

IND
SAN LUIS VALLEY REGIONAL MED CTR HEMODIALYSIS UNIT
106 BLANCA AVENUE
ALAMOSA, CO 81101
SURVEY START DATE: 06/21/2004 SURVEY EXIT DATE: 06/23/2004
SURVEY TYPE: Recertification

TAG: 0000 TITLE: INITIAL COMMENTS CFR:

INITIAL COMMENTS:

An unannounced re-certification survey was conducted at San Luis Valley Regional Medical Center Hemodialysis unit on June 22-23, 2004.

The facility was surveyed for compliance with 42 CFR Part 405 Subpart U-Conditions of Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services. As a result, two standard level deficiencies were cited.

The facility added patient treatment chairs and now total 10, but are using only 9 of them. The 10th chair is not routinely used, but is ready for use if necessary. An extra dialysis machine is kept at the 10th chair location.

The facility does not practice reuse.

TAG: 0145 TITLE: PERSONNEL P/P: SAFE AND SANITARY ENVIRO CFR: 405.2136(d)(2)

REGULATION:

The governing body, through the chief executive officer of the ESRD facility, is responsible for maintaining and implementing written personnel policies and procedures that ensure that a safe and sanitary environment for patients and personnel exists.

STATEMENT OF DEFICIENCY:

Based on observation and record review, the facility did not follow policy and procedure for maintaining a safe, sanitary environment.

Specifically, the crash cart was not routinely checked, equipment was soiled, and sanitary procedures were not followed by housekeeping staff. Unsanitary practice can lead to the potential spread of infection, impacting both patients and staff. The findings were:

1. During a tour of the patient treatment area on June 22, 2004, the surveyor observed the housekeeper emptying trash in the patient care area with no gloves on. At 10:00 AM, the housekeeper then left the unit without washing his/her hands, carrying the trash bags out into the hallway which was used by visitors, staff and patients. Failure to wash his/her hands could lead to the possible cross contamination between the dialysis unit and other patient units and areas in the hospital.
2. At 10:30 AM, on June 22, 2004, the surveyor observed 2 chairs and one stool in the patient treatment area that were upholstered with a loosely woven cloth. These chairs were used by staff, but they were out in the patient treatment area. All three were covered with multiple dark colored stains.
3. During a tour of the patient treatment area on the morning of June 22, 2004, the surveyor checked the crash cart. On top of the crash cart, there was an emesis basin that held 2 laryngoscopes. The emesis basin had no cover on it and the laryngoscopes were covered with dust. The top of the crash cart was also covered with dust.
4. Review on July 1, 2004 the facilities Policy No. 16 "Crash Carts" stated "The crash cart shall be inspected once daily."
 - a. According to documentation on the Crash Cart Checklist, the crash cart was not checked on 5 of 26 days the clinic was open in April, 2004.
 - b. According to documentation on the Crash Cart Checklist, the crash cart was not checked on 5 of 26 days the clinic was open in May, 2004.

c. According to documentation on the Crash Cart Checklist, the crash cart was not checked on 9 of 23 days the clinic was open so far in June, 2004.

TAG: 0190 TITLE: LTP: PT INVOLVED CFR 405.2137(a)(3)

REGULATION:

The written long-term program includes that the patient, parent, or legal guardian, as appropriate, is involved in the development of the patient's long-term program, and due consideration is given to his preferences.

STATEMENT OF DEFICIENCY:

Based on record review, it could not be determined if the patient was involved in their long term care plan, or that the long term care plan reflected the patients preference for two of five clinical records reviewed (Patient #1 and Patient #5). The findings were:

1. Review of the clinical record on June 22, 2004, for Patient #1 revealed diagnoses of Hypertension and Anticoagulant therapy, Further review of the agency form titled "Long Term Care Plan" evidenced no signature by the patient to show the patient had been involved in the planning of the his/her long term program.
2. Review of the clinical record June 22, 2004, for Patient #5, revealed diagnoses of Diabetes, Hypertension, Respiratory Failure and Rheumatic heart Disease. The patient had a catheter access site. Review of the agency titled "Long Term Care Plan" evidenced no signature by the patient to show the patient had been involved in the planning of his/her long term program.
3. In direct interview with Patient #1 and Patient #5 on June 22, 2004 between 11:45 AM and 1 PM, neither patient could recall if they were in a care plan meeting discussing any long term goals set for them.