

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152646	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2014
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NAME OF PROVIDER OR SUPPLIER SCOTTSBURG DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1619 W MCCLAIN AVE SCOTTSBURG, IN 47170
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V000000	<p>This was a federal ERSD [CORE] recertification survey.</p> <p>Survey Dates: 7.16.14, 7.17.14, 7.18.14</p> <p>Facility Number: 012585</p> <p>Medicaid Number: 201021380</p> <p>Surveyors: Michelle Weiss RN MSN PHNS Team Leader Vicki Harmon RN PHNS</p> <p>Scottsburg Dialysis was found to be out of compliance with Conditions for Coverage Number 42 CFR 494.30 Infection Control and 42 CFR 494.70 Patients' Rights.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 23, 2014</p>	V000000	Items in BOLD were revised on 8/6/14	
V000110	<p>494.30 CFC-INFECTION CONTROL</p> <p>Based on observation, interview, administrative and clinical record review, personal file review, and policy review, it</p>	V000110	<p>V110 A Governing Body (GB) meeting was held to review the Statement of Deficiencies (SOD) and</p>	08/15/2014

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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V000121	<p>was determined the facility failed to maintain compliance with this condition by failing to follow their own infection control precautions in 2 of 4 observations creating the potential to affect all of the facility's 23 current patients (see V 121); by failing to follow their own cleaning and disinfection policies in 2 of 4 observations creating the potential to affect all of the facility's 23 current patients (see V 122); by failing to ensure all staff were aware of and had followed the facility's policy regarding the provision of care to hepatitis B positive patients in 2 of 3 employees creating the potential to affect all of the facilities 23 current patients (see V 131); and by failing to ensure staff had been educated regarding the care of a patient with clostridium difficile in 2 of 2 files reviewed creating the potential to affect all of the facility's 23 current patients (see V 132).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition 42 CFR 494.30 Infection Control</p>		<p>formulate the Plan of Correction (POC). The standards under Condition –Infection Control (V110) that are not met have detailed POCs referenced to the specific V tags. Ongoing compliance to the POC includes promoting implementation of policies and procedures to ensure correct and effective practices in infection control techniques including but not limited to: infection control precautions, cleaning and disinfection, provision of care for Hep B positive patients, and staff educated on care of a patient with clostridium difficile. Members of the GB including the Facility Administrator (FA), Regional Operations Director (ROD), and Medical Director (MD), have agreed to meet weekly to monitor the facility's progress toward compliance. Then ongoing compliance to the POC will be monitored during GB meetings at least semi-annually. This POC will also be reviewed at each monthly QAPI meeting known as the Facility Health Meeting (FHM) when the FA will report progress, as well as any barriers to maintaining compliance, to the committee.</p> <p>Completion date: 8/15/14</p>		

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	<p>IC-HANDLING INFECTIOUS WASTE [The facility must demonstrate that it follows standard infection control precautions by implementing-] (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-</p> <p>(i) Handling, storage and disposal of potentially infectious waste; Based on observation, interview, and policy review, the facility failed to follow their own infection control policy in 2 (1 and 3) of 4 observations creating the potential to affect all of the facility's 23 current patients.</p> <p>Findings include:</p> <p>1. On 7-16-14 at 9:04 AM, environmental observation number 1 included the first tour of the dialysis treatment area where it was noted that the large red biohazard receptacles were in close proximity to clean patient supplies. The lid to the large receptacle bin was within a foot of the clean supplies that were kept on the counter just above.</p> <p>2. On 7-16-14 at 11:20 AM, observation number 3 employee D transported a dialyzer and blood lines to the large red biohazard receptacle and disconnected and capped the dialyzer. Then the bloodlines were discarded in the biohazard receptacle with the potential of</p>	V000121	<p>V121 100% of clinical teammates were in-serviced on <i>Policy 1-05-01 "Infection Control for Dialysis Facilities"</i>. Verification of attendance at in- service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Biohazard cans are to be kept away from clean area, with can pushed in an area as far from designated clean areas, potential splash zones, at a minimum of no less than 1 foot away from clean supplies. Can is to be brought to station being cleaned, for disposal of dirty line and supplies, and the lid is to be placed on the cans after use. The Facility Administrator (FA) or designee will conduct observational infection control audits on random shifts daily for two weeks, and then twice weekly for 2 weeks, and document via the quantitative</p>	08/15/2014

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V000122	<p>blood splashing on clean patient supplies kept in the clean area on the counter.</p> <p>3. The facility administrator indicated on 7-18-14 at 2:30 PM they (the biohazard receptacles) should be moved closer to the dirty area.</p> <p>4. The facility's March 2014, "Infection Control for Dialysis Facilities" policy 1-05-01 states, "Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, interview, and policy review, the facility failed to follow their own cleaning and disinfection policy in 2 (numbers 1 and 2) of 4</p>	V000122	<p>Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC). Completion date:</p> <p>V122 100% of clinical teammates were in-serviced on <i>Policy 1-05-01 "Infection Control for Dialysis Facilities"</i> and <i>Policy 1-05-08</i></p>	08/15/2014			

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	<p>observations creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Discontinuation of the dialysis treatment during observation number 1 was completed on 7/16/14 at 11:22 AM. Employee D, a patient care technician, was observed to discontinue dialysis and perform post dialysis access care on patient number 1. Two small drops of blood were observed on the chairside table beyond the border of the chux that was below the patient's left arm and access. It was not immediately cleaned and was still present at 11:30 after the patient had vacated the station. 2. On 7/16/14 at 11:30 AM, observation number 2 noted that clamps were used on patient number 1 at station 8. During the observation of cleaning and disinfection of the dialysis station, the clamps, non-disposable equipment, were left hanging on the Intravenous (IV) pole after the all surfaces and other equipment had been disinfected. The technician then discarded the wipes and removed her gloves. <p>The patient care technician, employee D, indicated she usually transports the</p>		<p><i>"Bleach Policy"</i>. Verification of attendance at in- service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) teammates will thoroughly wipe down all non-disposable items and equipment, such as the blood pressure cuff, the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment, and 2) cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or other potentially infectious materials. Use an appropriate disinfectant such as 1:100 bleach solution for environmental surfaces. For visible blood or gross blood spills, a 1:10 bleach solution must be utilized. After all visible blood is cleaned with the 1:10 bleach solution, teammates are to use a new disposable towel soaked with 1:10 bleach solution and clean area a second time. The FA or designee will conduct observational infection control audits on random shifts daily for two weeks, and then twice weekly for 2 weeks, and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the</p>		

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V000131	<p>clamps when disinfecting the dialysis station.</p> <p>4. The facility's March 2014 policy "Infection Control for Dialysis Facilities" number 1-05-01 states, "Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and the outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment . . . Cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or potentially infectious materials. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for environmental surfaces. For visible blood or gross spills, a 1:10 (one to ten) bleach solution must be utilized. After all visible blood is cleaned with the 1:10 (one to ten) bleach solution, clean the area a second time."</p> <p>494.30(a)(1)(i) IC-HBV-ISOLATION-STAFFING Isolation of HBV+ Patients</p> <p>Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during</p>		<p>monthly FHM. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>	

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	<p>the period when dialysis is terminated on one patient and initiated on another. Based on observation, facility policy and administrative record review, clinical record review, and interview, the facility failed to ensure all staff were aware of and had followed the facility's policy regarding the provision of care to hepatitis B positive patients in 2 (employees B, C, and E) of 3 employees observed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the entrance conference, on 7-16-14 at 12:40 PM, the facility identified, in writing, on a completed "Entrance Conference Questions" worksheet, the facility had 1 hepatitis B positive patient on census. The facility manager indicated the facility had 1 hepatitis B positive patient on census at this time (#5). 2. On 7-16-14 at 9:25 AM, observation noted patient number 5 receiving a dialysis treatment in the isolation room. Employee C, a registered nurse (RN), was observed to provide care to patient number 5 and the only RN on the treatment floor. <p>A. There were 6 other patients</p>	V000131	<p>V131 100% of clinical teammates were in-serviced on <i>Policy 1-05-09 "Infection Control and Isolation Measures for Known or Suspected Hepatitis B Surface Antigen Positive Patients"</i>. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observation as examples with emphasis on, but not limited to, the following: 1) teammates caring for confirmed or suspect hepatitis B surface antigen (HbsAg) positive patient(s) do not care for surface antibody negative (susceptible) patients simultaneously, and 2) when preparing patient assignments, teammates who care for confirmed or suspected hepatitis B surface antigen (HbsAG) positive patient(s) will only be assigned to simultaneously care for surface antibody positive (immune) patients. Discussion held with patient #5 regarding antibody > 150 and immunity so that treatment is no longer required in the isolation room. This is documented in the patient's medical record. The FA or designee will conduct observational infection control audits on random shifts daily for two weeks, and then twice weekly for 2 weeks, and document via the quantitative Infection Control Audit form. Ongoing compliance</p>	08/15/2014

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	<p>observed on the treatment floor receiving dialysis treatments including patients number 3 and 7 on 7-16-14 at 9:25 AM. The facility's 7-16-14 "Hepatitis B Report" evidenced patients numbered 3 and 7 did not have immunity to the hepatitis B virus.</p> <p>1.) At 11:30 AM, the RN was observed to remove her personal protective equipment (PPE, gown, shield, and gloves), wash her hands, and enter the isolation room. The RN washed her hands and donned PPE from the isolation room and provided care to the patient. The RN removed the PPE, washed her hands, departed the room, washed her hands, and donned the PPE worn previously.</p> <p>2.) The RN was observed to also provide care to patients numbered 3 and 7 on 7-16-14.</p> <p>3.) Clinical records 3 and 7 included post treatment flow sheets, dated 6-18-14, 6-23-14, 6-27-14, 7-2-14, 7-4-14, 7-7-14, and 7-11-14, that evidenced employee A, a registered nurse (RN), had provided care to these susceptible patients concurrently with providing care to patient number 5.</p> <p>4.) Clinical records 3 and 7</p>		<p>will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>				

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	<p>included post treatment flow sheets, dated 6-20-14, 6-25-14, 6-30-14, 7-9-14, and 7-14-14, that evidenced employee C, a RN, had provided care to these susceptible patients concurrently with providing care to patient number 5.</p> <p>B. On 7-17-14 at 3:05 PM, employee C, the RN, stated, "I thought the patient [# 5] was hepatitis B positive and did not know he really was not. I was not aware that the same nurse cannot take care of a positive patient at the same time as susceptible patients."</p> <p>3. On 7-16-14 at 1:00 PM, the facility administrator stated, "We keep susceptible patients at the other end of the isolation room. The immune patients are seated closer to the isolation room. We have dedicated supplies and a machine for the isolation room. Susceptible staff do not take care of the positive patients. The nurse that takes care of the patient in the isolation room only does assessments and administers medication to the susceptible patients at the other end of the treatment room. She does not initiate or discontinue the dialysis treatments."</p> <p>4. On 7-16-14 at 4:00 PM, the medical director was interviewed per telephone call. The medical director stated, "I am</p>			

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	<p>aware the same nurse is taking care of the patient in the isolation room and the other susceptible patients. That is because the patient in the isolation room is not really positive for hepatitis B. [The patient] should be considered normal. We are just treating [the patient] that way as a precaution. [The patient] was positive and is now negative."</p> <p>5. On 7-16-14 at 5:35 PM, the facility administrator stated, "I questioned why [the patient] was still in isolation if [the patient] was negative. The medical director said it was because [the patient] had a past acute infection and it was precautionary." When asked if the patient is aware of the negative status, the administrator replied, "I don't know."</p> <p>During an interview with patient number 5, on 7-18-14 at 9:10 AM, the patient stated, "I still have hepatitis 'lightly'."</p> <p>6. The facility administrator stated, on 7-17-14 at 11:00 AM, "My thinking was that doing an assessment and administering medications was not direct patient care because the nurse was not actually touching the patient." The administrator indicated that was why the same nurse could take care of a positive patient at the same time as taking care of</p>						

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V000132	<p>susceptible patients. The administrator indicated she was not aware of the facility's policy that identified the same nurse should not take care of both positive and susceptible patients.</p> <p>7. The facility's March 2014 "Infection Control and Isolation Measures For Known or Suspected Hepatitis B Surface Antigen Positive Patients" policy number 1-05-09 states, "Teammates caring for confirmed or suspect hepatitis B surface antigen positive (HBsAg) positive patient(s) do not care for surface antibody negative (susceptible) patients simultaneously. When preparing patient assignments, teammates who care for confirmed or suspected hepatitis B surface antigen (HBsAg) positive patient(s) will only be assigned to simultaneously care for surface antibody positive (immune) patients."</p> <p>494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education</p> <p>Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.</p> <p>Based on personnel file and facility policy review and interview, the facility failed to ensure staff had been educated</p>	V000132	V132 100% of clinical teammates were in-serviced on <i>Policy 1-05-05 "Infection Control for Bacterial Infections and Drug</i>	08/15/2014

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	<p>regarding the care of a patient with Clostridium difficile (C. diff) in 2 (files C and D) of 2 files reviewed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 4 included a laboratory report dated 7-9-14 that evidenced the patient had tested positive for Clostridium difficile (C. diff), a serious bacterial infection that causes diarrhea. 2. On 7-18-14 at 9:20 AM, observation noted patient number 4 was receiving treatment at station number 2. Employee C, the registered nurse, and employee D, a patient care technician (PCT), were observed to provide care to the patient. <ul style="list-style-type: none"> A. At 11:00 AM, employee D, the PCT, indicated she had not received any additional training and/or education related to caring for patients with C. diff infections. The PCT indicated she did not know she needed to wash her hands with soap and water instead of using alcohol hand cleanser after caring for the patient. B. At 11:20 AM, employee C, the RN, stated, "I don't know if they [the 		<p><i>Resistant Organisms</i>".</p> <p>Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observation as examples with emphasis on, but not limited to, the following: 1) additional precautions should be considered for treatment of patients who might be at increased risk for transmitting pathogenic bacteria...include Clostridium difficile, 2) for patients who are considered to be at increased risk for transmitting pathogenic bacteria, the Medical Director and attending physician are to be notified and additional precautions should be implemented: teammates treating patient should wear a separate long sleeved fluid resistant/fluid impervious garment, that is removed and discarded after caring for the patient, 3) teammates caring for the patient with active Clostridium difficile infection must perform frequent hand washing, as alcohol based hand gels may not be effective to eliminate C. diff spores, and 4) the patient should have his/her own supplies, including stethoscope and blood pressure cuff. When this is not possible, a non-disposable item should be disinfected between patients. The patient with active Clostridium difficile has been provided with his/her own supplies, including stethoscope and blood pressure</p>		

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	<p>facility] told me but I already knew to use soap and water to cleanse my hands."</p> <p>3. Personnel files C and D failed to evidence any education and/or training had been provided to the individuals regarding infection control procedures for patients with C. diff infections.</p> <p>4. The facility's September 2012 "Infection Control for Bacterial Infections Caused by Pathogenic Bacteria Including Drug Resistant Organisms" policy number 1-05-05 states, "Additional infection control precautions should be considered for treatment of patients who might be at increased risk for transmitting pathogenic bacteria . . . include Clostridium difficile . . . For patients who are considered to be at increased risk for transmitting pathogenic bacteria, the Medical Director and attending physician are to be notified and additional precautions should be implemented: Teammates treating the patient should wear a separate long sleeved fluid resistant/fluid impervious barrier garment, that is removed and discarded after caring for the patient. Teammates caring for the patient with active Clostridium difficile (C. diff) infection must perform frequent hand washing, as alcohol based hand gels may not be effective to eliminate C. diff</p>		<p>cuff, and thermometer. The FA or designee will conduct observational infection control audits on random shifts daily for two weeks, and then twice weekly for 2 weeks, and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>	

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V000401	<p>spores . . . The patient should have his/her own supplies, including stethoscope and blood pressure cuff. When this is not possible, a non-disposable item should be disinfected between patients."</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, interview, and facility policy review, the facility failed to ensure it had maintained a clean environment for patient care in 2 (#1 and 2) of 4 environmental observations completed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <p>1. On 7-16-14 at 9:15 AM, environmental observation number 1 included the water room and dialysate mixing area. Observation noted a white residue dripping from the upper pipe and collecting below the secondary tank labeled 2.0 K 2.5 Ca concentrate. The floor was wet in front of the carbon tanks. On the floor in the back of the room, beyond the Central Dialysis Water</p>	V000401	<p>V401</p> <p>100% of clinical teammates were in-serviced on <i>Policy 8-04-01 "Physical Environment"</i> and <i>Policy 2-07-01 "Bicarbonate Concentrate System Mixing"</i>. Verification of attendance at the in- service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) the dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment, and 2) bicarbonate mixing systems will have a tight fitting lid. The residue from the upper pipe and collecting below the secondary tank labeled 2.0 K</p>	08/15/2014

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	<p>System, were large coils of hose. There was also a cardboard box that was discolored and broken. On the floor in the opposite corner was a plunger from a syringe. The shelves of a cart were covered with dirty chuxs.</p> <p>2. On 7-17-14 at 11:25 AM, a second observation was made of the water room and dialysate area. Observation noted continued white residue dripping from the upper pipe and collecting below the secondary concentration tank. The Biomed technician, employee H, stated, "The banjo cap on the tank is missing."</p> <p>On 7-17-14 at 11:26 AM, the patient care technician, employee B, stated, in reference to the debris and hoses in the back of the room, "That doesn't belong there, we can clean this up right away."</p> <p>3. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p>		<p>and 2.5 Ca concentrate has been cleaned. The biomedical technician (BMT) has fixed all leaks on the dialysate concentrate system. The trash was cleaned out of the water room behind the CWP. The FA or designee will conduct observational audits of the physical environment daily for 2 weeks, and then weekly x 4 weeks. Ongoing compliance will be monitored by monthly completion of the OSHA and Safety Checklist. FA will report findings in the monthly FHM. The FA is responsible for compliance with this POC. Completion date: 8/15/14</p>		

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V000450	<p>494.70 CFC-PATIENTS- RIGHTS Based on clinical record and facility policy review, observation, and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure patients had been treated with respect and dignity in 2 of 4 records reviewed creating the potential to affect all of the facility's 23 current patients (See V 452); by failing to ensure patients had been informed of their status in 1 of 5 records reviewed creating the potential to affect all of the facility's 23 current patients (See V 456); and failed to ensure the patient had been informed of the facility's policy regarding isolation in 1 of 1 record reviewed of patients that received dialysis treatments in the isolation room creating the potential to affect any future patients to dialyze in the isolation room (See V 459).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.70 Patients' Rights.</p>	V000450	<p>V450The Governing Body (GB) has met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Condition –Patient Rights (V450) that are not met have detailed POCs referenced to the specific V tags. Ongoing compliance to the POC includes promoting implementation of policies and procedures to ensure correct and effective practices in patient rights including but not limited to: treating patients with respect and dignity, informing patient(s) of their status, and informing patient of facility's policy regarding isolation. Members of the GB including the Facility Administrator (FA), Regional Operations Director (ROD), and Medical Director (MD), have agreed to meet weekly to monitor the facility's progress toward compliance. Then ongoing compliance to the POC will be monitored during GB meetings at least semi-annually. This POC will also be reviewed at each monthly QAPI meeting known as the Facility Health Meeting (FHM) when the FA will report progress, as well as any barriers to maintaining compliance, to the committee. Completion date: 8/15/14</p>	08/15/2014

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V000452	<p>494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD Based on observation, clinical record review, and interview, the facility failed to ensure patients had been treated with respect and dignity in 2 (#s 4 and 5) of 4 records reviewed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 failed to evidence the patient had been cleaned and clothes changed after episodes of diarrhea during the dialysis treatment.</p> <p>A. Clinical record number 4 included a "Progress and POC [plan of care] Follow-up Notes Report" signed and dated by employee C, the registered nurse, on 5-2-14. The note states, "Patient arrived for tx [treatment] this AM and assisted by me into tx chair. [The patient] then said that [the patient] needed to use the bathroom. I asked [the patient] if [the patient] had to go now before beginning tx. [The patient] said, 'Yes, I think so.' As I was taking off BP [blood pressure] cuff, patient leaned to</p>	V000452	<p>V452 100% of clinical teammates were in-serviced on <i>Policy 1-05-02 "Hepatitis Surveillance, Vaccination, and Infection Control"</i> and <i>Policy 1-05-17 "Care of Patients who are Incontinent of Bowel While on Dialysis"</i>. Verification of attendance at the in- service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) isolation measures used for care of the confirmed hepatitis B surface antigen (HBsAg) positive patient may be discontinued only upon order of the patient's physician or facility Medical Director <u>and</u> when the patient has been hepatitis B surface antigen negative for 30 days with 2 negative test results; <u>or</u> the repeat hepatitis B surface antigen test result was negative <u>and</u> the initial positive results was determined by the physician to be a false positive or due to vaccine induced antigenemia, and 2) the facility must be equipped to clean patients if they should have an episode of bowel incontinence... the facility will maintain sufficient incontinence supplies to meet patient needs. They may do this</p>	08/15/2014
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	<p>the side and said 'I just [defecated] a pot full in my pants.' I told [the patient] that we did not have the supplies or staff to clean [the patient] up here and that I would send [the patient] back to the LTCF [long term care facility] and reschedule [the patient] for tomorrow. Patient was sent back to LTCF with regular transportation."</p> <p>The record failed to evidence dialysis facility staff had cleaned the patient prior to having the patient transported back to the LTCF.</p> <p>B. The record included a "Progress and POC Follow-up Notes Report", signed and dated by employee A, a RN, on 5-21-14. The note states, "Pt [patient] called RN to chairside. Pt reported [the patient] had accident. Pt reports ongoing diarrhea. Pt reports LTCF aware of problem. Pt d/c [discontinued] tx [treatment] early d/t [due to] accident. Pt noted vomited X 1 in waiting area post HD [hemodialysis] tx."</p> <p>The record failed to evidence dialysis facility staff had cleaned the patient prior to having the patient transported back to the LTCF.</p> <p>C. The record included a "Progress and POC Follow-up Notes Report"</p>		<p>by requesting the family or residential facility to routinely send disposable incontinence garments and clean clothes with the patient, or we will purchase and maintain our own supplies including disposable undergarments. FA or designee has reviewed "Patient Rights, Responsibilities, and Facility Rules" with 100% of patients to verify that patients are aware of these rights. A copy of this patient education was also placed in each patient's medical record. The FA or designee is conducting observational audits on each shift on each treatment day for 3 weeks to ensure that patient's rights including dignity and privacy are observed. This audit will be to observe that patients incontinent of bowel are treated per policy. Discussion held with patient #5 regarding antibody > 150 and immunity so that treatment is no longer required in the isolation room. This is documented in the patient's medical record. That treatment is no longer required in the isolation room. This is documented in the patient's medical record. The FA or designee will conduct observational infection control audits on random shifts daily for two weeks, and then twice weekly for 2 weeks, and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit.</p>	

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	<p>signed and dated by employee A, a RN, on 7-2-14. The note states, "Pt requested to d/c [discontinue] tx early d/t pt had diarrhea and had accident. Pt dc'd 93 minutes early. Pt educated on importance of running full HD tx . . . Tx d/c per RN. Transportation contacted RN contacted LTCF."</p> <p>The record failed to evidence dialysis facility staff had cleaned the patient prior to having the patient transported back to the LTCF.</p> <p>D. Post treatment flow sheets, dated 7-7-14, 7-14-14, 7-16-14, & 7-18-14, state, "c/o [complained of] diarrhea."</p> <p>E. A post treatment flow sheet dated 7-2-14 states, "treatment terminated . . . tx d/c AMA [against medical advice] per pt request. pt had accident and nothing to change into."</p> <p>F. The facility's March 2010 "Care of Patients Who Are Incontinent of Bowel While on Dialysis" policy number 1-05-17 states, "The facility must be equipped to clean patients if they should have an episode of bowel incontinence . . . The facility will maintain sufficient incontinence supplies to meet patients' needs. They may do this by requesting the family or residential facility to</p>		FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14				

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	<p>routinely send disposable incontinence garments and clean clothes with the patient, or they may purchase and maintain their own supplies including disposable undergarments."</p> <p>2. Clinical record number 5 failed to evidence the patient had been informed of, and had been provided the opportunity to participate in, the decision to continue the dialysis treatments in the isolation room even after the blood tests demonstrated the patient was negative for hepatitis B.</p> <p>A. During the entrance conference, on 7-16-14 at 12:40 PM, the facility identified, in writing, on a completed "Entrance Conference Questions" worksheet, the facility had 1 hepatitis B positive patient on census. The facility manager indicated the facility had 1 hepatitis B positive patient on census at this time.</p> <p>B. On 7-16-14 at 9:25 AM, observation noted patient number 5 receiving a dialysis treatment in the isolation room.</p> <p>C. On 7-16-14 at 4:00 PM, the medical director was interviewed per telephone call. The medical director stated, "I am aware the same nurse is</p>				

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	<p>taking care of the patient in the isolation room and the other susceptible patients. That is because the patient in the isolation room is not really positive for hepatitis B. [The patient] should be considered normal. We are just treating [the patient] that way as a precaution. [The patient] was positive and is now negative."</p> <p>The facility's 7-16-14 "Hepatitis B Report" evidenced the patient had been identified as hepatitis B positive on 8-17-11, 9-14-11, 11-16-11, and 11-14-12. The report evidenced the patient had been identified as negative on 11-13-13 and 11-25-13.</p> <p>D. On 7-16-14 at 5:35 PM, the facility administrator stated, "I questioned why [the patient] was still in isolation if [the patient] was negative. The medical director said it was because [the patient] had a past acute infection and it was precautionary." When asked if the patient is aware of the negative status, the administrator replied, "I don't know."</p> <p>E. During an interview with patient number 5, on 7-18-14 at 9:10 AM, the patient stated, "I still have hepatitis 'lightly'."</p> <p>F. On 7-18-14 at 9:55 AM, the</p>			

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V000456	<p>facility administrator was unable to provide any documentation regarding informing the patient of the current hepatitis B results and the decision by the medical director to continue to dialyze the patient in the isolation room "as a precaution." The administrator stated, "I told [the patient] about it and that's when I talked to [the patient] about staying in the isolation room. I don't know if I documented it." At 10:00 AM, the administrator stated, "I cannot find any documentation."</p> <p>494.70(a)(5) PR-PARTICIPATE IN CARE;DISC/REFUSE TX The patient has the right to-</p> <p>(5) Be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research; Based on clinical record review and interview, the facility failed to ensure patients had been informed of their status in 1 (# 5) of 5 records reviewed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to</p>	V000456	<p>V456 100% of clinical teammates were in-serviced on <i>Policy 3-01-07 "Patient Rights and Responsibilities"</i>, and <i>Policy 3-01-07A "Patient Rights, Responsibilities and Facility Rules"</i>. Verification of attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) the patient's right</p>	08/15/2014

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	<p>evidence the patient had been informed of, and had been provided the opportunity to participate in, the decision to continue the dialysis treatments in the isolation room even after the blood tests demonstrated the patient was negative for hepatitis B.</p> <p>A. During the entrance conference, on 7-16-14 at 12:40 PM, the facility identified, in writing, on a completed "Entrance Conference Questions" worksheet, the facility had 1 hepatitis B positive patient on census. The facility manager indicated the facility had 1 hepatitis B positive patient on census at this time.</p> <p>B. On 7-16-14 at 9:25 AM, observation noted patient number 5 receiving a dialysis treatment in the isolation room.</p> <p>C. On 7-16-14 at 4:00 PM, the medical director was interviewed per telephone call. The medical director stated, "I am aware the same nurse is taking care of the patient in the isolation room and the other susceptible patients. That is because the patient in the isolation room is not really positive for hepatitis B. [The patient] should be considered normal. We are just treating [the patient] that way as a precaution.</p>		<p>to receive a full explanation by your physician/allied health professional of the nature of your medical status and the necessity for recommended treatment/appointment(s), including the risks and side effects and other treatment/appointment options before giving consent to treatment/appointment. This includes a full explanation of facility policies regarding patient care, including, but not limited to, certain infectious diseases that may require you to be dialyzed in a separate space from other patients. FA or designee has reviewed "Patient Rights, Responsibilities, and Facility Rules" with 100% of patients to verify that patients are aware of these rights. A copy of this patient education was also placed in each patient's medical record. Discussion held with patient #5 regarding antibody > 150 and immunity so that treatment is no longer required in the isolation room. This is documented in the patient's medical record. The FA or designee has reviewed that 100% of the patient's rights & responsibilities have been completed, a patient tracking form with dates of each patients review has been placed in the evidence binder. Ongoing compliance will be monitored by monthly hepatitis audits to verify 100% of patients' current hepatitis</p>	

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	<p>[The patient] was positive and is now negative."</p> <p>The facility's 7-16-14 "Hepatitis B Report" evidenced the patient had been identified as hepatitis B positive on 8-17-11, 9-14-11, 11-16-11, and 11-14-12. The report evidenced the patient had been identified as negative on 11-13-13 and 11-25-13.</p> <p>D. On 7-16-14 at 5:35 PM, the facility administrator stated, "I questioned why [the patient] was still in isolation if [the patient] was negative. The medical director said it was because [the patient] had a past acute infection and it was precautionary." When asked if the patient is aware of the negative status, the administrator replied, "I don't know."</p> <p>E. During an interview with patient number 5, on 7-18-14 at 9:10 AM, the patient stated, "I still have hepatitis 'lightly'."</p> <p>2. On 7-18-14 at 9:55 AM, the facility administrator was unable to provide any documentation regarding informing the patient of the current hepatitis B results and the decision by the medical director to continue to dialyze the patient in the isolation room "as a precaution." The administrator stated, "I told [the patient]</p>		<p>status. Each HbsAG positive patient that has negative HbsAG test results for 30 days with documented 2 test results will be considered immune. Facility will obtain physician order to discontinue isolation. Patient will be informed within 7 days after test results of his/her hepatitis status and that he/she may be dialyzed without isolation requirements. The FA or designee will audit monthly for any HbsAG positive patients with negative HbsAg test results for 30 days with documentation of 2 test results to verify that patient has been informed of status. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>	

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V000459	<p>about it and that's when I talked to [the patient] about staying in the isolation room. I don't know if I documented it." At 10:00 AM, the administrator stated, "I cannot find any documentation."</p> <p>494.70(a)(8) PR-INFORMED OF PT CARE POLICIES The patient has the right to-</p> <p>(8) Be informed of facility policies regarding patient care, including, but not limited to, isolation of patients; Based on clinical record and facility policy review and interview, the facility failed to ensure the patient had been informed of the facility's policy regarding isolation in 1 (# 5) of 1 record reviewed of patients that received dialysis treatments in the isolation room creating the potential to affect any future patients to dialyze in the isolation room.</p> <p>The findings include:</p> <p>1. Clinical record number 5 failed to evidence the patient had been informed of the facility's policy regarding isolation.</p> <p>A. During the entrance conference, on 7-16-14 at 12:40 PM, the facility identified, in writing, on a completed "Entrance Conference Questions"</p>	V000459	<p>V459 100% of clinical teammates were in-serviced on <i>Policy 3-01-07 "Patient Rights and Responsibilities"</i>, and <i>Policy 3-01-07A "Patient Rights, Responsibilities and Facility Rules"</i>. Verification of attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) the patient's right to receive a full explanation by your physician/allied health professional of the nature of your medical status and the necessity for recommended treatment/appointment(s), including the risks and side effects and other treatment/appointment options before giving consent to treatment/appointment. This includes a full explanation of</p>	08/15/2014

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	<p>worksheet, the facility had 1 hepatitis B positive patient on census. The facility manager indicated the facility had 1 hepatitis B positive patient on census at this time.</p> <p>B. On 7-16-14 at 9:25 AM, observation noted patient number 5 receiving a dialysis treatment in the isolation room.</p> <p>C. On 7-16-14 at 4:00 PM, the medical director was interviewed per telephone call. The medical director stated, "I am aware the same nurse is taking care of the patient in the isolation room and the other susceptible patients. That is because the patient in the isolation room is not really positive for hepatitis B. [The patient] should be considered normal. We are just treating [the patient] that way as a precaution. [The patient] was positive and is now negative."</p> <p>The facility's 7-16-14 "Hepatitis B Report" evidenced the patient had been identified as hepatitis B positive on 8-17-11, 9-14-11, 11-16-11, and 11-14-12. The report evidenced the patient had been identified as negative on 11-13-13 and 11-25-13.</p> <p>D. On 7-16-14 at 5:35 PM, the</p>		<p>facility policies regarding patient care, including, but not limited to, certain infectious diseases that may require you to be dialyzed in a separate space from other patients. FA or designee has reviewed "Patient Rights, Responsibilities, and Facility Rules" with 100% of patients to verify that patients are aware of these rights. A copy of this patient education was also placed in each patient's medical record. Discussion held with patient #5 regarding antibody > 150 and immunity so that treatment is no longer required in the isolation room. This is documented in the patient's medical record. The FA or designee has reviewed that 100% of the patient's rights & responsibilities have been completed, a patient tracking form with dates of each patients review has been placed in the evidence binder. Ongoing compliance will be monitored by monthly hepatitis audits to verify 100% of patients' current hepatitis status. Each HbsAG positive patient that has negative HbsAG test results for 30 days with documented 2 test results will be considered immune. Facility will obtain physician order to discontinue isolation. Patient will be informed within 7 days after test results of his/her hepatitis status and that he/she may be dialyzed</p>				

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	<p>facility administrator stated, "I questioned why [the patient] was still in isolation if [the patient] was negative. The medical director said it was because [the patient] had a past acute infection and it was precautionary." When asked if the patient is aware of the negative status, the administrator replied, "I don't know."</p> <p>E. During an interview with patient number 5, on 7-18-14 at 9:10 AM, the patient stated, "I still have hepatitis 'lightly'."</p> <p>2. On 7-18-14 at 9:55 AM, the facility administrator was unable to provide any documentation regarding informing the patient of the current hepatitis B results and the decision by the medical director to continue to dialyze the patient in the isolation room "as a precaution." The administrator stated, "I told [the patient] about it and that's when I talked to [the patient] about staying in the isolation room. I don't know if I documented it." At 10:00 AM, the administrator stated, "I cannot find any documentation."</p> <p>3. The facility's March 2014 "Infection control and Isolation Measures For Known or Suspected Hepatitis B Surface Antigen Positive Patients" policy number 1-05-09 states, "Patients who are confirmed hepatitis B surface antigen</p>		<p>without isolation requirements. The FA or designee will audit monthly for any HbsAG positive patients with negative HbsAg test results for 30 days with documentation of 2 test results to verify that patient has been informed of status. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>		

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V000550	<p>positive (HBsAg) are dialyzed in an isolation room or area designated for use by only surface antigen positive patients . . . Discontinuation of Isolation Isolation measures used for care of the confirmed hepatitis B surface antigen (HBsAg) positive patient may be discontinued only upon the order of the patient's physician or facility Medical Director and when the patient has been hepatitis B surface antigen negative for 30 days with 2 negative test results. Measures implemented for care of the patient with suspect hepatitis B positive antigen status may be discontinued only upon the order of the patient's physician or facility Medical Director and only when the repeat hepatitis B surface antigen test result reveals a negative status and the initial positive results was determined by the physician to be a false positive or due to vaccine induced transient antigenemia."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate</p>			

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	<p>vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation and facility policy review, the facility failed to ensure its staff had cannulated (insert needles into) the patient dialysis access in a safe and aseptic manner in 1 (number 1) of 3 observations of Initiation of Dialysis creating the potential to affect all of the facility's 23 current patients.</p> <p>1. On 7.16.14 at 9:50 AM, observation number 1 of initiation of dialysis at station 6, patient care technician, employee D, had cleansed and prepped the access site. After cleansing and disinfecting, employee D then palpated extensively and auscultated the access. After several attempts to cannulate the access, she enlisted the assistance of the nurse. The nurse, employee C, also palpated and cannulated the access without cleansing the access again.</p> <p>2. The facility's March 2014 "AV Fistula or Graft Cannulation with safety Fistula Needles and administration of Heparin" policy 1-04-01 states, "Do not palpate insertion site once area has been prepped. Once the access site has been prepped, touching it will contaminate the site and possibly allow for the introduction of</p>	V000550	<p>V550</p> <p>100% of clinical teammates were in-serviced on <i>Policy 1-04-01A "AVF or AVG Cannulation with Safety Fistula Needles (SFN) and Administration of Heparin"</i>. Verification of attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) do not palpate insertion site once area has been prepped. Once the access site has been prepped, touching it will contaminate the site and possibly allow for the introduction of bacteria during cannulation. The FA or designee will conduct observational audits on access care for two weeks. Visual observation will include focus on prepping the access site per P&P, allowing for dry time, not touching the site post cleansing, and utilizing all infection control measures to ensure patient safety. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/14</p>	08/15/2014

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V000638	<p>bacteria during cannulation."</p> <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. Based on quality assessment performance improvement (QAPI) document review, facility policy review, and interview, the facility failed to ensure performance improvement plans were revised to address lack of improvement in the identified problem area in 4 (February, March, April, and May 2014) of 5 months reviewed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <p>1. The facility's 7-16-14 Adverse Event Report identified 8 infiltration events from January 2014 to April 2014. The facility's QAPI meeting minutes failed to evidence that an investigation of the root cause of the infiltration events had been completed and the performance improvement plan implemented to address the infiltrations had been updated to address continued infiltration events.</p>	V000638	<p>V638</p> <p>]The interdisciplinary team (IDT) was in-serviced on <i>Policy 1-14-06 "Continuous Quality Improvement Program"</i>. 100% of the clinical patient care team completed courses CEC 2105"Quick Vascular Access Check Course" and CEC 3062 "VA- New Fistula Assessment Cannulation Team". Verification of attendance at the in- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) the facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following...review of trends of adverse patient occurrences, and 2) continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will</p>	08/15/2014

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	<p>A. The facility's 7-16-14 Adverse Event Report identified 1 infiltration adverse event in January 2014. The facility's 2-19-14 QAPI meeting minutes state, "goal to decrease the number of AOR's, by routine monitoring of Vascular access monitoring tool, scheduling interventions as needed, education each patient in the importance of taking care of their access, minimizing movement during tx [treatment], decrease risk of infiltrations."</p> <p>B. The adverse event report identified 2 infiltration adverse events in February 2014. The facility's 3-26-14 QAPI meeting minutes state, "goal to decrease the number of AOR's by routinely monitoring of Vascular access monitoring tool, scheduling interventions as needed, educating each patient in the importance of taking care of their access, minimizing movement during tx, decrease the risk of infiltrations."</p> <p>C. The adverse event report identified 3 infiltration adverse events in March 2014. The facility's 4-22-14 QAPI meeting minutes state, "goal to decrease the number of AOR's by routine monitoring of Vascular access monitoring tool, scheduling interventions as needed, educating each patient in the importance of taking care of their access,</p>		<p>result in performance improvement, and will track this change in performance over time to verify that improvements are sustained. The dialysis facility will conduct monthly QAPI meetings known as Facility Health Meeting (FHM). The Clinical Services Specialist (CSS) will review the FHR meeting minutes monthly for three months and then quarterly to verify that AORs are reviewed and action plans developed as indicated. The FA is responsible for ongoing compliance with this POC. Completion date: 8/15/2014</p>	

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	<p>minimizing movement during tx, decrease the risk of infiltrations."</p> <p>D. The adverse event report identified 2 infiltration adverse events in April 2014. The 5-28-14 QAPI meeting minutes state, "goal to decrease the number of AOR's, by routine monitoring of Vascular access monitoring tool, scheduling interventions needed, educating each patient in the importance of taking care of their access, minimizing movement during tx, decrease the risk of infiltrations, keep access visible at all times."</p> <p>2. The facility administrator indicated, on 7-17-14 at 12:00 PM, the QAPI meeting minutes did not reflect an investigation of the root cause of the infiltration problem or that the performance improvement plan had been updated.</p> <p>3. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following: . . . Review of trends of adverse patient occurrences . . . Continuous monitoring of the above</p>						

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V000715	<p>indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on clinical record and facility policy review and interview, the medical director failed to ensure all personnel had provided services in accordance with facility policies in 3 (# 1, 2, and 3) of 4 records reviewed creating the potential to affect all of the facility's 23 current patients.</p> <p>The findings include:</p> <p>1. The facilities March 2012, "Interdialytic Treatment Monitoring" Policy 1-03-09 states, "Treatment checks should be every thirty (30) minutes."</p>	V000715	<p>V715 Governing body meeting held to discuss statement of deficiencies and review plan of correction already in place and to revise the plan of correction as indicated. Medical Director reviewed Policy #3-03-71 "Medical Director Qualifications and Responsibilities". 100% of clinical teammates were in-serviced on <i>Policy 1-03-09 "Intradialytic Treatment Monitoring"</i> and <i>Policy 1-03-12 "Post Treatment Patient Assessment"</i>. Verification of attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with</p>	08/15/2014

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	<p>A. Clinical record number 2 included hemodialysis treatment flow sheets dated 6-25-14 that failed to evidence the facility staff had checked the patient at least every 30 minutes.</p> <p>The treatment flowsheet dated 6-25-14 evidenced facility staff had checked the patient at 10:00 AM and not again until 11:00 AM, a period of 60 minutes between treatment checks.</p> <p>B. Clinical record number 3 included hemodialysis treatment flow sheets dated 7-2-14 and 7-16-2014 that failed to evidence the facility staff had checked the patient at least every 30 minutes.</p> <p>1.) The treatment flowsheet dated 7-2-14 evidenced the facility staff had checked the patient at 9:55 AM and not again until 12:30 PM, a period of 2 hours and 35 minutes between checks.</p> <p>2.) The treatment flowsheet dated 7-16-14 evidenced the facility staff had checked the patient at 9:34 AM and not again until 10:15 AM, a period of 39 minutes between checks.</p> <p>2. The facility's March 2011 "Post Treatment Patient Assessment" Policy 1-03-12 states, "The patient care staff</p>		<p>emphasis on, but not limited to, the following: 1) treatment checks should be every thirty (30) minutes, and 2) the patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. Beginning 07/28/14, the Facility Administrator initiated weekly Governing Body calls/meetings to update the Medical Director regarding any issues that are occurring or have occurred in the facility as evidenced by weekly Governing Body meeting minutes. These calls/meetings will continue until facility has reached compliance with this POC. FA/Designee will ensure any variances from policy are addressed immediately and will be reviewed with the Medical Director during the monthly QAPI meeting, known as Facility Health Meeting (FHM). The FA and Medical Director are responsible for ongoing compliance with this Plan of Correction.</p> <p>Completion date: 8/15/14</p>	

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	<p>will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings.</p> <p>A. Clinical record number 1 included a hemodialysis treatment flowsheet dated 6-30-14 that failed to evidence facility staff had completed an assessment of the patient post treatment.</p> <p>B. Clinical record number 2 included a hemodialysis treatment flowsheet dated 6-30-14 that failed to evidence facility staff had completed an assessment of the patient post treatment.</p> <p>3. On 7.18.14 at 2:30 PM Facility Administrator indicated that the lack of post treatment assessments and more than minutes between checks were not in compliance with facility policy.</p>				