

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

PRINTED: 10/29/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>052689</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>WALNUT CREEK DIALYSIS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH WIGET LANE</b> <b>WALNUT CREEK, CA 94598</b>	
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V 000	INITIAL COMMENTS  Surveyor: 05189  The following represents the findings of the Department of Public Health during an investigation of Complaint #CA00146919.  Representing the Department of Public Health: Dorothy Rice, HFEN.  The inspection was limited to the specific complaint being investigated and does not represent the findings of a full inspection of the facility.  The complaint was substantiated. The following deficiencies were issued as a result of the investigation of Complaint number CA00146919.	V 000		
V 715	494.150(c)(2)(i) POLICIES AND PROCEDURES  The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;  This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the medical director failed to ensure for one (Patient 1) of one patients reviewed, that the following policies and procedures were implemented: 1. the policy for "Adding Calcium And/Or Potassium Additives To Acid Concentrate", resulting in Patient 1 receiving part of the treatment with an incorrect dialysate solution, and	V 715		3/10/09
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

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V 715	<p>Continued From page 1</p> <p>2. the policy for "Quality Improvement and Facility Management Meeting Process", resulting in increased risk that an adverse occurrence be not investigated and no measures implemented that would prevent its reoccurrence.</p> <p>Findings:</p> <p>On 1/8/09, the record review showed that Patient 1 was admitted to the facility on 3/5/02 for hemodialysis treatments. On 11/17/06, the physician's prescription included:</p> <ol style="list-style-type: none"> <li>Tri-weekly (Tuesday, Thursday, Saturday) treatments;</li> <li>255 minutes (4.25 hours) duration; and</li> <li>Dialysate composition of 1.0 mEq/L [miliequivalent per liter] Potassium (K), and 2.0 mEq/L Calcium (Ca).</li> </ol> <p>Dialysis/Hemodialysis is a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment [blood] to another fluid compartment [dialysate] across a semi-permeable membrane. According to the "Hemodialysis for Nurses and Dialysis Personnel, 2005, 7 th Ed.", Dialysate fluid solution [containing potassium chloride, calcium chloride, and other electrolytes] carries away the waste materials from the blood and corresponds nearly to that of normal plasma water.</p> <p>1. On 1/8/09, the Facility Administrator and staff stated that the standard electrolyte composition of dialysate solution contained 2.5 mEq/L Calcium.</p> <p>Review of Patient 1's flowsheet, dated 3/27/08 showed that the current prescription was for 1.0 Potassium and 2.0 Calcium (non-standard)</p>	V 715		

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V 715	<p>Continued From page 2</p> <p>dialysate composition, that the treatment was initiated at 9:40 am, and that at 1:30 p.m., Patient 1 "c/o [complained of ] numbness and tingling sensation at lower face." By 1:56 p.m., Patient 1 was "Feeling better/Dialysate change to 1.0 K , 2.5 Ca ."</p> <p>On 1/8/09 at approximately 11:40 am, the surveyor interviewed Patient 1's caretaker (Staff E) who was present during the 3/27/08 incident mentioned above. Staff E stated Patient 1 had orders for a "special" dialysate solution bath and that the policy and procedure permitted only RNs (Registered Nurses) to "spike" (add electrolyte concentrations to) the dialysate solution in the containers. Staff E stated that when Patient 1 began to have the above symptoms, he/she immediately notified the charge nurse (Staff D). Staff E stated that Staff D (RN) indicated that an error had been made and asked Staff E to change the dialysate container to another container of a 2.5 Calcium solution.</p> <p>On 1/8/09 at approximately 12:45 p.m., during a telephone interview, Staff D stated she recalled the incident when Patient 1 had tingling around the mouth which "sounded like low Calcium". Staff D stated that when she contacted the physician, the physician also thought it was a "Calcium problem". Staff D stated that the physician ordered the change in dialysate concentration and had stated that the condition would resolve itself. (meaning the patient's blood calcium level will increase. Staff D acknowledged that the facility's practice was for only RNs to spike (add electrolyte) to the dialysate bath containers, and that she had probably made an error. Staff D stated it (dialysate) was probably a "no Calcium bath" (no Calcium concentrate</p>	V 715			

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V 715	<p>Continued From page 3 addition) occurrence . Staff D stated that she completed an Adverse Occurrence Report.</p> <p>On 1/8/09, the review of the facility's "Adding Calcium And/Or Potassium Additives To Acid Concentrate" policy/procedure showed the following:</p> <p>a. A physician's order will specify the desired calcium and/or potassium of the acid concentrate to be utilized.</p> <p>b. Licensed nurse teammates, ...may mix additives to acid concentrates.</p> <p>b. Prior to mixing the additive, the following (in part) will be verified:</p> <ul style="list-style-type: none"> <li>- The contents (in mEq) of the acid concentrate.</li> <li>- Volume of acid concentrate.</li> <li>- The molecular weight of one (1) mEq of electrolyte to be increased.</li> </ul> <p>c. Determine the desired milliequivalent of concentration increase.</p> <p>d. Label concentrate container with amount of calcium or potassium chloride added, final concentration of the added electrolyte, date, time prepared and initial of licensed teammate who mixed additive. Electrolyte additives added to concentrate will be documented on the appropriate Additive Log.</p> <p>On 1/8/09, the Additive Log was not available for review.</p> <p>Additionally, at approximately 2:45 p.m., Staff E stated that the jug (containing dialysate) was improperly labeled with the pre-existing orders for 1.0 (mEq/L) Potassium and 2.0 (mEq/L) Calcium at the beginning and during treatment until the jug was changed.</p> <p>2. On 1/8/09, the review of the the facility's "Adverse Occurrence Reporting Policy" showed</p>	V 715			

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V 715	Continued From page 4 that an Adverse Occurrence Report (AOR) was to be prepared for "any unexpected event that is inconsistent with the routine operation of a dialysis unit" that included "Treatment prescription incorrectly followed".  On 1/8/09 at approximately 8:45 am, during an interview, the Facility Administrator stated he found no Adverse Occurrence Report for the incident related to error in the dialysate formulation for Patient 1.  On 1/8/09, review of the facility policy for "Quality Improvement and Facility Management Meetings Process" showed that the facility administrator was to conduct Quality Improvement and Facility Meetings for the review of issues and indicators regarding facility management and performance. This policy also showed that the meeting minutes were to be documented on the QIFMM (Quality Improvement and Facility Management Meeting) form.  On 1/8/09 at approximately 5:15 p.m., Staff B stated that the facility's practice was to include the AORs into the Quality Improvement meetings for discussion and planning of improvement interventions. The "Adverse Occurrence Reporting" section of the 5/15/08 QIFMM did not include documented evidence that an Adverse Occurrence Report was reviewed. On 1/8/09, the Facility Administrator stated that the AOR report should have been available for review and included into the QIFMM report for discussion and intervention.	V 715			
V 726	494.170 MEDICAL RECORDS  The dialysis facility must maintain complete, accurate, and accessible records on all patients,	V 726		3/10/09	

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V 726	<p>Continued From page 5</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 05189 Based on staff interview and record review, the facility failed to maintain complete records for one (Patient 1) of one patients reviewed that included complete assessment and interventions prior to patient's transfer to an acute care hospital, and the physician's order for a new temporary dialysate prescription. This failure made it difficult to determine specific clinical assessment and interventions done during an incident immediately prior to the patient's acute care hospital transfer; and to ensure that the physician's order was implemented as written.</p> <p>Findings:</p> <p>On 1/8/09, the record review showed that Patient 1 was admitted to the facility on 3/5/02 for hemodialysis treatments.</p> <p>On 11/17/06, the physician ordered hemodialysis treatments three times per week for 255 minutes, and with a dialysate bath of 1.0 mEq/L (miliequivalent per liter) potassium (K) and 2.0 mEq/L Calcium (Ca).</p> <p>On 2/17/07, the updated physician's prescription included an additional treatment day on Wednesdays for 210 minutes duration and a dialysate bath of 1.0 mEq/L K and 2.0 mEq/L Ca.</p>	V 726			

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V 726	<p>Continued From page 6</p> <p>1. Review of Patient 1's flowsheet , dated 4/9/08, showed that Patient 1 received only 2.0 hours of treatment from 10:45 am to 12:45 p.m. At 10:45 am when the treatment was started, the UFR (ultrafiltration rate-fluid removal rate) was activated, and Patient 1's blood pressure was 107/60 mm Hg (millimeter of mercury). At 11:00 a.m., Patient 1's blood pressure was 113/54 and the patient was "resting comfortably". By 11:30 a.m., Patient 1's blood pressure lowered to 90/60, but Patient 1 was "alert..and watching television". At 12:05 p.m., the flowsheet showed Patient 1's blood pressure continued to lower at 72/29 with the following assessment and intervention: "Alert. UF [fluid removal mechanism] off. Saline 200 ml [milliliter] N/S [normal saline] given."</p> <p>According to the Post-Treatment section of the flowsheet, Patient 1's "Time Off" was at 12:45 p.m.</p> <p>At 1:00 p.m., the data entered in the Post Treatment Data Collection &amp; Assessment section of the flowsheet by Staff F showed the following: "Pt was sent to hosp [hospital] due to numbness of exit/face."</p> <p>On 1/18/09, the surveyor interviewed the caretaker (Staff G) who stated she was the caretaker for Patient 1 on the above-referenced day. Staff G stated that she was on a break and was called into the unit regarding the situation. Staff G stated when she returned to the unit, the nurse was present with the patient who was off of the machine (treatment discontinued). Staff G stated that Patient 1 was alert and lying back (reverse head lowering position) with oxygen and waiting for 911 paramedics.</p> <p>Staff G stated that two persons had checked/verified the dialysate (concentrates) prior</p>	V 726			

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V 726	<p>Continued From page 7 to treatment which was correct.</p> <p>The clinical record was incomplete for the continued assessment and interventions from 12:05 p.m. to 1:00 p.m. when Patient 1's treatment had to be discontinued and when Patient 1 was transferred to an acute care hospital transfer. For example,</p> <p>a. There was no documentation that showed if the UF discontinuation and normal saline administration initially improved Patient 1's condition.</p> <p>b. There was no documentation or indication (as well as the rate) for oxygen administration.</p> <p>c. There was no documentation or indication when the lowering head position intervention occurred.</p> <p>d. There was no documentation or indication when the "Numbness to exit/face" occurred.</p> <p>e. There was no documentation or indication when 911 was called.</p> <p>2. On 1/8/09, review of Patient 1's flowsheet, dated 3/27/08 showed that the physician had prescribed a dialysate bath of 1.0 Potassium and 2.0 Calcium (non-standard) dialysate composition, that the treatment was imitated at 9:40 am, and that at 1:30 p.m., Patient 1 "c/o [complained of ] numbness and tingling sensation at lower face." By 1:56 p.m., Patient 1 was "Feeling better/Dialysate change to 1.0 K , 2.5 Ca ."</p> <p>During a telephone interview on 1/8/09 at approximately 12:45 p.m., Staff D stated she contacted the physician regarding Patient 1's probable "Calcium problem". At that time, Staff D stated that she could not remember if she obtained an order to change the incorrect</p>	V 726			

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V 726	Continued From page 8 dialysate solution bath to the temporary 2.5 Calcium dialysate bath solution, but would not have requested staff to do so unless the physician had ordered the change. However, staff was unable to locate the physician order (via the computerized medical modules) regarding the temporary changed order. (See V 715 )  On 1/18/09, the Facility Administrator acknowledged the deficient practices and indicated that the staff should have included the pertinent documentation in Patient 1's clinical record.	V 726			