

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2013
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NAME OF PROVIDER OR SUPPLIER PLAINFIELD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8110 NETWORK DR PLAINFIELD, IN 46168
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V000000	<p>This was an ESRD federal complaint investigation survey.</p> <p>Complaint #: IN00126729 - Substantiated: Federal deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 011918</p> <p>Survey Dates: 05/06-07/13</p> <p>Medicaid Vender #: NA</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">May 15, 2013</p>	V000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V000113	<p>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.</p> <p>Based on observation, staff interview, and review of policy and procedure, the facility failed to ensure staff followed the facility's infection control policies and procedures for 5 of 7 observations of the in-center dialysis patient treatment area in 2 of 2 days of observations creating the potential for the transmission of disease causing organisms among staff and all of the facility's 57 in-center patients.</p> <p>The findings include:</p> <p>1. The facility's March 2012 "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 supplies . . . Alcohol-based hand rubs may be used: . . . Before gloving and after glove removal . . . Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station . . . Gloves should be changed when: . . . When moving from a</p>	V000113	<p>V113 Facility Administrator (FA) held mandatory in-service for all clinic teammates (TMs) on 5/7/2013, 5/8/2013, and 5/17/2013. In-service included but was not limited to: review of <i>Policy & Procedure 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure 1-05-01A: Use of Alcohol-Based Hand Rubs, and Policy & Procedure 1-05-01B: Hand washing</i>. TMs instructed using surveyor observations as examples to the following: 1). TMs must wear 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 each station. 3) TMs must wear gloves when there is a potential for exposure to blood, dialysate and other potentially infectious substances. 4) Appropriate PPE must be worn whenever there is the potential for contact with the body fluids, hazardous chemicals, contaminated equipment and environmental surfaces. 5) Patient charts are not to be</p>	06/07/2013			

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	<p>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 [chairside computer] keyboard."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. On 5-6-13 at 3:05 PM, employee D was observed to touch the computer keyboard between stations 1 and 2, don clean gloves, touch machine 9's screen, remove her gloves, toss them into waste container, and move across the room to the nurses' station all without cleansing her hands.</p>		<p>placed on top of the dialysis delivery system. A barrier must be placed between the machine and supplies. 6) TMs must perform hand hygiene every time gloves are removed. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager or Charge Nurse will conduct infection control audits for every shift daily X 2 weeks, then weekly x 2 weeks, then monthly. FA/Charge nurse will review results of all audits with TMs during home room meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), minutes will reflect. Facility Administrator is responsible for compliance with this Plan of Correction.</p>				

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	<p>4. On 5-6-13 at 3:45 PM, employee D, without wearing gloves, was observed to enter into station 5, picked up the patient's run records, look at them, and replace them back on top of the dialysis machine #12 where they had been without any type of barrier. Employee D failed to cleanse her hands prior to entering and leaving station # 5 area.</p> <p>5. On 5-7-13 at 6:30 PM, employee C was observed to touch the machine at station #1 with a blue glove just wrapped around the right hand pointer finger and silenced the screen alarm on the dialysis machine. Employee C removed the glove and tossed the same glove on top of the dialysis machine landing next to the patient's supply box that was also on top of the machine with no barrier in place. Employee C walked away from the area without ever cleansing his hand.</p> <p>6. On 5-7-13 at 8:00 PM, employee E was observed with gloved hands at station 16 to silence an alarm. The employee removed the gloves and toss them into an opened trash container without sanitizing her hands until she was on the other side of the room at the front of the nurses station.</p> <p>7. On 5-7-13 at 8:30 PM, employee E was observed to initiate dialysis on</p>			

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	<p>patient number 1 at station 24. The employee sanitized her hands, donned gloves, and placed the patient's individual supply box and run sheets on top of the dialysis machine without any type of barrier. She then walked away from the station, removed her gloves at the nurses station, sanitized her hands, and walked back to station 24 and waited for the RN. She then removed her gloves and, without sanitizing her hands, she reached up for the patient's run sheets that were under the individual supply box on top of the dialysis machine. With her bare hands, she moved the supply box off the run sheets and then clipped the run sheets to the clamp dangling from the IV pole at the side of the machine. The employee then left the area and walked to the far far end of the nurses' station where she then sanitized her hands</p> <p>8. The facility administrator indicated, on 5-7-13 at 9:30 PM during the exit conference, the run records are not to be on top of the dialysis machines but to be clamped and hanging from the IV poles. The facility administrator indicated employees C, D, and E had not followed the facility's infection control policies and procedures.</p>				

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V000401	<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.</p> <p>Based on observation, administrative record and facility policy review and interviews, the facility failed to ensure it had maintained and/or provided a comfortable environment in 2 of 2 days of observation with patient interviews creating the potential to effect all 57 in-center dialysis patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's revised policy dated for December 2012 titled "Physical Environment" policy number 8-04-01 states, "1. The dialysis facility will be ... equipped, and maintained to provide dialysis patients ... a safe ... comfortable treatment environment." <p>Telephone interviews</p> <ol style="list-style-type: none"> On 5-6-13 at 12:30 PM, via telephone call, patient # 1 indicated the new dialysis chairs bought in November and December of 2012 were uncomfortable, just hard, 	V000401	<p>V401 FA held a mandatory in-service on 5/7/2013, 5/8/2013, and 5/17/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 8-04-01: Physical Environment</i>. TMs educated that team must make reasonable steps to make accommodations for patients who are not comfortable such as suggesting patients bring items to help aid in comfort such as pillows, blankets, egg crate, etc. Pillows ordered to help aid in patient comfort while at dialysis. Sleep cushions and sleep guards are available for any patient that wishes to utilize them. No sleep cushion is to be used without the use of sleep guards for patient safety. TMs must immediately assist patients with position change upon request when possible or as soon as possible if assisting another patient when request is made. TMs instructed to go over operation of chairs with patients so that the patients are aware of where lever is to recline chair independently if they are physically able. TMs must assist in repositioning patients as needed for comfort. Verification of attendance at in-service will be</p>	06/07/2013

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	<p>and patient is unable to turn related to body becoming stiff from the chairs. The facility manager and the medical director do not attempt to help, saying they just do dialysis there. Large chair cushions were tried but these were worthless and, if you turn in the chair with the cushions in place, you could just roll onto the floor. The patient is unable to recline the chair per self related to being so hard and stiff. Therefore, the staff have to recline them and lock the chairs into place. If the patient wants to get back into a sitting position, they have to ask the staff and, if the staff is busy, they have to stay in an uncomfortable position. This patient further indicated that sometimes they just want to leave dialysis before the prescribe time is up because they are just too uncomfortable in the chairs. They haven't left early yet because they understand the importance of what dialysis is doing, but something needs to be done about the chairs.</p> <p>3. On 5-6-13 at 1:13 PM, via telephone call, patient #2 indicated dissatisfaction with the facility manager related to the dialysis chairs. The patient further indicated the dialysis chairs turn the patient's back numb by the time the dialysis treatment is over, and, therefore, it is difficult to get out of the chair and walk out of the building to leave. The</p>		<p>evidenced by TMs signature on in-service sheet. FA/Clinical Services Specialist (CSS) held a mandatory in-service on 5/7/2013 and 5/8/2013 and in addition FA held another in-service on 5/17/2013 on <i>Policy & Procedure# 3-01-06A: Addressing Patient Grievances: Davita Teammates</i> emphasizing importance of knowing external grievance mechanisms and processes in order to follow-up with the patients who verbalize a grievance. All details of patient grievances must be documented; all patient grievances must be reported to the charge nurse who will report to FA if unresolved; TM review of no retaliation policy; Medical director must be notified if FA unable to resolve patient grievance, and team will continue to escalate and follow up per policy & procedure. All patient grievances must be addressed per policy & procedure up to resolution. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA followed up with one on one conversation with the nocturnal patients regarding their concerns with the chairs on 5/19/2013, documentation placed in medical record. Medical Director will also talk to all patients about their concerns, and documentation will be placed in medical record. FA will verify that each patient grievance is documented on Patient</p>		

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	<p>chairs do not recline or lay flat without the help of staff. The facility offered an alternative method of dialysis in the home program, but patient's house is too small for all of the equipment needed. "I fear retaliation from the management but not from the floor staff. The floor staff know and their hands are tied."</p> <p>4. Patient # 3 at 3:30 PM on 5/7/13 indicated the chairs were bad.</p> <p>5. Patient # 4 at 3:45 PM on 5/6/13 indicated the dialysis chairs were difficult to sleep in or rest comfortably.</p> <p>6. Patient # 6 at 3:45 PM on 5/7/13 indicated the dialysis chairs were not comfortable. Patient brings a cushion and own blanket from home. Facility gave patients new blankets when they first start dialysis, and it is patient's to keep and use. "The facility does not share blankets or at least I have never seen that here."</p> <p>7. Patient # 7 at 3:50 PM on 5/6/13 indicated runs 3.5 hours on the dialysis machine and has dialyzed since last year and can stand the dialysis chairs for that long, but "I wouldn't stay on them for 8 hours because they are too uncomfortable. Staff is good here, always changing gloves and washing hands."</p>		<p>Grievance Log, each grievance will have complete documentation of grievance, actions taken to date to address the grievance, and when indicated resolution to the grievance. FA, Medical Director and Divisional Vice president will meet to discuss further options for the nocturnal patients. Social worker/FA will educate patients on grievance policy and no retaliation policy. Patients provided with FA's business card and contact information on 5/19/2013. FA will audit complaint/grievance log weekly x4 and continue to follow up on all complaints including each complaint concerning chairs as they arise. FA will be responsible for maintaining Grievance Log and bringing log for review with Medical Director during monthly QIFMM. Supporting documentation will be included in the meeting minutes with evaluation of complaints, action plans, resolution, and follow up with the patients noted Facility Administrator is responsible for compliance with this Plan of Correction.</p>				

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	<p>8. Patient # 8 at 4 PM on 5/6/13 indicated the dialysis chairs were terrible and kill patient's back. "I couldn't stay in them any longer than 4.5 hours. Otherwise this place is like family."</p> <p>9. Patient # 9 at 3:15 PM on 5/6/13 indicated the dialysis chairs were horrible. The patient runs 3.5 hours and then is ready to get out of the chairs. The facility does not share pillows or blankets. Patients bring their own.</p> <p>10. Patient # 10 on 5/7/13 at 7:30 PM indicated chairs are ok for 4 hours, but patient couldn't do an all nighter.</p> <p>11. Patient # 11 on 5/7/13 at 7:45 PM indicated the staff treat patients like human beings. Chairs are uncomfortable, but, hopefully, patient will get used to them.</p> <p>12. Patient # 12, via telephone interview at 9:45 AM on 5-8-13, indicated the in-center dialysis chairs were uncomfortable. The patient is 6' 5 " in height and 315 pounds. The patient does not fit into the new dialysis chairs and, because of this, made the decision to try dialysis at home.</p> <p>Face to face interviews</p>			

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	<p>13. On 5-7-13 at 8:30 PM, a face to face interview, patient # 1 indicated very uncomfortable in the dialysis chairs but did bring own pillows, blankets, and pad for chair. Patient was offered home dialysis, but patient's house is too small for equipment. Patient was not offered a hospital bed but would try one if offered, and the bed was electric with head and lower extremities that could be adjusted. "If the facility manager talks to me about it, I will listen and possibly try it."</p> <p>14. On 5-7-13 at 6:30 PM, a face to face interview, patient # 2 indicated the staff was great but the "chairs suck." Patient brings own pad to set on, can't lay down in chairs, can't place them in a reclining position, and can't get them up if they are placed in a reclining position so staff has to do it. The facility ordered sleep cushions, but they are "worthless." The facility offered home dialysis, but the patient's house is too small for the equipment. A couple of patients were offered hospital beds, but no one asked patient if patient would like to try one. "I have mentioned the concerns on these chairs to the social worker. I stay in these chairs 8 hours no matter how sore my hips and back are because of the importance of the treatment."</p>						

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