STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPREHENSIVE RENAL CARE EAST CHICAGO	4320 FIR ST STE 404 EAST CHICAGO, IN 46312

(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	[CORE] This visit was a federal ESRD recertification survey. Survey Dates: July 23, 24, and 25, 2013 Facility #: 010824 Medicaid Vendor #: 200315330 Surveyors: Bridget Boston, RN, PHNS Janet Brandt, RN, PHSN Quality Review: Joyce Elder, MSN, BSN, RN August 1, 2013	V000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
V000111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, interview, and review of policy and administrative documents, the facility failed to ensure that 1 of 1 dialysis facility maintained a sanitary and clean environment creating the potential to spread infection causing agents among facility staff and all 49 current in-center hemodialysis patients. The findings include: In-Center observation on July 23, 2013: 1. At 11:12 AM, two sinks on the middle of the in-center unit were observed labeled as "clean." A white crystal like substance was observed under one of the two clean sinks with layers coating the the drain pipe and hard dry layers forming icicle like shapes falling from the drain connectors. The inside base of the cabinet was degraded with the appearance of a blistered area in the center of the cabinet base with degraded construction material throughout. In the inside back of the cabinet base a build up of the same crystal material which was was light brown / caramel in color was observed.	V000111	**V111** Supplies and unlabeled spray bottle stored under the sinks were immediately discarded on 7/23/13. Cabinets were cleaned by housekeeping 7/24/13. A qualified plumber replaced sink traps on 7/24/13. A qualified contractor evaluated sink cabinets on 7/25/13 and is scheduled to remove/repair sink cabinet. Facility Administrator (FA) conducted mandatory in-services on 8/2/13 & 8/6/13 to educate teammates (TMs) on Policy & Procedures #1-05-01 Infection Control for Dialysis Facilities and #1-04-08 Utilizing Vascular Access Clamps. The in-services reviewed the importance of, but not limited to: 1) keeping clean supplies in designated clean areas 2) supplies are not to be stored under clinical sinks, 3) prepared bleach solutions must remain covered, and 4) an adequate supply of bleach solution and cloths for disinfection must be readily available at all times. TMs were instructed on proper procedure for disinfecting clamps between patient use and an appropriately labeled container for clamp submersion & disinfection has been placed in a designated dirty area on the treatment floor. A new daily Infection Control audit has been created. The Charge Nurse or designee will perform the audit on random shifts daily for 8	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	Stored inside the cabinet was one open / unsealed cardboard box of sealed BD Leur Lok 10 milliliter syringes and two boxes of gloves. A. Under the second clean sink, directly across from the first, was observed two boxes of BD Leur Lok 10 milliliter syringes, one that was opened, and anchored to the top of this box was an unlabeled hand trigger spray bottle containing a clear liquid; one box of gloves; one sealed gallon of solution labeled "2 K Naturalyte"; and one folded white gown, personal protective equipment, as worn by the staff on the in-center floor during patient care. B. At 11:21 AM, employee C, a patient care technician, indicated the sink had leaked in the past and was fixed. Employee C was not aware what solution was contained in the unlabeled bottle and why it was stored where it was found. 2. On 7/23/13 at 11:55 AM on the in-center hemodialysis floor, two sinks were observed labeled as "dirty sinks" and on the counter beside each "dirty" sink were two clear 1000 milliliter graduated containers with markings at every 100 milliliters to measure liquid volume. One of the containers was labeled as 1:10 bleach which contained 1000 milliliters		weeks, then weekly for 8 weeks, then monthly. The FA will review the audit results daily. Variances noted on the audit will be addressed with the team or TMs involved. FA will review audit results monthly with Medical Director during Quality Improvement Facility Management Meetings (QIFMM), continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this Plan of Correction. Completion Date: 08/24/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	and one container was labeled as 1:100 bleach and contained 100 milliliters. Both labels contained the initials of the patient care technician that made the solution, employee B, and evidenced the solutions were made at 5 AM on 7/23/13 and would expire at 5 AM on 7/24/13. There were no cloths readily available for staff use during patient care. Neither of the containers were covered nor were there any covers in sight. On 7/23/13 at 1 PM, employee F indicated the facility had 11 active stations and all were used for patient care on the morning of 7/23/13 with 11 patients during the first and second shift. 3. At 1:30 PM, white clamps were observed in use with patients on the treatment floor. However, no container was observed in which to soak and decontaminate them. At 1:30 PM, employee C indicated there was no other readily available bleach solution for routine cleansing and the container to soak clamps could not be found. In-Center observation of July 24, 2013: 1. At 1:05 PM, a white clamp was observed on the basin of one of the two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	dirty sinks. 2. On the counters beside each of two sinks labeled "dirty sinks" were the same two clear 1000 milliliter graduated containers as observed July 23. At each sink, one of the containers was labeled as 1:10 bleach which contained 1000 milliliters and one container was labeled as 1:100 bleach and contained 100 milliliters. Both containers were labeled with the initials of the patient care technician that made the solution, employee B, and evidenced the solutions were made at 5 AM on 7/24/13 and would expire at 5 AM on 7/25/13. There were no cloths readily available for staff use during patient care. Neither of the containers were covered nor were covers in sight. 3. At 2:50 PM, observed employee D place two white clamps in the covered container labeled "clean clamps." When asked, employee D indicated the unit did not have a container to soak the clamps; therefore, he wiped the clamps with a bleach soaked cloth and returned them to the container labeled "clean clamps." A. At 1:30 PM, employee C indicated the facility did have a container for soaking clamps, but it was not found when the employee searched. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	employee could not recall the last time the referenced container was in use. B. At 3 PM, when asked, employee K indicated the container for soaking clamps and hemostats was not found and the items were to soak in a 1:100 bleach solution. She indicated that, since the container was not located, she informed the staff to place in the graduated container labeled 1:10 bleach and indicated dirty clamps were not to be placed in the bottom of a dirty sink. White clamps were observed at this time partially submerged in one of the graduated container labeled 1:10 bleach. The container did not have a cover. 5. Administrative documents titled "Physical Environment" dated March, April, May, June, and July of 2013 were reviewed. The documents contain 18 elements which were to be audited daily when the facility was open and dialysis patients. Line three (3) on the monthly audit form stated, "Clamps completely submerged in bleach solution." This line was not completed for the last five months. When this audit tool was reviewed with the facility administrator on 7/25/13 at 5:30 PM, she indicated to not be aware of the lapse in documentation and that the clamps were to be submerged and to soak in a bleach			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	solution before using on another patient. 6. A policy titled "Infection Control For Dialysis Facilities", Revision Date March 2013, Policy 1-05-01, states, "22. Non-disposable items, such as stethoscopes, are not to be shared unless disinfected between patients. Stethoscopes that are visibly contaminated with blood or body fluids should be disinfected with a 1:10 (one to ten) bleach solution. ... 32. If a previous patient remains in the treatment chair while dialysis delivery system is prepared for the next patient, extreme caution is to be employed to prevent cross-contamination. ... 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 system, 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 other potentially infectious materials. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for environmental surfaces.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPREHENSIVE RENAL CARE EAST CHICAGO	4320 FIR ST STE 404 EAST CHICAGO, IN 46312

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
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. 3. On 7/23/13 at 12:25 PM, employee J was observed in station # 11. The employee had removed his gloves and then the dialysis machine began to alarm. The employee was observed to insert his index finger into the soiled glove and touch the dialysis machine, the machine was then silenced, he then through away the gloves and then was observed to touch the keyboard at the computer terminal with out completing hand hygiene. He was observed to complete hand hygiene after leaving the keyboard. A blue, disposable barrier / chux [A disposable paper product that provides a clean area and barrier during dialysis treatment. Will absorb blood and other fluids, is placed under the limb / access of the patient prior to dialysis and is replaced when soiled.] had fallen from the patient's dialysis chair and was on the floor in station 11. The employee picked up the chux and wadded up with his bare hands. Transferred the wadded chux to his right hand, and while holding, he placed his right hand on the mobile table which held the computer keyboard, pushed the table	V000113	**V113** Facility Administrator (FA) held mandatory in-services for all Clinical Teammates (TMs) on 8/2/13 & 8/6/13. In-services included, but were not limited to: review of Policy & Procedure #1-05-01 Infection Control for Dialysis Facilities, emphasizing 1) TMs must wear disposable gloves appropriately when caring for the patient or touching the patient's equipment, or any potentially contaminated supplies 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 and after touching contaminated equipment, 3) TMs must conduct hand hygiene prior to, and after documenting on keyboards, 4) TMs must remove gloves and perform hand hygiene before entering clean supply cart, 5) TMs must perform hand hygiene every time gloves are removed. A new daily Infection Control audit has been created. The Charge Nurse or designee will perform the audit on random shifts daily for 8 weeks, then weekly for 8 weeks, then monthly. The FA will review the audit results daily. Variances noted on the audit will be addressed with the team or TMs involved. FA will review audit results monthly with Medical Director during Quality Improvement Facility	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	aside to reach a biohazard container which was located at the back of the station, behind the computer terminal and to the rear of the dialysis chair, he disposed of the chux, moved the table back with his hands, then completed hand hygiene. The computer keyboard and table were not decontaminated once soiled with this contact. The employee then walked to station 10, patient dialyzing at the time and the patients eyes were shut. The employee obtained gloves, did not don, placed his right hand inside the dialysis chair and slightly stoked the patient, the patient's eyes opened, the employee then went to the computer terminal between station 9 and 10 and touched the keyboard, entered information and then completed hand hygiene. 4. On July 23, 2013, at 12:40 PM, employee F, a registered nurse, was observed with gloved hands carrying three (3) syringes containing a clear liquid into station 10. With her gloved right hand, the employee grabbed the handle of a wheeled biohazard / sharps container and placed it in the station beside her. Without changing her gloves and completing hand hygiene, the nurse was observed to administer the intravenous medications.		Management Meetings (QIFMM), continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this Plan of Correction. Completion Date: 08/24/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	Observation # 3: 5. On 7/24/13 at 12:50 PM, employee D was observed in station # 5. After terminating dialysis and removing his gloves, the employee failed to complete hand hygiene before he placed his hands on the keyboard at the computer terminal. 6. On 7/24/13 at 1:28 PM, employee D was observed in station # 2. After terminating dialysis on a patient with a central venous catheter, he removed his gloves. Without completing hand hygiene, he left the station and walked to a counter top with supplies in the middle of the unit, obtained one wrapped 4 X 4 gauze, returned to station 2, and placed the wrapped gauze on the tray attached to the dialysis chair. Without completing hand hygiene, he donned gloves and walked to station 10 where a dialysis machine was alarming. He touched the dialysis machine, removed his gloves, applied an alcohol based gel to his hands, rubbed them together three times, walked to the computer terminal for station 10, and entered information at the keyboard. Then he went to the sink and washed his hands. 7. On July 24, 2013, at 2:05 PM, employee D was observed in station # 8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	where patient 6 was dialyzing. The employees hands were gloved and touching the face screen of the dialysis machine. He removed his gloves and walked to the computer terminal and, without cleansing his hands, began touching the keyboard. 8. A policy titled "Infection Control For Dialysis Facilities", Revision Date March 2013, Policy 1-05-01, states, "Hand hygiene is to be performed upon entering the facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area." Based on observation, policy review, and interview, the facility failed to ensure staff members provided care in compliance with hand hygiene infection control policies and procedures in 2 of 3 observations completed creating the potential for spread of infection causing agents among facility staff and patients. (employees D, F, J) The findings include: Observation #1:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPREHENSIVE RENAL CARE EAST CHICAGO	4320 FIR ST STE 404 EAST CHICAGO, IN 46312

(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
	1. On 7-23-13 at 12:30 PM CST, employee J was observed to leave station #10, machine #20, after performing patient care. Employee J removed gloves and went to the computer next to station #2 and began charting on the computer without sanitizing hands prior to placing hands on the computer key board. Employee C, in an interview on 7-23-13 at 12:40 PM, indicated staff were supposed to sanitize hands after removing gloves worn for patient care, then wash them at the sink or apply hand sanitizer to hands before touching clean equipment. The computer keyboard was considered clean equipment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
V000122	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, staff interview, and policy review, the facility failed to ensure appropriate and adequate disinfecting solution was readily available and equipment was decontaminated with an appropriate disinfecting solution in 2 of 3 observations creating the potential to spread infectious and communicable disease to facility staff and all 49 current in-center patients. The findings include: In-Center observation on 7/23/13 1. On 7/23/13 at 11:55 AM on the in-center hemodialysis floor, two sinks were observed labeled as "dirty sinks" and on the counter beside each "dirty" sink were two clear 1000 milliliter graduated containers with markings at every 100 milliliters to measure liquid volume. One of the containers was labeled as 1:10	V000122	**V122** FA held mandatory in-services for all Clinical TMs on 8/2/13 & 8/6/13. In-services included, but were not limited to: review of Policy & Procedure # 1-05-01 Infection Control for Dialysis Facilities and #1-04-08 Utilizing Vascular Access Clamps. The in-services reviewed the importance of, but was not limited to: 1) prepared bleach solutions must remain covered, 2) an adequate supply of bleach solution and cloths for disinfection must be readily available at all times, 3) TMs must fully clean machine including front, top, sides, IV pole, and interior/exterior of prime container prior to setting up for the next patient, 4) if a previous patient remains in the treatment chair while the dialysis delivery system is prepared for the next patient, extreme caution must be employed to prevent cross-contamination, and 5) education and reinforcement of Clean vs. Dirty areas in order to prevent cross contamination. TMs were instructed on proper procedure	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	bleach which contained 1000 milliliters and one container was labeled as 1:100 bleach and contained 100 milliliters. Both labels contained the initials of the patient care technician that made the solution, employee B, and evidenced the solutions were made at 5 AM on 7/23/13 and would expire at 5 AM on 7/24/13. There were no cloths readily available for staff use during patient care. Neither of the containers were covered nor were there any covers in sight. A. At 1:30 PM, employee F indicated the facility is scheduled to treat 11 patients during the first and second shift, Monday through Saturday daily, and that they had every station, 11 active stations, during the morning of 7/23/13. B. At 1:15 PM, employee C indicated there was no other bleach solution readily available, and the facility did not have any other container for the bleach solutions to be stored in until use. In-Center observation on July 24, 2013 1. At 1:05 PM, a white clamp was observed on the basin of one of the two dirty sinks. A. At 1:30 PM, employee C indicated the facility did have a container		for disinfecting clamps between patient use and an appropriately labeled container for clamp submersion & disinfection has been placed in a designated dirty area on the treatment floor. A new daily Infection Control audit has been created. The Charge Nurse or designee will perform the audit on random shifts daily for 8 weeks, then weekly for 8 weeks, then monthly. The FA will review the audit results daily. Variances noted on the audit will be addressed with the team or TMs involved. FA will review audit results monthly with Medical Director during Quality Improvement Facility Management Meetings (QIFMM), continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this Plan of Correction. Completion Date: 08/24/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	for soaking clamps but it was not found when the employee searched. The employee could not recall the last time the referenced container was in use. B. At 2:40 PM, the one white clamp still remained in the basin of the sink labeled 'dirty.' 2. On the counters beside each of two sinks labeled "dirty sinks" were the same two clear 1000 milliliter graduated containers as observed July 23. At each sink, one of the containers was labeled as 1:10 bleach which contained 1000 milliliters and one container was labeled as 1:100 bleach and contained 100 milliliters. Both containers were labeled with the initials of the patient care technician that made the solution, employee B, and evidenced the solutions were made at 5 AM on 7/24/13 and would expire at 5 AM on 7/25/13. There were no cloths readily available for staff use during patient care. Neither of the containers were covered nor were covers in sight. 3. At 1:22 PM, employee D was observed cleaning the dialysis machine # 25 in station # 2 while the previous patient sat in the chair. The employee had already removed the tubing and dialyzer from patient's treatment and disposed of it			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	in the biohazard bin. He then used a cloth with bleach water and washed the machine. He did not wash the sides and the prime bucket to the side, nor the intravenous pole attached to the machine. He then took the dialysis tubing and dialyzer for the next patient and set up the machine, which included attaching the open tubing to the unclean bucket on the side of the machine that would later be attached to the next patient's access. At 1:36 PM, employee D was still in station 2 with the previous patient still in the dialysis chair. Employee D asked the patient to stand to take a blood pressure. While waiting for the blood pressure reading, employee D removed the patient's face mask, checked the patient's access dressing on the left upper extremity, then touched the "clean" face of the dialysis machine, and rested his left gloved hand on the top of the "clean" dialysis machine. Employee D readjusted the blood pressure cuff and retook the patient's blood pressure. While waiting for the results, the employee again rested his left hand on the the top of the dialysis machine. After obtaining a blood pressure reading, the blood pressure cuff was removed and placed on the clean intravenous pole without decontaminating. At 1:42 PM, employee D was observed to decontaminate the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	dialysis chair and prepare the station for the next patient. The employee did not decontaminate the IV pole and the blood pressure cuff. 4. At 2:20 PM, employee L, a registered nurse, was observed to ask employees C and D, "Where are the wipes?" and indicated there was insufficient bleach solution available. 5. At 2:50 PM, employee D was observed to place two white clamps in the covered container labeled "clean clamps." When asked, employee D indicated the unit did not have a container to soak the clamps; therefore, he wiped the clamps with a bleach soaked cloth and returned to the container labeled "clean clamps." At 3 PM, when asked, employee K indicated the container for soaking clamps and hemostats was not found and the items were to soak in a 1:100 bleach solution. 7. A policy titled "Infection Control For Dialysis Facilities", Revision Date March 2013, Policy 1-05-01, states, "22. Non-disposable items, such as stethoscopes, are not to be shared unless disinfected between patients. Stethoscopes that are visibly contaminated with blood or body fluids			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	should be disinfected with a 1:10 (one to ten) bleach solution. ... 32. If a previous patient remains in the treatment chair while dialysis delivery system is prepared for the next patient, extreme caution is to be employed to prevent cross-contamination. ... 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 system, 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 other potentially infectious materials. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for environmental surfaces."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
V000143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation and interview, the facility failed to ensure intravenous medications were drawn up and administered in compliance with current aseptic techniques for 2 of 2 observations with intravenous medications with the potential to affect all 49 patients of the facility. (Employees F and D) The findings include: 1. On July 23, 2013, at 12:40 PM, employee F, a registered nurse, was observed with gloved hands and carrying three (3) syringes containing a clear liquid into station 10. With her gloved right hand, the employee grabbed the handle of a wheeled biohazard / sharps container and placed it in the station beside her. Without changing her gloves and decontaminating the ports on the intravenous (IV) tubing, she administered the intravenous medications. 2. On July 24, 2013, at 2:10 PM, employee D, a patient care technician, was observed to withdraw heparin from a	V000143	**V143** FA held mandatory in-services for all Clinical TMs on 8/2/13 & 8/6/13 on Policy #1-06-01 Medication Policy with emphasis onproper procedure for safe and aseptic medication preparation and administration. In-service included but was not limited to: 1) a new alcohol prep pad is required for cleaning the vial stopper prior to withdrawing all IV medications, 2) a new alcohol prep pad is required for cleaning the IV access points and ports on the bloodline prior to administering all IV medications, and 3) gloves must be removed, hand hygiene performed, and clean gloves reapplied between dirty to clean tasks prior to administration of medication. A new daily Infection Control audit has been created. The Charge Nurse or designee will perform the audit on random shifts daily for 8 weeks, then weekly for 8 weeks, then monthly. The FA will review the audit results daily. Variances noted on the audit will be addressed with the team or TMs involved. FA will review audit results monthly with Medical Director during Quality Improvement Facility Management Meetings (QIFMM), continued frequency of audits determined by the team, with supporting documentation included	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	multi-dose vial. The employee failed to wipe the stopper of the multi-dose vial with alcohol or other disinfectant prior to inserting the needle of the syringe and withdrawing the medication. The employee had placed two (2) alcohol wipes beside the vial, but failed to open and use them. 3. On July 24, 2013, at 1 PM, employee E indicated all multi-dose medication vials were to be decontaminated prior to withdrawal of medication as well as all intravenous access points and ports before administration of an IV medication.		in the meeting minutes. The FA is responsible for compliance with this Plan of Correction. Completion Date: 08/24/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
V000637	494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must- (A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents. 4. The administrative documents titled "Infection Control Audit" completed by employee A weekly and dated April and May 2013 evidenced breaks in infection control procedures were identified during the audits.	V000637	**V637** The Clinical Services Specialist (CSS) will conduct a mandatory in-service for all QIFMM members to review Policy & Procedure #1-14-06: Continuous Quality Improvement Program. The in-service will emphasize the QIFMM team must ensure facility monitoring and identify problems such as TM non-compliance with policies and procedures related to Infection Control by analyzing data collected including facility internal audits, conducting evaluation of areas not meeting facility goals, identifying root causes for underperformance, develop recommendations and action plans to minimize infection transmission. QIFMM Team must review current action plans in place, evaluate effectiveness, and initiate new plans as needed to meet goals along with tracking performance over time to ensure improvements are sustained. QIFMM minutes must reflect discussion, actions and evaluation by team. CSS will review monthly QIFMM minutes x3, then quarterly to ensure IDT remains in	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	Based on administrative document and policy review and interview, the facility failed to ensure a quality assessment and performance improvement (QAPI) program addressed identified noncompliant infection control practices, developed recommendations and action plans to minimize infection transmission; and took actions to reduce future incidents for 1 of 1 ESRD reviewed creating the potential to affect all of the facility's current 49 patients. The findings include: 1. On 7-25-13 at 4:30 PM CST, the regional nurse consultant indicated there was no action plan in place to address infection control issues identified by staff audits. While the facility documented daily infection control audits and performed immediate in-servicing for staff when deficit practices were identified and documented, there was no action plan to improve facility performance.		compliance. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect. The FA is responsible for compliance with this Plan of Correction. Completion Date: 08/24/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	2. On 7-25-13 at 4:30 PM, employee K indicated daily infection control audits were documented but there was no documentation to evidence a follow up was conducted to address the noncompliance with infection practice standards and there was not any documentation to support the actions taken and follow up audits to determine if the compliance was improving. 3. The policy titled "Quality Assessment and Performance Improvement (QAPI) for FMS Inpatient Services Programs" with revision date 2/1/13 stated, "The objectives of the QAI program: ... Identify aspects of care that are essential in determining quality of patient care in the inpatient setting. Monitoring, evaluation, and improvement activities are focused on those identified aspects of care and criteria / factors that have an impact on patient outcomes and clinical performance. Quality indicators should be selected in accordance with the following: ... High risk, problem prone processes. ... Quality indicators are composed of objective and measurable criteria, based on current knowledge and clinical experience, and can be identified and monitored through: Direct observation, audit [sic] of documentation."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPREHENSIVE RENAL CARE EAST CHICAGO	4320 FIR ST STE 404 EAST CHICAGO, IN 46312

(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
V000715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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; 4. Clinical record number 4 evidenced the patient was admitted to the facility on 6/15/13. The record failed to evidence an initial assessment by the RN. 5. Clinical record number 5 evidenced the patient was admitted to the facility on 3/4/13. The record failed to evidence an initial assessment by the RN. 6. The facility administrator indicated on 7/25/13 at 12:15 PM there was not an initial assessment by the RN for patients 1, 4, and 5. Based on clinical record and facility	V000715	**V715** FA held mandatory in-service for all Registered Nurses on 8/6/13 to review Policy & Procedure #1-03-07 New Patient Pre-Treatment Evaluation. The in-service emphasized the requirement that the Registered Nurse must perform an initial pre-treatment evaluation of all new patients prior to initiation of first treatment at facility, and the pre-treatment evaluation will be documented on the New Patient Pre-Treatment Evaluation Form. FA or designee will conduct monthly Medical Records Audits for 100% of new patient admissions to ensure RN evaluation is conducted and documented prior to first treatment for the next 6 months. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA and Medical Director are responsible for compliance with POC. Completion Date: 08/24/13	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	policy review and interview, the medical director failed to ensure the registered nurse completed an initial assessment prior to the initiation of a patient's first treatment in the facility for 3 (#1, 4, and 5) of 3 in-center clinical records reviewed of patients admitted in the previous 120 days creating the potential to affect all admissions to the facility. The findings include: 1. The policy titled "New Patient Pre-Treatment Evaluation, Policy : 1-03-07, Revision Date: September 2007" states: "A registered nurse as required by federal regulation will perform an initial pre treatment evaluation of all new patients prior to the initiation of their first treatment at the facility. The minimal nursing evaluation prior to initiating treatment for a patient new to the facility should include: a) neurological, b) respiratory, c) cardiovascular, d) gastrointestinal, e) fluid status, f) general assessment, g) Personal, h) Subjective Complaints; and i) access: assessment. This pre-treatment evaluation will be documented on the: [New Patient Pre-Treatment Evaluation Form.]" 2. Clinical record # 1 evidenced the patient had orders for dialysis written on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152561	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE EAST CHICAGO		STREET ADDRESS, CITY, STATE, ZIP CODE 4320 FIR ST STE 404 EAST CHICAGO, IN 46312	

(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
	7-1-13 with the first dialysis treatment at the facility on 7-3-13. There was documentation of an initial assessment on 7-3-13 by a nurse at 16:10; however, dialysis was begun at 15:59, prior to the initial assessment having been performed. On 7-25-13 at 11:30 AM, employee K, the facility administrator, indicated the medical record for patient #1 failed to evidence a registered nurse completed an initial assessment prior to the patient's first treatment in the facility and no "New Patient Pre-Treatment Form" had been completed or was available for the patient. The agency had not followed its own policy and no further documentation was available.			