Patient 4 did not achieve the target weight during any of the treatments and left the facility weighing between 107.7 to 110.9 kg. There was no assessment regarding the reason the EDW was not being met or plan to correct the issue.</p> <p>During seven of the 12 treatments Patient 4 experienced hypertension during dialysis with no assessment or action to address the abnormal values. Patient 4's blood pressures included a high systolic value of 209/110 and a high diastolic value of 203/125. Patient 4 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110. Although Patient 4 met the criteria for receiving the medication, the medication was not administered.</p> <p>During the review period, Patient 4's vital signs were not monitored every 30 minutes during treatment in accordance with facility policy for any</p>	V 543			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	<p>Continued From page 82 of the 12 treatments. Times between monitoring varied by as much as 72 minutes.</p> <p>5. On 8/24/10 at 9 a.m., Patient 5's record was reviewed and indicated an EDW had been established at 59.5 kg. Twelve treatment records reviewed from 7/29/10 through 8/24/10 revealed Patient 5's target weight was not met and the patient left the facility after six of the treatments weighing between 60.1 and 60.5 kg. There was no assessment why the EDW was not being met or plan to address the issue.</p> <p>6. During an interview with Patient 15 on 8/31/10 at 9:05 a.m. during his treatment, Patient 15 complained of a headache, and the screen on his dialysis machine indicated his blood pressure was 193/96. A review of Patient 15's treatment record at 10 a.m., indicated that Patient 15 was hypertensive during 3.5 hours of his 4 hour treatment that day.</p> <p>Patient 15 had an order for Clonidine to be given as needed for a systolic blood pressure greater than 180 and/or a diastolic blood pressure greater than 110, and the order indicated the medication could be repeated in 30 minutes if still unchanged. Patient 15 started his dialysis treatment at 5:30 a.m. with a blood pressure of 154/89 and at 6:10 a.m. it was 169/87. Patient 15 met the criteria to receive Clonidine at 6:45 a.m. when his blood pressure was 180/89 however, there was no documentation that he received the medication at this time. At 7:20 a.m. Patient 15's blood pressure was 188/93; 190/95 at 8:08; 204/97 at 8:26 a.m.; 199/99 at 9:03 a.m., and 193/96 at 9:14 a.m. Despite continued hypertension during the three hour period of time, the patient was not assessed and medication to</p>	V 543			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 543	Continued From page 83 treat the hypertension was not administered until 9:35 a.m.	V 543			
V 562	494.90(d) POC-PT/FAMILY EDUCATION & TRAINING The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that two unsampled patients were trained on care of their access sites, including infection prevention. Both patients failed to wash their access sites prior to treatment. Findings: During an observation on 8/23/10 at 10:03 a.m., Patient 17 and Patient 18 entered the treatment area, passed the sink designated for patients to wash their access sites and went to their dialysis stations for treatment. Staff on the treatment floor did not stop and remind the patients to wash their access sites prior to treatment. Patient 18 was interviewed on 8/31/10 at 11:02 a.m.. When questioned about the observation, Patient 18 indicated he felt no need to wash his access site before treatment because he showers	V 562		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 562	Continued From page 84	V 562			
V 625	<p>in the morning before he comes to the facility.</p> <p>494.110 CFC-QAPI</p> <p>This CONDITION is not met as evidenced by: Based on a review of the facility's Quality Assessment and Performance Improvement (QAPI) program and interview, it was determined that the facility failed to implement a QAPI program and the Condition of Participation for Quality Assessment and Performance Improvement was not met. The facility failed to:</p> <p>Implement an effective, data-driven QAPI program with participation of the professional members of the IDT. (refer to V 626).</p> <p>Implement an ongoing program to achieve measurable improvement in health outcomes and reduction of medical errors by reviewing indicators, trending outcomes and developing an improvement plan when indicated. (refer to V 627)</p> <p>Measure, analyze and track quality indicators to monitor the improvement of care in the facility. (refer to V 628)</p> <p>Review data, identify factors affecting adequacy of dialysis, identify opportunities for improvement and track progress to maximize the number of patients who achieve goals for adequate dialysis. (refer to V 629)</p> <p>Identify opportunities for improvement and track progress of patients' nutritional status, mineral metabolism, renal bone disease and anemia management, to maximize the number of patients</p>	V 625		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 625	<p>Continued From page 85</p> <p>who achieve goals in these areas. (refer to V 630, V 631 and V 632)</p> <p>Identify opportunities for improvement and track the progress of efforts to reduce the use of catheters and incidence of infections related to catheter use. (refer to V 633)</p> <p>Identify, review and trend medical errors and injuries to minimize the number of occurrences and limit the number of patients and staff adversely affected by occurrences. (refer to V 634)</p> <p>Monitor patient satisfaction and investigate grievances to identify opportunities to improve care. (refer to V 636)</p> <p>Analyze and track the incidence of infection, identify trends, develop plans to minimize transmission of infection, promote immunization and reduce incidents, to ensure the safety of patients. (refer to V 637)</p> <p>Continually monitor performance, and develop, implement, review and revise improvement plans as indicated to ensure improvement is sustained. (refer to V 638)</p> <p>Identify all areas needing improvement and give priority to performance improvement activities that affect clinical outcomes or patient safety. (refer to V 640)</p> <p>Have a plan in place to identify and immediately correct problems posing a threat to the health and safety of patients. (refer to V 640)</p> <p>The cumulative effect of these systemic</p>	V 625			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 625	Continued From page 86	V 625			
V 626	<p>deficiencies resulted in the facility's inability to ensure that dialysis patients were provided with quality healthcare in a safe environment.</p> <p>494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL</p> <p>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 CMS.</p> <p>This STANDARD is not met as evidenced by: Based on record review, review of facility policy and procedure, and interview, the facility failed to implement a Quality Assessment and Performance Improvement (QAPI) program through its professional members. The only QAPI committee meeting minutes presented for review were for a meeting in January 2010.</p> <p>Findings:</p> <p>The facility's policy and procedure titled, "Quality Improvement and Facility Management Meeting Process" dated 12/08 was reviewed and indicates, "Quality Improvement meetings are normally conducted monthly, but no less than</p>	V 626		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 626	Continued From page 87 quarterly."	V 626			
V 627	<p>The facility's QAPI program plan was reviewed on 8/31/10 at 8:45 a.m., and QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that no QAPI committee meetings have taken place since the facility changed ownership in April 2010.</p> <p>494.110(a)(1) QAPI-ONGOING;USES INDICATORS=IMPROVEMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement an ongoing program to achieve measurable improvement in health outcomes and reduction of medical errors by reviewing indicators, trending outcomes and developing an improvement plan when indicated.</p> <p>Findings:</p> <p>The facility's policy and procedure titled, "Quality Improvement and Facility Management Meeting Process" dated 12/08 was reviewed and indicates, "Quality Improvement meetings are normally conducted monthly, but no less than quarterly."</p> <p>The facility's policy and procedure, "Continuous</p>	V 627		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 627	Continued From page 88 Quality Improvement Program", revised 9/08, was also reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 627			
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS 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:	V 628		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 628	Continued From page 89 Based on record review and interview, the facility failed to measure, analyze and track quality indicators to monitor the improvement of care in the facility. Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance..." During a review of the facility's QAPI program on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 628			
V 629	494.110(a)(2)(i) QAPI-INDICATOR-ADEQUACY OF DIALYSIS The program must include, but not be limited to, the following: (i) Adequacy of dialysis. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to review data, identify factors affecting adequacy of dialysis, identify opportunities for improvement and track progress to maximize the number of patients who achieve goals for adequate dialysis. Findings:	V 629		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 629	Continued From page 90 The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis During a review of the facility's QAPI program on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 629			
V 630	494.110(a)(2)(ii) QAPI-INDICATOR-NUTRITIONAL STATUS The program must include, but not be limited to, the following: (ii) Nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify opportunities for improvement and track progress of patients' nutritional status, to maximize the number of patients who achieve goals in this areas. Findings:	V 630		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 630	Continued From page 91 The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status..." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 630			
V 631	494.110(a)(2)(iii) QAPI-INDICATOR-CKD-MBD The program must include, but not be limited to, the following: (iii) Mineral metabolism and renal bone disease. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify opportunities for improvement and track progress of patients' mineral metabolism, renal bone disease, to maximize the number of patients who achieve goals in this areas. Findings:	V 631		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 631	Continued From page 92 The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was also reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease..."	V 631			
V 632	494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify opportunities for improvement and track progress of patients' anemia management, to maximize the number of patients who achieve goals in these areas.	V 632		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 632	Continued From page 93 Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management..." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 632			
V 633	494.110(a)(2)(v) QAPI-INDICATOR-VASCULAR ACCESS The program must include, but not be limited to, the following: (v) Vascular access. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify opportunities for improvement and track the progress of efforts to reduce the use of catheters and incidence of infections	V 633		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 633	Continued From page 94 related to catheter use. Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access.." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 633			
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	V 634		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 634	Continued From page 95 failed to identify, review and trend medical errors and injuries to minimize the number of occurrences and limit the number of patients and staff adversely affected by occurrences. Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 634			
V 636	494.110(a)(2)(viii) QAPI-INDICATOR-PT SATIS & GRIEVANCES The program must include, but not be limited to, the following:	V 636		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 636	Continued From page 96 (viii) Patient satisfaction and grievances. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to monitor patient satisfaction and investigate grievances to identify opportunities to improve care. Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 636			
V 637	494.110(a)(2)(ix) QAPI-INDICATOR-INF	V 637		11/8/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 637	<p>Continued From page 97 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-</p> <p>(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 and interview, the facility failed to analyze and track the incidence of infection, identify trends, develop plans to minimize transmission of infection, promote immunization and reduce incidents, to ensure the safety of patients. Findings:</p> <p>The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states in part, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal</p> <p>During a review of the facility's QAPI program</p>	V 637			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 637	Continued From page 98	V 637			
V 638	<p>plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.</p> <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE</p> <p>The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to continually monitor performance, and develop and implement plans and review and revise the plans as indicated to sustain improvement.</p> <p>Findings:</p> <p>The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional</p>	V 638		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 638	Continued From page 99 status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 638			
V 639	494.110(c) QAPI-PRIORITIZING IMPROVEMENT ACTIVITIES The dialysis facility must set priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes or patient safety. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to identify all areas needing improvement and give priority to performance improvement activities that affect clinical outcomes or patient safety. Findings: The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient	V 639		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 639	Continued From page 100 safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 639			
V 640	494.110(c) QAPI-QAPI-IMMEDIATELY CORRECT ANY IJ ISSUES The facility must immediately correct any identified problems that threaten the health and safety of patients. This STANDARD is not met as evidenced by: Based on interview, the facility failed to have a plan in place to identify and immediately correct problems posing a threat to the health and safety of patients. Findings: The facility's policy and procedure titled, "Quality Improvement and Facility Management Meeting Process" dated 12/08 was reviewed and	V 640		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 640	Continued From page 101 indicates, "Quality Improvement meetings are normally conducted monthly, but no less than quarterly." The facility's policy and procedure, "Continuous Quality Improvement Program", revised 9/08, was also reviewed and states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to the following: patient safety including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, review of deaths, hospitalizations and emergency ambulance transfers, patient satisfaction and grievances." During a review of the facility's QAPI program plan on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 640			
V 684	494.140(b)(1) PQ-NURSE MANAGER-12 MO RN+6 MO DIALYSIS (1) Nurse manager. The facility must have a nurse manager responsible for nursing services in the facility who must- (i) Be a full time employee of the facility; (ii) Be a registered nurse; and	V 684		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 684	Continued From page 102 (iii) Have at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis. This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure the nurse manager responsible for nursing services in the facility had 6 months of experience in providing nursing care to patients on maintenance dialysis. Findings: During the initial tour of the facility starting on 8/23/10 at 8:18 a.m., the FA introduced herself to the survey team as the FA and nurse manager for the unit. When questioned about her nursing background, she indicated that she was hired by the organization, approximately six weeks earlier, and had no previous experience caring for dialysis patients.	V 684			
V 696	494.140(f) PQ-H2O TREATMENT SYSTEM TECHS TRAINING Technicians who perform monitoring and testing of the water treatment system must complete a training program that has been approved by the medical director and the governing body. This STANDARD is not met as evidenced by: Based on observation, interview and review of employee records, the facility failed to ensure that two employees (PCT 2 and PCT 3) who worked in the water treatment area completed an approved training program. There was no documentation of training and competency verification related to the water treatment system in the employees' records.	V 696		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 696	<p>Continued From page 103</p> <p>Findings:</p> <p>In an interview on 8/23/10 at 2:12 p.m., PCT 2 indicated that he normally works Monday, Wednesday and Friday, and usually takes care of the water treatment area and bicarbonate mixing area. He indicated that he was trained by the former owners of the facility.</p> <p>On 8/23/10 at 3:00 p.m., the RBMT and the BMT were interviewed. The BMT indicated that he comes to the facility two days one week, one day the following week, and covers a total of three facilities in the area. The RBMT and BMT indicated that the PCT staff handle the water testing on a daily basis. The BMT also indicated that when the water test is being completed, staff performing the testing need to make sure that they rinse the water test collection container three times before starting the test.</p> <p>PCT 3 was interviewed on 8/25/10 at 11:20 a.m., and indicated that he works on Tuesday, Thursday and Saturday and usually takes care of the water treatment and bicarbonate mixing area on the days that he works. He indicated that was taught by the corporation how to perform duties related to the water treatment area.</p> <p>On 8/25/10 at 11:20 a.m., PCT 3 was asked to perform the water testing in the water treatment area. The testing was also observed by the BMT. During the observation, PCT 3 obtained the testing supplies and obtained water samples from the ports. PCT 3 did not rinse the water test collection container three times prior to starting the test, and when he obtained the water sample, the color of the water was a light shade of</p>	V 696			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 696	Continued From page 104 lavender. PCT 3 proceeded with the testing without recognizing that he failed to rinse the water test collection container. The testing was stopped at the point when PCT 3 was supposed to add a chemical to the water that would turn water lavender. In an interview concurrent with the observation, the BMT concurred that PCT 3 failed to perform the water testing procedure correctly. The employee records for PCT 2 and PCT were reviewed on 8/31/10 at 9:00 a.m., and did not contain any documentation that the employees had completed an approved training program that included quality testing, risks/hazards of improper concentrate and bacterial issues. The Regional BMT and BMT concurred.	V 696			
V 712	494.150(a) MD RESP-QAPI PROGRAM Medical director responsibilities include, but are not limited to, the following: (a) Quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on record review, facility document review, and interview, the facility failed to ensure the medical director assumed operational responsibility for the QAPI program, including reviewing quality indicators related to improved patient health outcomes, monitoring data on a continual basis, educating facility and medical staff in QAPI objectives, prioritizing improvement projects, encouraging staff participation in achieving QAPI goals, maintaining communication with the governing body regarding the needs identified by QAPI, and evaluating the effectiveness of performance improvement activities.	V 712		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 712	Continued From page 105 Findings: The facility's policy, "Medical Director Qualifications and Responsibilities", revised 9/09, was reviewed and indicates, "The Medical Director is responsible for the delivery of patient care and outcomes in the facility. Medical Director responsibilities include, but are not limited to, The Quality Assurance (QA)/Quality Improvement (QI) program. Staff education, training, and performance. Participation in the development, periodic review, and approval of the patient care policies and procedures for the facility. Complying with all federal, state, and local laws, including the Conditions for Coverage." The facility's policy titled, "Quality Improvement and Facility Management Meeting Process", revised 12/08, states, "Quality Improvement meetings are normally conducted monthly, but no less than quarterly." The facility's policy titled, "Continuous Quality Improvement Program", revised 9/08, states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited, to the following: Patient Safety, including review of sentinel events, review of trends of adverse patient occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls, Infection control, including incidence of infections, vaccination rates for Hepatitis B, Influenza, and Pneumococcal, adequacy of dialysis, nutritional status, mineral metabolism, renal bone disease, anemia management, vascular access, growth and capacity, mortality, hospitalizations and	V 712			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 712	Continued From page 106 emergency ambulance transfers, patient satisfaction and grievances, other indicators as reflected in the Quality Improvement and Facility Management Meeting minutes form." During a review of the facility's QAPI program on 8/31/10 at 8:45 a.m., QAPI committee meeting minutes were requested for review. The only minutes provided were from a meeting in January 2010. There was no evidence that the QAPI committee was meeting monthly or at least quarterly, that quality indicators related to improved patient health outcomes were reviewed, that data was monitored on a continual basis or that the effectiveness of performance improvement activities was evaluated. In an interview concurrent with the review, the DCS verified that there have been no QAPI committee meetings since the facility changed ownership in April 2010.	V 712			
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on record review , it was determined that the timing of entries in the electronic medical records of 4 of 5 sampled patients (Patients 1, 2, 3 and 4) and one unsampled patient (Patient 15) were not accurate. Information on patient flowsheet histories noting the actual time patients	V 726		11/8/10	

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 726	<p>Continued From page 107</p> <p>were placed on and taken off dialysis and the times that blood pressures were taken differed from the times that were entered manually in their records by staff.</p> <p>Findings:</p> <p>The "Flowsheet History" is the actual (real) time stamp of when prescription information, machine setup, vitals, catheter care, pre treatment data collection and assessment, post treatment data collection and assessment, medications and ancillaries are administered, and the intradialytics (patient statistics) are entered into chairsnappy flowsheet.</p> <p>1. On 8/31/10 at 3 p.m., Patient 2's treatment "Flowsheet History" dated 8/9/10 was reviewed. According to the flowsheet, the patient was placed on the dialysis machine at 12:44 p.m. The time documented by staff, however, was 12:35 p.m. According to the flowsheet, the patient received 180 minutes of treatment. According to the times documented by staff, the patient's treatment was 194 minutes. Actual blood pressure times also differed from the times documented by staff by as much as 56 minutes. According to the flow sheet, the patient's blood pressure was taken at 12:44 p.m., 13:05 p.m. and 14:05. However, staff documented that the patient's blood pressure was taken at 12:35 p.m. , 13:27 p.m. and 15:01 p.m.</p> <p>2. On 8/26/10 at 2:30 p.m., Patient 3's treatment "Flowsheet History" dated 8/4/10 was reviewed. According to the flowsheet, the patient was placed on the dialysis machine at 5:56 a.m. and received 180 minutes of treatment. Staff documented however, that the patient was placed</p>	V 726			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 726	<p>Continued From page 108</p> <p>on treatment at 5:45 a.m. and received 210 minutes of treatment. The actual time the patient's blood pressure was taken also differed from the time documented by staff by as much as 43 minutes. According to the flowsheet, the patient's blood pressure was taken at 5:58 a.m., 6:39 a.m., 7:28 a.m., 7:29 a.m. and 8:58 a.m. According to staff documentation, the patient's blood pressure was taken at 5:45 a.m., 6:15 a.m., 6:45 a.m., 7:15 a.m. and 8:15 a.m.</p> <p>3. On 8/31/10 at 3:30 p.m., Patient 5's treatment "Flowsheet History" dated 8/24/10 was reviewed. According to the flowsheet, the patient was placed on dialysis at 4:57 a.m. and received 195 minutes of treatment. However, staff documented the patient was placed on the dialysis machine at 4:53 a.m. and received 203 minutes of treatment.</p> <p>4. On 8/31/10 at 10 a.m., Patient 15's treatment "Flowsheet History" dated 8/31/10 was reviewed. The actual time the patient's blood pressure was taken differed from the times documented by staff by as much as 17 minutes. According to the flowsheet, the patient's blood pressure was taken at 5:34 a.m., 6:11 a.m., 6:46 a.m., 7:21 a.m., 8:09 a.m., 8:43 a.m., 9:06 a.m., and 9:16 a.m. However, the times documented by staff were 5:32 a.m., 6:10 a.m., 6:45 a.m., 7:20 a.m., 8:08 a.m., 8:26 a.m., 9:03 a.m. and 9:14 a.m. The flow sheet also noted that the medication Clonidine was given to the patient at 9:35 a.m., however, time documented by staff was 9:25 a.m.</p> <p>5. On 8/31/10 at 3 p.m., Patient 4's treatment "Flowsheet History" dated 8/24/10 was reviewed and noted that the patient was placed on the dialysis machine at 12:23 p.m., taken off the machine at 4:05 p.m., and received 222 minutes of treatment. However, staff documented the</p>	V 726			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 726	Continued From page 109 patient was placed on the machine at 11:20 a.m., taken off at 3:55 p.m., and received 275 minutes of treatment. The actual time and the documented time the patient's blood pressure was taken were also different. According to the flowsheet history, the patient's blood pressure was taken at 1:35 p.m., however, staff documented that the patient's blood pressure was taken at 1:20 p.m., a difference of 15 minutes. Review of the 8/10/10 "Flowsheet History" noted that Patient 4 was placed on the dialysis machine at 12:04 p.m., taken off the machine at 3:47 p.m. and received 223 minutes of treatment. However, staff documented the patient was placed on the machine at 11:58 a.m., taken off at 3:35 p.m., and received 217 minutes of treatment.	V 726			
V 757	6. On 8/31/10 at 3 p.m., Patient 1's treatment "Flowsheet History" dated 8/6/10 was reviewed. According to the flowsheet the patient was placed on the dialysis machine at 12:53 p.m., and taken off the machine at 3:51 p.m. However, staff documented the patient was placed on the machine at 12:35 p.m. and taken off the machine at 3:35 p.m. The actual time and the documented time the patient's blood pressure was taken were also different. According to the flowsheet history, the actual times the patient's blood pressure was taken were 12:53 p.m., 1:08 p.m., 1:39 p.m., 2:22 p.m., 2:56 p.m., and 2:57 p.m. The times documented by staff, however, were 12:35 p.m., 1:05 p.m., 1:35 p.m., 2:05 p.m., 2:35 p.m. and 3:05 p.m. In an interview concurrent with the review, the FA and DCS concurred with the findings.	V 757		11/8/10	
	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS				

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 757	<p>Continued From page 110</p> <p>The governing body or designated person responsible must ensure that-</p> <p>(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients;</p> <p>This STANDARD is not met as evidenced by: Based on interview and a review of staffing, the facility failed to meet its staffing pattern and ensure sufficient numbers of qualified staff were on duty to meet the care needs of patients during dialysis.</p> <p>Findings:</p> <p>In an interview on 9/23/10 at 9:04 a.m., the FA indicated that staffing for the Tuesday, Thursday and Saturday shifts is one RN and two PCT's. She further indicated the staffing ratio is one PCT for every four patients and one RN for every 12 patients. The FA indicated the RN is responsible for putting patients with central lines on treatment and taking them off, and PCTs monitor the patients once they are on the dialysis treatment machine. In addition, the RN is responsible for administering medications, performing patient assessments, the immediate oversight of the facility, and fills in as a PCT when a PCT is absent.</p> <p>The facility document, "Department Employee for time period 8/1/10 through 8/21/10", was reviewed. According to the document, the facility did not meet its staffing requirements on 8/14/10, 8/17/10 and 8/19/10. On 8/14/10 (Saturday) and</p>	V 757			

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: 052800	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER SANTA PAULA DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 253 MARCH ST SANTA PAULA, CA 93060		
(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 757	Continued From page 111 8/17/10 (Tuesday), there was one RN and only one PCT working on the first shift with ten patients, including two patients with catheters. On Saturday, 8/19/10, there was one RN and only one PCT working on the first shift for ten patients, including 3 patients with catheters.	V 757			
V 770	494.180(g)(3) GOV-TRANSFER AGREEMENT W/HOSP FOR INPT CARE (3) The dialysis facility must have an agreement with a hospital that can provide inpatient care, routine and emergency dialysis and other hospital services, and emergency medical care which is available 24 hours a day, 7 days a week. The agreement must: (i) Ensure that hospital services are available promptly to the dialysis facility ' s patients when needed. (ii) Include reasonable assurances that patients from the dialysis facility are accepted and treated in emergencies. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to maintain a transfer agreement with a hospital to provide inpatient and emergency care including routine and emergency dialysis to its patients when needed. Findings: The facility's transfer agreement with a hospital was requested for review. During an interview on 8/31/10 at 8:45 a.m., the DCS verified the facility does not have a transfer agreement with a local hospital.	V 770		11/8/10	