

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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 was a federal ESRD recertification survey and survey for the addition of peritoneal dialysis services, including home training for peritoneal dialysis and support.</p> <p>Survey Dates: 12/17/12 - 12/19/12</p> <p>Facility #: 002935</p> <p>Medicaid Vendor #: 200827250C</p> <p>Surveyors: Kelly Ennis, RN, BSN, Public Health Nurse Surveyor, Team Leader Dawn Snider, RN, BSN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 52 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 1</p> <p>Total: 53</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 3, 2013</p>	V0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0113	<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 facility policy review and observation, the facility failed to ensure 2 of 3 Patient Care Technicians (PCT) (employee F and G) observed provided care in compliance with hand hygiene / infection control policies and procedures creating the potential to spread infectious and communicable disease which could affect all 52 in-center patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "Hand Hygiene (Handwashing and Hand Rubs)" policy number 800-28 with a revision date of 9/1/07 states, "The Wash hands with soap and water, or antibacterial soap and water when: hands are visibly dirty, hands are contaminated with blood or body fluids ... The CDC recommends alcohol-based hand rubs (gels or foams) for routine hand decontamination because it is more effective than plain soap and water or antimicrobial soap and water ... Routinely decontaminate (i.e., reduce</p>	V0113	<p>1.-10. Clinic Manager will in-service all staff regarding DSIPolicy &amp; Procedure 800-28: Hand Hygiene; 800-01:Dialysis Infection Control Precautions by 1/18/13. The staff will verbalize understanding of Standard Precautions which includes but not limited to the use of gloves: changing appropriately; hand hygiene when donning or removing gloves. Proper identification of clean/dirtyareas. Emphasis on cross contamination from touching possibly contaminated surfaces and hand hygiene performed after that contact.Clinic Manager or designee will monitor all staffdaily x 2 weeks, or until compliance is established,weekly x 2, monthly x 2 then bi-monthly per the Quality Management Workbook audit.Any staff found not to be in compliance with DSI Policy &amp; Procedure will receive progressive disciplinary action.Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>bacterial counts) hands using a a hand rub when: ... before direct patient contact ... before inserting invasive devices (e.g., AV fistula needles) ... after removing gloves; if moving from a contaminated body site to a clean body site during care; after contact with objects, including equipment, located in the patient's environment; when leaving patient treatment area."</p> <p>2. On 12/17/2012 at 10:50 AM, employee F, PCT, placed her bare hand on dialysis machine #13 and then leaned behind machine to obtain a box of gloves. The PCT then removed a pair of gloves out of the box and applied them with no sanitation prior.</p> <p>3. On 12/17/2012 at 11:05 AM, employee G, PCT, was at station #18 preparing to initiate treatment on patient #6. The PCT obtained pain spray from the patient's bag and placed it on the wood side table. The PCT then applied gel, touched the wood side table, and then applied gloves, with no sanitation prior. The PCT applied Chloraprep swab stick to the access site, picked up the pain spray with gloved hand and applied it to patient's arm, and then inserted needle #1. The PCT then applied the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>pain spray to the 2nd access site and inserted needle #2. The PCT removed her gloves, applied gel, touched machine #16 with bare hand while reaching behind it to obtain gloves, and applied gloves, with no sanitation prior. The PCT then returned to station #18 to connect lines to the patient. The PCT then removed her gloves, applied gel, and touched machine #17 with bare hand while leaning behind it to obtain gloves. The PCT then applied her gloves with no sanitation prior and returned to Station #18 to set machine. The PCT then removed her gloves, applied gel, and touched machine #17 while obtaining gloves from box behind the machine. The PCT placed the box of gloves on the stool beside Station #18. The PCT then applied gloves with no sanitation prior. The PCT then placed the patient pain spray back into patient's bag and threw away supplies.</p> <p>4. On 12/17/2012 at 11:15 AM, employee F, PCT, was at station #13 preparing to initiate treatment on patient #8. The PCT applied hand gel, touched machine #14 with bare hands while leaning behind it to obtain gloves, and applied new gloves with no sanitation prior. The PCT then applied Chloraprep swab stick to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>access site and inserted needle #1. The PCT then applied Chloraprep swab stick to second access site and inserted needle #2. The PCT then removed her gloves, applied gel, and touched machine #14 with bare hands while reaching behind it to obtain gloves. The PCT then applied the gloves with no sanitation prior. The PCT then flipped the patient access needle, removed her gloves, and applied gel. The PCT then touched machine #14 with bare hands while reaching behind it to obtain gloves, and applied new gloves with no sanitation prior. The PCT then connected the lines to the patient, threw away supplies, removed gloves, and applied gel. The PCT then touched machine #14 with bare hands while reaching behind it to obtain gloves, and applied gloves with no sanitation prior.</p> <p>5. On 12/17/2012 at 11:28 AM, employee G, PCT, was at station #15 preparing to initiate treatment on patient #10. The PCT inserted the needles, removed her gloves, and applied gel. The PCT then touched machine #15 with bare hands while reaching behind it to obtain gloves and applied gloves with no sanitation prior.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>6. On 12/17/2012 at 11:43 AM, employee F, PCT, was at station #10 preparing to initiate treatment on patient #12. The PCT touched the laptop screen with bare hands and applied gloves with no sanitation prior. The PCT then connected the patient lines and began treatment.</p> <p>7. On 12/19/2012 at 11:02 AM, employee F, PCT, was at Station #3 applying tape and gauze to patient #14's access site after treatment had been discontinued. The PCT then applied a clamp to the patient's arm and the access site began to bleed. The PCT re-taped the access site and re-applied the clamp. Blood was visible on the PCT's gloves. The PCT removed her gloves, and applied gel. The PCT failed to wash her hands with soap and water.</p> <p>8. On 12/19/12 at 10:45 AM, employee G removed her gloves, retrieved supplies for the next patient, and placed the supplies on top of machine #14. She applied new gloves without washing or applying gel.</p> <p>9. On 12/19/12 at 10:50 AM, employee G touched station #14 without changing gloves and touched machine #13 that had been cleaned and set up for the next patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	10. On 12/19/12 at 11:00 AM, employee G was at station # 17 and changed gloves but did not wash or gel her hands prior. The PCT then walked over to station #14 to assist the patient.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0115	<p>494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.</p> <p>Based on facility policy review and observation, the facility failed to ensure all staff providing direct patient care wore a face mask to provide protection for 1 of 1 facility with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 12/19/12 at 10:38 AM, employee G, the patient care technician, was observed providing direct patient care wearing a mask pulled down on her chin which did not cover her mouth and nose.</li> <li>The policy titled "800-13: POLICY/PROCEDURE: Personal Protective Equipment (PPE)" revised 10/1/10 states, "Fluid Resistant Mask 1. Masks protect, and should fully cover, the nose and mouth. Adjust the nose piece or</li> </ol>	V0115	<p>1.-2.Clinic Manager will in-service all clinical staff regarding DSI Policy &amp; Procedure 800-13: Personal Protective Equipment; 800-01: Dialysis Infection Control Precautions; 800-10: Blood Borne Pathogens Exposure Control Plan by 1/18/13. This includes but not limited to the correct way to wear PPE during initiation/termination of the dialysis treatment. Clinic Manager or designee will monitor all clinical staff daily x 2 weeks, or until compliance is established, weekly x 2, monthly x 2, then quarterly per the Quality Management Workbook audit. Any staff found not to be in compliance with DSI Policy &amp; Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	the elastic/ties for a good fit."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on facility policy review, observation, and staff interview, the facility failed to ensure 2 of 2 Registered Nurses (RN) (employee B and C) and 3 of 3 Patient Care Technicians (PCT) (employee F, G, and I) observed kept clean areas clearly separated from contaminated areas creating the potential to spread infectious and communicable disease to all 52 in-center patients of the</p>	V0117	<p>1.-8.The Clinic Manager &amp; Biomed Technician disposedof all the wooden tables at the patient stations. ClinicManager will in-service all staff regarding DSI Policy &amp;Procedure 800-01: Dialysis Infection Control Precautions;300-14: Cleaning the External Machine &amp; SurroundingAreas; 300-63: Phoenix Meter Use by 1/18/13. Their-service will included but not limited to: placing a barrierpiece of tape before placing torn tape at the patientstation; disinfection of</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	<p>facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Dialysis Infection Control Precautions" policy number 800-01 with a revision date of 4/1/10 states, "Clean areas should be clearly identified and designated for handling and storage of medications, and unused supplies and equipment ... Dirty or contaminated areas should be clearly identified and designated for used supplies and equipment, and for handling and storing blood samples ... Never place supplies that will be used for other patients on the top of the dialysis machine."</li> <li>2. On 12/18/12 at 10:28 AM, wood side tables were observed placed on top of clean bed linen's at station #4, 10, 14, and 18.</li> </ol> <p>During an interview on 12/18/12 at 10:30 AM, employee G, PCT, indicated the table would be removed from the bed when the nocturnal shift arrived and no linen change would be required.</p> <ol style="list-style-type: none"> <li>3. On 12/19/12 at 11:05 AM, employee F, PCT, was cleaning the dialysis machine at station #3. The PCT did not clean the saline bucket,</li> </ol>		<p>the Phoenix Meter after use; notplacing paperwork on the dialysis machine without barrier. Clinic Manager or designee will monitor all clinicalstaff daily x 2 weeks, or until compliance has beenestablished, weekly x 2, monthly x 2, then bi-monthlyper the Quality Management Workbook schedule. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>computer, keyboard, or hand sanitizer. The PCT then obtained new supplies for the next patient and placed them on top of the dialysis machine. The PCT then opened the blood lines and saline bags and laid them on top of the dialysis machine with no barrier underneath.</p> <p>4. On 12/19/12 at 11:07 AM, employee C, RN, was at station #8 preparing to initiate treatment on patient #16. The RN pre-tore the tape and applied it to the wood side table with no barrier underneath.</p> <p>5. On 12/19/12 at 11:15 AM, patient #18 arrived for treatment at station #6. The RN, employee C, placed the patient's paperwork on top of the dialysis machine with no barrier underneath.</p> <p>6. On 12/19/12 at 11:20 AM, employee B, RN, was at station #9 using the Phoenix meter. When complete, the RN placed the Phoenix meter behind the dialysis machine on the ledge by the clean supplies with no disinfection prior.</p> <p>Surveyor: Snider, Dawn</p> <p>7. On 12/17/12 at 11:40 AM, employee I,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>PCT, was observed to place clean linens on top of the dialysis machine at station #2 with no barrier underneath.</p> <p>8. On 12/19/12 at 11:00 AM, a Phoenix meter was observed in a wire basket attached to the side of machine # 17. Employee I, the PCT, removed the meter from the basket to test at Station #16 and placed it back in the basket at station # 17 without disinfection.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0120	<p>494.30(a)(1)(i) IC-TRANSDUCER PROTECTORS-NOT WETTED/CHANGED</p> <p>Use external venous and arterial pressure transducer filters/protectors for each patient treatment to prevent blood contamination of the dialysis machines' pressure monitors.</p> <p>If the external transducer protector becomes wet, replace immediately and inspect the protector. If fluid is visible on the side of the transducer protector that faces the machine, have qualified personnel open the machine after the treatment is completed and check for contamination. This includes inspection for possible blood contamination of the internal pressure tubing set and pressure sensing port. If contamination has occurred, the machine must be taken out of service and disinfected using either 1:100 dilution of bleach (300-600 mg/L free chlorine) or a commercially available, EPA-registered tuberculocidal germicide before reuse.</p> <p>Change filters/protectors between each patient treatment, and do not reuse them. Internal transducer filters do not need to be changed routinely between patients.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure staff replaced and inspected external transducer protectors as required when they became wet during 1 of 3 days of observations creating the potential to spread infectious and communicable disease to all 52 in-center patients of the facility.</p> <p>The findings include:</p>	V0120	<p>1.-5.Clinic Manager will in-service all clinical staff regarding DSI Policy &amp; Procedure: 800-01: Dialysis Infection Control Precautions; 300-24: Monitoring During Patient Treatment by 1/18/13.</p> <p>Clinic Manager or designee will monitor all clinical staff daily x 2 weeks, or until compliance has been established, weekly x 2, monthly x 2, then bi-monthly per the Quality Management Workbook schedule.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	<p>1. Facility policy titled "Dialysis Infection Control Precautions" policy number 800-01 with a revision date of 4/1/10 states, "Use external venous and arterial pressure transducer filters/protectors for each patient treatment to prevent blood contamination of the dialysis machine pressure monitors."</p> <p>2. On 12/17/2012 at 10:30 AM, transducer protectors were observed bloody and wet at stations #12, 16, and 17.</p> <p>3. On 12/17/2012 at 11:41 AM, transducer protectors were observed bloody and wet at station #18.</p> <p>4. During an interview on 12/17/2012 at 10:48 AM, employee F, patient care technician (PCT), indicated blood should not be on the transducer protector. Employee F stated, "It was probably wet when I put it on." The PCT failed to replace or inspect the wet transducer protector after it was brought to her attention.</p> <p>5. During an interview on 12/19/12 at 5:22 PM, employee A, Clinic Manager, indicated transducer protectors need to be changed out immediately when they become wet.</p>		Any staff found not to be in compliance with DSIPolicy & Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &Local Governing Board meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0122	<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-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on facility policy review and observation, the facility failed to ensure staff cleaned and disinfected contaminated surfaces, medical devices, and equipment as required during 3 of 3 days of observations creating the potential to spread infectious and communicable disease to all 52 in-center patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "Dialysis Infection Control Precautions" policy number 800-01 with a revision date of 4/1/10 states, "Clean and disinfect the treatment station at the end of each dialysis treatment ... Disinfect the front, top, and sides of the dialysis machine, plus dialysis chairs, side tables, designated computer equipment, IV poles, TV, TV remote, phones, etc ... Disinfect scissors,</p>	V0122	<p>1.-14.The Clinic Manager &amp; Biomed Technician disposedof all the wooden tables at the patient stations. ClinicManager will in-service all staff regarding DSI Policy &amp;Procedure 800-01: Dialysis Infection Control Precautions;300-14: Cleaning the External Machine &amp; SurroundingAreas by 1/18/13. The in-servicing will include but notlimited to: placing a barrier piece of tape before placingtorn tape at the patient station; not placing paperworkon the dialysis machine without a barrier; cleaning thetop and sides of the attached sharps container. Clinic Manager or designee will monitor all clinicalstaff daily x 2 weeks, or until compliance has beenestablished, weekly x 2, monthly x 2, then bi-monthlyper the Quality Management Workbook schedule. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction.</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
	<p>stethoscopes, blood pressure cuffs, etc. between patients ... Place used pressure clamps, holders, and tourniquets in a container filled with 1:100 bleach, making sure items are completely submerged, unclamped and in an open position ... Between patients, remove the prime bucket from the side of the machine and pour residual fluid into a designated "dirty" sink. Disinfect the bucket with 1:100 bleach solution before returning the prime bucket to the machine."</p> <p>2. Facility policy titled "Cleaning the External Machine and Surrounding Areas" policy number 300-14 with a revision date of 4/1/12 states, "Clean dialysis machine including prime containers/funnels, blood pressure cuffs, attached computer monitors and keyboard/mouse equipment beginning at the top and finishing at the bottom ... Spot check and clean area behind machine as needed ... clean chair/bed beginning at the top and finishing at the bottom. Include side trays if present. Place chair in reclining position to clean ... If patient station has individual TV's or other equipment (including trash can), ensure that all parts are cleaned."</p> <p>3. On 12/17/2012 at 10:45 AM, employee F, patient care technician</p>		Clinic Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI & Local Governing Board meeting.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>(PCT), cleaned machine #13. The PCT failed to clean the IV pole and saline bucket.</p> <p>4. On 12/17/12 at 10:53 AM, observed wood side tables placed beside all stations with a bed (Station 10, 12, 14, and 18). The wood tables are not impervious and cannot be adequately disinfected.</p> <p>5. On 12/18/2012 at 10:43 AM, dried blood was noted on sharps containers at stations #1, 2, 3, 6, 7, 8, 10, 12, 13, 16, 17, and 18.</p> <p>6. On 12/19/2012 at 10:35 AM, employee F, PCT, cleaned machine #2. The PCT failed to clean the IV pole or hand sanitizer attached to the dialysis machine</p> <p>7. On 12/19/2012 at 11:05 AM, employee F, PCT, cleaned machine #3. The PCT did not clean the saline bucket, computer, keyboard, or hand sanitizer.</p> <p>8. On 12/19/2012 at 11:17 AM, employee F, PCT, was cleaning the recliner at station #3. The PCT failed to recline the chair when cleaning.</p> <p>9. On 12/19/2012 at 11:40 AM, clamps were not fully submerged in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
	<p>the disinfectant basin. There was a clamp lying on top of the lid not fully submerged.</p> <p>10. On 12/17/12 at 10:55 AM, the PCT, employee I, cleaned station #3. The PCT failed to clean the IV pole, Blood Pressure (BP) cuff, computer, and keyboard.</p> <p>11. On 12/19/12 at 10:30 AM, the PCT, employee I, cleaned the chair at station#18. The PCT cleaned the right side of the chair first, then the table top of the chair, seat, and the left side of chair. She failed to lay the chair back to clean.</p> <p>12. On 12/19/12 at 10:35 AM, the PCT, employee I, cleaned station #15. The PCT did not empty and clean the saline bucket or IV pole attached to the machine. The PCT failed to clean the BP cuff, computer, and keyboard.</p> <p>13. On 12/19/12 at 10:45 AM, pre torn tape was observed on the wood side table at station #14 that was not protected by a barrier.</p> <p>14. On 12/19/12 at 10:50 AM, the PCT, employee G, cleaned station #14. The PCT cleaned the top of the mattress and the top of the wood side table. She failed to clean the sides of the mattress, the bed side rails, the TV, BP cuff, IV pole, saline</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	bucket, computer, and keyboard.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
V0126	<p>494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Hepatitis B Vaccination</p> <p>Vaccinate all susceptible patients and staff members against hepatitis B.</p> <p>Based on personnel file review and staff interview, the facility failed to ensure all patient care staff had evidence of being vaccinated for Hepatitis B and or the serologic immune status in 1 (file P) of 7 personnel staff files reviewed of employees providing patient care with the potential to affect all of the facility's staff, visitors, and 52 current In-center hemodialysis patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file P, the Medical Director, failed to evidence documentation of being vaccinated for Hepatitis B.</li> <li>2. On 12/19/12 at 4:35 PM, the clinical manager, employee A, indicated the medical director did not have any evidence of serologic testing or vaccination.</li> </ol>	V0126	<p>1.-2.Clinic Manager will audit all personnel files by 1/18/13.All staff including the Medical Director will haveevidence of serologic testing or vaccination for HepatitisB. Director of Operations in-serviced Clinic Managerregarding DSI Policy &amp; Procedure: 800-07: EmployeeHealth Screening; 800-10 Blood Borne PathogensExposure Control Plan by 1/18/13. Director of Operations or designee will monitormonthly or until compliance is established, then bi-annuallyper the Quality Management Workbook audit schedule. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0143	<p>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</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure drugs were not expired and clinic staff followed facility policy and procedures to properly label multi-dose vials with the date first opened to ensure expired medications were not available for use with the potential to affect all 53 patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "Administration of Medications", policy number 500-06 with a revision date of 10/1/08, states, "Multi-dose vials will be labeled with the date first opened. Opened multi-dose vials will be discarded after 30 days unless the manufacturer guidelines or package inserts specify a different time period. Expired medications will be discarded and inventory will be notified on a monthly basis"</p> <p>2. Observations on 12/17/2012 at</p>	V0143	<p>1.-3.Clinic Manager will in-service all nurses regarding DSIPolicy &amp; Procedure 500-06: Administration ofMedications by 1/18/13. This includes but not limitedto the disposing of all expired meds (manufacturersexpiration date or post opening expiration date); labelingmultidose vials after opening. Clinic Manager or designee will monitor all nursesdaily x 2 weeks, or until compliance has beenestablished, weekly x 2, monthly x 2, then bi-monthlyper the Quality Management Workbook schedule. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	<p>10:05 AM evidenced 3 packages of Tuberculin Purified Protein Derivative (Mantoux) Tubersol with an expiration date of 10/13/12 in refrigerator located in the in-center treatment area.</p> <p>During an interview on 12/19/12 at 5:20 PM, employee Q, Clinic Manager, indicated the registered nurses should be checking the medications daily and they should have caught that the drug was expired it and thrown it away.</p> <p>3. Observations on 12/19/2012 at 11:50 AM evidenced one open Zemplar multi-dose vial lying on a chux in the medication preparation area not labeled with date first opened.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on policy review, observation, and staff interview, the facility failed to ensure 1 of 1 Patient Care Technicians (PCT) (employee F) observed treating a patient with a central venous catheter (CVC)</p>	V0147	1.-3.Clinic Manager will in-service all clinical staff regarding DSI Policy & Procedure 300-21: Preparation of External Access for Treatment Initiation by 1/18/13. Clinic Manager or designee will monitor all clinical staff daily x 2	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	<p>provided care in compliance with central venous catheter policy creating the potential to spread infectious and communicable disease which could affect all patients with a CVC.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Preparation of the External Access for Treatment Initiation," policy number 300-21 with a revision date of 9/1/07, states, "The catheter exit site should be examined prior to the preparation of the access for treatment initiation. If any problems noted, the charge nurse would be informed."</li> <li>2. On 12/19/2012 at 10:15 AM, employee F, PCT, was at Station #1 preparing to initiate treatment on a patient with a CVC. The PCT initiated treatment without inspecting the catheter site first.</li> <li>3. During an interview on 12/19/12 at 5:27 PM, employee A, clinic manager, indicated the PCT should have at least looked at catheter exit site before beginning treatment.</li> </ol>		<p>weeks, or until compliance has been established, weekly x 2, monthly x 2, then bi-monthly per the Quality Management Workbook schedule.</p> <p>Any staff found not to be in compliance with DSI Policy &amp; Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0401	<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 facility policy review and observation, the facility failed to ensure all medications were properly labeled for 1 of 1 days medications were reviewed with the potential to affect all 52 in-center patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Administration of Medications", policy number 500-06 with a revision date of 10/1/08, states, "Medications drawn up will always be labeled clearly if not immediately administered with the following information: Drug name and dose; Date and time drawn up; initials of staff drawing up drug."</li> <li>2. Observations on 12/17/2012 at 10:07 AM evidenced the following: <ul style="list-style-type: none"> <li>A. One pre-drawn vial of Heparin for patient #20 was labeled as "Heparin 4000 IV [intravenous] Initial" with no</li> </ul> </li> </ol>	V0401	<p>1.-2. A.B.CClinic Manager will in-service all nurses regarding DSIPolicy &amp; Procedure 500-06: Administration ofMedications by 1/18/13. This includes but not limitedto the labeling of all multidose vials after opening andpre-drawn syringes if not used immediately.</p> <p>Clinic Manager or designee will monitor all nursesdaily x 2 weeks, or until compliance has beenestablished, weekly x 2, monthly x 2, then bi-monthlyper the Quality Management Workbook schedule.</p> <p>Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction.</p> <p>Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>date, time, or initials.</p> <p>B. Two pre-drawn vials of Heparin for patient #22 were labeled as "Heparin 5000 IV Initial" and "1000 Q [every] hour" with no date, time, or initials.</p> <p>C. One pre-drawn vial of Heparin for patient #8 was labeled as "Heparin 2000 IV Initial" with no date, time, or initials.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0403	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>Based on observation and staff interview, the facility failed to ensure all equipment was maintained and operated in accordance with accepted standards for 1 of 1 dialysis facility reviewed with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 12/18/12 at 10:33 AM, the dialysis machine at station #13 evidenced the arterial chamber was not two thirds full with blood. On 12/18/12 at 10:40 AM, employee E, patient care technician, indicated the arterial chamber on station #13 should have been two thirds full with blood to prevent air from going into the arterial line.</li> <li>On 12/18/12 at 11:36 AM, the dialysis machine at station #8 evidenced the arterial chamber was not two thirds full with blood.</li> </ol>	V0403	<p>1.-3.Clinic Manager or designee will in-service all clinicalstaff regarding DSI Policy &amp; Procedure 375-31:Initiation of Dialysis-Fresenius 2008 H/K/K2. This willinclude but not limited to arterial chamber at 2/3 fullduring the patient treatment; Clinic Manager or designee will monitor daily x 2weeks or until compliance is established, weekly x 2,monthly x 2, then per the Quality ManagementWorkbook audit schedule.</p> <p>4. The seal was replaced on the preventer and the rustwas removed from the drain cup. ATM or designee will monitor water system for leaksor corrosion on pipes weekly x 8 or until complianceis established, then monthly. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>3. On 12/19/12 at 5:30 PM, employee A, clinical manager, indicated the arterial chamber should be maintained at two thirds of blood to prevent air from entering the arterial line.</p> <p>4. On 12/17/12 at 3:00 PM during the tour of the water treatment room, the back flow pump valve system marked #1 leaked with evidence of corrosion present. The bio med tech, employee M, indicated that it was leaking.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0410	<p>494.60(d)(1) PE-PT CARE STAFF-CURRENT CPR CERT Staff training must be provided and evaluated at least annually and include the following: Ensuring that, at a minimum, patient care staff maintain current CPR certification</p> <p>Based on personnel file review and staff interview, the facility failed to ensure all patient care staff were CPR (Cardiopulmonary Resuscitation) certified in 1 (file P) of 7 personnel files reviewed of patient care staff with the potential to affect all of the facility's 52 current In-center hemodialysis patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file P, the Medical Director, failed to evidence documentation of CPR certification.</li> <li>2. On 12/19/12 at 4:35 PM , the clinical manager, employee A, indicated the medical director had not been certified in CPR.</li> </ol>	V0410	<p>Clinic Manager will audit all personnel files by 1/18/13. All staff including the Medical Director will have evidence of current CPR certification. Director of Operations in-serviced Clinic Manager regarding all staff specific job descriptions. Director of Operations or designee will monitor monthly or until compliance is established, then bi-annually per the Quality Management Workbook audit schedule.</p> <p>Any staff found not to be in compliance with DSI Policy &amp; Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO</p> <p>The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.</p> <p>Based on observations, staff interview, and policy review, the facility failed to ensure 2 of 3 Patient Care Technicians (PCT) (employee F and G) observed returning blood after the completion of dialysis treatment provided the necessary care and services to sustain the clinically appropriate hemoglobin / hematocrit level creating the potential for an increased risk anemia for all patients whose dialysis is discontinued by employees F and G.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On 12/19/2012 at 10:30 AM, employee F, PCT, was discontinuing treatment at station #2 with patient #28. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color.</li> <li>2. On 12/19/2012 at 10:59 AM,</li> </ol>	V0547	<p>1.-6.Clinic Manager or designee will in-service all clinicalstaff regarding DSI Policy &amp; Procedure 375-15:Termination of Dialysis Fresenius 2008H/K/K2Machine by 1/18/13.</p> <p>Clinic Manager or designee will monitor all clinicalstaff daily x 2 weeks or until compliance is established,weekly x 2, monthly x 2, then bi-monthly per theQuality Management Workbook schedule.</p> <p>Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>employee F, PCT, was discontinuing treatment at station #3 with patient #14. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color.</p> <p>3. On 12/19/12 at 5:28 PM, employee A, Clinic Manager, indicated the blood lines should be light pink after returning the blood at the completion of dialysis.</p> <p>4. Facility policy titled "Termination of Dialysis - Fresenius 2008H/K/K2 Machine" policy number 375-15 with a revision date of 10/1/10 states, "When the blood lines are light pink, turn off blood pump."</p> <p>5. On 12/19/12 at 10:35 AM, employee G, PCT, was discontinuing treatment at station #13 with patient # 11. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color.</p> <p>6. On 12/19/12 at 10:45 AM, employee G, PCT, was discontinuing treatment at station #14 with patient #13. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0553	<p>494.90(a)(7)(i) POC-HOME DIALYSIS PLAN OR WHY NOT The interdisciplinary team must identify a plan for the patient's home dialysis or explain why the patient is not a candidate for home dialysis.</p> <p>Based on facility policy review, clinical record review, and interview with facility staff, the facility failed to ensure follow up occurred for a patient who was interested in home hemodialysis in 1 of 4 in-center medical records reviewed with the potential to affect all the facility's patients. (#5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Documentation of Medical Records" policy number 600-02 with a revision date of 4/1/12 states, "Medical documents pertaining to the patient are to be scanned into the PEARL System within 30 days of generation ... Late entries must be entered into the record no later than 24 hours from the original date/time of the missed documentation."</li> <li>2. Facility policy titled "Plan of Care" policy number 600-12 with a revision date of 10/1/10 states, "The plan of care must address, but not be limited to, the following: ... Modality.</li> </ol>	V0553	<p>1.-4.The Clinic Manager or designee will audit all patientscharts with a Plan of Care completed in the last 3 monthsfor follow up of modality requests. The Clinic Managerwill in-service the IDT (Interdisciplinary Team)regarding DSI Policy &amp; Procedure 600-02:Documentation of Medical Records; 600-12: Plan ofCare. This will include but not limited to addressingmodality evaluation; follow up on patient requests formodality changes; timely documentation in the patientmedical record by 1/18/13. Clinic Manager or designee will monitor all patientPlan of Cares monthly x 6 months or until compliancehas been established, then quarterly per the QualityManagement Workbook audit schedule. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	<p>Evaluation and appropriateness of patient's chosen modality ... If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must adjust the plan of care to reflect the patient's current condition, document in the record the reasons why the patient was unable to achieve the goals."</p> <p>3. Clinical record number 5 included a plan of care dated 9/26/12 that indicated the patient was interested in Nx Stage home hemodialysis. Review of the record failed to evidence the interdisciplinary team ever followed up on this.</p> <p>4. On 12/18/12 at 4:00 PM, employee A, Clinic Manager, indicated she was unable to find any documentation that the facility had followed up on the patient's interest. She indicated she called the Social Worker who indicated that he documented the follow up in his notes, but never put it in the clinical record.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
V0587	<p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record.</p> <p>Based on clinical record review and interview, the facility failed to ensure the Peritoneal Dialysis Nurse reviewed completed the self-monitoring data and other information from self-care patients or their designated caregiver(s) in 1 of 1 home peritoneal dialysis (PD) records reviewed with the potential to affect all patients receiving home peritoneal dialysis. (#1)</p> <p>Findings:</p> <p>1. Clinical record #1 evidenced PD Home Record Sheets for the dates of 11/30/12 - 12/17/12. There was no indication if the PD Home Record Sheets had been reviewed by a RN.</p> <p>2. On 12/19/2012 at 2:00 PM, employee A, clinical manager, verified the home record sheets were not signed by an RN. The clinical manager further indicated she could find no documentation in the progress notes to prove they had been</p>	V0587	<p>1.-2.Clinic Manager will in-service the PD Home staff regarding DSI Policy &amp; Procedures 200-03: DialysisRecord-CCPD Flowsheet; 200-04: Dialysis Record-CAPD Flowsheet by 1/18/13. Clinic Manager or designee will monitor PD patients flowsheets for RN review monthly x 6 or until compliance is established, then quarterly per the Quality Management Workbook audit schedule. Any staff found not to be in compliance with DSI Policy &amp; Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>	01/18/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	reviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012	
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143			
(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			
V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;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;</p> <p>Based on facility policy and procedure review, observation, interview, and clinical record review, the medical director failed to ensure the facility had provided services in accordance with its own policies with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The medical director failed to ensure the facility policy titled "Hand Hygiene (Handwashing and Hand Rubs)" policy number 800-28 with a revision date of 9/1/07, was followed. (See V 113)</p> <p>2. The medical director failed to ensure the facility policy titled "Dialysis Infection Control Precautions" policy number 800-01 with a revision date of 4/1/10, was followed. (See V 117, V 120, and V 122)</p>	V0715	<p>The Medical Director was informed of all deficiencies cited during the survey.</p> <p>1. Clinic Manager will in-service all staff regarding DSIPolicy &amp; Procedure 800-28: Hand Hygiene; 800-01: Dialysis Infection Control Precautions by 1/18/13. The staff will verbalize understanding of Standard Precautions which includes but not limited to the use of gloves: changing appropriately; hand hygiene when donning or removing gloves. Proper identification of clean/dirty areas. Emphasis on cross contamination from touching possibly contaminated surfaces and hand hygiene performed after that contact.</p> <p>2. The Clinic Manager &amp; Biomed Technician disposed of all the wooden tables at the patient stations. Clinic Manager will in-service all staff regarding DSI Policy &amp; Procedure 800-01: Dialysis Infection Control Precautions; 300-14: Cleaning the External Machine &amp; Surrounding Areas; 300-63: Phoenix Meter Use; 300-24:</p>	01/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	<p>3. The medical director failed to ensure the facility policy titled "Cleaning the External Machine and Surrounding Areas" policy number 300-14 with a revision date of 4/1/12 was followed. (See V 122)</p> <p>4. The medical director failed to ensure the facility policy titled "Administration of Medications", policy number 500-06 with a revision date of 10/1/08 was followed. (See V 143 and V 401)</p> <p>5. The medical director failed to ensure the facility policy titled "Preparation of the External Access for Treatment Initiation," policy number 300-21 with a revision date of 9/1/07 was followed. (See V 147)</p> <p>6. The medical director failed to ensure the facility policy titled "Termination of Dialysis - Fresenius 2008H/K/K2 Machine" policy number 375-15 with a revision date of 10/1/10 was followed. (See V 547)</p> <p>7. The medical director failed to ensure the facility policy titled "Plan of Care" policy number 600-12 with a revision date of 10/1/10 was followed. (See V 553)</p> <p>8. The medical director failed to</p>		<p>Monitoring During Patient Treatment by 1/18/13. The in-service will include but not limited to: placing a barrier piece of tape before placing torn tape at the patient station; disinfection of the Phoenix Meter after use; not placing paperwork on the dialysis machine without barrier.</p> <p>3. The Clinic Manager &amp; Biomed Technician disposed of all the wooden tables at the patient stations. Clinic Manager will in-service all staff regarding DSI Policy &amp; Procedure 800-01: Dialysis Infection Control Precautions; 300-14: Cleaning the External Machine &amp; Surrounding Areas by 1/18/13. The in-servicing will include but not limited to: placing a barrier piece of tape before placing torn tape at the patient station; not placing paperwork on the dialysis machine without a barrier; cleaning the top and sides of the attached sharps container.</p> <p>4. Clinic Manager will in-service all nurses regarding DSI Policy &amp; Procedure 500-06: Administration of Medications by 1/18/13. This includes but not limited to the disposing of all expired meds (manufacturer's expiration date or post opening expiration date); labeling multidose vials after opening.</p> <p>5. Clinic Manager will in-service all clinical staff regarding DSI Policy &amp; Procedure 300-21: Preparation of External Access for Treatment Initiation by 1/18/13.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/19/2012
NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143		
(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	
	ensure the facility policy titled "Documentation of Medical Records" policy number 600-02 with a revision date of 4/1/12 was followed. (See V 553)		6. Clinic Manager or designee will in-service all clinical staff regarding DSI Policy & Procedure 375-15: Termination of Dialysis Fresenius 2008H/K/K2 Machine. 7. The Clinic Manager or designee will audit all patients charts with a Plan of Care completed in the last 3 months for follow up of modality requests. The Clinic Manager will in-service the IDT (Interdisciplinary Team) regarding DSI Policy & Procedure 600-02: Documentation of Medical Records; 600-12: Plan of Care. This will include but not limited to addressing modality evaluation; follow up on patient requests for modality changes; timely documentation in the patient medical record by 1/18/13. 8. The Clinic Manager or designee will audit all patients charts with a Plan of Care completed in the last 3 months for follow up of modality requests. The Clinic Manager will in-service the IDT (Interdisciplinary Team) regarding DSI Policy & Procedure 600-02: Documentation of Medical Records; 600-12: Plan of Care. This will include but not limited to addressing modality evaluation; follow up on patient requests for modality changes; timely documentation in the patient medical record by 1/18/13. 9. Clinic Manager will in-service all clinical staff regarding DSI Policy & Procedure 800-13: Personal Protective Equipment; 800-01: Dialysis Infection		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DSI GREENWOOD RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 AIRPORT PKWY STE 140 GREENWOOD, IN 46143
--	--

(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
	9. The medical director failed to ensure the facility policy titled "Personal Protective Equipment (PPE)" policy number 800-13 with a revision date of 10/1/10 was followed. (See V 115)		ControlPrecautions; 800-10: Blood Borne Pathogens ExposureControl Plan by 1/18/13. This includes but not limited tothe correct way to wear PPE during initiation/terminationof the dialysis treatment. Clinic Manager or designee will monitor as per theindividual Plan of Correction for each VTag. Any staff found not to be in compliance with DSIPolicy & Procedure will receive progressive disciplinaryaction. Clinic Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &Local Governing Board meeting.	