

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222
---	---

(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
V000000	<p>This was a federal ESRD complaint investigation.</p> <p>Date: 11/14/13</p> <p>Complaint # IN00138621 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Facility # 010129</p> <p>Medicaid # 200144930A</p> <p>Surveyors: Miriam Bennett, RN PH Nurse Surveyor, Lead Surveyor Tonya Tucker, RN PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">November 18, 2013</p>	V000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/14/2013	
NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222			
(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			
V000461	<p>494.70(a)(10) PR-INFORMED OF OWN MEDICAL STATUS The patient has the right to-</p> <p>(10) Be informed by the physician, nurse practitioner, clinical nurse specialist, or physician's assistant treating the patient for ESRD of his or her own medical status as documented in the patient's medical record, unless the medical record contains a documented contraindication; Based on clinical record review and interview, the clinic failed to ensure the patient was notified of critical lab value for 1 of 3 clinical records reviewed with the potential to affect all the clinic's patients. (#1)</p> <p>Findings include</p> <p>1. Clinical record #1 evidenced the patient's INR to be 3.8 on 10/14/13. The record failed to evidence the patient or their physician were notified of the elevated value.</p> <p>2. During interview on 11/14/13 at 1:55 PM, employee D indicated the clinic does not have a policy for lab results notification, only a process which includes the staff nurse or Nurse Practitioner (NP) reviewing the labs and dealing with them according to who is managing the patients' labs. The NPs manage the coumadin here unless the</p>	V000461	V461 The Medical Director will assume responsibility for the physicians, physician assistants, nurse practitioners, or clinical nurse specialists (credentialed associates) that have privileges at DCI, Indianapolis, 152547. These associates will provide diagnostic information to all patients under their care regarding normal and abnormal results, and provide ongoing documentation of such in the EMR (electronic medical record). A policy has been developed stating lab reporting and follow-up process and all current credentialed associates treating patients at DCI, Indianapolis, and DCI patient care and administrative staff, will be educated regarding this policy by December 6,, 2013. In future, this policy will be given to new credentialed associates, and new DCI staff. These policies will include V-tag information for clarification. We will audit charts monthly, for 6 months, to ensure proper action and documentation has occurred.	12/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222
---	---

(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
	patients' personal physicians or coumadin clinics manage them. Employee D also indicated since there was not a staff signature on this patient's lab results page dated 10/14/13, the clinic doesn't know that the patient was notified of the results.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/14/2013	
NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222			
(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			
V000636	<p>494.110(a)(2)(viii) QAPI-INDICATOR-PT SATIS &amp; GRIEVANCES</p> <p>The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances.</p> <p>Based on document review, policy review, and interview, the clinic failed to ensure patient complaints were documented through investigation and resolution and failed to ensure the Quality Assurance and Performance Improvement (QAPI) contained patient complaints for 1 of 1 QAPI documents reviewed with the potential to affect all of the clinic's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>On 11/14/13 at 11:00 AM, employee A provided a risk management report. This report failed to evidence any complaints and was an adverse event list.</li> <li>A risk management report dated 8/23/13 concerned patient #1 and states, "Pt [patient] admitted treated for s/s [signs and symptoms] of CVA [cerebrovascular accident]."</li> <li>On 11/14/13 at 11:25 AM, employee A indicated the risk management staff pulls the incidents off the computer to create the risk management report.</li> </ol>	V000636	<p>V636 A policy has been developed which includes educating nurses to complete general progress notes, risk management reports, and the complaint form in response to a patient's complaint. All clinic staff will be educated by 12-6-2013, regarding the grievance and complaint procedure which will be included in the orientation process in future. This includes: forms for reporting complaints, complaint resolution procedure, complaint/grievance forms within patient care areas, and the development of a complaint/grievance tracking mechanism which will be reviewed by the Clinical Nurse Manager (CNM) and Facility Administrator (FA) for resolution on an on-going basis as needed. A box will be placed in lobby with grievance forms for patients to fill out anonymously, and the box will be checked daily by the FA. The CNM and FA will have final sign-off on all complaints/grievances, and will review in monthly QAPI meeting. The DCI Corporate Nurse Consultant will provide training and follow-up regarding QAPI activities and documentation, focusing on patient</p>	12/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/14/2013	
NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222			
(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			
	<p>4. On 11/14/13 at 11:30 AM, employees A and B indicated the risk management report is for quality assessment and performance improvement purposes and the clinic does not have a specific document for complaints and grievances, but they do investigate and resolve grievances as they learn about them. Employee B also indicated if patients have a complaint, the complaint should be listed on the flow sheet.</p> <p>5. On 11/13/14 patient #1 was contacted via telephone at 12:53 PM. Patient #1 indicated they did file a complaint with the clinic.</p> <p>6. On 11/14/13 at 3:20 PM, employee A indicated they did not realize patient #1 had filed a complaint to the clinic on 10/24 or 10/25/13 as indicated on the Release of Responsibility for Early Termination from Hemodialysis form dated 10/24 for treatment provided 10/25/13.</p> <p>7. The clinic's policy titled "Handling Patient Grievances," #1.9, dated 12/18/03 states, "1. If a patient wishes to make a complaint or grievance regarding the administration of health care, discriminatory practices or privacy practices, the clinic will request that the patient complete the DCI form entitled</p>		complaints/grievance as an opportunity to improve care.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152547	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/14/2013
NAME OF PROVIDER OR SUPPLIER  DIALYSIS CLINIC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222		
(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	
	'Patient Complaint and grievance Form.' ... 4. The clinic will complete the complaint/grievance process within 30 days of receipt Patient and Grievance Form completed by the patient. 5. The clinic will maintain all documents related to the patient complaint/grievance and resolution in a file separate from the medical record in a secure location. 6. DCI's goal is to hear, review, and address complaints / grievances to ensure a mutually satisfactory patient-clinic relationship. DCI will not subject a person filing a complaint / grievance to negative treatment."				