

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2015
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH AND LIVING DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR STE 114 CARMEL, IN 46032
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V000000	This was a Federal ESRD recertification survey. Survey Dates: 1-14-15, 1-15-15, & 1-16-15 Facility #: 012554 Medicaid Vendor #: 201056570A Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN January 21, 2015	V000000		
V000113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, interview, and review of facility policy, the facility failed to ensure staff changed gloves and cleansed hands in accordance with facility policy in 3 (#s 1, 7, and 8) of 14 observations completed creating the potential to affect all of the facility's 24 current patients. (Employees A, H, and	V000113	V113 Facility Administrator (FA) held mandatory in-service for all clinical Teammates (TMs) on 1/19/2015. In-service included but was not limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing 1) TMs must wear	02/16/2015

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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	<p>D)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee A, a patient care technician (PCT), was observed to initiate the dialysis treatment using a central venous catheter (CVC) on patient number 4 on 1-15-15 at 12:35 PM. The PCT was observed to assist the patient to sit up in the chair, adjust the blood pressure cuff, and apply a mask to the patient's nose and mouth. Without cleansing her hands or changing her gloves, the PCT began the initiation procedure by disinfecting the catheter limbs and connector devices. Employee H, a PCT, was observed to initiate the dialysis treatment using a fistula on patient number 5 on 1-14-15 at 9:20 AM. The PCT was observed to evaluate the access and palpate the cannulation sites. The PCT failed to change his gloves and cleanse his hands prior to cleansing the needle insertion sites and inserting the needles. Employee D, a registered nurse (RN), was observed to initiate the dialysis treatment using a graft on patient number 6 on 1-15-15 at 11:30 AM. The RN was observed to take the patient's temperature, remove her gloves, and without cleansing her hands, touched the 		<p>disposable gloves appropriately when caring for the patient or touching the patient's equipment at the dialysis station; 2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station.; 3) TMs must remove gloves and perform hand hygiene before entering clean supply area; 4) TMs must perform hand hygiene every time gloves removed. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meeting (FHM), minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>				

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	<p>keyboard to enter data. The RN then donned clean gloves without cleansing her hands and used the Phoenix meter to check the dialysis machine. The RN removed her gloves and failed to cleanse her hands. The RN touched the keyboard and entered data.</p> <p>The RN changed her gloves and cleansed her hands. She applied a tourniquet to the patient's right upper arm and cleansed the needle insertion sites with Betadine. The RN gathered the trash from the chairside table and removed her gloves. Without cleansing her hands, the RN donned clean gloves and touched the dialysis machine. The RN was then observed to insert the needles into the patient's access.</p> <p>4. The above-stated observations were discussed with the facility administrator on 1-15-15 at 3:05 PM. The administrator indicated the employees had not changed gloves and cleansed hands in accordance with facility policy.</p> <p>5. The facility's "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed . . . prior to gloving, after removal of gloves . . . after patient and dialysis delivery system contact . . . before touching clean areas such as</p>			

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V000122	<p>supplies and on exiting the patient treatment area . . . Gloves should be changed when: . . . When going from a 'dirty' area to tasks to a 'clean' area or task. When moving from a contaminated body site to a clean body site of the same patient . . . Gloves are to be removed and hands washed or alcohol based hand rubs used before and after touching the keyboard."</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 review of facility policy, the facility failed to ensure dialysis station had been cleaned in accordance with facility policy in 2 (#s 1 and 2) of 2 observations completed creating the potential to affect all of the facility's 24 current patients. (Employees B and H)</p> <p>The findings include:</p> <p>1. Employee B, a registered nurse (RN),</p>	V000122	V122 FA held mandatory in-service for all clinical TMs on 1/19/2015. In-service included but was not limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment. 1) TMs must fully clean machine including top, front, sides,	02/16/2015			

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	<p>was observed to clean the dialysis chair and surrounding area at station number 1 on 1-14-15 at 8:55 AM. The RN was not observed to clean the front of the arms of the chair where patients place their hands. The RN was not observed to clean the television control panel, the data entry station, or the countertops around the dialysis station.</p> <p>2. Employee H, a patient care technician (PCT), was observed to clean the dialysis chair and surrounding area at station number 3 on 1-14-15 at 11:35 AM. The PCT was not observed to clean the front of the arms of the chair where patients place their hands. The PCT was not observed to clean the television control panel, the data entry station, or the countertops around the dialysis station.</p> <p>3. The above-stated observations were discussed with the facility administrator on 1-15-15 at 3:05 PM. The administrator indicated the employees had not cleaned the dialysis station in accordance with facility policy.</p> <p>4. The facility's September 2014 "Infection Control for Dialysis Facilities: policy number 1-05-01 states, "Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair</p>		<p>and bottom lip. TMs must completely recline chair, open foot rests, and side arms if applicable in order to thoroughly clean all crevasses of chair. Tables on chairs will be lowered and wiped with bleach solution between patients; 2) All other equipment including TVs, TV control panels, blood pressure cuffs, and IV poles must be wiped with a bleach solution between patients; 3) Keyboards must be cleaned at a minimum end of day or if contaminated. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>				

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V000401	<p>and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates . . . as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment."</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 and interview, the facility failed to maintain a safe environment creating the potential to affect all of the facility's 24 current patients.</p> <p>The findings include:</p> <p>1. During a tour of the facility, on 1-14-15 at 10:15 AM, observation noted 16 cases of dry acid mixture in front of the 2 carbon tanks in the water room. Employee B, a registered nurse (RN),</p>	V000401	<p>V401</p> <p>TMs immediately moved dry acid mixture in front of the 2 carbon tanks in the water room where chlorine testing occurs. TMs immediately moved biohazard containers, trash cans, wheelchairs, oxygen concentrator and sharps containers on the dialysis treatment floor.</p> <p>FA conducted mandatory in-service for all clinical TMs on 1/19/2015. In-service included but was not limited to: review of Policy &</p>	02/16/2015

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	<p>was observed to obtain a water sample from the port after the first tank to complete a total chlorine test. The RN was observed to encounter difficulty reaching the port to obtain the water sample.</p> <p>2. The treatment floor area was observed to be rectangular in shape approximately 12 feet in width. Six dialysis stations were on the west side of the treatment area and cabinets lined the east wall. A nurse's station was located mid way with a countertop that protruded out into the pathway between the 2 walls. The emergency crash cart was located on the east wall on the north end of the treatment floor.</p> <p>A. On 1-14-15 at 10:30 AM, observation noted 2 large trash cans, 2 large biohazard materials container, 2 wheelchairs, and 2 sharps containers blocking the pathway between the east and west walls of the treatment floor on both the north and south ends of the treatment floor. On the south end of the treatment floor, a supply cart was also observed along the east wall.</p> <p>B. On 1-15-15 at 10:35 AM, observation noted a large biohazard trash container and a large trash can sitting directly in front of the emergency crash</p>		<p>Procedure # 08-04-01 Physical Environment, Policy & Procedure # 12-03-10 Patient Fall Prevention Policy and Program emphasizing 1) the dialysis facility is designed to provide dialysis patients and teammates a safe, functional and comfortable treatment environment; 2) TMs must secure equipment and cords out of pathway, keep hallways free of boxes, supplies or obstacles; 3) Patient wheelchairs must be kept in a separate location, away from main traffic areas. TMs educated that obstacles preventing access to water room monitoring equipment or emergency equipment could have the potential to affect 100% of facility patient census. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct visual inspection audit daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>				

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	<p>cart. A large wheelchair was observed to be blocking the pathway between the 2 walls of the treatment area.</p> <p>C. On 1-15-15 at 10:35 AM, observation noted a large trash container, a large biohazard trash container, and an oxygen concentrator in the pathway on the south end of the treatment floor.</p> <p>3. The facility administrator observed the blocked pathway and emergency cart on 1-15-15 at 11:05 AM and indicated the pathway should be kept clear.</p> <p>4. 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 . . . The space for treating each patient will be sufficient to provide needed care and services, prevent cross contamination, and to accommodate medical emergency equipment and teammates."</p> <p>The facility's March 2012 "Patient Fall Prevention Policy and Program" policy number 4-13-01 states, "Environmental Clutter: . . . Secure equipment and cords out of pathway . . . Keep hallways free of</p>			

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V000544	<p>boxes, supplies, or obstacles, keep all patient wheelchairs in a separate location, away from the main traffic areas."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record and facility policy review and interview, the facility failed to maintain the prescribed dose of dialysis by failing to maintain physician ordered blood flow rates in 2 (#s 2 and 3) of 4 records reviewed and by failing to ensure continuous heparin had been administered as ordered during the treatment in 2 (#s 2 and 3) of 2 records reviewed of patients with continuous heparin orders creating the potential to affect all of the facility's 24 current patients</p> <p>The findings include:</p> <p>Regarding blood flow rates:</p> <p>1. Clinical record number 2 included physician orders dated 9-15-14 that identified the blood flow rate (BFR) was to be maintained at 400 cubic centimeters</p>	V000544	<p>V544</p> <p>FA held mandatory in-service for all clinical TMs on 1/19/2015. In-service included review of Policy & Procedure #1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, Policy & Procedures#1-03-09 Intradialytic Treatment Monitoring emphasizing 4TMs must verify patient dialysis prescription, and set all treatments as prescribed. Nurses are responsible for ensuring patients receive prescribed dose of dialysis and physician orders are followed. 1) Heparin must be administered per physician orders. Heparin pump is used to administer constant infusion maintenance, and must be consistently documented accurately to show the time and amount of Heparin being administered. TMs must accurately document the amount and time of Heparin administered, time that the Heparin</p>	02/16/2015

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	<p>(cc) per minute.</p> <p>A. A hemodialysis treatment flow sheet dated 12-17-14 evidenced the BFR had been maintained at 350 cc per minute.</p> <p>B. A hemodialysis treatment flow sheet dated 12-19-14 evidenced the BFR had been maintained at 200-300 cc per minute.</p> <p>C. A hemodialysis treatment flow sheet dated 12-26-14 evidenced the BFR had been maintained at 300 cc per minute.</p> <p>D. A hemodialysis treatment flow sheet dated 12-28-14 evidenced the BFR had been reduced to 375 cc per minute 2 hours into the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 12-30-14 evidenced the BFR had been maintained at 375 cc per minute.</p> <p>F. A hemodialysis treatment flow sheet dated 1-2-15 evidenced the BFR had been reduced to 350 cc per minute 1 1/2 hours into the treatment.</p> <p>G. A hemodialysis treatment flow sheet dated 1-5-15 evidenced the BFR</p>		<p>maintenance is completed, and post treatment document the total amount administrated during the treatment. Heparin infusions must be discontinued and documented per physician orders, 2) Treatment monitoring must be completed at a minimum of every 30 minutes during, evaluation and documentation must include at a minimum patient's blood pressure, heart rate, blood and dialysate flows, arterial & venous pressures, fluid removal and/or replacement, vascular access status, line connections, patient status and subjective wellbeing. TMs must report and document any significant changes or indicators outside of ordered parameters to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record; 3) Interdisciplinary Team (IDT) must develop and implement a written individualized comprehensive plan of care addressing, but not be limited to dose of dialysis, when a patient is unable to achieve the desired outcomes, the plan of care must be adjusted to reflect the patient's current condition; documentation in patient's medical record the reasons why the patient was unable to achieve the goal. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p>		

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	<p>had been maintained at 250-300 cc per minute.</p> <p>H. A hemodialysis treatment flow sheet dated 1-7-15 evidenced the BFR had been maintained at 300 cc per minute.</p> <p>I. A hemodialysis treatment flow sheet dated 1-12-15 evidenced the BFR had been maintained at 360 cc per minute.</p> <p>2. Clinical record number 3 included physician orders dated 10-24-14 that identified the BFR was to be maintained at 400 cc per minute.</p> <p>A. A hemodialysis treatment flow sheet dated 12-22-14 evidenced the BFR had been maintained at 325 cc per minute.</p> <p>B. A hemodialysis treatment flow sheet dated 12-24-14 evidenced the BFR had been maintained at 250 cc per minute.</p> <p>C. A hemodialysis treatment flow sheet dated 12-27-14 evidenced the BFR had been maintained at 250 cc per minute.</p> <p>D. A hemodialysis treatment flow</p>		<p>FA or designee to conduct daily audits on 25% of patient treatment flow sheets x 2 weeks, then weekly x 4 weeks, and then monthly on 10% of treatment sheets to ensure compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>		

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	<p>sheet dated 12-29-14 evidenced the BFR had been maintained at 300 cc per minute.</p> <p>E. A hemodialysis treatment flow sheet dated 1-3-15 evidenced the BFR had been maintained at 300 cc per minute.</p> <p>F. A hemodialysis treatment flow sheet dated 1-6-15 evidenced the BFR had been maintained at 250 cc per minute.</p> <p>G. A hemodialysis treatment flow sheet dated 1-8-15 evidenced the BFR had been maintained at 225-350 cc per minute.</p> <p>H. A hemodialysis treatment flow sheet dated 1-10-15 evidenced the BFR had been maintained at 300 cc per minute.</p> <p>I. A hemodialysis treatment flow sheet dated 1-13-15 evidenced the BFR had been maintained at 175-300 cc per minute.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 1-14-15 at 3:50 PM regarding the blood flow rates.</p>						

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	<p>Regarding the continuous heparin administration:</p> <p>1. Clinical record number 2 included physician orders dated 9-15-14 that identified a total of 4000 units of continuous heparin was to be administered during the dialysis treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 1-9-15 evidenced only 3800 units of continuous heparin had been administered during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 1-12-15 evidenced only 3400 units of continuous heparin had been administered during the treatment.</p> <p>2. Clinical record number 3 included physician orders dated 10-24-14 that identified a total of 1500 units of continuous heparin was to be administered during the treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 12-24-14 evidenced a total of 2000 units of continuous heparin had been administered during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 12-29-14 evidenced a total of</p>			
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	<p>1800 units of continuous heparin had been administered during the treatment.</p> <p>C. A hemodialysis treatment flow sheet dated 12-31-14 evidenced a total of 1100 units of continuous heparin had been administered during the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 1-3-15 evidenced a total of 2000 units of continuous heparin had been administered during the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 1-6-15 evidenced a total of 1900 units of continuous heparin had been administered during the treatment.</p> <p>F. A hemodialysis treatment flow sheet dated 1-8-15 evidenced a total of 1900 units of continuous heparin had been administered during the treatment.</p> <p>G. Hemodialysis treatment flow sheets, dated 1-10-15 and 1-13-15, evidenced a total of 2000 units of continuous heparin had been administered during the treatment.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 1-14-15 at 3:50 PM regarding the blood flow rates.</p>				

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V000546	<p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary . . . The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed dose of dialysis."</p> <p>494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. Based on clinical record and facility policy review and interview, the facility failed to ensure blood specimens had been obtained monthly for the management of mineral metabolism in 1 (# 1) of 4 records reviewed creating the potential to affect all of the facility's 24 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included</p>	V000546	<p>V546</p> <p>Interdisciplinary Team (IDT) met on 1/19/2015 and audited 100% of patients' lab results to ensure blood specimens had been obtained for the management of mineral metabolism</p> <p>FA will hold mandatory in-service with IDT on 1/19/2015 reviewing Policy & Procedure #1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis emphasizing IDT must develop and implement a written individualized</p>	02/16/2015

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V000550	<p>physician orders dated 1-7-14 that identified the patient's calcium and phosphorous levels were to be drawn monthly. The record failed to evidence the labs had been drawn in November 2014.</p> <p>2. Employee F, the registered dietician, indicated, on 1-14-15 at 2:40 PM, the calcium and phosphorous levels had not been obtained in November 2014. The dietician stated, "It may have been a lab error."</p> <p>3. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specified the services necessary to address the patient's needs . . . The plan of care will address, but not be limited to, the following: . . . Mineral metabolism which addresses the necessary care to manage mineral metabolism and prevent or treat renal bone disease."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate,</p>		<p>comprehensive plan of care address the patient's needs; the plan of care will address, but not be limited to mineral metabolism which addresses the necessary care to manage mineral metabolism and prevent or treat renal bone disease. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee to conduct lab review audits weekly x 2 weeks on 100% of patients, then every other week x 4 on 50% of patients and then monthly on 100% of patients to ensure compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>		

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	<p>timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate 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, interview, and review of facility policy, the facility failed to ensure post access care had been completed per the facility's own policy in 1 (# 1) of 2 discontinuation of dialysis and post dialysis access care for arteriovenous fistula or graft observations completed creating the potential to affect all of the facility's patients with fistulas or grafts.</p> <p>The findings include:</p> <p>1. Employee B, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 7 on 1-14-15 at 8:50 AM. The RN removed the needles and applied a folded 2 x 2 gauze and tape and clamps to stop the bleeding. When the bleeding had stopped, observation noted a small amount of blood on the gauze over the needle sites. The RN applied more gauze over the gauze already in place and applied more tape to secure the dressing. The RN failed to replace the soiled gauze with clean gauze on each needle site.</p>	V000550	<p>V550</p> <p>FA will hold mandatory in-service for all clinical TMs on 1/19/2015. In-service will include review of Policy & Procedure #1-04-01B Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles, emphasizing vascular access sites must be held at a minimum 5 – 10 minutes before checking to see if bleeding has stopped. Once bleeding has stopped, discard gauze or Band-Aid used to hold site, inspect site for any trauma and for hemostatis, and apply band aid type or sterile dressing over cannulation site. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee to conduct daily infection control audits x 2 weeks, then weekly x 4 weeks, and then monthly to ensure compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p>	02/16/2015			

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V000626	<p>2. The facility administrator indicated, on 1-15-15 at 3:05 PM, the RN had not followed facility policy.</p> <p>3. The facility's March 2014 "Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles" procedure number 1-04-01B states, "Hold site for at least 5-10 minutes before checking to see if bleeding has stopped. Once bleeding has stopped, discard gauze or band-aid used to hold site. Inspect site for any trauma and hemostasis. Apply band-aid type of sterile dressing over cannulation site."</p> <p>494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.</p>		Completion date: 2/16/2015	

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	<p>Based on administrative record and facility policy review and interview, the facility failed to ensure all members of the interdisciplinary team had participated in the monthly quality assessment performance improvement (QAPI) meetings in 2 (September and November 2014) of 6 months reviewed creating the potential to affect all of the facility's 24 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QAPI committee meeting minutes dated 9-24-14 and 11-26-14 failed to evidence the medical social worker member of the interdisciplinary team had participated in the meetings. 2. The 9-24-14 meeting minutes failed to evidence the biomedical technician had participated in the meeting. 3. The facility administrator indicated, on 1-16-14 at 12:05 PM, the social worker and the biomedical technician had not been present at the 9-24-14 meeting and that the medical social worker had not been present at the 11-26-14 meeting. 4. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, 	V000626	<p>V626</p> <p>FA held an in-service for Facility Health Team on 1/19/2015 reviewing Policy & Procedure 1-14-06: Continuous Quality Improvement Program emphasizing all members of the IDT including but not limited to Medical Director, FA, Renal Dietician, Social Worker, and Biomedical Technician must attend monthly FHM. All members will be notified that if they are unable to attend FHM in person that they may attend telephonically, or they may report off to a committee member and designate another person from his/her discipline to attend in their absence. FHM minutes must reflect signatures of participating members, discussion, actions and evaluation by team. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>CSS and ROD will attend FHM or review meeting minutes for the next 3 months to ensure team remains in compliance, minutes are comprehensive, and reflective of actions taken. FHM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>The FA and Medical Director are responsible for compliance with this plan of correction</p> <p>Completion date: 2/16/2015</p>	02/16/2015			

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	"Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: . . . Biomed Technician . . . Social Worker."				