

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

PRINTED: 02/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380	
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V 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a RECERTIFICATION SURVEY. The census on the day of the survey was 58. Representing the California Department of Public Health: Juanita Glick, HFEN, and Patti Tomko, HFEN	V 000		
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, staff interview, and policy review, the facility failed to ensure that staff changed gloves and washed hands between patients, dirty and clean equipment, and dirty and clean supplies resulting in the possibility of cross contamination from one patient to another. Findings: 1. During observations on 8/9/10 at 12:30 p.m., Certified Hemodialysis Tech (CHT) Staff E picked up several small items and scraps of paper from the floor with gloved hands. Staff E placed one of the items, a pen cap, on the chair side table of the patient sitting at Station 7. She threw the other items into the trash. Without removing gloves, cleansing hands or putting on new gloves, Staff E lifted up the blanket of the patient sitting at Station	V 113		8/22/10

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

TITLE

(X6) DATE

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

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V 113	<p>Continued From page 1</p> <p>6, pressed the buttons on the patient's dialysis machine, then removed a blood pressure cuff from the patient's arm. Staff E removed her gloves and, without cleansing her hands, picked up another small item off of the floor, threw it in the trash and typed data on the chairside keyboard located between Stations 5 and 6. Without cleansing hands, Staff E put on new gloves and assisted a patient out of the dialysis unit.</p> <p>During an observation on 8/9/10 at 12:41 p.m., Staff E prepared the access site for the patient sitting at Station 8. Staff E then removed her gloves, and without cleansing her hands, put on new gloves and touched the buttons on the dialysis machine of the patient sitting at Station 7. Staff E then removed her gloves and without cleansing, put on new gloves and continued to prepare the access site for the patient who sat at Station 8. At 12:46 p.m., Staff E removed her gloves and without cleansing her hands, typed information in the chairside computer between Station 7 and 8. Without cleansing her hands, Staff E then put on new gloves and removed caps from the access site of the patient sitting at Station 7.</p> <p>During an observation on 8/9/10 at 1 p.m., Staff E, with gloved hands, used cleansing wipes to wipe off a dialysis machine and chair in between patients. Staff E removed her gloves, and without cleansing her hands reached into the supply cart located near Station 8 and obtained a new patient dialysis kit. Without cleansing hands, Staff E put on new gloves and brought a walker to the patient sitting at Station 7. Staff E removed her gloves and without cleansing hands, put on new gloves and assisted the patient sitting at Station 7 out of</p>	V 113			

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V 113	<p>Continued From page 2 the dialysis unit.</p> <p>At 1:15 p.m., Staff E went to the sink, turned on the water, applied soap to her hands and ran her hands together under the faucet for approximately two second before drying her hands.</p> <p>During an interview on 8/9/10 at 2:10 p.m., Staff E stated the policy was to change gloves and wash hands between patients and stated hands should be washed or cleansed with hand sanitizer after removing gloves and between glove changes. Staff E stated she put the pen cap on the tray table of the patient sitting at Station 7 because the patient would have been upset if she threw the cap away. Staff E stated she should have sanitized the pen cap prior to placing it on the tray table and stated she should have cleansed her hands after picking up items from the floor.</p> <p>2. During an observation of medication pass on 8/10/10 between 7:40 a.m. and 8:05 a.m., Licensed Staff C placed bags of individually prepared syringes of intravenous medications at each station for the six patients who received dialysis in Treatment Area 3. Licensed Staff C dropped one of the bags of medications on the floor. After picking up the dropped medication bag from the floor, Licensed Staff C placed the contaminated bag of medications in the patient's dialysis station. Without changing gloves or cleansing hands, Licensed Staff C continued to place the rest of the medication bags in the individual dialyses stations.</p> <p>Without changing gloves or cleansing hands, Licensed Staff C proceeded to administer the intravenous medications to each of the six patients who received dialysis in Treatment Area</p>	V 113			

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V 113	<p>Continued From page 3</p> <p>3. Licensed Staff C touched the buttons on each patient's dialyses machine, touched the blood tubing and medication ports of each patient to administer the intravenous medications. In addition, at one point during the medication pass, Licensed Staff C responded to an alarming machine at another station, touched the buttons on the alarming machine and went back to the previous station to complete the medication pass. Licensed Staff C did not change gloves or cleanse hands during the entire medication pass.</p> <p>During an interview on 8/10/10 at 3:30 p.m., Licensed Staff C stated the policy was to remove gloves and cleanse hands in between each patient, when moving from one dialyses station to another and after contamination of gloves or hands. Licensed Staff C stated he had just realized he did not change gloves during the medication pass and stated he should have. Licensed Staff C stated when he dropped the medication bag on the floor he should have changed the contaminated gloves and cleansed his hands and placed the medication in a clean bag prior to placing the bag at the patient's dialysis station.</p> <p>3. During observation on 8/11/10 at 10:30 a.m., CHT Staff D removed the used dialysis tubing from the dialysis machine at Station 14 and disposed of it in the trash can. Staff D then moved to the bleach cart and without changing gloves or washing hands, Staff D took cloths from the cart and dunked them into the container of disinfecting solution. Staff D went back to Station 14 and wiped down the dialysis machine with the damp cloths.</p> <p>During an observation on 8/11/10 at 11:59 p.m.,</p>	V 113			

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V 113	<p>Continued From page 4</p> <p>CHT Staff D, with gloved hands, carried a used clamp (used to clamp off a patient's blood lines during dialysis) to the "bleach cart" located in Treatment Area 3. Staff D used his gloved hand to open the lid of the container that held dirty clamps and dropped the used clamp into the container. Without removing his gloves or cleansing his hands, Staff D took clean paper cloths and dipped them into the container of bleach solution sitting next to the container of dirty clamps and took them back to the dialysis station to clean the station.</p> <p>4. During an observation on 8/11/10 at 12:01 p.m., CHT Staff G, with gloved hands, carried a used clamp to the Treatment Area 3 bleach cart and dropped the used clamp in the bleach container of dirty clamps. Without removing her gloves or cleansing hands, Staff G reached into the bleach container with several paper cloths to moisten them then placed them on top of the dirty clamp container while she attended to an alarming machine in the adjacent treatment area.</p> <p>5. On 8/12/10, review of the policy titled, "Infection Control for dialysis Facilities," revised 3/10, documented that hand hygiene was to be performed prior to gloving, after removal of gloves, after contamination with blood or infectious material, after patient and dialysis delivery system contact, between patients even if the contact was casual, before touching clean areas such as supplies and before leaving the patient care area. If hands were not visibly contaminated, use of an alcohol-based hand rub may be substituted for handwashing. Gloves would be worn when caring for the patient or touching the patient's equipment at the dialysis station and administering medications. Staff</p>	V 113			

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V 113	Continued From page 5 would remove gloves and wash hands or perform hand hygiene between each patient and/or station. Gloves should be changed when going from a "dirty" area or task to a "clean" area or task; 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.	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: Based on observation, staff interview, and document review, the facility failed to: 1. Maintain stainless steel sinks in a clean condition, and 2. Designate which sinks in the treatment area were to be used as hand washing sinks ("clean" sinks) and which were to be used for discarding waste ("dirty" sinks) resulting in the possibility of cross contamination. Findings: 1. During the initial tour on 8/9/10 at 12:10 a.m., the stainless steel sink in the treatment area had a collection of chalky debris built up around the faucet and down the sides of the sink. The sink was designated as a, "clean" sink to be used for handwashing. During concurrent interview, Administrative Staff A stated that the sink had	V 114		8/22/10	

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V 114	Continued From page 6 hard water deposits and stated that the contracted housekeeper was responsible for cleaning the sink. Staff A agreed that the sink, with the current layer of hard water deposits, did not appear clean and she could not be sure that the sink had been thoroughly cleaned. 2. During observation on 8/9/10 at 2:15 p.m., there were 3 white porcelain sinks in the treatment. At one of the sinks located near Station 1 there was an intravenous (IV) solution bag draining. Licensed Staff B went to the sink and washed hands over the draining IV bag. There was no sign near the sink to indicate whether it was a designated, "clean" sink or a designated, "dirty" sink. During observation on 8/11/10 at 12:10 p.m., there were two IV bags draining in a sink near Station 15. A sign on the wall above the sink indicated, "soiled area." Staff were observed washing hands at the sink. During interview on 8/11/10 at 10:30 p.m., Admin Staff A stated that the staff should not be using the sinks for both "clean" and "dirty" activities. Review of facility policy titled, "Infection Control for Dialysis Facilities," dated March 2010, indicated under Facility Hygiene, "...Hand washing sinks should be dedicated only for hand washing purposes and remain clean. Avoid placing, cleaning or draining used items in hand washing sinks. Used or contaminated items should be handled in designated utility sinks."	V 114			
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the	V 117		8/22/10	

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V 117	<p>Continued From page 7</p> <p>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.</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: Based on observation, staff interview, and document review, the facility failed to maintain designated clean areas holding cleaning supplies separate from designated dirty where used equipment was collected resulting in the potential for cross contamination.</p> <p>Findings:</p> <p>During observation on 8/9/10 at 1:00 p.m., there were two, "Bleach Carts" in the treatment area. On the top shelf of each cart, located side by side, there were two plastic bins. One bin contained a clear liquid and was labeled as a bleach solution for disinfection. The other bin contained a clear liquid and had blue plastic clamps soaking in it. (The blue clamps were</p>	V 117			

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V 117	<p>Continued From page 8</p> <p>used to clamp patient blood lines during treatment.) On the second shelf of the cart were stacks of white paper cloths.</p> <p>During observation on 8/11/10 at 10:30 a.m., CHT Staff D removed the used dialysis tubing from the dialysis machine at Station 14 and disposed of it in the trash can. Staff D then moved to the bleach cart and without changing gloves or washing hands, Staff D took cloths from the cart and dunked them into the container of disinfecting solution. Staff D went back to Station 14 and wiped down the dialysis machine with the damp cloths.</p> <p>During an observation on 8/11/10 at 11:59 p.m., CHT Staff D, carried a used blue clamp to the, "Bleach Cart" located in Treatment Area 3. Staff D opened the lid of the container and dropped the used clamp into the container. Without removing his gloves or cleansing his hands, Staff D took clean paper cloths and dipped them into the container of bleach solution sitting next to the container of dirty clamps and took them back to the dialyses station to clean the station.</p> <p>During an observation on 8/11/10 at 12:01 p.m., CHT Staff G, with gloved hands, carried a used clamp to the Treatment Area 3 bleach cart and dropped the used clamp in the bleach container of dirty clamps. Without removing her gloves or cleansing hands, Staff G reached into the bleach container with several paper cloths to moisten them then placed them on top of the dirty clamp container while she attended to an alarming machine in the adjacent treatment area.</p> <p>Review of facility policy titled, "Infection Control for dialysis Facilities," dated March 2010,</p>	V 117			

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V 117	Continued From page 9 indicated, "Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled." During interview on 8/11/10 at 10:30 a.m., Admin Staff A agreed that the bin containing the contaminated clamps should not be placed on the same cart with the clean cloths and cleaning solution.	V 117			
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [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: Based on observation, staff interview, and document review, the facility failed to ensure that staff followed facility procedure for cleaning the dialysis station chairs, equipment, and contaminated counter tops resulting in the possibility of cross contamination. Findings: 1. During an observation on 8/9/10 at 1 p.m., a CHT was cleaning the treatment station in preparation for the next patient. When cleaning the treatment chair the CHT cleaned the top of the chair cushion but did not lift the cushion to clean the other side of the cushion, the bottom of the chair seat, or wipe down the exterior of the	V 122		8/22/10	

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V 122	<p>Continued From page 10</p> <p>chair. Additionally, the CHT did not clean the television.</p> <p>During an observation on 8/11/10 at 12:10 p.m., a CHT was cleaning treatment station 15. The CHT cleaned the top of the chair cushion but did not lift the cushion to clean under it or to clean the other side of the cushion. The CHT also did not clean the exterior of the chair or the television.</p> <p>During the same observation period, CHT D cleaned station 14. CHT D removed the tubing from the dialysis machine and put it in the trash container, then without changing gloves, obtained a cleaning cloth from the container of disinfectant and wiped the front of the dialysis machine. CHT D did not clean the drainage bucket attached to the machine, did not wash the IV pole attached to the machine, and did not remove the used blue clamps from the IV pole. Additionally, CHT D did not clean the television.</p> <p>2. During interview on 8/11/10 at 4:15 p.m., CHT D stated that he was aware that the entire chair inside and out was to be cleaned but stated that the staff, "couldn't always do it." CHT D stated that he was confused about the drainage bucket on the machine and wasn't sure when it was supposed to be cleaned. CHT D couldn't remember if the clamps were supposed to be changed by the CHTs or the nurses. The CHT stated that the disinfectant container should be entered only with "clean" gloves and was aware that he had been wearing "dirty" gloves when he dipped a hand into the disinfectant solution.</p> <p>3. Review of the facility policy titled, "Infection Control for Dialysis Facilities," indicated under, "Facility hygiene," that, "Equipment including the</p>	V 122			

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V 122	<p>Continued From page 11</p> <p>dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices...television arms and control knobs...IV poles, as well as all work surfaces will be wiped clean with a bleach solution ...before being used by another patient."</p> <p>4. During interview on 8/12/10 at 9 a.m., Admin Staff L stated that she was responsible for observing staff behavior once a month to identify non compliance with handwashing and cleaning procedures. Staff L had forms with lists of activities to be observed. The identify of the staff was sometimes included and sometimes not. Staff L stated that the information gained from the observations was shared with staff at staff meetings by Admin Staff A. Staff L stated that she was not tracking specific staff for performance improvement.</p> <p>During an observation on 8/11/10 at 11:50 a.m., a large tool box with various tools inside was opened on the counter in the nurse's station in the treatment area. The outside of the tool box had a thin layer of visible dust and gray spots. There was no barrier between the counter top and the tool box to prevent contamination of the counter. Bio Med Staff F worked on a dialysis machine at Station 5 while the patient received dialysis. Bio Med Staff F returned a tool to the tool box, closed it and placed it on the floor and rolled the tool box out of the treatment area. Bio Med Staff F did not clean the nurse's station counter after removing the contaminated tool box. Observation of the treatment area between 11:50 a.m. to 12:35 p.m. revealed staff did not clean the nurse's station counter after removal of the tool box.</p>	V 122			

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V 122	Continued From page 12 During an interview on 8/12/10 at 3:40 p.m., Administrative Licensed Staff A stated Bio Med Staff F should not have made repairs to the dialysis machine during treatment. Staff A stated it was not appropriate for the tool box to be brought into into the dialysis treatment area and it should not have been placed on the nurse's station counter.	V 122			
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, staff interview, and policy review, the facility failed to ensure that staff practiced aseptic technique by changing gloves and washing hands between patients, during the administration of intravenous medications, resulting in the potential for cross contamination between patients. Findings: During an observation of medication pass on 8/10/10 between 7:40 a.m. and 8:05 a.m., Licensed Staff C placed bags of individually prepared syringes of intravenous medications at each station for the six patients who received dialysis in Treatment Area 3. Licensed Staff C dropped one of the bags of medications on the floor. After picking up the dropped medication bag from the floor, Licensed Staff C placed the	V 143		8/22/10	

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

PRINTED: 02/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
(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	<p>Continued From page 13</p> <p>contaminated bag of medications in the patient's dialysis station. Without changing gloves or cleansing hands Licensed Staff continued to place the rest of the medication bags in the individual dialyses stations.</p> <p>Without changing gloves or cleansing hands Licensed Staff C proceeded to administer the intravenous medications to each of the six patients who received dialysis in Treatment Area 3. Licensed Staff C touched the buttons on each patient's dialyses machine, touched the blood tubing and medication ports of each patient to administer the intravenous medications. In addition, at one point during the medication pass, Licensed Staff C responded to an alarming machine at another station, touched the buttons on the alarming machine and went back to the previous station to complete the medication pass. Licensed Staff did not change gloves or cleanse hands between any of the patients during the entire medication pass.</p> <p>During an interview on 8/10/10 at 3:30 p.m., Licensed Staff C stated the policy was to remove gloves and cleanse hands in between each patient, when moving from one dialyses station to another and after contamination of gloves or hands. Licensed Staff C stated he had just realized he did not change gloves during the medication pass and stated he should have. Licensed Staff C stated when he dropped the medication bag on the floor he should have changed the contaminated gloves and cleansed his hands and placed the medication in a clean bag prior to placing the bag at the patient's dialysis station.</p> <p>During an interview on 8/12/10 at 3:40 p.m.,</p>	V 143			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
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V 143	Continued From page 14 Administrative Licensed Staff A stated staff needed to change gloves and cleanse hands during medication pass anytime staff went from one patient to another, or touched lines or machines, or anytime gloves become contaminated. On 8/12/10, review of the policy titled, "Infection Control for dialysis Facilities," revised 3/10, documented that gloves should be changed when going from a "dirty" area or task to a "clean" area or task; 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.	V 143			
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 an independent method before starting the treatment of the next patient. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure staff followed the manufacturer specifications for monitoring of pH / conductivity when the solutions used to verify calibration of the Phoenix meter (used to test the dialysis machine's pH/conductivity) were expired resulting in the potential for injury to patients if improper dialysate was not accurately detected. Findings:	V 250		8/12/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
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V 250	Continued From page 15 During an observation on 8/9/10 at 3:55 p.m., with Bio Med Staff F, a bottle of opened 14.0 Conductivity Solution was located on the sink counter near the nurse's station. The bottle had an opened date of 7/2/10. During a concurrent interview, Staff F stated the manufacture guidelines are to discard the solution 30 days after opening. Staff F stated staff should not use that bottle for calibrating the Phoenix meter and stated it needed to be thrown away. An opened 32 ounce bottle of 7.0 pH solution was also on the counter. The hand written "opened" date documented it was opened on 1/4/10. The printed expiration date on the bottle was 3/27/10. Staff F stated the manufacturer guidelines were to discard that solution 90 days after opening and that it should have been discarded prior to the expiration date. He stated staff should have noticed that the bottle was expired and should have obtained a new bottle. On 8/9/10, review of the policy titled, "Phoenix Meter Disinfection and Calibration Verification," revised 9/09, documented to use unexpired 14 mS Conductivity Standard and unexpired 7 pH buffer solution. When a new bottle of conductivity or pH solution was opened, place a label with the date opened on the bottle. Follow manufacturer's labeling for the solution for expiration dates. Procedures included to confirm that the conductivity standard and pH buffer solution expiration dates have not been exceeded as outdated solutions may give inaccurate results and must not be used.	V 250			
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE	V 401		9/17/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
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V 401	<p>Continued From page 16</p> <p>ENVIRONMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to ensure that the medication refrigerators were locked at all times resulting in the potential for tampering and theft.</p> <p>Findings:</p> <p>Observation during the initial tour on 8/9/10 at 12:30 a.m., revealed that the medication area was a small counter and cabinet space located across from a larger counter used for charting and computer work. There was no medication refrigerator in the medication area.</p> <p>A doorway adjacent to the medication area opened into a large conference room. The conference room had a second doorway at the end of the room. Located in the conference room was the medication refrigerator which contained multiple boxes of injectable Epogen (Epogen is a medication used to increase the production of red blood cells.) There was a lock on the refrigerator but the lock was open. Observation of the refrigerator throughout the day on 8/9/10 revealed that it remained unlocked all day.</p> <p>During interview on 8/10/10 at 8:15 a.m., Licensed Staff B stated that staff knew the nurses were supposed to lock the refrigerator but did not</p>	V 401			

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

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V 401	Continued From page 17 always do so. Staff B stated that non licensed staff used the conference room and that, although the conference room door was often left open, she could not see the refrigerator and could not see who was in the room. During interview on 8/11/10 at 10:30 a.m., Admin Staff A stated that Epogen was expensive and could be a theft item because of it's potential use by athletes. Staff A acknowledged that the refrigerator should remain locked. Observation of the offices on 8/10/10 at 10:00 a.m., revealed that there was a small refrigerator located in the dietician's office that contained ampules of Epogen and a box of injection needles. During concurrent interview Admin Staff A stated that the office was used by a physician on two days a week and that the refrigerator belonged to the physician, not the clinic. Therefore the clinic was not responsible for monitoring the refrigerator. Staff A acknowledged that patients and staff have free access to the offices and could get into the refrigerator unobserved. Staff A agreed that the refrigerator should be locked. Review of facility policy titled, "Medication Policy," dated March 2010, indicated that, "All refrigerated medications, for example Epogen and vaccines are to be locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations."	V 401			
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:	V 503		9/4/10	

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V 503	<p>Continued From page 18</p> <p>(2) Evaluation of the appropriateness of the dialysis prescription,</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure that assessment of the patients' dialysis treatments identified that dialysis flow rates and blood flow rates were inaccurately set or different from the physician's ordered rates. (Dialysis flow rate is the rate at which the dialysate solution runs through the system in milliliters [ml] per minute. Blood flow rate is the rate at which the blood flows through the system in ml per minute. Changes in flow rates alters the amount of water and waste products removed from the blood and could potentially negatively impact the patient's therapy outcome.</p> <p>Findings:</p> <p>1. Flow rates: Clinical Post Treatment records reviewed on 8/10/10, revealed the following:</p> <p>a. Patient 3 received dialysis through a central venous catheter inserted into the vein in the upper chest area. Dialysis Post Treatment records dated 7/2/10 indicated that the physician's order for DFR was 500 ml/min and for BFR was 300 ml/min. At 4:52 a.m., Licensed Staff C documented that the patient's treatment was started at a DFR of 800 ml/min and a BFR of 350 ml/min. There was no documentation of why the flow rates were changed from what the physician had ordered.</p> <p>A CHT performed an assessment of the patient's treatment at 6 a.m., and documented that the flow</p>	V 503			

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V 503	<p>Continued From page 19</p> <p>rates were DFR 800 ml/min and BFR 350 ml/min. At 6:30 a.m., a second CHT documented that the flow rates were the same. At 7 a.m., a third CHT documented that the DFR was 800 ml/min but the BFR was now 300 ml/min. There was no documentation of why the change in the BFR was made.</p> <p>The DFR remained at 800 ml/min through four additional assessments until treatment ended at 8:57 a.m. There was no documentation explaining why the DFR continued at a rate other than what was ordered by the physician.</p> <p>On 7/5/10 the treatment record indicated that the physician's order remained DFR 500 and BFR 300. Licensed Staff C documented that treatment started at 4:47 a.m. at a DFR of 800 and a BFR of 350. There was no documentation explaining the change in rates.</p> <p>Two different CHTs assessed the patient at 5:30 a.m. and 6 a.m. Both documented that the DFR was 800 and the BFR was 350. At 6:30 a.m. a third CHT assessed the patient and documented that the DFR was now 500 and the BFR was now 300. The rates continued unchanged to the completion of treatment at 8:57 a.m. There was no documentation explaining why the rate was changed.</p> <p>The treatment record dated 7/28/10 indicated that Patient 3 was receiving dialysis through an arteriovenous graft (AVG) in the left upper thigh. (An AVG is a surgically created access site used for dialysis treatments.) The physician's order for DFR was 500 and BFR was 300.</p> <p>A CHT documented that Patient 3's treatment</p>	V 503			

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

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V 503	<p>Continued From page 20</p> <p>started at 4:54 a.m. at a DFR of 800 and a BFR of 200. At 5:30 a.m. the CHT documented that the BFR was changed to 300. The DFR was still 800. At 6 a.m. a second CHT documented that the BFR was 450 and the DFR was now 500. There was no documentation in the nursing notes to explain the changes to the rates.</p> <p>On 8/9/10 the treatment record indicated that the order for DFR was 700 and the BFR was 450. Licensed Staff C started the patient's treatment at a DFR of 800 and a BF of 350. There was no documentation of why the rates were different than those ordered by the physician.</p> <p>b. Patient 2's treatment record dated 7/6/10 indicated that the Physician's order for DFR was 600 ml/min. At 10:08 a.m., Licensed Staff C documented that the dialysis treatment was started at a DFR of 800 ml/min. The CHT documented assessments every 30 mins at 10:30 a.m., 11 a.m., 11:30 a.m., 12 p.m., 12:30 p.m., 1 p.m., and 1:24 p.m. Each time the CHT documented that the DFR was 800 ml/min. There was no documentation in the record to explain why the rate was increased from the rate ordered by the physician.</p> <p>c. Patient 6's treatment record dated 7/2/10 indicated that the patient's DFR order was 700 ml/min. The Staff G documented that the DFR was set at 800 ml/min at the start treatment at 9:30 a.m. At 10:10 a.m., Staff G documented that the patient had shortness of breath and the blood pump was decreased per licensed staff. There was no documentation that addressed why the DFR was not set as ordered.</p> <p>Licensed Staff I documented at 10:24 a.m. that</p>	V 503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
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V 503	<p>Continued From page 21</p> <p>the patient felt better and that the BFR was reset to the ordered BFR of 450 ml/min. The DFR remained set at 800 ml/min. There was no documentation that Licensed Staff I noted the DFR was not set per order.</p> <p>At 10:30 a.m., CHT Staff J noted that the patient watched television and the DFR remained set at 800. There was no documentation that Staff J noted the DFR was not set at the ordered rate. The DFR remained at 800 for the duration of dialyses treatment from 9:30 a.m. to 12:30 p.m. There was no documentation why the DFR was not set per order or of communication with the physician for an order change.</p> <p>The treatment record, dated 7/7/10, indicated Patient 6's DFR order remained 700 ml/min. The Patient Statistics section documented that treatment started at 9:30 a.m. Staff D documented that the DFR at 9:30 a.m. and 10 a.m. was set at 800. At 10:30 a.m., Licensed Staff K documented that the DFR was 700. There was no documentation related to the incorrect DFR or the adjustment.</p> <p>The treatment record dated 7/9/10, indicated that Patient 6's DFR order was 700 ml/min. Staff D documented on the Patient Statistics section that the DFR was set at 800 for the duration of dialysis treatment from 9:08 a.m. to 12:09 p.m. At 11:11 a.m., Staff F checked on the patient, but did not note that the BFR was not set at the ordered rate. There was no documentation why the DFR was not set per order or communication with the physician for an order change.</p> <p>d. During interview on 8/11/10 at 10:30 a.m., Admin Staff A stated that the dialysis machines</p>	V 503			

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NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
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V 503	Continued From page 22 have a default DFR rate of 800 ml/min and that Staff setting up treatments must enter the DFR rate manually if it differs from 800 ml/min. Staff A stated that it appeared that staff did not set the computer correctly and acknowledged that staff performing the assessments should have identified that the DFR did not match the order. Staff A stated that some changes in BFR are a result of changes in the patents's blood pressure readings and that depending on the access site, the BFR may not always be reached. Staff A acknowledged that the variations from the ordered DFR and BFR should have been explained in the assessment notes.	V 503			
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 staff interview, and record review, the facility failed to ensure that staff accurately documented: 1. Heparin dosages that reflected the physician's orders and, 2. Notification of the registered nurse (RN) when patients had significant changes in blood pressure. This has the potential for the care needs of the dialysis patients not to be met. Findings: 1. Heparin: Review of Post Treatment clinical records on 8/10/10 revealed the following:	V 726		9/4/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 552528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
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V 726	<p>Continued From page 23</p> <p>a. The record dated 7/14/10 indicated that Patient 1 received dialysis through an arteriovenous fistula (AVF) located in the left arm. (An AVF is a surgically created access site for hemodialysis treatment.) The physicians's orders included a Heparin maintenance dose of 2250 units to run at 1000 units per hour. (Heparin is a blood thinning agent that reduces the risk of clotting during the dialysis treatment. A maintenance dose is given automatically by a syringe pump that is part of the dialysis machine. The concentration of Heparin is 1000 units per 1 ml. Staff document the amount of Heparin that remains in the pump syringe at the time of each assessment.)</p> <p>CHT D documented on the treatment sheet dated 7/14/10 that Patient 1 started treatment at 1:16 p.m. with a total of 1 ml of Heparin in the pump syringe. There was no explanation in the notes why the total amount was not the 2000 units (2 ml) ordered by the physician. At 2 p.m. CHT G documented that the syringe had 2 ml remaining. At the conclusion of the treatment CHT G documented that the total dose of the Heparin maintenance dose was "2 units" instead of the 2250 units ordered.</p> <p>Review of Patient 1's treatment record dated 7/16/10 indicated that the Heparin maintenance dosage was still 2250 units. At 1:13 CHT G documented that at the start of treatment there was "1.6" ml (1600 units) of Heparin in the syringe (600 units less than the 2250 units ordered.)</p> <p>At 1:45 p.m. a second CHT documented that the amount remaining in the syringe was "2" ml (2000 units). There was no explanation of why the</p>	V 726			

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V 726	<p>Continued From page 24</p> <p>amount had increased. At the completion of treatment at 4:30 p.m. CHT G documented that the patient received "2 units" of maintenance Heparin instead of the 2250 units ordered.</p> <p>The treatment record dated 8/2/10 indicated that the patient started treatment at 1:25 p.m. with "2.25" ml of Heparin in the maintenance syringe. At 4 p.m., one half hour later, the record indicated that there was "0" in the syringe. At 4:30 p.m., after another half hour, the record indicated that there was 0.8 ml in the syringe. At the conclusion of therapy the CHT documented that the patient received "2 units" of maintenance Heparin (not the 2250 ordered).</p> <p>On 8/9/10 the treatment record indicated that Patient 1 started treatment with a maintenance dose of "2250" ml instead of 2.25 ml.</p> <p>b. Patient 2 received dialysis through a CVC. The post treatment record indicated that the maintenance dose of Heparin ordered was 2600 units (2.6 ml) to be delivered at 800 units per hour. The CHT documented that the patient started therapy at 10:49 a.m. with 2 ml of Heparin in the syringe. Licensed Staff documented at the completion of therapy that the patient received 2600 units of maintenance Heparin.</p> <p>The treatment record dated 7/3/10 indicated that the maintenance dose for Heparin was still 2600 units. Licensed Staff B documented that Patient 2 started therapy at 9:23 a.m. with 2 ml (2000 units) of Heparin in the maintenance syringe. Licensed Staff B documented at the completion of therapy that the patient received a total maintenance dose of 2600 units of Heparin.</p>	V 726			

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

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NAME OF PROVIDER OR SUPPLIER TURLOCK DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 50 W SYRACUSE AVENUE TURLOCK, CA 95380		
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V 726	<p>Continued From page 25</p> <p>The treatment record dated 7/10/10 indicated that the maintenance remained 2600 units but that the patient started treatment with "2.2" ml (2200 units) of Heparin in the maintenance syringe. The total maintenance dose delivered was documented as 2600 units.</p> <p>c. Patient 3 received dialysis through an AVG in the left arm. The treatment record dated 7/30/10 indicated that the Heparin maintenance dose was 4000 units to be given at 1000 units per hour. The CHT documented that Patient 3 started therapy at 5:20 a.m. with "3" ml (3000 units) of Heparin in the maintenance syringe. (1000 units less than what was ordered.) Licensed Staff B documented at the conclusion of the treatment that the total maintenance dose of Heparin delivered was "4000 units."</p> <p>d. Patient 4's treatment record dated 6/30/10 indicated the patient had a Heparin maintenance dose order for 1000 units of Heparin to be given at 400 units per hour. The record indicated that the patient began treatment with "2" ml of Heparin at 5:13 a.m., rather than the ordered 1 ml (1000 units).</p> <p>The treatment record dated 7/2/10 indicated that at 12:10 p.m. the patient received "1.2" ml (1200 units) of Heparin. (200 units more than was ordered.)</p> <p>The treatment record dated 7/9/10 indicated "0" heparin was provided at 11:08 a.m. At 12 p.m. the flow sheet documented the patient had "0.8" ml of Heparin remaining. At 2 p.m., the patient had "0.4" of Heparin remaining and at 3 p.m. the patient again had "0.8"ml of Heparin remaining. (The dose remaining should be reduced by 0.4</p>	V 726			

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V 726	<p>Continued From page 26 every hour, per the order).</p> <p>The treatment record dated 7/23/10 indicated that at 11:14 a.m. the patient started dialysis with '2" ml (2000 units) maintenance dose of Heparin. That was 1000 units more than the ordered 1000 units.</p> <p>The treatment record dated 8/4/10 indicated that at 11:48 a.m. at the start of treatment the patient had a maintenance dose of "1.4" ml (1400 units) of Heparin. That was 600 units less than what was ordered.</p> <p>e. Patient 5's treatment record dated 7/5/10 documented the patient's Heparin maintenance order was 900 units, to be given at 400 units per hour. The treatment record indicated that the patient's Heparin dose was "0" throughout the course of dialyses treatment from 9:18 a.m. to 12:36 p.m.</p> <p>The treatment record dated 7/7/10 indicated the patient had "0.4" ml (400 units) of Heparin at the start of treatment at 9:38 a.m. and at 10:30 a.m. the patient had "0.8" ml (800 units) of Heparin remaining. (The documentation should reflect a reduction of Heparin at a rate of 400 units/hour, not an increased amount).</p> <p>Patient 5's treatment record dated 7/23/10 indicated that the patient had '2" ml (2000 units) of Heparin at the start of treatment at 8:51 a.m., rather than the ordered 900 units. At 9:30 a.m., the amount of Heparin remaining was ".8" (800 units) which would have amounted to 1200 units of Heparin given in less than an hour.</p> <p>The treatment record dated 8/4/10 the patient had</p>	V 726			

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V 726	<p>Continued From page 27</p> <p>'2.2" ml (2200 units) of Heparin at the start of treatment at 8:59 a.m., rather than the ordered 900 units (0.9 ml). At 9:30 a.m. the flow sheet indicated that the patient had 1.4 (1400 units) of Heparin remaining, indicating 800 units infused over 30 minutes. The order was for 400 units over an hour. At 11:30 a.m. the patient was documented as having "0.6" ml (600 units) of Heparin left, which would indicate the patient received 1600 units over the course of treatment, rather than the 900 units ordered. Staff documented at the end of treatment that the patient received a total of "0" units of Heparin maintenance dose.</p> <p>The treatment record dated 8/7/10, indicated that the patient started treatment at 6:19 a.m. with "1.2" ml (1200 units) of Heparin maintenance dose. At 7:30 a.m. the patient had "2" ml (2000 units) of Heparin remaining. That was 800 units more than the patient started with. Staff documented in the Medications Administered section that the patient received 900 units of maintenance Heparin infusion.</p> <p>f. Patient 6's treatment record, dated 7/5/10, documented the patient's order for Heparin maintenance was 1000 units to be given at 500 units per hour. Staff documented "0" in the Heparin section as the amount administered hourly for the duration of treatment.</p> <p>g. During an interview on 8/12/10 at 3:30 p.m., Administrative Licensed Staff A stated syringes could not be changed once the treatment was started and therefore, staff would not be able to add Heparin once the dialysis treatment started. Staff A stated that staff should document the amount provided at the beginning of treatment</p>	V 726			

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V 726	<p>Continued From page 28</p> <p>and should document the amount of Heparin that was actually given at each assessment time. The assessment check entries should reflect the correct administration rate. The end of treatment total should reflect the total ordered Heparin maintenance dose.</p> <p>After reviewing the documentation, Admin Staff A acknowledged that there were many errors on the treatment records. Specifically, Staff A acknowledged that documentation that indicated syringes had smaller amounts of Heparin when starting treatment than they had 30 to 45 minutes into the treatment did not make sense. Additionally, Staff A acknowledged that the documentation of the total dose as "2 units" must be an error and should have been written "2000" units. Staff A also noted that staff were not consistent in accurately documenting during the 30 minute assessments the amount of Heparin the patients received throughout dialysis treatment. Staff A stated that the facility was performing audits of treatment sheets but the audits had not included these particular elements of Heparin administration. Staff A stated they needed to be included in future audits.</p> <p>2. BLOOD PRESSURES: Review of Post Treatment clinical records on 8/10/10 revealed the following:</p> <p>a. Patient 4's Kardex, (a summary of the patient's current orders), included orders dated 9/18/07 to notify the physician of any persistent symptoms that included hypertension (high blood pressure), systolic (first number) greater than 180 or diastolic (second number greater than 105 sustained over one hour. The Kardex included a PRN (as needed) order dated 9/18/07, for</p>	V 726			

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V 726	<p>Continued From page 29</p> <p>Clonidine, (a medication used to lower blood pressure), 0.10 milligram (mg) by mouth for blood pressure (B/P) 180/105 sustained for over one hour, may repeat one tablet in 30 minutes.</p> <p>The treatment record dated 7/16/10 documented that Patient 4's B/P at the start of treatment at 11:29 a.m. was 205/107. At 12 p.m. the B/P was 209/98, the note documented that the patient watched television. At 12:30 p.m. the B/P was 219/103, and staff noted that the patient watched television. At 1 p.m. the B/P was 220/99 and staff noted that the patient watched television. At 1:35 p.m. the B/P was 228/108 and staff noted that the patient watched television. At 2 p.m. the B/P was 230/105, and staff noted that the patient watched television. At 2:30 p.m., the B/P was 219/102, and staff noted that patient watched television. At 3 p.m. the B/P was 219/102 and treatment was ended.</p> <p>There was no documentation during the dialysis treatment that the licensed nurse was notified or evaluated the patient's sustained elevated blood pressure or documentation of actions taken. The first documentation of evaluation by a licensed staff was at 3:18 p.m., after treatment had ended. The licensed nurse documented on the post treatment assessment that the patient was instructed to take her blood pressure medications when she went home and that Clonidine (a medication used to lower blood pressure) was offered but the patient stated she would take it at home. The licensed nurse documented that she instructed the patient if there were any problems to go to the emergency room for evaluation.</p> <p>The treatment record dated 7/19/10 documented that Patient 4 had sustained elevated blood</p>	V 726			

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V 726	<p>Continued From page 30</p> <p>pressure that ranged from 214/75 to 216/100 for the duration of dialyses treatment. At the end of treatment at 3:48 p.m., the patient's blood pressure was 221/95. There was no documentation that a licensed nurse was notified of the elevated blood pressure and there was no documentation of actions taken or assessments of the elevated blood pressure or notification of the physician of the sustained high blood pressure.</p> <p>During an interview on 8/11/10 at 1 p.m., Physician H stated that baseline B/P's varied from one dialysis patient to another and also for each single individual. He stated Patient 4's B/P tended to run high and stated that he relied on the licensed staff to conduct a clinical assessment and notify him as needed in response to the patient's symptoms. He stated there should have been documentation in the clinical record that a nurse was notified when the patient's B/P remained elevated and documentation of assessments and action taken.</p> <p>During an interview on 8/12/10 at 3:30 p.m., Administrative Licensed Staff A stated Patient 1 had a history of elevated blood pressures, but stated when the blood pressure remained elevated after an hour there should have been documentation that the licensed staff was notified and the licensed nurse assessment and evaluation and action taken, including notification of the physician.</p> <p>b. Patient 5's Post Treatment record, dated 7/23/10, documented the patient's B/P at the start of treatment at 8:51 a.m. was 117/62. At 9:30 a.m., staff documented the patient's B/P was 81/35 and that the patient's eyes were closed and</p>	V 726			

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V 726	<p>Continued From page 31</p> <p>the patient was "resting comfortably." At 10 a.m. the patient's B/P was 82/30 and the patient,"tolerated treatment well at this time." At 10:30 a.m. the patient's B/P was 86/48. Staff documented, "Eyes Closed Resting Comfortably." There was no documentation of notification of the supervising nurse or actions taken.</p> <p>The Post Treatment record dated 7/30/10 documented the patient's B/P at the start of treatment at 9:04 a.m. was 109/52. At 9:30 a.m. staff documented the patient's B/P was 75/41 and the patient tolerated treatment well. At 10 a.m. and 10:30 a.m. the patient's B/P was 79/37 and 88/48 respectively, and the patient "tolerated treatment." At 11:30 a.m., the patient's B/P was 70/28. The hemodialysis tech documented the patient's B/P was low, but the patient admitted no complaints. At the end of treatment at 12:21 p.m. the patient's B/P was 76/29. There was no documentation that the licensed nurse was notified of the sustained low blood pressures or actions taken.</p> <p>c. During an interview on 8/11/10 at 1 p.m., Physician H stated it was not unusual for Patient 5 to have a low blood pressure during dialyses and stated he expected licensed staff to evaluate the patient's symptoms to determine what action should be taken or if the physician should be notified and stated the flow sheets should document communication between the hemodialyses techs and licensed staff and specific actions taken.</p> <p>d. During an interview and review of Patient 5's record on 8/12/10 at 10:25 a.m., Licensed Staff B stated she usually wanted the hemodialysis techs to notify her if the systolic blood pressure dropped</p>	V 726			

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V 726	<p>Continued From page 32</p> <p>below the 100 or 90 range so she could assess what may be going on and determine if the patient needed saline or a drop in the ultra filtration rate or if notification to the physician was indicated. She stated if staff did not inform her when the patient's vital signs were out of range, she would not know. Licensed Staff B stated the hemodialysis techs were usually pretty good about notifying her of changes in the patient's condition, but they needed to get better at documenting their interventions.</p> <p>e. During an interview and review of Patient 5's record on 8/12/10 at 2:30 p.m., Administrative Licensed Staff A stated there should have been documentation of specific actions taken by staff regarding the patient's low blood pressure, regardless if the patient had a tendency to have low blood pressure. She stated she expected staff to immediately readjust the B/P cuff and recheck the blood pressure if the readings were below or above the normal range. She stated the documentation should reflect those reassessments. Staff A stated when Patient 5's B/P remained low, there should have been documentation of communication with licensed staff and evaluation of the patient and specific actions taken. Staff A stated if the patient was resting with eyes closed when the B/P was low, staff should make sure to awaken the patient and evaluate the patient's level of consciousness. Staff A stated on 7/23/10, the licensed staff who documented some of the low blood pressures was still in orientation and there should have been documentation that the supervising nurse was notified of the patient's low blood pressure, including specific actions taken.</p> <p>f. Patient 2's Post Treatment record dated 7/7/10</p>	V 726			

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V 726	<p>Continued From page 33</p> <p>indicated that the patient's blood pressure at the beginning of treatment at 10:48 a.m. was 144/65. At 2 p.m. the CHT documented that the patient's blood pressure had dropped to 82/28. There was no documentation that the nurse was aware of the drop.</p> <p>The treatment record dated 7/10/10 indicated that at 10:33 a.m., at the beginning of dialysis, Patient 2's blood pressure was 125/55. At 11:01 a.m. the CHT documented that the patient's blood pressure had fallen to 74/32. There was no documentation that the RN was notified.</p> <p>At 11:30 the RN documented that the patient's blood pressure was 91/48 and that the patient was given 200 ml of normal saline.</p> <p>During interview and review of Patient 2's clinical record on 8/11/10 at 10:30 a.m., Administrative Staff A stated that there should have been documentation that the RN was aware of the drop in BP when it first fell at 11:01 a.m., and that preferably the treatment of normal saline should have been given and documented at that time rather than 30 minutes later.</p> <p>The treatment record on 7/20/10 indicated that at 10:08 a.m. when Patient 2 started dialysis, the blood pressure reading was 113/51. At 10:30 a.m. the CHT documented that the blood pressure was 80/41. There was no documentation that the RN was made aware of the drop in BP or that the RN assessed the patient.</p> <p>During interview and review of Patient 2's clinical record on 8/11/10 Staff A stated that it was not uncommon for patient's blood pressures to drop</p>	V 726			

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

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V 726	Continued From page 34 after starting treatment and that staff often waited to see if the pressure would recover on it's own before giving additional fluid. Staff A agreed that the RN should be notified of the drop so that an assessment could be completed and that the notification, assessment and any interventions should be documented.	V 726			