

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2012
NAME OF PROVIDER OR SUPPLIER LAKE AVENUE DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3909 LAKE AVE FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0000	<p>This visit was an ESRD complaint investigation.</p> <p>Complaint IN00116957 - Substantiated: Federal deficiency related to the allegations was cited.</p> <p>Date: September 27, 2012</p> <p>Facility #: 005153</p> <p>Medicaid # 2008272501</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2012</p>	V0000	See plan of correction for V 0456 completed 9-30-12		

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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V0456	<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 interview and review of documents and clinical records, the facility failed to ensure patients were allowed to participate in decisions regarding a change of treatment facility in 5 of 5 clinical records reviewed with the potential to affect all 90 patients. (#1, 2, 3, 4 and 5)</p> <p>Findings:</p> <p>1. Clinical record 1, with dialysis orders starting 09/06/2012 for Hemodialysis on Tuesday, Thursday, Saturday, evidenced a temporary transfer letter dated 9/20/2012 stating, "Patient is OK with TThS [Tuesday, Thursday, Saturday] at 3:45 PM at West [a different facility]." The record failed to evidence the patient had been involved in the decision regarding the transfer.</p> <p>2. Clinical record 2, with dialysis orders starting 8/21/2012 for Hemodialysis Tuesday, Thursday, Saturday, evidenced a temporary transfer letter dated 9/20/2012</p>	V0456	<p>V456</p> <p>- CMS, State Survey Agency and ESRD Network notified effective 9-30-2012 Davita Lake Avenue officially closed, last patient treatment completed on 9-29-2012. Facilities interdisciplinary team assisted each patient in obtaining dialysis in other facilities; good faith efforts were made and documented to accommodate patient needs, and find facility close to patient's residence that would accept patient in transfer. All patients successfully transferred to other dialysis facilities; Social Worker following up with transferred patients to review transfer process; as applicable identified grievances will have documentation of grievance, actions taken to date to address grievance, and when indicated resolution to grievance.</p> <p>Completion Date: 9/30/2012</p>	09/30/2012	

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	<p>stating, "Patient will transfer to TThS at 10:45 PM at West." No agreement is identified on the letter. The record failed to evidence the patient had been involved in the decision regarding the transfer.</p> <p>3. Clinical record 3, with dialysis orders starting 7/19/2012 for Hemodialysis Tuesday, Thursday, Saturday, evidenced a temporary transfer letter dated 9/20/2012 stating, "Patient [Pt] notified in writing this date of temporary transfer. Pt states she is ok with transfer." The record failed to evidence the patient had been involved in the decision regarding the transfer.</p> <p>4. Clinical record 4, with dialysis orders starting 03/01/2012 for Hemodialysis Tuesday, Thursday, Saturday, evidenced a temporary transfer letter dated 9/20/2012 stating, "Schedule time at West T, Th, Sat 4:30 PM. Does not want. ... Patient prefers Ft. Wayne South and earlier shift because she has difficulty driving at night." The record failed to evidence the patient had been involved in the decision regarding the transfer.</p> <p>09/27/2012 at 1:10 PM, Patient 4 indicated patients were not given a choice of where to transfer but were told where they would go. Transportation is a problem for many of the patients as the transportation service ends at 6 PM, and</p>			

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	<p>many of the patients ended up on 3rd shift and would not have transportation home. Patient 4 drives, but money for gas was an issue. The social worker was going to try to get help with money through the Renal Network. Patient 4 indicated patients are just frustrated the notification was so late, and they had no say in where they would go but is mostly happy with the care received through this facility. Patient 4 spoke highly of the majority of the staff and indicated they have a very caring nature. This problem is more of an administrative problem. Patient 4 indicated the patients have complained but are being told to wait until they get to the new facility.</p> <p>5. Clinical record 5, with dialysis orders starting 08/23/2012 for Hemodialysis Tuesday, Thursday, Saturday, evidenced a temporary transfer letter dated 9/20/2012 stating, "Husband called back. Wants referral to FMC New Haven-feels it is not safe for Pt. to be out after dark." The record failed to evidence the patient had been involved in the decision regarding the transfer.</p> <p>09/27/2012 at 12:45 PM, Patient 5, while dialyzing, indicated the facility and times had been picked for the patients without their input. The patient had not been happy with the first choice, but the</p>			

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	<p>dialysis center had made arrangements for the second facility and the patient was happy with the second facility. It allowed the patient to get home earlier since the patient lived in an area that was not safe.</p> <p>6. The facility's complaint log did not list any complaints for 2012.</p> <p>7. On 9/27/2012 at 11:40 AM, the Facility Administrator indicated they had not had any formal complaints. He does not write down complaints unless he feels they are formal and need a formal resolution. That is the reason there were no complaints in his complaint log for this year even with over 90 patients. There have been several conversations over the transfer, but he didn ' t write anything down or follow anything to resolution.</p>			