

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

PRINTED: 10/10/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012592	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/21/2006
NAME OF PROVIDER OR SUPPLIER BIRMINGHAM CENTRAL DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 728 RICHARD ARRINGTON BLVD, SOUTH BIRMINGHAM, AL 35233		
(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 188	<p>405.2137(a)(1) LONG-TERM PLAN TEAM MEMBERS</p> <p>There is a written long-term program representing the selection of a suitable treatment modality (i.e., dialysis or transplantation) and dialysis setting (i.e., home, self-care) for each patient that is developed by a professional team which includes but is not limited to the physician director of the dialysis facility or center where the patient is currently being treated, a physician director of a center or facility which offers self-care dialysis training (if not available at the location where the patient is being treated), a transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on agency policy, interview and record review the dialysis facility failed to ensure the long term care plan was developed by a professional team including the physician director of the dialysis facility, the transplant surgeon, a qualified nurse responsible for nursing services, a qualified dietitian and a qualified social worker for eight of seventeen records.</p> <p>The policy titled, "Development of Patient Care Plans and Long Term Programs," documented, "4. The multidisciplinary team and the patient develop the Long Term Program within 30 days of admission. These plans are to be reviewed and revised as necessary every 12 months or when there is a change in modality, vocational rehabilitation or transplant status. 5. The multidisciplinary team consists of the patient, patient's physician or facility's Medical Director, transplant surgeon/designee, registered nurse,</p>	V 188			

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 188	<p>Continued From page 1 social worker and dietitian."</p> <p>Findings include:</p> <p>1. Medical Record # 2 was admitted 11/19/03 and 11/23/04 with diagnoses including End Stage Renal Disease, Diabetes Mellitus, Hepatitis B and Cerebral Vascular Accident.</p> <p>The Long Term Care Plan dated 7/27/05 had no signatures other than the nurse's signature. There was no documentation by the Medical Director, Social Worker, Dietitian or Transplant Surgeon/Designee.</p> <p>The Long Term Care Plan dated 2/10/06 was signed by the patient and Registered Nurse on 2/10/06, by the Medical Director and Transplant Surgeon /Designee on 4/27/06, the Social Worker on 5/2/06 and the Dietitian on 5/3/06.</p> <p>An interview with facility management staff on 9/21/06 at 2:00 PM confirmed the above documentation on the Long Term Care Plan.</p> <p>2. Medical Record # 12 was admitted 5/29/06 with diagnoses including End Stage Renal Disease and Hypertension.</p> <p>The Long Term Care Plan dated 6/26/06 had no signatures other than the patient and the nurse's signature, which was a Licensed Practical Nurse instead of a Registered Nurse. There was no documentation by the Medical Director, Social Worker, Dietitian or Transplant Surgeon/Designee.</p> <p>3. Medical Record (MR) # 6 was admitted to the</p>	V 188			

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V 188	<p>Continued From page 2</p> <p>agency with Chronic Kidney Disease secondary to Hypertension and first treated by the agency on 08/03/2006. A review of the medical record on 09/19/2006 revealed there was no long term care plan for MR # 6. The Facility Administrator was asked if the facility had a long term care plan in place for MR # 6 and she stated she would find it.</p> <p>On 09/19/2006 at 3:55 PM, the Facility Administrator brought a care plan to the surveyor and stated, " I got my nurse to do one on her. I thought we had on on her, I need to have the medical director sign it for me." The date on the long term care plan was 09/19/2006, the medical director, transplant surgeon/designee and attending physician had not signed the plan of care.</p> <p>4. Medical Record # 15 was admitted to the agency with Glomerulonephritis and Hypertension and first treated by the agency on 06/30/2000. A review of the medical record revealed the " Long Term Care Plan/Life Plan " for the year 2005 was only signed by the nurse on 03/26/2005. The plan of care for 2006 was signed by the nurse and patient on 02/16/2006, the dietitian on 04/05/2006, the social worker on 04/06/2006 and the medical director and transplant surgeon/designee on 04/27/2006.</p> <p>5. Medical Record # 16 was admitted to the agency with Hypertension, Cerebrovascular Accident and Seizures and first treated by the agency on 09/08/2005. A review of the medical record revealed the " Long Term Care Plan/Life Plan " for the year 2005 was only signed by the nurse on 11/08/2005. There was a second plan of care that was signed by the nurse on 02/14/2006, the social worker and dietitian on</p>	V 188			

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V 188	Continued From page 3 03/28/2006 and the medical director and transplant surgeon/designee on 04/27/2006. 6. MR # 4 was admitted to the agency with End Stage Renal Disease (ESRD) and Hypertension on 8/17/06. A review of the medical record on 09/19/2006 revealed there was no long term care plan available for review. An interview with the facility administrator on 9/19/06 at 3:30 PM confirmed a long term care plan had not been completed. 7. MR # 5 was admitted on 6/6/01 with diagnosis including Chronic Renal Failure. A review of an annual long term care plan revealed signatures by the medical director on 3/10/06, the nurse, social worker and dietitian on 11/7/05. 8. MR #11 was admitted on 1/1/06 with diagnosis of ESRD and Diabetes. A review of an annual long term care plan revealed signatures by the medical director on 4/27/06, the nurse on 2/10/06, the social worker on 5/2/06 and dietitian on 5/3/06.	V 188			
V 226	405.2138(d) CONFIDENTIALITY All patients are ensured confidential treatment of their personal and medical records, and may approve or refuse release of such records to any individual outside the facility, except in case of their transfer to another health care institution or as required by Federal, State, or local law and the Secretary for proper administration of the program.	V 226			

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V 226	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on facility policy, interview and interoffice communication notes, the facility failed to maintain the patient's confidential personal information for all patients.</p> <p>The policy titled, "Patient Rights and Responsibilities," documented, "Your Rights as a Patient:...15. To know your medical records and information will be considered confidential..."</p> <p>Findings include:</p> <p>During the survey 9/19/06 to 9/21/06 patient and staff interviews revealed the names and addresses of all patients had been obtained and a letter sent anonymously to all patients at their current home address. The letter contained personal information about certain staff members.</p> <p>Interoffice communication dated 7/13/06 documented, "...I attended the Patient Services Committee ...The following points were discussed: Patient confidentiality - The patients felt their confidentiality had been broken by someone getting their home addresses and sending out a letter to several of the patients regarding the clinic hiring nurses...I explained that the letter was signed by "Your Fellow Patient" and we had been trying to find out if it was indeed sent by a patient that somehow got everyone's addresses or if had been sent by a (facility employee)..."</p> <p>Interview with the facility administrator on 9/20/06 at 4:00 PM confirmed the anonymous letter had been sent to all patients. The administrator stated the facility had not determined how the</p>	V 226			

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V 226	Continued From page 5 addresses had been obtained or who sent the letter.	V 226			
V 227	405.2138(e) GRIEVANCE MECHANISM All patients are encouraged and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the network organization, and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's choice, without restraint or interference, and without fear of discrimination or reprisal. This STANDARD is not met as evidenced by: Based on interviews and review of the facility's policy and procedure the facility failed to address grievances and assure patients were able to file a grievance without fear of reprisal. This affected 2 of 10 patients interviewed and 3 of 3 meetings with patients. Findings include: A review of the minutes from a patient meeting held on November 9, 2005 was done on 09/21/2006. Three patients were in attendance along with four facility staff members. Problems reported to the facility staff were: "1. Training of PCT's (Patient Care Tech) how to stick patient's. 2. Tech's needed to assist the patients when they needed assistance getting into the patient care area. i.e. wheelchair, weak, etc. 3. Noise from the PCT's on the dialysis floor. 5. People acting non-professional. 6. Nurses should tell the patient's what medications they are giving them not just give them and not tell them what is going on. 7. Watch the way that they are pulling	V 227			

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V 227	<p>Continued From page 6</p> <p>needles and do it correctly so that it does not make the patient's graft area sore. 12. One patient had a complaint regarding putting dirty bandages on patients after dialysis. 13. Personal business should not be on the nursing floor for everyone to hear."</p> <p>On the bottom of the problem list the following statement was typed, "(Staff member name) advised the patient's that these problems would be discussed in the monthly staff meetings..."</p> <p>A review of the November and December 2005 monthly staff meetings was done on 09/21/2006 at 10:48 AM. There was no documentation of where the facility addressed the problems mentioned in the November 9, 2005 patient meeting. On January 11 and 12, 2006 in the staff meetings the tech's non-professional behavior was mentioned. None of the other patient problems were addressed.</p> <p>A review of the minutes from a patient meeting held on January 10, 2006 was done on 09/21/2006. There was no listing of which patients were present during the meeting and only two staff members were named in the minutes. Problems listed in the minutes included: 1. Alarms on dialysis machines are not attended to in a timely manner, takes staff as long as five minutes to address. 2. The building was not clean and there was a roach problem.</p> <p>These problem areas were to be addressed by a staff member "in the next staff meeting."</p> <p>A review of the January 11 and 12, 2006 monthly staff meetings was done on 09/21/2006 at 10:48 AM. There was no documentation of where the</p>	V 227			

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V 227	<p>Continued From page 7</p> <p>facility addressed the problem of alarms on machines and the building not clean.</p> <p>A review of the minutes from the patient meeting held on April 12, 2006 with 9 patients and at least one facility staff member was reviewed. Problems brought up in the meeting were: 1. Patient's have to wait 30 to 45 minutes before their treatment starts and they are not being called back until 7:00 AM. This was suppose to be addressed in the next staff meeting. 2. Patients asked if something could be done about the bug problem.</p> <p>A review of the monthly staff meetings from April to August 2006 was done on 09/21/2006 at 10:48 AM. There was no documentation from the meeting minutes to show where the patient's problems had been addressed.</p> <p>On 9/20/2006 at 9:30 AM, Medical Record (MR) # 8 was asked if he had a complaint what would he do. MR # 8 responded, "I use to go to meetings but nothing comes of it."</p> <p>During an individual interview with MR # 7 on 09/20/2006 at 12:50 PM, he was asked what he would do if he had a complaint and stated, "I don't complain because when someone does the staff treat them different and can give them a hard time."</p> <p>A review of the facility's "Patient Grievance Procedure" states, "2. Patients using this procedure to address issues will not be intimidated, threatened, coerced, or retaliated against for the use of the grievance procedure." Under the subheading "Submitting a Formal</p>	V 227			

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V 227	Continued From page 8 Complaint" the fourth statement reads, "The FA/CD or designee will investigate the grievance, attempt to resolve it and communicate a decision to the past, current or potential patient in writing within 10 working days. The FA/CD or designee will prepare a written and dated summary of the grievance and the proposed attempts by the FA/CD or designee to resolve the matter."	V 227			
V 256	410.2140(a) PE: CONSTRUCT/ MAINTAIN FOR SAFETY The physical structure in which the ESRD services are furnished is constructed, equipped, and maintained to ensure the safety of the patients, staff, and the public. This STANDARD is not met as evidenced by: Based on observation and interview the dialysis agency failed to maintain the walls in the facility to ensure the safety of staff and patients in the Isolation Room and in the laboratory area and to ensure the water temperature was at a comfortable level for one of three faucets in the Isolation Room. Findings include: 1. The Isolation room for Hepatitis B positive patients was observed on 9/19/06 at 1:30 PM to have the lower portion of the wall expanded, pushing outward at various places, with discoloration noted. Interview on 9/19/06 at 1:30 PM with the facility	V 256			

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V 256	Continued From page 9 administrator revealed the pipes had leaked acid and had caused the wall to break down. 2. The water temperature for faucet # 2 in the Isolation room was determined to be 80 degrees. 3. On initial tour of the facility on 09/19/2006 at 10:35 AM, a section of the half wall dividing the lab and patient care area was observed to have a hole in the wall. The hole was in the lower section directly above the floor molding approximately 8 inches in length by 6 inches in width. 4. The outer support wall in the corner of the patient care area outside of the lab was eroded and noted to have yellow stains with a red rust appearance. The bottom part of the wall was pulled open and two different colors of gray was painted over a section of the wall.	V 256			
V 264	405.2140(a)(5)(ii) AAMI - CHEMICAL CONTAMINANTS (AAMI 3.2.2) Maximum Level of Chemical Contaminants. The water used to prepare dialysate shall not contain chemical contaminants at concentrations in excess of those in AAMI's Table 2. The manufacturer or supplier of the water treatment device shall recommend a system capable of meeting the requirements of this section. The physician in charge of dialysis has the ultimate responsibility for selecting the water treatment system and is also responsible for monitoring the water. Table 2 - Hemodialysis Water Quality: Maximum Allowable Chemical Contaminant Levels:	V 264			

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V 264	<p>Continued From page 10</p> <table border="0"> <tr> <td>Contaminant</td> <td>Suggested Max Level</td> </tr> <tr> <td>Calcium</td> <td>2 (0.1 mEq/l)</td> </tr> <tr> <td>Magnesium</td> <td>4 (0.3 mEq/l)</td> </tr> <tr> <td>Sodium**</td> <td>70 (3.0 mEq/l)</td> </tr> <tr> <td>Potassium</td> <td>8 (0.2 mEq/l)</td> </tr> <tr> <td>Fluoride</td> <td>0.2</td> </tr> <tr> <td>Chlorine (free)</td> <td>0.5</td> </tr> <tr> <td>Choloramine</td> <td>0.1</td> </tr> <tr> <td>Nitrate (N)</td> <td>2.0</td> </tr> <tr> <td>Sulfate</td> <td>100.0</td> </tr> <tr> <td>Copper, Barium,</td> <td>each 0.1</td> </tr> <tr> <td>Zinc</td> <td></td> </tr> <tr> <td>Aluminum</td> <td>0.01</td> </tr> <tr> <td>Arsenic, Lead,</td> <td>each 0.005</td> </tr> <tr> <td>Silver</td> <td></td> </tr> <tr> <td>Cadmium</td> <td>0.001</td> </tr> <tr> <td>Chromium</td> <td>0.014</td> </tr> <tr> <td>Selenium</td> <td>0.09</td> </tr> <tr> <td>Mercury</td> <td>0.0002</td> </tr> </table> <p>**230 mg/l (10mEq/l) where sodium concentration has been reduced to compensate for the excess sodium in the water, as long as conductivity of the water is being continually monitored.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observations, interviews and review of the water system log and policies and procedures, the facility failed to ensure that water used for hemodialysis was safe for patient treatment.</p> <p>The policy titled, "Chloramine Test of Water Using Hach DR 100 Colorimeter" for Total Chlorine Test included to add contents of one DPD Chlorine Powder Pillow to sample. Cap cell</p>	Contaminant	Suggested Max Level	Calcium	2 (0.1 mEq/l)	Magnesium	4 (0.3 mEq/l)	Sodium**	70 (3.0 mEq/l)	Potassium	8 (0.2 mEq/l)	Fluoride	0.2	Chlorine (free)	0.5	Choloramine	0.1	Nitrate (N)	2.0	Sulfate	100.0	Copper, Barium,	each 0.1	Zinc		Aluminum	0.01	Arsenic, Lead,	each 0.005	Silver		Cadmium	0.001	Chromium	0.014	Selenium	0.09	Mercury	0.0002	V 264		
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Sulfate	100.0																																									
Copper, Barium,	each 0.1																																									
Zinc																																										
Aluminum	0.01																																									
Arsenic, Lead,	each 0.005																																									
Silver																																										
Cadmium	0.001																																									
Chromium	0.014																																									
Selenium	0.09																																									
Mercury	0.0002																																									

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012592	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/21/2006
NAME OF PROVIDER OR SUPPLIER BIRMINGHAM CENTRAL DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 728 RICHARD ARRINGTON BLVD, SOUTH BIRMINGHAM, AL 35233		
(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 264	Continued From page 11 and swirl several times to mix. START STOPWATCH. Allow at least three minutes but not more than 6 minutes before completing" Findings include: On 9/19/06 at 2:15 PM the surveyor requested an observation of the third shift testing for Chlorine/Chloramine levels. The employee obtained the water sample from the sample port and placed in the Hach Colormeter. The employee failed to set the timer as stated in the policy, for the required three minutes, located in the area, prior to reading the results and documenting.	V 264			
V 266	405.2140(b)(1) PE: INFECTION CONTROL There are written policies and procedures in effect for preventing and controlling hepatitis and other infections. These policies include, but are not limited to, appropriate procedures for surveillance and reporting of infections, housekeeping, handling and disposal of waste and contaminants, and sterilization and disinfection, including the sterilization and maintenance of equipment. Where dialysis supplies are reused, there are written policies and procedures covering the rinsing, cleaning, disinfection, preparation, and storage of reused items which conform to requirements for reuse in 405.2150. This STANDARD is not met as evidenced by: Based on observations and interviews the facility staff failed to follow their infection control policies for environmental cleaning and failed to ensure the prevention and control of infections for the storage of an emergency cart and unused	V 266			

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V 266	<p>Continued From page 12 equipment.</p> <p>The Policy titled "Bleach Policy" included, "A 1:100 bleach solution is used for routine disinfection procedures of environmental surfaces or non-disposable supplies which are not visibly contaminated with blood or body fluids."</p> <p>The Procedure titled, "Preparation of 1:100 Bleach Solution" included, "Label container with the expiration date, time and initials. The solution is good for 24 hours only."</p> <p>Findings include:</p> <p>1. Observations during the initial tour on 9/19/06 at 10:10 AM in the treatment area revealed unlabeled containers of bleach solution.</p> <p>On 9/19/06 at 2:10 PM an interview with a Patient Care Tech (PCT) revealed the solution is prepared with 10 cc of bleach, however the tech was unable to demonstrate the amount of water added to the bleach to ensure an adequate proportion was being used to clean the chairs and machines. There were no calibrated perimeters indicated on the solution containers for the staff to ensure the 1:100 bleach solution requirements.</p> <p>An interview with the Facility Administrator on 9/21/06 at 2:00 PM confirmed the facility was not following their policy for preparing the required 1:100 bleach solution.</p> <p>2. Observations on 9/21/06 at 2:15 PM revealed an emergency crash cart stored in the isolation room restroom. The cart contained items including Ambu bags and packaged IV (intravenous) supplies. A centrifuge laboratory</p>	V 266			

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V 266	Continued From page 13 machine was located on top of the cart. This restroom is used by Hepatitis B positive patients.	V 266		
V 281	3. Observations of the left side treatment room area on 9/20/06 at 9:50 AM revealed connector lines for acid extending from the walls behind the dialysis machines. Six lines not in use were observed to be lying directly on the floor beside the machines. 405.2140(d)(3) EMERGENCY PREP: DRUGS & SUPPLIES There is available at all times on the premises a fully equipped emergency tray, including emergency drugs, medical supplies, and equipment. This STANDARD is not met as evidenced by: Based on interview and observations of the facility emergency crash cart and checklist, the facility failed to ensure all medications on the checklist were present and outdated medications were replaced in a timely manner. Findings include: Observation of the Emergency Crash Cart on 9/20/06 at 8:15 AM revealed Benzocaine 20 %, a topical anesthetic which expired February, 2003. The Crash Cart Checklist for 2006 included the medications, Nitrostat 0.4 milligrams and Benadryl 50 milligrams. Neither Nitrostat or Benadryl was present. Promethazine 25 milligrams was present but was not a required medication on the Emergency Crash Cart checklist.	V 281		

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V 281	Continued From page 14 Interview with the facility management staff present confirmed the Emergency Crash Cart checklist and the expiration date.	V 281			