

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

PRINTED: 10/06/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052893	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2009
NAME OF PROVIDER OR SUPPLIER TEMPLE CITY DIAYSIS FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 9945 LOWER AZUSA ROAD TEMPLE CITY, CA 91780	
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V 000	INITIAL COMMENTS Surveyor: 11683 The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: Rosalinda Ramos, RN, HFEN Sylvia Villaflores, REHS, HFE I Elizabeth Arenas, REHS, HFE I	V 000		
V 111	494.30 INFECTION CONTROL 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: Surveyor: 15727 Based on observation, interview and record review, the facility failed to provide and monitor a sanitary environment to minimize the transmission of infectious agents within the unit. Findings: During an observation on June 17, 2009, from 8:48 a.m.-11:50 a.m., the following was observed: 1. CHT (Certified Hemodialysis Technician) A brought an ExSept first aid antiseptic to Station 5. She proceeded to Station 8 with the same antiseptic. After use, the patient handed the antiseptic to CHT A who proceeded to the nurses' station and placed the antiseptic on top of the table. She then placed gloves on and proceeded to Station 4 with the antiseptic and started to prepare the patient. There was no handwashing observed and no hand gel applied before putting	V 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 111	Continued From page 1 on the gloves. CHT A removed her gloves, put on new gloves and returned to Station 4. There was no handwashing observed and there was no hand gel applied. CHT A placed the antiseptic back on the table in the nurses' station. At the same time, during an interview, the director of nursing stated there should be one antiseptic for each station. 2. CHT B was observed in Station 4. The staff removed gloves and touched the dialyzer and anchored the bloodlines. 3. While reviewing a medical record, a blood pressure cuff protective sleeve was inserted in the plastic containing the face sheet. At the same time, during an interview, CHT C stated the protective blood pressure cuff was single use and should have been discarded. 4. CHT D was observed going to station 6 and turned off the alarm without gloves. He then proceeded to station 7, touched the machine and charted. He proceeded to station 10 and charted with no gloves. 5. CHT D placed the used dialyzer in a plastic container on top of the clean sink counter in front of the microwave. The dialyzer was there for approximately 1 hour and 15 minutes. A review of the facility's policy and procedure entitled Cross Contamination revealed gloves will be changed after contact with each patient. Hands will be washed before and after contact with each patient using an approved bacteriostatic liquid soap.	V 111			
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY	V 113			

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V 113	Continued From page 2 REFERENCE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Surveyor: 14041 Based on observation, interview and record review, the facility failed to ensure the staff consistently removed gloves and washed hands between each patient or station. Findings: On June 26, 2009 between 9:35 a.m. to 9:50 a.m., a patient care technician (PCT 1) was observed in Station 1 (Isolation area). PCT 1 was wearing a white gown open in front and gloves, holding a clipboard and taking the vital signs while the patient was standing. After taking the patient's vital signs, PCT 1 removed his gloves, put on another pair of gloves, and with the white gown still open in front, removed the linen covering the treatment chair in Station 2 (Isolation area), placed it in the large yellow bin, removed the used dialyzer and tubing and discarded them into the large Biohazard bin. Wearing the same pair of gloves with the white gown open in front, PCT 1 removed the linen covering the treatment chair in Station 1, placed it into a large yellow bin, removed the used dialyzer and tubing and discarded them into the large Biohazard bin. PCT 1 changed gloves then proceeded to clean Station 1 and 2 with cloth with bleach solution.	V 113			

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V 113	Continued From page 3 After cleaning Stations 1 and 2 (Isolation areas), PCT 1 removed his gloves, washed his hands and still wearing the same white gown open in front went to Station 6 and proceeded to remove the linen covering the treatment chair, discarded it in the large yellow bin, removed the dialyzer, and bloodline tubing then holding the tubing walked several feet from Station 6 towards the large Biohazard bin. During an interview with PCT 1 on June 26, 2009 at 10:20 a.m., he stated he was taking care of the patients in the Isolation area. PCT 1 stated he must remove gloves and wash hands before leaving the isolation area. PCT 1 stated the gown was open in front because it was hot and he was not aware he had to change gown. During an interview with the director of nursing (DON), she stated the staff must wear the yellow isolation gown when in the isolation area. The DON stated the PCT did not have to walk towards the large Biohazard bin, the tubing must be discarded in the Biohazard container in each station.	V 113			
V 117	A review of the Protocol for Hepatitis B indicated, "Yellow isolation gown will be utilized." 494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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	V 117			

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V 117	<p>Continued From page 4 handled.</p> <p>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.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation, interview and record review, the facility failed to ensure that the multi-dose vial medications were dated and initialed when first opened. The facility failed to ensure that there were no expired medications along with the current medications in use, the medications should not be accessible to unauthorized persons in the facility, and that a dedicated medication preparation area was used to prevent cross contamination of clean area.</p> <p>Findings:</p> <p>1. On June 15, 2009, at approximately 8 a.m., RN 2 was observed preparing medications in the Nurses Station 1. There were contaminated bottles of Except First Aid Antiseptic, box of tapes, boxes of syringes and blood pressure cuffs. The nurses station was also used by the staff members at times to document and review the patient charts. In an interview with the director of nursing (DON), she stated that the facility had a dedicated medication preparation</p>	V 117			

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V 117	Continued From page 5 room, however, the licensed nurses were not using it. The DON was aware of the issue of cross contamination issue when having the medication preparation in the nurses station. 2. On June 18, 2009, at approximately 7:50 a.m., during the medication storage observation, the following was noted: a. In the medication room, there was a vial of Pneumococcal vaccine that was opened and undated. b. In Nurses Station 1, there was a 10 mg/ml bottle of Lidocaine HCL and 1000 USP units/ml bottle of Heparin Sodium opened and undated. Also there were 2 boxes of 0.9% Sodium Chloride bottles and 2 boxes of needles located on top of the table which were accessible to any patient, staff and visitor passing through the nurses station 1. c. In Nurses Station II, there was a bottle of Povidone Iodine with expiration date of November 2007 and a bottle of Perassay 500 (Paracetic Acid Test Strips) with an expiration date of January 2009. d. The Glucometer Control Solution Solution/Strip bottles were opened and undated. The label indicated to discard 90 days after opening. On June 18, 2009, at approximately 11 a.m., in an interview with the clinical manager, she stated that as per facility's policy multi-dose vial medications should be dated and initialed upon opening.	V 117			
V 119	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY	V 119			

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V 119	<p>Continued From page 6 REFERENCE</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility staff member failed to ensure that the patient supplies such as tapes and gauzes used for a particular patient were not being used for another patient or taken back to the supply area to avoid contamination with blood.</p> <p>Findings:</p> <p>On June 15, 2009, at approximately 8:30 a.m., Certified Hemodialysis Technician 1 was observed in Station 4 cutting pieces of tapes.</p> <p>On June 17, 2009, at approximately 7:45 a.m., RN 2 was observed wearing gown, mask and gloves while attending to a patient in station 7. The patient had a right subclavian catheter access site and was wearing a mask. The patient was taken off the hemodialysis machine and the bottle of Exsept antiseptic and a roll tape that was used for the patient was taken back to the nurses station and mixed with other patient supplies.</p> <p>At approximately 8:50 a.m., RN 1, who was observed with wearing a mask, gloves and gown,</p>	V 119			

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V 119	Continued From page 7 was putting a patient on hemodialysis machine in Station 6. The patient was wearing a mask and had a right subclavian catheter access site. After using the bottle of Exsept antiseptic and and a roll of tape on the patient, RN 1 placed the supplies back in the nurses station together with other patient supplies. Surveyor: 14041 Based on observation and interview, the facility failed to ensure that a common supply cart is not used to deliver supplies between stations. Finding: On June 17, 2009, at 10 a.m., the evaluator conducted a survey of the facility and observed Staff 5 exchanging the jugs of bicarbonate at each of the dialysis stations. An interview was held with the Nurse in Charge and she stated that Staff 5 should not be walking between the stations at any time.	V 119			
V 122	494.30(a)(4)(ii) PROCEDURES FOR INFECTION CONTROL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to ensure that the cleaning and disinfection	V 122			

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V 122	Continued From page 8 of contaminated surfaces, medical devices, and equipment were done in accordance with standard infection control precautions. Findings: During observations at different times during the survey, after a dialysis treatment, the staff are observed wiping the machine with a cloth soaked in a disinfectant. However, the staff just lift the clip board and wipe the top of the dialysis machine. The clip board on top of each dialysis machine are not disinfected.	V 122		
V 143	494.30(b)(2) OVERSIGHT [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: Surveyor: 11683 Based on observation and interview, the facility staff failed to demonstrate compliance with the current aseptic technique when dispensing intravenous medications from vials and ampules. Findings: On June 15, 2009, during the medication preparation observation at 8 a.m., RN 2 was noted to be preparing medications in the nurses' station. The licensed staff pulled the top of Hectorol bottle and inserted the needle to draw medication. However, the licensed staff failed to clean the top of the bottle with alcohol prior to	V 143		

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V 143	Continued From page 9 drawing medication. Shortly thereafter, the same licensed staff, took an opened multi-dose vial Epogen, inserted the needle and drew up the medications without cleaning the port with alcohol.	V 143		
V 178	At 10 a.m., interview with RN 2, she stated that she should wipe the top of the bottle prior to drawing medication. 494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 4.1.2 Bacteriology of water: max & action levels Product water used to prepare dialysate or concentrates from powder at a dialysis facility, or to process dialyzers for reuse, shall contain a total viable microbial count lower than 200 CFU/mL and an endotoxin concentration lower than 2 EU/mL The action level for the total viable microbial count in the product water shall be 50 CFU/mL, and the action level for the endotoxin concentration shall be 1 EU/mL. If those action levels are observed in the product water, corrective measures shall promptly be taken to reduce the levels. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on interview and record review, the facility failed to repeat cultures after disinfection for results above the action levels. Findings: A review of laboratory reports on the colony count of water revealed the following results above the	V 178		

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V 178	Continued From page 10 action level greater than 50: 1/14/09 Machine 2 - 70 cfu/ml Machine 17 - 60 2/6/09 Machine 8 - 80 Machine 10 - 70 Machine 1 - 130 Bicarb tank - 120 Machine 19 - 80 Machine 17 - 130 Machine 16 - 70 Machine 15 - 90 Machine 13 - 60 Machine 4 - 110 Machine 3 - 60 3/6/09 Bicarb Tank- 630 Machine 1 -100 Machine 18 -90 Machine 19 -80 Machine 19 -80 Machine 2 - 90 Machine 20 - 120 Machine 4 - 120 Machine 6 - 70 Machine 7 -80 Machine 8 -80 Machine 6 - 90 4/3/09 Machine 5 - 220 Machine 2 - 230 Machine 3 - 250 Machine 18- 80 Machine 17 -60 Machine 16 -120 Machine 13 - 100 Machine 11 - 60 Machine 1 - 110 Machine 4 - 190 Machine 20 - 220 Machine 19 - 60 Machine 8 - 130	V 178		

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V 178	Continued From page 11 Machine 7 - 220 Machine 6 - 150 There was documentation that disinfection was done. However, there was no documentation that repeat cultures were done after disinfection. During an interview on June 18, 2009 at 11:32 a.m., the chief technician stated for cultures 50-200 cfu/ml, disinfection was done but cultures were not repeated. Cultures were repeated after disinfection when the results were above 200.	V 178			
V 180	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 4.3.2.1 Bacteriology of conventional dialysate: max & action limits Conventional dialysate should contain a total viable microbial count lower than 200 CFU/mL and an endotoxin concentration of lower than 2 EU/mL. The action level for the total viable microbial count in conventional dialysate should be 50 CFU/mL and the action level for the endotoxin concentration should be 1 EU/mL. If levels exceeding the action levels are observed in the dialysate, corrective measures, such as disinfection and retesting, should promptly be taken to reduce the levels. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on interview and record review, the facility failed to retest the dialysate after disinfection when levels exceeding 50 cfu/ml were obtained. Findings: A review of the colony count results from January	V 180			

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V 180	Continued From page 12 13, 2009 - May 6, 2009 revealed results exceeding the action level. Disinfection was done. However, the colony counts were not repeated.	V 180		
V 187	At the same time during an interview, the chief technician stated the colony count was not repeated after disinfection. 494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 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: Surveyor: 15727 Based on observation and record review, the facility failed to label the contents of the pipe and direction of flow and the major components of the water system. Findings: During a tour of the water system room on June 15, 2009, from 8:05 a.m.- 8:20 a.m., the following was observed: 1. The pipes were not labelled to indicate the	V 187		

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V 187	Continued From page 13 direction of flow. 2. The major water system components were not labelled as to function, how performance is verified, and what actions to take in the event performance is not within an acceptable range. A review of the Water Treatment Flow Diagram revealed the diagram did not identify valves, sample ports and flow direction.	V 187		
V 190	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution. 5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration. The face of the timers used to control the regeneration cycle should be visible to the user. 6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated. The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in	V 190		

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V 190	Continued From page 14 the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and pistons and clog orifices in the softener control head. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview, and record review, the facility failed to monitor the softener brine tank. Findings: During a tour of the water treatment room on June 15, 2009, at 8:05 a.m., the salt pellets in the brine tank was below the water level. The sign attached to the brine tank read "Keep salt above water level." At the same time during an interview, the certified hemodialysis technician stated he needed to add more salt pellets. The technician was observed adding 3 bags of salt pellets. A review of the facility's policy and procedure entitled Reverse Osmosis System Startup Procedure revealed to keep the salt level above the water level.	V 190			
V 191	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 6.2.4 Softeners: Testing hardness/log Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total	V 191			

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V 191	Continued From page 15 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: Surveyor: 15727 Based on interview and record review, the facility failed to measure the total hardness of the water at the end of each treatment day. Findings: A review of the RO Systems Daily Log from 1/2/09 - 6/19/09 revealed that on 1/2/09/, 1/5/09, 1/16/09, 1/19/09/, 1/21/09,1/23/09, 2/6/09, 2/9/09, 2/11/09, 2/13/09, 2/16/09, 2/18/09, 2/20/09, 2/23/09/, 2/25/09, 2/27/09, 3/2/09, 3/4/09, 3/6/09, 3/9/09, 4/20/09, 4/22/09, 6/15/09 and 6/17/09 there were no measurement of total hardness of the water exiting the water softener that was done at the end of the treatment day (a total of 24 days). During an interview on June 18, 2009, at 11:35 a.m., the chief technician could not explain why the total hardness of the water was not done at the end of the treatment day on the above mentioned dates.	V 191		
V 226	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 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	V 226		

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V 226	Continued From page 16 instructions for mixing the powder with the correct amount of water. If a concentrate mixing system is used, the number of bags or the weight of powder added should be determined and recorded. 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). 6.4.1 Mixing systems: Systems for preparing either bicarbonate or acid concentrate from powder should be monitored according to the manufacturer's instructions. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain records indicating the date, time and person performing the procedure. Findings: During an observation tour on June 15, 2009, at 8:03 a.m., the bicarbonate tank had water at the 30 gallon level. At the same time during an interview, the technician stated he was filling up the tank with water for the bicarbonate mixture. He stated they did not put a label on the tank indicating the date and time of preparation and the person performing the procedure.	V 226			
V 228	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED	V 228			

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V 228	<p>Continued From page 17 BY REFERENCE</p> <p>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.</p> <p>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.</p> <p>Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents.</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to label bicarbonate mixing tank.</p> <p>Findings:</p> <p>During an observation on June 15, 2009, at 8:05 a.m., the bicarbonate mixing tank was not labeled with a date.</p> <p>At the same time during an interview, the technician stated they did not label the tank with</p>	V 228			

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V 228	Continued From page 18	V 228			
V 243	<p>the date of preparation.</p> <p>494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to store bicarbonate jugs in the inverted position.</p> <p>Findings:</p> <p>During an observation tour of the water treatment room on June 18, 2009, at 8:30 a.m., 28 bicarbonate jugs were stored horizontally in a 2 shelf cart.</p> <p>When the director of nursing was requested to open a jug and invert it, the water was observed coming out of the jug.</p> <p>At the same time during an interview, the director of nursing stated the jugs should not have been stored horizontally with the covers in place.</p> <p>A review of the facility's policy and procedure entitled Bicarb Jugs Placement After Washing revealed bicarb jugs after being washed are to be placed on a wire rack for drying. Each wire shelved rack will be lined with a sheet to catch the</p>	V 243			

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V 243	Continued From page 19	V 243			
V 318	draining water. The sheet must be changed each day of operation. 494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1) 8 Physical plant and environmental safety considerations 8.1 Reprocessing area and ventilation The reprocessing area should be designed to suit the operation carried out and maintain acceptable ambient concentrations of harmful substances (see Table 1). The area should be kept clean and sanitary. It may be part of the dialysis treatment area, as long as equipment used is properly designed and vented to meet the requirements for environmental safety (see [AAMI] 8.5). Table 1-OSHA environmental exposure limits (29 CFR 1910, 1 July 1998), except as indicated Substance/material Limits (PEL)a Acetic acid 10 ppm TWAb Chlorine dioxide (syn: chlorine oxide) 0.1 ppm TWA Citric acid None developed Formaldehyde 0.75 ppm TWA 2 ppm STELc(15 min) 0.5 ppm action level Glutaraldehyde 0.2 ppm ceiling NIOSH/OSHA Hydrogen peroxide 1 ppm TWA	V 318			

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V 318	Continued From page 20 Peracetic acid None developed Phenol 5 ppm TWA ppm = parts per million a) PEL (permissible exposure limit) represents the limit of what employees can be exposed to; PELs can be TWAs or STELs. b) TWA (time-weighted average) represents the limit of what an employee can be exposed to in an eight-hour period. c) STEL (short-term exposure limit) represents the limit of what an employee can be exposed to in any 15-minute time period. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to keep the reprocessing area clean and sanitary. Findings: During an observation of the reprocessing area on June 15, 2009, at 7:55 a.m., and on June 18, 2009, 8:40 a.m., the following was observed: 1. There was a damaged section of the wall between the reprocessed dialyzer storage and the designated clean area. 2. The designated clean area had dusty walls and counter tops. 3. Under the sink, there were brown stained towels. 4. The ceiling vent had an accumulation of dust. During an interview on June 18, 2009, at 8:40 a.m., the director of nursing stated the reprocessing area should be kept clean.	V 318		

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V 318	Continued From page 21	V 318			
V 320	<p>A review of the facility's daily reuse checklist from 1/1/09 - 6/16/09 revealed to maintain reuse room in a neat and clean manner. It was checked out as done. However, based on the observations this was not done by staff.</p> <p>494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE</p> <p>8.4 Personnel protection: gear Personnel shall wear durable gloves and protective clothing when handling the dialyzer during initiation and termination of dialysis and during the reprocessing procedure. Standard Precautions shall be observed. Personnel shall wear eye protection when performing steps that may result in spills or splashes of substances of known or suspected toxicity. These agents shall be handled only in areas with adequate ventilation, washing facilities, eyewash stations, appropriate respirators, and spill control materials. When personnel are handling concentrated toxic substances, they shall wear aprons impervious to these substances.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation, interview and record review, the facility failed to provide a handwashing sink and an eyewash station in the reuse room.</p> <p>Findings:</p> <p>During an observation tour of the reuse room on June 15, 2009, at 7:55 a.m., there was no eyewash station and no handwashing sink provided.</p> <p>During an interview on June 15, 2009, at 1:40</p>	V 320			

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V 320	Continued From page 22	V 320			
V 334	<p>p.m., the reuse technician stated there was no eyewash station or handwashing sink in the reuse room.</p> <p>494.50(b)(1) AAMI RD47:2002/A1:2003 ADOPTED BY REFERENCE</p> <p>11.4.1.2 Dialyzer header cleaning and disinfection The cleaning and disinfection of the header space should be done only when necessary and only before the dialyzer is reprocessed. The manufacturer's instructions should be followed. Header caps and O-rings shall be kept with their respective dialyzers.</p> <p>If the header cap is removed to clean the header space, cleaning shall be done with water meeting the requirements of these regulations related to allowable bacterial and endotoxin levels.</p> <p>Once the O-ring and the header cap are cleaned and before they are reassembled at the end of the dialyzer, they should be disinfected. The disinfectant shall not be rinsed and shall be allowed to remain on the dialyzer components as they are reassembled. If any cracking of the header occurs, the process should be evaluated.</p> <p>If the header space is cleaned with the header cap in place, it is necessary to ensure that the end of the fiber bundle is not damaged. If water is used, it shall meet the requirements of these regulations.</p> <p>If automated equipment is used, the manufacturer's instruction for use shall be followed.</p> <p>This STANDARD is not met as evidenced by:</p>	V 334			

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V 334	Continued From page 23 Surveyor: 15727 Based on observation and interview, the facility staff failed to disinfect the header cap of the dialyzer. Findings: During an observation of reprocessing on June 15, 2009, at 1:40 p.m., the reuse technician was observed removing the header of a dialyzer during the cleaning process. After removing the blood clots from the fibers, he proceeded to reassemble the header cap at the end of the dialyzer. He did not disinfect the header cap. At the same time during an interview, the reuse technician was not aware he had to disinfect the header cap prior to reassembling.	V 334			
V 401	494.60 PHYSICAL ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain a safe and comfortable environment. Findings: During a tour of the facility on June 15, 2009, from 7:15 a.m.- 8:45 a.m., the following was observed: 1. In the parking lot, the biohazard enclosure had an accumulation of dust and debris under the	V 401			

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V 401	<p>Continued From page 24</p> <p>wooden pallets.</p> <p>2. In the waiting room, the chairs had stains.</p> <p>3. Under the sink between stations 7 and 8, there was a plastic container with an accumulation of green and white deposits.</p> <p>During an interview on June 18, 2009, at 8:05 a.m., the director of nursing stated the pipe had a leak and the plastic container should have been removed after the pipe was fixed.</p> <p>4. There was a water stained ceiling panel above the nurses' station in front of station 17.</p> <p>5. In the reuse room, there was a section of the wall that was damaged. The counter top and the wall was dusty in the clean area. Under the sink, there were brown stained towels. Milk crates were used to store the Renalin (3 piles of 4 boxes high for each pile.</p> <p>6. In the water treatment room, there was a leaking pipe above the booster pump. The wall above the booster pump was damaged. The wooden pallet storing the bags of salt pellets was severely damaged. There was a pool of water around the pallet. The rubber tubing attached to the water outlet marked "R.O. Water" was touching the sink surface.</p> <p>At the same time during an interview, the certified hemodialysis technician stated that was the sink they used to rinse and wash the bicarbonate jugs.</p> <p>7. In the water treatment room, there were 4 water stained ceiling panels. The cart and the jugs used for the bicarbonate mix had white deposits on the surfaces.</p> <p>8. In the supply room, the floor had an accumulation of dust and debris. Two floor tiles had holes measuring approximately 2 inches x 2</p>	V 401			

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V 401	<p>Continued From page 25</p> <p>inches. In the area above the water heater, the ceiling tile was water stained and bulging.</p> <p>9. In the soiled linen room, the floor was dusty with gloves and gauze on the floor.</p> <p>10. In the biomed room, the sink was not accessible for handwashing. There was a telephone directory, boxes and a glass cylinder stored in the sink.</p> <p>11. In the treatment area, there were 3 water stained ceiling tiles.</p> <p>12. In the clean sink between station 7 and 8, there were 8 empty bags of sodium chloride.</p> <p>During an interview on June 18, 2009, at 8:05 a.m., the director of nursing stated the staff should discard the empty sodium chloride bags and not leave them in the clean sink.</p> <p>13. In the laboratory area, there was a missing ceiling tile. There was a water stained bulging ceiling tile.</p> <p>During an observation on June 18, 2009, from 7:30 a.m.- 8:05 a.m., the following was observed:</p> <p>14. The trash containers were placed on top of the base of the 14 dialysis machine in stations 1, 2, 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, and 18.</p> <p>At the same time, during an interview, the chief nursing officer stated the trash containers should not have been placed on top of the base of the dialysis machines. She stated the janitorial services they have contract with will be told about it.</p> <p>There were no patients on this day.</p> <p>15. In the water treatment room, 28 empty jugs for bicarbonate concentrate were stored</p>	V 401		

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V 401	Continued From page 26 horizontally in a 2 shelf cart. There was water left in the jugs.	V 401			
V 403	494.60(b) EQUIPMENT MAINTENANCE The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Surveyor: 15727 Based on observation and interview, the facility failed to maintain the chairs in the waiting room. Findings: During an observation on June 15, 2009, at 7:15 a.m. and on June 18, 2009, at 7:50 a.m., the chairs in the waiting area were observed to have stains. During an interview on June 18, 2009, at 8 a.m., the director of nursing stated the chairs needed to be cleaned.	V 403			
V 407	494.60(c)(4) PATIENT CARE ENVIRONMENT 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: Surveyor: 11683 Based on observation and interview, the facility	V 407			

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V 407	Continued From page 27 staff failed to ensure the patients access sites were visible during hemodialysis treatments. Findings: On June 15, 2009, at approximately 7:40 a.m., during the tour of the treatment area, the patients' access sites were not visible in stations 5, 10 and 12. At 2:30 p.m. during observation rounds, it was noted that the patients' access sites were not visible in stations 1, 4, 5, 6, 11 and 16. On June 17, 2009, at approximately 7:30 a.m., it was observed that patients' access sites were not visible in stations 3, 4, 5, 6, 7, 8, 12 and 14. At 9:05 a.m. during observation rounds, it was noted that the patients' access sites were not visible in stations 1, 5, 10, 13, 15 and 18. At 11:15 a.m., the patients' access sites were not visible in stations 1, 6, 7, 13, 14 and 15. The facility staff members were observed passing by the patients without reminding the patients that their access sites should be visible while receiving treatments. On June 17, 2009, at approximately 1 p.m., during an interview with the clinical manager, she stated that access sites should be visible during treatments.	V 407			
V 412	494.60(d)(2) EMERGENCY PREPAREDNESS The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Surveyor: 14041 Based on observation, interview, and record	V 412			

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V 412	Continued From page 28 review, the facility failed to provide documentation that all patients were oriented and trained in case of an emergency. Finding: The evaluator conducted a review of the Medical Records and the records were incomplete in regards to the patients being prepared for an emergency. A review of the policy and procedure stipulated that if a patient requiring assistance, it would be identified by a red flag "Patient Needs Assistance" and should be assisted by the staff to clamp and cut the blood lines from the Dialyzer Machines. The evaluator observed several patients were weak or non-ambulatory and were not capable of disconnecting themselves in case of an emergency. The evaluator did not observe any of the patients "flagged" at the time of the survey. An interview was held with the charge nurse and she stated that the staff know which patients need assistance.	V 412			
V 413	494.60(d)(3) EMERGENCY PREPAREDNESS 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: Surveyor: 11683 Based on observation and interview, the facility staff failed to ensure that the emergency	V 413			

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V 413	Continued From page 29 equipment such as emergency cart, portable oxygen tank and suction machine were secured, functional and readily available for use. Findings: On June 15, 2009, at approximately 8:25 a.m., during the emergency equipment/supplies check, with RN 1, the following was noted: 1. The emergency cart was found to be opened. In an interview with RN 1, she stated that the emergency cart should be locked at all times. A review of the facility's policy on crash cart integrity and inventory stipulated that a plastic breakable crash cart lock should be used to secure the cart. 2. The portable oxygen tank listed in the emergency cart was found to have 1/4 full. According to the facility's policy on emergency cart, the oxygen tank should be greater than 50 % full. 3. The suction machine was found to be dusty. RN 1 was requested to demonstrate the use of the suction machine, starting from attaching the tubing to various ports. The licensed staff turned on the machine, placed the Yankauer on a container with water and water spurted out instead of going through the canister. An interview with RN 1 indicated that she got nervous and the attachments/tubings were not properly placed. The last preventive maintenance done on the machine was November 2007 as indicated on the side of the machine.	V 413			
V 415	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] Evaluate at least annually the effectiveness of the	V 415			

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V 415	Continued From page 30 emergency and disaster plans and update them as necessary; This STANDARD is not met as evidenced by: Surveyor: 14041 Based on observation and interview, the facility failed to provide documentation that the effectiveness of the emergency and disaster plans were reviewed annually. Finding: The evaluator conducted a survey of the facility and requested documentation regarding emergency and disaster plans including the drills. An interview was held with the director of nursing and she stated that there was no evidence or documentation of actual emergency drills conducted with the facility staff and that the effectiveness of the emergency and disaster plans were reviewed at least annually.	V 415			
V 416	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency. This STANDARD is not met as evidenced by: Surveyor: 14041 Based on interview, the facility failed to contact its local disaster management agency at least annually in the event of an emergency.	V 416			

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V 416	Continued From page 31	V 416			
V 454	<p>Finding:</p> <p>On June 19, 2009, during the survey, the evaluator interviewed director of nursing regarding documentation that the facility had contacted its local disaster management agency at least annually in the event of an emergency. The director of nursing stated that she has no documentation at this time.</p> <p>494.70(a)(3) PATIENTS' RIGHTS</p> <p>[The patient has the right to-] (3) Privacy and confidentiality in all aspects of treatment;</p> <p>This STANDARD is not met as evidenced by: Surveyor: 11683 Based on observation and interview, the facility failed to provide privacy for one of 10 sampled patients (Patient 10).</p> <p>Findings:</p> <p>During observation on June 17, 2009, at approximately 11:35 a.m., Patient 10 was observed seating on a chair by station 1. The certified hemodialysis technician (CHT) prepared the patient's tubing and access site to start the treatment. The CHT failed to provide privacy curtain while he started to cleanse and cannulate on the patient's access site which was located on her right upper thigh. During treatment, the patient's access site was not visible as the patient was fully covered with a blanket from neck down. At the termination of hemodialysis treatment, the CHT again failed to provide privacy curtain when</p>	V 454			

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V 454	Continued From page 32 the patient was being taken off from hemodialysis treatment.	V 454			
V 503	494.80(a)(2) ASSESSMENT CRITIERIA [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: Surveyor: 11683 Based on observation, interview and record review, the facility staff failed to ensure that physician's orders were being followed for Patients 1 and 2, failed to obtain a physician's order for Patients 2 and 9 prior to administering Tylenol medication for temperature of 100 and above and oxygen therapy, failed to assess Patient 3's access site was assessed at the time of discharge and failed to take Patient 3's blood glucose reading every week as ordered. Findings: 1. Patient 1 was admitted to the facility on September 12, 2007, with diagnoses that included end stage renal disease, hypertension	V 503			

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V 503	<p>Continued From page 33</p> <p>and diabetes mellitus. The patient had a permacath on the left upper chest as his access site. However, he has an AV fistula access as well but had not mature yet. On January 19, 2009, there was a physician's order for Blood Flow Rate (BFR) of 300 and blood glucose check every week.</p> <p>A review of the daily hemodialysis treatment records dated May 11, 25 and 29, 2009 through June 5, 8, 12, and 15, 2009, revealed that the blood flow rate was documented 350. The daily hemodialysis record failed to show documentation that the blood glucose was being taken every week as ordered. An interview with the DON on June 18, 2009, at 9 a.m., while reviewing the clinical record, revealed there was no documented evidence to indicate the reason why the prescribed BFR was not being followed.</p> <p>2. Patient 2 was admitted to the facility on April 6, 2007, with diagnoses that included hyperkalemia with end stage renal disease and diabetes mellitus.</p> <p>A review of the daily hemodialysis treatment record dated May 29, 2009, revealed the patient had a temperature of 101.4 Fahrenheit (F) and was administered Tylenol 650 mg. On June 5, 2009, the hemodialysis record documented that the patient had a temperature of 100.1 (F) and was administered Tylenol 650 mg. Further review of the clinical record failed to show a physician's order for Tylenol to be administered when patient had a temperature of 100.1 (F) and above.</p> <p>On June 18, 2009, at approximately 10 a.m., interview with the DON, while reviewing the clinical record, the DON agreed that there was no</p>	V 503			

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V 503	<p>Continued From page 34</p> <p>physician's order for Tylenol to be administered to Patient 2.</p> <p>3a. According to the admission record, Patient 3 had diagnoses that included diabetes mellitus and hypertension. A review of Patient 3's daily hemodialysis record dated February 27, 2009 through June 15, 2009, failed to show that the patient's blood glucose was checked prior to receiving hemodialysis treatments. The clinical record revealed that on January 19, 2009, there was a physician's order to take blood glucose reading every week.</p> <p>On June 17, 2009, at approximately 10 a.m., during an interview with the DON, while reviewing the clinical record, the DON agreed that there was no written documentation that the blood glucose test was being done as ordered on a weekly basis.</p> <p>3b. Patient 3 was a resident in a SNF and had a right subclavian catheter access site. A review of the nurses dialysis communication record between the SNF and dialysis center dated May 6, 8 and 11, 2009, failed to show documentation that Patient 3's access site was assessed at the time of discharge. This concern was pointed out to the DON and the DON stated that it would be addressed.</p> <p>4. Patient 9 was admitted to the facility on September 15, 2008, with diagnoses that included end stage renal disease, diabetes mellitus and hypertension.</p> <p>On June 17, 2009, at approximately 8:50 a.m., Patient 9 was observed in Station 13 receiving hemodialysis treatment. The patient had 2. 5</p>	V 503			

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V 503	Continued From page 35 liters of oxygen via nasal cannula. A review of the hemodialysis treatment record that day revealed the patient was receiving 2 liters of oxygen via cannula. However, there was no documentation to indicate the use of oxygen.	V 503			
V 504	An interview with Patient Care Technician (PCT) 1, he stated that the patient was on oxygen for shortness of breath. Further review of the clinical record failed to show documentation that there was a physician's order for oxygen use. 494.80(a)(2) ASSESSMENT CRITERIA [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: Surveyor: 11683 Based on record review and interview, the facility staff failed to ensure that Patient 1 was consistently assessed and re-assessed when the blood pressure readings were not within normal levels prior to, during, and post hemodialysis treatments. Findings: Patient 1 was admitted to the facility on September 12, 2007, with diagnoses that included end stage renal disease, hypertension and diabetes mellitus. On January 19, 2009, there was a physician's order to administer Clonidine 0.1 mg if the patient's systolic blood pressure (SBP) was greater than 190 or diastolic blood pressure (DBP) was greater than 100 and	V 504			

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V 504	Continued From page 36 notify the physician. A review of the daily hemodialysis treatment record revealed the blood pressure readings prior to, during and post dialysis treatments on the following dates: Date 5/25/09 217/137 190/100 5/20/09 206/118 195/112 5/11/09 221/145 201/120 5/04/09 170/105 202/115 4/15/09 188/130 201/123 On June 18, 2009, at approximately 10 a.m., interview with the DON, while reviewing the clinical record, the DON stated that there was no documentation to indicate that the licensed nurse was assessing the patient during hypertensive episode, administered the medication as ordered, and notified the physician.	V 504			
V 541	494.90 PATIENT PLAN OF CARE The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by:	V 541			

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V 541	<p>Continued From page 37</p> <p>Surveyor: 11683</p> <p>Based on record review and interview, the interdisciplinary team failed to develop an individualized care plan that involved the patient as well as the nursing home staff who were responsible for Patient 3's needs and care.</p> <p>Findings:</p> <p>Patient 3 was admitted to the facility on November 13, 2006, with diagnoses that include end stage renal disease, hypertension and diabetes mellitus. The patient received hemodialysis treatment twice a week for 3 hours every treatment. The patient's access was a right subclavian catheter. Patient 3 was a resident in a skilled nursing home.</p> <p>On June 17, 2009, at approximately 10 a.m., interview with the DON while reviewing the clinical record failed to show any documentation to indicate that an interdisciplinary care plan was developed and coordinated with the skilled nursing home to address the various needs of Patient 3. Also there was no other written evidence or communication to indicate that the skilled nursing home was involved in the care needs of the patient such as his diet, medications, new orders and transportation to name a few.</p> <p>A review of the written contract between the dialysis facility and the skilled nursing facility (SNF) stipulated the development and implementation of patient's plan of care would be done by the SNF in coordination with the dialysis facility. Also it stipulated a communication between the contracting parties to communicate issues and/or concern related to the management</p>	V 541			

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V 541	Continued From page 38 of dialysis treatment such as diet, fluid restrictions and medications.	V 541						
V 545	494.90(a)(2) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the interdisciplinary team failed to provide documentation to indicate necessary care and counseling services to achieve the required albumin level for an effective nutritional status for the patient. Findings: Patient 3 had been admitted to the facility on November 13, 2006, with diagnoses that included end stage renal disease, hypertension and diabetes. A review of the patient's laboratory values revealed the following: <table border="1" style="margin-left: 40px;"> <tr> <td>Month</td> <td>Result</td> </tr> <tr> <td>May 18, 2009</td> <td>3.3</td> </tr> </table>	Month	Result	May 18, 2009	3.3	V 545		
Month	Result							
May 18, 2009	3.3							

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052893	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/19/2009
NAME OF PROVIDER OR SUPPLIER TEMPLE CITY DIAYSIS FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 9945 LOWER AZUSA ROAD TEMPLE CITY, CA 91780		
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V 545	Continued From page 39 April 24, 2009 3.0 March 23, 2009 3.3 February 23, 2009 3.4 The normal value for Albumin was between 3.5 to 5 mg/dl and the goal for chronic kidney disease patient was greater than 4.0. The patient's laboratory results for Albumin for 4 months was below the normal values. On June 17, 2009, at 10 a.m., interview with the registered dietitian (RD) while reviewing the clinical record failed to show documentation that low albumin levels was addressed.	V 545			
V 546	494.90(a)(3) DEVELOPMENT OF PATIENT PLAN OF CARE [The plan of care must address, but not be limited to, the following:] Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the facility failed to follow physician order for Hectorol (Vitamin D Analogue- use for management of secondary hyperparathyroidism in patients undergoing long-term renal dialysis) which was necessary care to manage mineral metabolism and prevent or treat renal bone disease. Findings:	V 546			

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V 546	Continued From page 40 Patient 3 was admitted to the facility on November 13, 2006, with diagnoses that included end stage renal disease, hypertension and diabetes mellitus. On January 19, 2009, the physician ordered Hectorol as per protocol. The laboratory result of the PTH (parathyroid hormone) level for January 19, 2009, was 108.2 and for April 24, 2009, was 54.2. On January 17, 2009, at 10 a.m., interview with the DON, while reviewing the Hectorol Dosing Protocol and Patient 3's daily hemodialysis record revealed that on February 27, 2009, and March 13, 2009, the patient did not receive the required dosage of 5 mcg of Hectorol on those days as per protocol. On May 6, 2009, the patient received 6 mcg of Hectorol when the patient should not be given a dose at that time.	V 546			
V 561	494.90(c) TRANSPLANTATION REFERRAL TRACKING The interdisciplinary team must- (1) Track the results of each kidney transplant center referral; (2) Monitor the status of any facility patients who are on the transplant wait list; and (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status. This STANDARD is not met as evidenced by: Surveyor: 11683 Based on record review and interview, the interdisciplinary team failed to keep a tracking system of monitoring and communicating to Patient 1 regarding transplant center referral.	V 561			

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V 561	Continued From page 41 Findings: On June 17, 2009, at approximately 7 a.m., during review of Patient 1's clinical record revealed that a Life Plan (Long Term Program) Evaluation was completed on September 12, 2007, by the interdisciplinary team. It was noted in the Life Plan that the patient wanted to be evaluated for a transplant/referral to a transplant center. On June 18, 2009, at 1 p.m., interview with the social worker, while reviewing the clinical record, the social worker agreed that there was no documentation to indicate that the issue of transplant referral/evaluation had been further discussed with the patient.	V 561			