

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/26/2013	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V000000	<p>This was a federal ESRD complaint investigation survey.</p> <p>Complaint #: IN00128947; Substantiated; Deficiencies related to the complaint are cited.</p> <p>Survey Date: 6-26-13</p> <p>Medicaid Vendor #: 200815900A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>QA: Linda Dubak, R.N. July 2, 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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V000636	<p>494.110(a)(2)(viii) QAPI-INDICATOR-PT SATIS &amp; GRIEVANCES The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances. Based on administrative record and facility policy review and interview, the facility failed to ensure patient complaints had been reviewed as a part of the quality assurance performance improvement (QAPI) program in 2 (May and June) of 2 months reviewed creating the potential to affect all of the facility's 94 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The facility's "Patient Complaint/Grievance Log" included an entry dated 5-6-13 that evidenced a family member of patient number 6 had voiced a complaint to the facility. The log states, "Date reviewed by QAI Team 5-22-13."</li> <li>The agency's QAPI meeting minutes binder failed to evidence the team had met on 5-22-13. The binder evidenced the team had met on 5-28-13. The meeting minutes for the 5-28-13 failed to evidence any patient complaints had been discussed.</li> </ol> <p>The binder evidenced the team had met on 6-18-13. The meeting minutes</p>	V000636	<p><b>V 636</b> On <b>7/31/2013</b> the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. On <b>7/9/2013</b>, the Director of Operations scheduled a meeting with all participants of the QAI committee for the purpose of reeducation on the Quality Assessment and Performance Improvement Program. This education included but was not limited to the following:</p> <ul style="list-style-type: none"> <li>·QAI processes including monthly analysis and trending of patient complaints and grievances</li> <li>·Reviewing requirements within the QAI Meeting Minute Template</li> </ul> <p>On <b>6/26/2013 &amp; 7/9/2013</b> the Director of Operations met with the Clinical Manager to review and reinforce the Clinical Manager's responsibility to utilize the QAI Minute Template to report, analyze, trend and develop action plans as necessary for all indicators defined within QAI. Additionally to utilize the Minutes to document all QAI Committee activities with emphasis placed on patient</p>	07/31/2013			

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	<p>dated 6-18-13 failed to evidence the complaint regarding patient number 6 had been reviewed.</p> <p>3. The facility's Regional Quality Manager, employee J, indicated, on 6-26-13 at 12:15 PM, the QAPI meeting minutes did not evidence the patient complaint had been discussed. The meeting minutes state, "Patient Feedback/Grievances. Review pt complaint/grievance log monthly . . . n/a."</p> <p>4. The facility's 4-4-12 "Quality Assessment and Performance Improvement Program (QAPI)" policy number FMS-CS-IC-I-101-001A states, "Elements to be reviewed in the QAI meeting include: . . . Patient Satisfaction."</p>		<p>complaints and grievances as defined within the Patient Complaints and Grievances policy. The Clinical Manager will assure that the cited deficiency does not reoccur by reviewing all patient complaints/grievances weekly using the QAI complaint/grievance tracking tool. The complaints will be analyzed, a plan of action determined and resolution addressed. All appropriate individuals will be contacted so as to resolve the complaints timely. The respective patient will be notified of the resolution and if not satisfactory, the complaint will remain open until resolved. The Clinical Manager will report a summary of all complaints, actions taken monthly in QAI and compliance will be monitored by the Governing Body. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		