

APPROVED 3/5/12
Jennifer Calum, HFEN

PRINTED: 03/05/2012
 FORM APPROVED
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - BAY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WILLOW STREET ALAMEDA, CA 94501
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INITIAL COMMENTS

The following represents the findings of the California Department of Public Health during the investigation of an entity reported incident.

Entity reported event number: CA00248567

The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility.

Representing the California Department of Public Health: [REDACTED], HFEN

F 309

Class "AA" Citation Number: 02-2343-009078-F
483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

The facility failed to provide services to ensure Resident 1's highest practical physical condition when the facility did not provide care when Resident 1 was bleeding which resulted in Resident 1 bleeding to death.

Record review on 12/20/10 showed that the facility admitted Resident 1, a 74-year old, on

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F 309

Affected Resident

No correction is possible for affected resident.

Identification of others

1. In house dialysis residents have been assessed for potential access related complications IE patency, bleeding, infection

2. Licensed Nurse competencies related to dialysis management and center protocol for post dialysis monitoring have been reviewed.

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5 Mar 12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Andrew W. Reese* TITLE: *Interim Executive Director* (X6) DATE: *5 Mar*

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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F 309	Continued From page 1 <p>█/10. Resident 1 had diagnoses that included █. His █ did not adequately remove waste, salts and water from his body and Resident 1 was treated with artificial █ treatments (█) three times each week; on Monday, Wednesday, and Friday.</p> <p>Resident 1 had an █ (█) in his upper left arm. The █ had been created by a surgeon. In the upper arm, under the skin, a large artery had been connected to a large vein so that a large amount of blood flowed rapidly. The █ was necessary to perform █ treatments.</p> <p>According to radiological studies of █ fistulas and success for █ treatments, "successful fistulas," had an average blood flow rate in AVF of, "780," milliliters (ml) every minute." (Blood flowed at a rate of approximately 1.6 pints every minute.) [Reference: Radiology, October 2002, Hemodialysis Arteriovenous Fistula Maturity: US Evaluation, pages 59 - 63] Blood flow rates in mature devices typically may reach up to 2000 ml/min. but more typically they are 800-1200 ml/min. [Reference: "Clinical Dialysis" 4th edition; 2005 Nissenson, Fine]. "If an AVF bleeds, apply direct pressure until the bleeding stops. Rationale: Bleeding can be a life threatening emergency." Reference: "Textbook of Basic Nursing," 9th edition, 2008 Lippincott Williams & Wilkins.</p> <p>Resident 1's nursing care plan, titled, █: Potential Problems," dated 10/18/10, instructed that the nurse was to monitor and check the AVF every shift. There were no interventions for bleeding included in the plan.</p>	F 309	F 309 continued Systemic Changes <ol style="list-style-type: none"> Care plans have been updated to reflect specific monitoring parameters necessary for early detection of dialysis related complications/emergencies. Care plans have been updated to reflect emergency management of bleeding. Licensed nursing staff have received in-servicing on dialysis management, including emergency management of access related complications. Licensed nursing staff have received in-servicing on professional standards of documentation. Center has developed and implemented a C.N.A. dialysis kardex 	5 Mar 12
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F 309	Continued From page 2 Review of nurse's progress notes, dated [REDACTED]/10 at 12:30 a.m., showed an entry that recorded RN A's assessment of Resident 1's condition; he was [REDACTED] and [REDACTED]. RN A gave Resident 1 a breathing treatment and recorded his blood pressure as 110/80, pulse=70, temperature=96.4 and respirations=24. The Medication Administration Record (MAR) records, for the date [REDACTED]/10, showed the initials of RN A to indicate that RN A gave Resident 1 a breathing treatment of Acetylcysteine (mucolytic agent: loosens up thick mucus) at 1 a.m. Nurses notes, at 2:35 a.m. on [REDACTED]/10, showed that RN A recorded that a Certified Nurse Aide (CNA 1) told her that there was blood on Resident 1's, "chest, (left AVF) shunt and abdomen." Resident 1, "was breathing," but RN A was unable to measure his blood pressure or an oxygen saturation level (amount of circulating oxygen in the blood). Facility staff made a, "911," telephone call to transfer Resident 1 to a hospital emergency department and RN A documented in the nurse's notes the administration of another breathing treatment to Resident 1. RN A did not record any information as to the cause of blood on Resident 1's body, nor was there any information recorded as to any attempt to stop bleeding. Review of the ambulance emergency response team report, dated [REDACTED]/10, indicated the emergency response team arrived at the bedside of Resident 1 at 2:56 a.m. Paramedic A recorded that the response team found Resident 1 with,	F 309	F 309 continued Monitoring 1. Center will monitor for sustained compliance through weekly audits of dialysis monitoring logs. 2. Routine and random staff competency reviews related to dialysis management/monitoring and through daily IDT walking rounds. Responsibility The DNS is responsible for overall implementation of the plan. Concerns stemming from audits and competency reviews will be discussed during the performance improvement (PI) committee and modifications will be made as necessary.	5 Mar 12

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F 309	<p>Continued From page 3</p> <p>"blood on the bed and his bandages. "Paramedic A recorded that a CNA had told him that there was, "blood everywhere..." Resident 1 went by ambulance to the hospital emergency department (ED) and arrived at 3:12 a.m.</p> <p>A review of hospital ED records, dated [REDACTED]/10, showed that on arrival Resident 1 was, "pulseless," and not breathing. "...the patient (Resident 1) was [REDACTED] [REDACTED] at 3:22 a.m."</p> <p>The death of Resident 1 was referred to the Alameda County Coroner. Coroner Autopsy Examination Findings, dated 11/10/10, included examination of Resident 1's AVF. "There is an (oval shaped opening) defect, measuring 3/4 inch in length..." "The opening leads into the (vessel)...no other abnormalities are noted." There was a hole in Resident 1's AVF.</p> <p>During an interview on 12/28/10 at 11:00 a.m. Paramedic A stated a call was received from the facility on [REDACTED]/10 concerning a resident, "who was vomiting blood." Paramedic A stated he found Resident 1 lying in bed, looking pale, skin cool to touch, sweating and with an abnormal breathing pattern. Paramedic A stated "...there was no blood in (Resident 1's) mouth which is not consistent with vomiting blood." Resident 1's left arm bandage was soaked in blood.</p> <p>On [REDACTED]/10 at 11:a.m. during an interview, Emergency and Fire Response Captain H stated that (Resident 1) was all cleaned up but had a blood soaked bandage on his left arm where the shunt was. He noted that the bed sheets were clean but there were blood soaked sheets on the bathroom floor. A bandage on Resident 1's left</p>	F 309		
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F 309	<p>Continued From page 4</p> <p>arm was blood soaked. The nurses were, "vague," about what happened and the story kept changing about when the resident was last seen by facility staff.</p> <p>The Coroner stated in an interview on [REDACTED]/10 at 8:08 a.m., that his preliminary report indicated that Resident 1 [REDACTED] on [REDACTED]/10 from shock due to [REDACTED].</p> <p>During an interview on [REDACTED]/10 at 2:23 p.m., Police Officer 1 stated he did an investigation because Resident 1 was [REDACTED] on arrival to the hospital. Review of Police Officer 1's investigative report of the interview with RN A dated [REDACTED]/10, indicated that RN A stated that she failed to identify the source of Resident 1's bleeding and had not lifted, changed, removed or touched any portion of the access shunt device dressing. Digital photographs taken by the Police Officer showed several blood soaked linens and a bloody bandage from Resident 1's left upper arm where the access device was located.</p> <p>In an interview on 12/20/10 at 2:19 p.m. RN A confirmed that she did not apply direct pressure to the bleeding AVF and that she did not check Resident 1's AVF during her work shift or contact the physician regarding the observed change in Resident 1's condition. She stated "I was exhausted. I made up the vital signs and did not give a breathing treatment as documented at 1 a.m. I didn't know where the blood was coming from." RN A was unable to identify the signs/symptoms of hemorrhaging and stated, "I don't know ...I am blank."</p> <p>During an interview on 12/23/10 at 3:54 p.m.,</p>	F 309		
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F 309	<p>Continued From page 5</p> <p>CNA 1 said she took a break at 2:00 a.m. and returned at 2:30 a.m. to check on Resident 1 and found a lot of blood around the left side of his body. CNA 1 stated she noted Resident 1 was, "breathing big breaths," so she immediately called RN A. She said RN A came into the room, took one look at Resident 1 and left to call 911. During this time, CNA 1 said she observed RN A walking back and forth in front of Resident 1's room and returning to the nurses' station to check the chart or use the phone at least three times while she (CNA 1) cleaned Resident 1 of the blood.</p> <p>Facility staff did not assess Resident 1 for bleeding from the AVF and did not apply pressure to the bleeding AVF.</p> <p>During an interview on 12/20/10 at 1:53 p.m., the facility's Executive Director stated that the facility had a Policy and Procedure (P&P) titled "Bleeding Control" dated 4/28/09, which indicated that firm direct pressure was to be applied to the site of the injury and pressure was to be maintained until the bleeding stops.</p> <p>In an interview on 12/20/10 at 3:09 p.m., Resident 1's attending physician stated she would expect the staff to do a full assessment of Resident 1's pale and weak condition, notify the physician and apply a gloved hand or use a towel to control the bleeding.</p> <p>The nephrologist, (a physician specializing in [REDACTED] disorders) during an interview on 12/21/10 at 9:56 a.m., stated he would expect the staff to put pressure if there was bleeding at the AVF.</p> <p>In an interview on 4/4/11 at 3:00 p.m. the Staff</p>	F 309		

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F 309	<p>Continued From page 6</p> <p>Developer Coordinator (SDC) who was responsible for staff training, confirmed there was no training for care of a hemodialysis dependent resident during RN A's orientation. The SDC stated that she eventually gave staff a mandatory dialysis in-service, but RN A was always too busy to attend the meeting. The SDC was unable to provide any documentation which validated a staff in-service training of care of the [REDACTED] dependent resident prior to [REDACTED]/10.</p> <p>Therefore:</p> <p>The facility failed to assess the condition of Resident 1 to determine the cause of bleeding and did not apply pressure to the hemorrhaging AVF thus allowing Resident 1 to bleed to death.</p>	F 309		
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