STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	332633	A. BUILDING _____ B. WING _____	C 03/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUTCHESS DIALYSIS CENTER	2585 SOUTH ROAD POUGHKEEPSIE, NY 12601

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S 000	INITIAL COMMENTS Surveyor: 00765 INITIAL COMMENTS PRI # 6481 OC # 1302210R THE FOLLOWING DEFICIENCIES ARE CITED AS A RESULT OF AN INVESTIGATION CONDUCTED ON 3/3/06. COMPLAINT # 27000. NOTE: THE NEW YORK OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS (10NYCRR) DEFICIENCIES BELOW ARE CITED AS A RESULT OF A SURVEY CONDUCTED IN ACCORDANCE WITH ARTICLE 28 OF THE NEW YORK STATE PUBLIC HEALTH LAW. THE PLAN OF CORRECTION, HOWEVER, MUST RELATE TO THE CARE OF ALL PATIENTS AND PREVENT SUCH OCCURRENCES IN THE FUTURE. INTENDED COMPLETION DATES AND THE MECHANISM(S) ESTABLISHED TO ASSURE ONGOING COMPLIANCE MUST BE INCLUDED.	S 000		
S2008	751.2 (b) ORGANIZATION AND ADMINISTRATION. Operator. The responsibilities of the operator shall include but not be limited to: (b) ensuring that all patients receive quality health care and services provided in accordance with generally accepted standards of professional practice. This Regulation is not met as evidenced by:	S2008		5/31/06

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S2008	Continued From page 1 Surveyor: 00765 Based on observation, interview and record review, the operator failed to provide adequate monitoring of dialysis patients to ensure that access sites remain visible during treatment for MR #1 and one (1) unidentified patient observed during tour and failed to ensure that blood lines are taped to the patient's limb per facility policy (MR #1.) Findings include: 1. Patient access sites are not always kept visible during dialysis treatment. a. On 12/28/05, MR #1 ambulated into the center for hemodialysis. Staff #1, Patient Care Technician (PCT), initiated the treatment at 2PM. Staff #10, PCT, performed safety checks at 2:30PM and 3PM and documented them on the treatment sheets. b. According to the interviews conducted on 3/3/06, staff were not aware of any bleeding until the patient complained to Staff #2 of not feeling well at 3:05PM. Staff #2 indicated that when the chair was placed in a reclined position, blood, "pooled in the plastic barrier lining the patient's chair splashed to the floor." The patient then went unconscious. c. During interview on 3/3/06, Staff #3, PCT, stated that he removed the blanket that was covering the patient's sites. This is consistent with the conclusion of the 2/17/06 facility investigation that a blanket hindered staffs' ability to monitor the patient and respond quickly. d. Review of facility policy for Patient	S2008		

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S2008	Continued From page 2 Monitoring reveals, "All patients are continually under visual observation by patient care staff...Staff leaving the patient care area will report off to another staff member to assure that continual monitoring of patients...To facilitate monitoring, patients should be instructed to leave access sites uncovered so that they are readily visible." f. During Tour of the treatment area on 3/3/06, one unidentified patient undergoing dialysis (of up to 26 patients) was observed with an access site covered by a blanket. Staff #6, spoke to the patient in the presence of the surveyor, but failed to remind the patient of facility policy that requires sites to be visible at all times. 2. Based on interview, review of policies and observation, facility staff do not ensure that blood lines are taped to a patient's limb when treatment is initiated according to a. Facility policy for Initiation of Dialysis Treatment for AV Fistulas and AV Graphs, dated 6/15/03, indicates, "Be sure lines are free of air and make sure all connections are secure. Tape lines to the patient's limb." b. During interview on 3/3/06, staff #5 stated that on 12/28/05, the blood lines had not been taped to the MR # 1's limb by Staff #1.	S2008		
S2032	751.2 (r) ORGANIZATION AND ADMINISTRATION. Operator. The responsibilities of the operator shall include but not be limited to: (r) ensuring that all equipment is maintained in safe and working order.	S2032		5/1/06

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S2032	Continued From page 3 This Regulation is not met as evidenced by: Surveyor: 00765 Based on record review and interview, the preventive maintenance schedule for dialysis machines did not comply with facility policy. Findings include: 1. Review of the Preventive Maintenance Checklist for dialysis machine #6 revealed that an inspection was conducted on 10/7/05. Machine Hours were documented as 22,591. Quarterly/1,000 inspection preventive maintenance for dialysis machine #6 was next completed on 1/29/06 after 1,504 hours and three (3) months and twenty-two (22) days of service. 2. Facility policy regarding Preventive Maintenance of Dialysis Machines states inspections are to occur every three months or after 1,000 hours of treatment. 3. Review of the Master PM Schedule for Machines revealed a notation on 3/2/06 that the schedule needs to be adjusted due to the adding of a fourth shift. 4. During interview on 3/3/06, Staff #7, the Equipment Technician indicated that a new technician had been hired three weeks earlier for the purpose of performing the necessary checks in a timely manner. This is a repeat deficiency from the survey of November 7, 2003.	S2032		
S2049	751.4 (d) ORGANIZATION AND ADMINISTRATION. Medical director.	S2049		5/22/06

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S2049	Continued From page 4 The operator shall appoint a medical director who: (d) develops and recommends to the operator policies and procedures governing patient care in accordance with generally accepted standards of professional practice. This Regulation is not met as evidenced by: Surveyor: 00765 Based on observation, interview, and record review, the Medical Director failed to ensure that written policies governing the monitoring of patients and maintaining visible access sites during dialysis treatments are implemented for MR #1 and an unidentified patient during tour. Findings include: 1. MR # 1 has diagnoses that include End Stage Hemodialysis, Acute Hemorrhage AV Graft, Acute Myocardial Infarction, and Post Traumatic Anxiety. On 12/28/05, hemodialysis treatment for MR #1 was initiated at 2PM by Staff #1. The BFR (blood flow rate) prescribed by the physician in the MD orders of 12/06 was 450 millimeters per minute. Checks at 2:30PM and 3PM were conducted and documented on the treatment sheets by Staff #10. The patient complained of not feeling well at 3:05PM. Review of the Facility Investigation, dated 2/17/06, revealed, "Shortly afterwards, she became unresponsive." Further inspection by staff revealed that the venous tubing was disconnected from the AV Graph and blood was noted on the chair and floor. On 3/3/06, Staff #2 stated that the patient's blood was on the patient's cushion, the chair and	S2049		

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S2049	Continued From page 5 chucks."On 3/3/06, Staff #3 stated during interview, "It was a lot of blood." Staff #6, a Registered Nurse, stated during interview on 3/3/06, that when she came over, the patient looked pale; she saw blood; called 911 and got the code cart. Staff #1 indicated in her statement to the facility that she administered 2 1/2 liters of normal saline by bolus to this patient following the incident. During interview on 3/3/06, Staff #2 reported when MR #1 received 300-450cc of Normal Saline,"the patient came to and became alert times three (3) for a few minutes." According to the EMT transfer records, Emergency Medical Technicians arrived at the scene at 3:08PM and assessed the patient. Vital signs at 3:10PM were Blood Pressure + distal pulses, Respiration Rate 18; Pulse 138. At 3:13PM, no vital signs were noted and MR #1 again became unresponsive. Cardio Pulmonary Resuscitation began immediately. Epinephrine, Atropine and intra-venous normal saline were provided during the eight (8) minute ride to the hospital. The History and Physical from the hospital, dated 12/28/05, conducted by Staff #8, the Medical Director of the dialysis center, indicated that one nurse estimated that MR #1 lost 1 liter or more of blood after her venous line became disconnected. The patient's blood pressure became very low; she passed out and was asystolic for a few seconds. The patient was admitted to ICU in Critical/Guarded condition and treatments included two liters of normal saline and two units of packed red blood cells."Following the transfusion, the Hematocrit rose from 22% to 28%." Diagnoses included	S2049		

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S2049	Continued From page 6 Respiratory Failure, Severe Anemia and Shock. 2. The conclusion of the facility's investigation of 2/17/06 was that the staff member who initiated treatment did not tighten the blood lines sufficiently and that the patient's access sites were covered by a blanket which hindered a quick response by staff. 3. Review of facility policy for Patient Monitoring reveals,"Access sites are to remain uncovered so that we can see you at all times." During Tour of the treatment area on 3/3/06, one unidentified patient was observed with an access site covered by a blanket. Staff #6 did not remind the patient to remove the blanket.	S2049		
S2074	751.5 (c) ORGANIZATION AND ADMINISTRATION. Operating Policies and Procedures. The operator shall ensure: (c) that the center's policies and procedures are reviewed at least annually and revised as necessary. This Regulation is not met as evidenced by: Surveyor: 00765 Based on interview and record review, the operator has not ensured that all facility employees have appropriate orientation to the facility and their work responsibilities upon employment. Findings include: 1. During interview on 3/3/06, Staff #6, stated that Staff #1 was an experienced temporary Patient Care Technician who worked at the facility only a	S2074		5/22/06

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S2074	Continued From page 7 few days and required only a two day preceptor orientation. 2. On 4/14/06, Staff #9, the Nurse Educator, provided contradictory information that the Date of Hire for Staff #1 was 10/24/05 and indicated that the staff member was an "Inexperienced New Hire." Facility Training Manual for new employees requires successful completion of a 90-day probationary period. Educator Training was to occur 10/24/05-1/14/06 followed by Preceptor Training from 11/20/05 -1/14/06. There was no evidence provided that Staff #1 received appropriate orientation to the facility's policies and procedure or Emergency Awareness training despite requests for training records on 3/3/06, 3/13/06 and 4/10/06. In addition, Staff #9, Nurse Educator did not know the name of the preceptor assigned to Staff #1 and said that she would find it on the schedule. The preceptor's name was not provided as of 4/20/06. There was no evidence of a demonstration of competencies that bears the employee's signature/initials. 2. On 4/10/06, orientation and inservice records were requested for Staff #10, who initialed safety checks for MR #1 on 12/28/06. Although Staff #6 indicated that the facility had these records, no documentation has been provided through 4/20/06.	S2074		
S2097	751.6 (g) ORGANIZATION AND ADMINISTRATION. Personnel. The operator shall ensure: (g) the assignment of duties and functions to each employee that are commensurate with	S2097		5/11/06

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S2097	Continued From page 8 his/her licensure, registration and/or certification, and experience and competence. This Regulation is not met as evidenced by: Surveyor: 00765 Based on interview and record review, the operator failed to ensure that staff are qualified to perform the duties and responsibilities of Patient Care Technicians (#1 and #10.) Findings include: During interview on 3/3/06, Staff #6, the Clinical Nurse Manager indicated that Patient Care Technician #1 was a traveler (temporary) employee who worked at the facility only a short time. Credentials were requested but were not provided. On 4/10/06, a request was made for evidence of the qualifications and experience for Staff #1 and Staff #10. On 4/12/06, date of hire for Staff #1 was found to be 10/05 and Staff # 6 indicated that the agency did not provide the dialysis center with documentation of the education and training of Staff #1. The facility was given only a letter of recommendation and was unable to obtain further information from the employee because, "the facility where she obtained her experience no longer exists."	S2097		
S2100	751.6 (j) ORGANIZATION AND ADMINISTRATION. Personnel. The operator shall ensure: (j) that each new employee is provided with a planned orientation to the center's operation and personnel policies.	S2100		6/26/06

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S2100	Continued From page 9 This Regulation is not met as evidenced by: Surveyor: 00765 Based on interview and record review, the operator has not ensured that all facility employees have appropriate orientation to the facility and their work responsibilities upon employment. Findings include: 1. During interview on 3/3/06, Staff #6, stated that Staff #1 was an experienced temporary Patient Care Technician who worked at the facility only a few days and required only a two day preceptor orientation. On 4/14/06, Staff #9, the Nurse Educator, provided information that the Date of Hire was 10/24/05 and Staff #1 was an "Inexperienced New Hire." Facility policy requires successful completion of a 90-day probationary period. Educator Training was to occur 10/24/05-1/14/06. Preceptor Training was to occur 11/20/05 -1/14/06. Staff #9, Nurse Educator did not know the name of the preceptor assigned to Staff #1. She indicated that there was no documented evidence of a demonstration of competencies of this employee new to the facility that bears the employees signature. No evidence was provided that Staff #1 received appropriate orientation to the facility's policies and procedure and Emergency Awareness training despite requests on 3/3/06, 3/13/06 and 4/10/06. 2. On 4/10/06, orientation and inservice records	S2100		

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S2100	Continued From page 10 were requested for Staff #10, who initialed safety checks for MR #1 on 12/28/06. Although Staff #6 indicated that the facility had these records, no documentation has been provided through 4/20/06.	S2100		
S2141	751.8 (a) ORGANIZATION AND ADMINISTRATION. Quality assurance program. (a) The operator shall ensure the development and implementation of a written quality assurance program that includes a planned and systematic process for monitoring and assessing the quality and appropriateness of patient care and clinical performance on an ongoing basis. The program shall resolve identified problems and pursue opportunities to improve patient care. This Regulation is not met as evidenced by: Surveyor: 00765 Based on observation, interview and record review, the facility failed to thoroughly review an incident that resulted in injury to a patient; did not identify health/safety hazards and did not take appropriate corrective action to prevent recurrence of identified problems for 1 patient (MR #1) and an unidentified patient during tour. Findings include: 1. On 3/3/06, an unidentified patient was observed receiving dialysis on the treatment floor. Her access site was covered by a blanket. Staff #6 spoke to the patient, but neglected to remind the patient to uncover the access site. 2. Although the facility conducted an investigation of an incident following faulty initiation of	S2141		5/31/06

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S2141	Continued From page 11 treatment, covered access sites, and faulty monitoring resulting in disconnection of a venous blood line with injury to MR #1, a full analysis was not completed to prevent recurrence. As a plan of corrective action, an inservice on keeping "Patient Access uncovered at all times," was conducted on 12/29 and 12/30/05, however, based on the above observation, facility policy is not being implemented. 3. There is no evidence that the Quality Assurance Committee reviewed the facility policies for initiating dialysis treatment and for monitoring of patients during treatment following the incident. 4. There was no evidence of a program Quality Assurance would implement, how many cases would be reviewed, or over what period of time to prevent recurrence. No monitoring mechanism has been implemented. The facility's focus was on the action of one staff and it failed to thoroughly examine other system problems that might have contributed to the adverse event.	S2141		