

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2013
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NAME OF PROVIDER OR SUPPLIER NORTH EVANSVILLE DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1151 W BUENA VISTA RD EVANSVILLE, IN 47710
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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Survey dates: 1-3-13, 1-4-13, 1-7-13, and 1-8-13</p> <p>Facility: 009368</p> <p>Medicaid Vendor: 200071340A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>North Evansville Dialysis was found to be out of compliance with the Condition for Coverage 42 CFR 494.90 Patient Plan of Care.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">January 16, 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.

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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 observation, interview, and review of facility policy, the facility failed to ensure staff changed gloves and performed hand hygiene in accordance with facility policy in 5 (#s 4, 5, 6, 7, and 8) of 8 observations creating the potential for the transmission of disease causing organisms among staff and the facility's 74 current patients.</p> <p>Findings include:</p> <p>1. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "The Centers for Disease Control (CDC) 'Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients' (Dialysis Precautions) will be followed when caring for all patients . . . 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,</p>	V0113	<p>V113 Facility Administrator (FA) held mandatory in-service for all Clinical Teammates (TMs) on 1/22/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure # 1-04-02C Central venous Catheter (CVC) Cleaning and Dressing Change</i>. TMs instructed using surveyor observations as examples to the following: 1) TMs must wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. 2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station. 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart. 4) During CVC Cleaning and Dressing Change: After removing old CVC dressing and assessing access site, TMs must remove and discard gloves, conduct hand hygiene, don new gloves, cleanse exit site and clean entire length of catheter limb all the way down to catheter hub and cap to thoroughly clean all surfaces of</p>	02/08/2013			

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	<p>before touching clean areas such as supplies and before leaving the patient care area . . . Gloves should be changed when: When soiled with blood, dialysate or other body fluids, When going from a 'dirty' area or task to a 'clean' area or task, When moving from a contaminated body site to a clean body site of the same patient; and After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Observation number 4 was completed on 1-4-13 at 9:25 AM. The facility</p>		<p>the catheter limb and remove accumulated biological matter, remove and discard gloves, conduct hand hygiene, don new gloves, and then apply CVC dressing.; 5) TMs must perform hand hygiene every time gloves are removed. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>Infection Control Manager will conduct infection control audits on every shift daily x2 weeks, weekly x4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>	

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	<p>administrator, employee P, was observed to don clean gloves without cleansing her hands to assist patient number 8. The patient was preparing to leave the facility when a large amount of blood was observed to be dripping from the patient's arm.</p> <p>A. The patient was assisted back to the dialysis chair and employee L, a registered nurse (RN), prepared to assist the patient. The RN gathered the supplies to apply a clean dressing to the access site. The RN touched the machine, removed her glove and donned a clean glove without cleansing her hands. The RN then touched the machine at another station (# 18). The RN then changed her gloves and washed her hands.</p> <p>B. The RN, employee L, prepared the supplies to apply a clean dressing to the patient's access site. The RN cleansed the patient's arm and applied the clean dressings. A large amount of blood was observed on the patient's arm and the patient's shirt and coat sleeve. After applying the clean dressing, the RN changed her left glove without cleansing her hands. She wrapped a Chux around the patient's arm and pulled the blood soaked shirt sleeve above the access site. The RN then removed the glove from her right hand, and without cleansing her</p>				

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	<p>hands, picked up a plastic supply bag from the top of the dialysis machine. While walking to the nurse's station, the RN removed the glove from her left hand, cleansed the fingers only of both hands with alcohol cleanser, and placed the plastic bag in a bin with other patients' plastic bags.</p> <p>4. Observation number 5 was completed on 1-4-13 at 9:40 AM. Employee E, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 5. After placing the needles in the patient's access and securing them with tape, the PCT was observed to remove her gloves and cleanse her hands. The PCT then obtained a test strip from a community bottle and donned clean gloves without cleansing her hands. The PCT completed the test using the test strip and obtained a pen from the top of the dialysis machine and initialed the dialyzer. The PCT then primed the tubing and, after a second check was performed by another PCT, connected the tubing to the patient. The PCT failed to change her gloves and cleanse her hands prior to connecting the tubing to the patient.</p> <p>5. Observation number 6 was completed on 1-4-13 at 9:55 AM. Employee L, a RN, was observed to touch the keyboard</p>				

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	<p>at station number 18. The RN then held a glove in her left hand and touched the machine at station number 18 (patient number 17 was on the machine). The RN was not observed to don the glove. The RN then cleansed her fingertips with alcohol cleanser and touched the keyboard again. The RN obtained a clean glove, held it in her hand, and again touched the machine without donning the glove.</p> <p>6. Observation number 7 was completed on 1-4-13 at 10:05 AM. Employee Z, a RN, was observed to remove a pen from the pocket of her pants and document an event. The RN then prepared the supplies to initiate the treatment on patient number 6. The RN donned clean gloves without cleansing her hands. The RN obtained the needles and tubing, removed her gloves, and obtained clean gloves. The RN touched the computer keyboard and donned the clean gloves without cleansing her hands. The RN cleansed the insertion site, inserted the needles, and administered 1000 units of bolus heparin. The RN removed her gloves and cleansed her hands. The RN then touched the dialysis machine and donned clean gloves without cleansing her hands. The RN completed the treatment initiation.</p> <p>7. Observation number 8 was completed</p>				

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	<p>on 1-4-13 at 10:20 AM. Employee E, a PCT was observed to perform a central venous catheter dressing change. The supplies to be used for the catheter change and 3 syringes were observed to be on top of the dialysis machine without a barrier. The PCT obtained the supplies from the top of the dialysis machine. The PCT cleansed around the catheter insertion with with an Exsept-soaked gauze pad. The PCT was not observed to cleanse the catheter limbs. A small amount of crusted, light brown exudate was noted around the catheter insertion site. The PCT applied a clean dressing without changing her gloves and cleansing hands after cleansing the site.</p> <p>A. The PCT gathered the trash and changed her gloves and cleansed her hands. The PCT then obtained the 3 syringes from the top of the machine and placed them on the chairside table without a barrier. The PCT administered the contents of the syringes to the patient (2000 units of bolus heparin and normal saline).</p> <p>B. The facility's March 2011 "Central Venous Catheter (CVC) Cleaning and Dressing Change" procedure number 1-04-02C states, "Using fresh germicidal moistened gauze, clean catheter limbs, starting at exit site and cleaning entire</p>						

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	<p>length of catheter limbs . . . Remove gloves and discard. Wash hands or use hand gel as long as there is no visible blood or body fluids on hands. Re-glove. Place sterile gauze over catheter and exit site."</p> <p>8. The above-stated observations were discussed with the facility administrator, employee P, and the group facility administrator, employee AA, on 1-4-13 at 10:40 AM. The employees indicated the observations were not in compliance with facility infection control policies and procedures.</p>			

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V0124	<p>494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B</p> <p>The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit.</p> <p>Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. Based on administrative record and facility policy review and interview, the facility failed to ensure hepatitis B monthly antigen testing had been completed for 13 (#s 3, 5, 11, 18, 19, 20, 21, 22, 23, 25, 26, 27, and 28)) of 41 patients known to be susceptible creating the potential to affect the facility's 41 current susceptible patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's March 2011 "Hepatitis Surveillance, Vaccination and Infection Control Measures" policy number 1-05-02 states, "Monthly hepatitis B surface antigen (HBsAg) testing will be completed on patients who are susceptible or not immune to hepatitis B infection, including non-responders to the vaccine." 2. The facility's "Audit: Hepatitis status 	V0124	<p>V124</p> <p>FA immediately obtained lab orders and scheduled lab draws for identified patients (#3,5,11,18,19,20,21,22,23,25,26,27,and 28) for Hepatitis Antigen (HBsAg) and results placed in patient's medical record.</p> <p>FA held mandatory in-service for TMs on 1/22/2013 reviewing <i>Policy & Procedure #1-05-02: Hepatitis Surveillance, Vaccination and Infection Control Measures, and Schedule for Hepatitis B Testing</i>, FA will review each facility patient and the required testing regimen ensuring each patient has correct and current Hepatitis testing per policy and CDC schedule for Hepatitis Surveillance. TMs are responsible for ensuring each patient has Hepatitis labs drawn per policy and instructed to review patients Hepatitis status upon admission</p>	02/08/2013

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	<p>and Compliance with CDC Recommendations For Hepatitis B Testing on ESRD Patients" report dated 1-4-13 evidenced monthly hepatitis B antigen testing had not been completed for patients the facility had determined to be susceptible.</p> <p>A. The hepatitis status report evidenced the antibody status for patient number 3 had been determined to be less than 10 on 4-17-12, 5-24-12, 6-21-12, 7-19-12, and 8-9-12. The report failed to evidence monthly antigen testing had been completed in May, June, July, and December 2012.</p> <p>B. The hepatitis status report evidenced the antibody status for patient number 5 had been determined to be less than 10 on 3-5-12 and 7-18-12. The report failed to evidence monthly antigen testing had been completed in June 2012.</p> <p>C. The hepatitis status report evidenced the antibody status for patient number 11 had been determined to be less than 10 on 9-7-10. The report failed to evidence monthly antigen testing had been completed in December 2012.</p> <p>D. The hepatitis status report evidenced the antibody status for patient number 18 had been determined to be</p>		<p>and monthly for to ensure monthly Hepatitis B Surface Antigen (HBsAg) testing is completed on all patients who are susceptible or not immune to hepatitis B infection: Hepatitis B Surface Antibody (HBsAb) is <10 mIU/mL, including non-responders to the vaccine. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will audit hepatitis lab values and lab orders monthly to ensure all lab results are current and scheduled as appropriate. FA will review results of all audits with Medical Director during monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>				

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	<p>less than 10 on 8-17-12. The report failed to evidence monthly antigen testing had been completed in December 2012.</p> <p>E. The hepatitis status report evidenced the antibody status for patient number 19 had been determined to be less than 10 on 12-6-11. The report failed to evidence monthly antigen testing had been completed in December 2012.</p> <p>F. The hepatitis status report evidenced the antibody status for patient number 20 had been determined to be less than 10 on 5-14-12. The report failed to evidence monthly antigen testing had been completed in June 2012.</p> <p>G. The hepatitis status report evidenced the antibody status for patient number 21 had been determined to be less than 10 on 2-3-09. The report failed to evidence monthly antigen testing had been completed in February and November 2012.</p> <p>H. The hepatitis status report evidenced the antibody status for patient number 22 had been determined to be less than 10 on 2-20-12. The report failed to evidence monthly antigen testing had been completed in May 2012.</p> <p>I. The hepatitis status report</p>			

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	<p>evidenced the antibody status for patient number 23 had been determined to be less than 10 on 10-18-12. The report failed to evidence monthly antigen testing had been completed in November 2012.</p> <p>J. The hepatitis status report evidenced the antibody status for patient number 25 had been determined to be less than 10 on 3-17-12. The report failed to evidence monthly antigen testing had been completed in December 2012.</p> <p>K. The hepatitis status report evidenced the antibody status for patient number 26 had been determined to be less than 10 on 3-6-12. The report failed to evidence monthly antigen testing had been completed in May 2012.</p> <p>L. The hepatitis status report evidenced the antibody status for patient number 27 had been determined to be less than 10 on 5-4-09. The report failed to evidence monthly antigen testing had been completed in March 2012.</p> <p>M. The hepatitis status report evidenced the antibody status for patient number 28 had been determined to be less than 10 on 1-19-12. The report failed to evidence monthly antigen testing had been completed in March 2012.</p>			

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	3. The clinical services specialist, employee BB, stated, on 1-4-13 at 2:30 PM, "We found we were not doing antigen testing monthly through a CAT audit in June 2012 and developed a plan of correction. We have not done any follow-up to determine if the plan was effective."			

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V0320	<p>494.50(b)(1) PERSONNEL PROTECTIVE GEAR 8.4 Personnel protection: gear Personnel shall wear durable gloves and protective clothing when handling the dialyzer during initiation and termination of dialysis and during the reprocessing procedure. Standard Precautions shall be observed. Personnel shall wear eye protection when performing steps that may result in spills or splashes of substances of known or suspected toxicity. These agents shall be handled only in areas with adequate ventilation, washing facilities, eyewash stations, appropriate respirators, and spill control materials. When personnel are handling concentrated toxic substances, they shall wear aprons impervious to these substances.</p> <p>Based on observation and interview, the facility failed to ensure the reuse technician appropriately utilized personal protective equipment while performing the reuse procedure creating the potential for the transmission of disease causing organisms among staff and the facility's 74 current patients.</p> <p>The findings include:</p> <p>1. Employee B, the facility's reuse technician, was observed to perform the reuse procedure on 1-7-13 at 11:57 AM. The technician donned a cover gown but failed to tie the gown in the back to secure it.</p>	V0320	<p>V320 FA held mandatory in-service for all clinical TMs on 1/22/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities</i>, emphasizing the proper way to wear PPE, emphasizing the need to tie the gown in back to secure and to protect themselves from any infectious material. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager will conduct infection control audits on every shift daily x2 weeks, weekly x4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. FA is</p>	02/08/2013	

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	2. The group facility administrator, employee AA, indicated, on 1-7-13 at 3:45 PM, the cover gown should be tied securely in the back for adequate protection.		responsible for compliance with this Plan of Correction.	

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V0356	<p>494.50(b)(1) RECORD ADV EVENTS/DIALYZER C/O LOG 13.2.3 Recording: adverse events dialyzer complaint log Any significant events such as the occurrence of symptoms listed in [AAMI] 13.2.1 and 13.2.2 should be recorded on an incident report form which would include the results of any evaluations conducted by the physician and others, and the event should be considered for reporting to the manufacturer(s) in accordance with the FDA's Medical Device User Reporting procedures. The resolution of actual or suspected problems caused by reprocessed dialyzers should be indicated. This form should be kept in the complaint investigation record file (see [AAMI] 4.5).</p> <p>4 Records 4.5 Complaint investigation record Records shall be kept of all complaints by patients and staff members about failures of preprocessed and reprocessed dialyzers or possible adverse reactions to any dialyzers; the results of a comprehensive investigation of these alleged problems; and, if appropriate, the corrective actions taken. The records shall be reviewed periodically for trends of adverse reactions. Compliance with the FDA's Medical Device User Reporting procedures shall be demonstrated.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure failed dialyzers were investigated in accordance with facility policy in 2 (June 2012 and</p>	V0356	<p>FA conducted mandatory in-service for facility reuse technician on 1/22/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 6-01-13 Complaint</i></p>	02/08/2013	

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	<p>September 2012) of 7 months reviewed creating the potential to affect all of the facility's 73 current patients that are in the reuse program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's September 2011 "Complaint Investigation Record" policy number 6-01-13 states, "A Complaint Investigation Record is maintained that includes all patient and teammate complaints related to reuse dialyzers . . . A Complaint Investigation Record is completed for the following: Cracked headers, Header leak, Defective/broken blood port, Defective/broken dialysate port, Blood leak, Lost dialyzer, Mislabeled, Clearance abnormality, Visual inspection failure, Pressure test failure, Clotted dialyzer, Improper storage, Not reprocessable, Equipment failure, Ultrafiltration abnormality." The facility's "Daily Log of Failed Dialyzers" for 6-1-12 through 6-30-12 evidenced 2 dialyzers had been failed on 6-26-12 due to "pressure." The facility's administrative records failed to evidence a complaint investigation record had been completed for the 2 failed dialyzers. The facility's "Daily Log of Failed Dialyzers" for 9-1-12 through 9-30-12 		<p><i>Investigation Record Policy, emphasizing Complaint Investigation Record must be completed and maintained. Complaint Investigation and Reuse Communication Log must be reviewed monthly during QIFMM. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</i></p> <p>FA or designee will audit the complaint investigation records to ensure completion for failures outlined in policy weekly x 1 month, then monthly. Result of audits, Complaint Investigation Records and Reuse Communication Log will be reviewed monthly with Medical Director during QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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	<p>evidenced 1 dialyzer had been failed on 9-3-12 due to "not reprocessable" and 2 had been failed on 9-11-12 due to "mislabeled." The facility's administrative records failed to evidence complaint investigation records had been completed for the 3 failed dialyzers.</p> <p>4. The facility administrator, employee P, was unable to provide any additional documentation and/or information when asked on 1-7-13 at 12:47 PM and 1:07 PM.</p>			

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V0511	<p>494.80(a)(8) PA-DIALYSIS ACCESS TYPE & MAINTENANCE</p> <p>The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(8) Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts and peritoneal catheters).</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure comprehensive assessments identified the type and location of the patients' accesses in 4 (#s 4, 5, 6, and 7) of 6 records reviewed that included comprehensive assessments creating the potential to affect all of the facility's 74 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 4 included a comprehensive assessment dated 10-27-12. The assessment failed to identify the type and location of the patient's access. 2. Clinical record number 5 included a comprehensive assessment dated 6-15-12. The assessment failed to identify the type and location of the patient's access. 3. Clinical record number 6 included a comprehensive assessment dated 7-7-12. 	V0511	<p>V511</p> <p>Interdisciplinary Team (IDT) will update Comprehensive Assessment for patients #4, 5, 6, and 7 to reflect evaluation and identification of patient's current dialysis access type, location and maintenance.</p> <p>FA held mandatory in-service for all members of IDT on 1/22/2013 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, emphasizing IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. Assessment must include but not be limited to evaluation of patient dialysis access, indentifying access type, location and maintenance of that access. Verification of attendance at in-service will be evidenced by TMs signature on in-service</p>	02/08/2013

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	<p>The assessment failed to identify the type and location of the patient's access.</p> <p>4. Clinical record number 7 included a comprehensive assessment dated 5-23-12. The assessment failed to identify the type and location of the patient's access.</p> <p>During an interview with the patient, on 1-4-13 at 10:20 AM, the patient stated, "I had a fistula, it lasted approximately 6 years, then it clotted, then I had a graft that lasted about 3 to 4 months. Now I have a CVC with plans for a new fistula."</p> <p>5. The facility administrator, employee P, indicated, on 01/07/2013 at 4:13 PM, the comprehensive assessments do not specify whether the accesses are a fistula or graft and do not specify the location of the accesses.</p> <p>6. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "Assessment criteria will include, but not be limited to, evaluation of: . . . Dialysis access type and performance."</p>		<p>sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions, and 10% of current patient census to ensure current individualized Comprehensive Assessments and Plans of Care are in place, up-to-date, and documentation appropriate. Results of audit will be reviewed with Medical Director monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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V0517	<p>494.80(b)(2) PA-F/U REASSESSMENT-WITHIN 3 MO OF INITIAL A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. Based on clinical record and facility policy review and interview, the facility failed to ensure a follow-up comprehensive assessment had been completed within 3 months of the patients' transfer to the facility in 1 (#s 3) of 2 records reviewed of patients that had transferred to this facility creating the potential to affect all patients that transfer to the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced the patient had transferred from another facility on 3-1-12. The record failed to evidence the facility had completed a comprehensive assessment at any time since the patient's transfer to this facility. 2. The group facility administrator, employee AA, indicated, on 1-4-13 at 2:00 PM, the facility had not updated the patient's comprehensive assessment or plan of care within 3 months of the patient's transfer to this facility. 	V0517	<p>V517</p> <p>IDT initiated Comprehensive Assessment, followed by Individualized Plan of Care for Patient #3 on 1/14/2013.</p> <p>FA held mandatory in-service for all members of IDT on 1/22/2013 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, emphasizing 1) IDT must ensure that a comprehensive assessment followed by a initial plan of care based on the findings from comprehensive assessment is conducted on all new patients within 30 calendar days or 13 outpatient dialysis sessions beginning with the first outpatient dialysis treatment, 2) If Comprehensive Assessment and Plan of Care is received with experienced dialysis patient is transferring in from one facility to another, and was completed by IDT in the last year, the IDT must review patient assessment and plan of care to determine that documents reflect patient's current status and needs. If documents are inadequate or</p>	02/08/2013	

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	3. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "Assessment and Plans of Care for Patients Transferring In: If the comprehensive Patient Assessment and Plan of Care for an experienced dialysis patient transferring from one facility to another is received with the patient . . . the IDT will review the PA/POC to determine that the documents reflect the patient's current status and needs . . . If the documents are adequate and the patient is stable, the IDT [interdisciplinary team] may conduct a re-assessment within 3 months of admission."		<p>patient deemed unstable, IDT will assess patient within usual 30 days. If documents are adequate and patient is stable, IDT must conduct re-assessment within 3 months of admission. IDT must meet within 15 days of completion of re-assessment to complete and initiate plan of care. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions to ensure current individualized Comprehensive Assessments and Plans of Care are in place, up-to-date, and documentation appropriate. Results of audit will be reviewed with Medical Director during monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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V0540	<p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on clinical record and facility policy review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure the interdisciplinary team (IDT) had developed a plan of care within 3 months of the patients' transfer to the facility in 2 of 2 records reviewed of patients that had transferred from another facility creating the potential to affect all patients who transfer to the facility (See V 542); failed to ensure patients' albumin and potassium levels had been measured and monitored at least monthly in 2 of 7 records reviewed creating the potential to affect all of the facility's 74 current patients (See V 545); failed to ensure plans of care provided for the monitoring of patients' accesses in 6 of 6 records reviewed that included plans of care creating the potential to affect all of the facility's 74 current patients (See V 551); and failed to ensure the IDT had addressed abnormal albumin and potassium levels in 2 of 7 records reviewed creating the potential to affect all of the facility's 74 current patients (See V 559).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this</p>			V0540	<p>V540</p> <p>DaVita North Evansville Dialysis takes the conditions of coverage very seriously, immediate step were taken to ensure facility continuously assesses patients outcomes, updates patients plan of care to meet goals. These actions are outlined in depth in the POC for V542, V545, V551, and V559.</p> <p>Governing Body (GB) meeting was held on 1/8/2013 to review the deficiencies received as a result of survey concluded on 1/8/2013. Members of the GB including the Medical Director, FA and Regional Operations Director (ROD) have agreed to meet weekly to monitor facility's ongoing progress towards compliance including but not limited to: 1) Ensuring IDT develops comprehensive IDT and individualized plan of care for all transfer patients per policy; 2) Ensuring IDT assesses and monitors patient outcomes, identifies need for adjustment of patient plan of care when goals are not met, and implements changes based on patients current health status. GB will review QIFMM minutes to ensure minutes reflect, action plans initiated, evaluated for effectiveness, new plans developed as applicable. Once compliance is achieved, Plan of</p>		02/08/2013

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	condition for coverage 42 CFR 494.90 Patient Plan of Care.		Correction will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.	

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V0542	<p>494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. Based on clinical record and facility policy review and interview, the facility failed to ensure the interdisciplinary team (IDT) had developed a plan of care within 3 months of the patients' transfer to the facility in 2 (#s 3 and 7) of 2 records reviewed of patients that had transferred from another facility creating the potential to affect all patients who transfer to the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced the patient had transferred from another facility on 3-1-12. The record failed to evidence the facility had developed a plan of care at any time since the patient's transfer to this facility. <p>The group facility administrator, employee AA, indicated, on 1-4-13 at 2:00 PM, the facility had not updated the patient's comprehensive assessment or plan of care within 3 months of the patient's transfer to this facility.</p> <ol style="list-style-type: none"> 2. Clinical record number 7 evidenced the patient had transferred from another facility on 2-1-11. The record failed to evidence the facility had developed a plan 	V0542	<p>V542 IDT will initiate and develop Comprehensive Assessment, followed by Individualized Plans of Care for Patient #3 and 7.</p> <p>FA held mandatory in-service for all members of IDT on 1/22/2013 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, emphasizing 1) IDT must ensure that a comprehensive assessment followed by a initial plan of care based on the findings from comprehensive assessment is conducted on all new patients within 30 calendar days or 13 outpatient dialysis sessions beginning with the first outpatient dialysis treatment, 2) If Comprehensive Assessment and Plan of Care is received with experienced dialysis patient is transferring in from one facility to another, and was completed by IDT in the last year, the IDT must review patient assessment and plan of care to determine that documents reflect patient's current status and needs. If documents are inadequate or patient deemed unstable, IDT will assess patient within usual 30 days. If documents are adequate and patient is stable, IDT must conduct re-assessment within 3</p>	02/08/2013			

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	<p>of care until 6-6-12.</p> <p>The group facility administrator, employee AA, indicated, on 1-8-13 at 11:30 AM, the facility had not developed a plan of care for patient number 7 within 3 months of transfer to this facility.</p> <p>3. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "Assessment and Plans of Care for Patients Transferring In: If the comprehensive Patient Assessment and Plan of Care for an experienced dialysis patient transferring from one facility to another is received with the patient . . . the IDT will review the PA/POC to determine that the documents reflect the patient's current status and needs . . . If the documents are adequate and the patient is stable, the IDT [interdisciplinary team] may conduct a re-assessment within 3 months of admission."</p>		<p>months of admission. IDT must meet within 15 days of completion of re-assessment to complete and initiate plan of care. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions to ensure current individualized Comprehensive Assessments and Plans of Care are in place, up-to-date, and documentation appropriate. Results of audit will be reviewed with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this Plan of Correction.</p>		

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V0545	<p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. Based on clinical record and facility policy review and interview, the facility failed to ensure patients' albumin and potassium levels had been measured and monitored at least monthly in 2 (#s 3 and 7) of 7 records reviewed creating the potential to affect all of the facility's 74 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 failed to evidence the patient's albumin and potassium levels had been obtained for the month of December 2012. <p>A. The record included laboratory values for the months of October 2012 and November 2012 that identified the albumin levels were 3.5 and 3.6 milligrams per deciliter (mg/dL), respectively. These values are below the desired value of 4.0 mg/dL according to the Centers for Medicare and Medicaid Services (CMS) Measurement Assessment Tool (MAT).</p>	V0545	<p>V545 IDT will initiate and develop Comprehensive Assessments followed by Individualized Plan of Care for Patients (#3and 7) to include measureable goals and timetables in POC specific to patient identified issues with nutrition related to potassium and albumin levels.</p> <p>FA held mandatory in-service for all members of IDT on 1/22/3013 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, emphasizing to the IDT or individual IDT member that Plan of Care must evaluate and address current nutritional needs of patient including albumin and potassium levels to achieve and sustain effective nutritional status. IDT must develop, and implement, individualized comprehensive plan of care that will include measurable and expected outcomes and timetables for achieving goals, IDT must follow up and readjust plan of care as necessary and document as such</p>	02/08/2013			

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	<p>B. The laboratory values for the months of October 2012 and November 2012 identified a marked increase in the potassium levels. The level was 3.7 in October 2012 and increased to 5.5 in November 2012. The desired level is 3.6 to 5.0 milliequivalents per liter (mEq/L) according to the CMS MAT.</p> <p>C. The record included a "Care Notes Report" with an entry by the registered dietician (RD), employee F, on 12-12-12, that states, "Pt's albumin, K+ [potassium] and a1c [blood sugar related measurement] are within goal range."</p> <p>D. The group facility administrator, employee AA, stated, on 1-7-13 at 10:24 AM, "The patient was in the hospital the day the missing labs were drawn." The administrator indicated the labs were drawn on 12-18-12 and the patient returned from the hospital on 12-22-12. The administrator stated, "We could have drawn the labs upon the patient's return from the hospital."</p> <p>2. Clinical record number 7 failed to evidence the patient's albumin and potassium levels had been obtained for the month of November 2012.</p> <p>A. The record included laboratory</p>		<p>in patient's medical record. Identified unstable patients must have monthly updated progress of interventions and response documented in medical record. TMs also in-serviced on new facility process "Scheduling Labs and Follow up". Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will audit RD progress notes monthly to ensure nutrition notes are completed, and appropriate interventions are documented to meet patient needs for indicators not meeting goal. FA or designee will conduct Medical Records Audits on 10% of current patient census monthly to ensure assessments and plans of care are in place, current, needs of patient including nutritional status are evaluated/addressed, and documentation of action plans and response to interventions are present. Results of audits will be discussed with the Medical Director during monthly meetings at QIFMM meetings, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this Plan of Correction.</p>		

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	<p>results for the months of October and December 2012 that identified a marked increase in the potassium levels. The potassium level was 3.8 in October and had increased to 6.5 in December 2012. The desired potassium levels are 3.6 to 5.0 mEq/L according to the CMS MAT.</p> <p>B. The record included a "Care Notes Report" with an entry by the RD, employee F, on 12-27-12 that states, "RD contacted patient per phone to review monthly Dec. [December] labs. Patient did not answer so call was placed and talked with [parent]." The parent indicated the parent was not aware of the patient eating any high potassium foods. The note states, "Explained I would try to contact [the patient] later this afternoon." The record failed to evidence any further follow-up by the RD to address the elevated potassium level.</p> <p>C. Employee AA, the group facility administrator, stated, on 1-8-13 at 11:09 AM, "The labs were not drawn for December. The patient was not in the hospital. They were just missed."</p> <p>3. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "A patient's albumin level and body weight should be measured at</p>						

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	least monthly."			

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V0551	<p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care provided for the monitoring of patients' accesses in 6 (#s 1, 2, 4, 5, 6, and 7) of 6 records reviewed that included plans of care creating the potential to affect all of the facility's 74 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included a plan of care (PoC) established by the interdisciplinary team (IDT) on 12-10-12 that identified the patient had a fistula (AVF). The plan failed to provide for the monitoring of the fistula. Clinical record number 2 included a PoC established by the IDT on 11-23-11 that identified the patient had a central venous catheter (CVC) in the left jugular. <ul style="list-style-type: none"> A. The record included a "Comprehensive Orders Worksheet" that evidenced hemodialysis orders effective 9-29-12 that identified the patient had an arteriovenous graft in the right lower arm. 	V0551	<p>V551</p> <p>IDT will update Comprehensive Assessments and Individualized Plans of Care for Patients (#1, 2, 4, 5, 6 and 7) to ensure vascular access problems are evaluated, addressed, and provide updated monitoring of vascular access to detect symptoms of access problems and assist in preventing failure.</p> <p>FA held mandatory in-service for all members of IDT on 1/22/2013 to reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, emphasizing plan of care must include/address patients vascular access including vascular access monitoring, goals, interventions, outcome of treatment, surveillance to detect symptoms of access problems and assist in preventing failure. Vascular Access Manager is responsible for updating IDT of patient's vascular access status and needs. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p>	02/08/2013			

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	<p>B. The record failed to evidence the plan of care had been updated to reflect the patient's current access, an AVG, and failed to provide for the monitoring of the AVG.</p> <p>3. Clinical record number 4 included a PoC established by the IDT on 11-5-12 that identified the patient had an AVF. The plan failed to provide for the monitoring of the fistula.</p> <p>4. Clinical record number 5 included a PoC established by the IDT on 6-18-12 that identified the patient had an AVF. The plan failed to provide for the monitoring of the fistula.</p> <p>5. Clinical record number 6 included a PoC established by the IDT on 7-9-12 that identified the patient had an AVF. The plan failed to provide for the monitoring of the fistula.</p> <p>6. Clinical record number 7 included a PoC established by the IDT on 6-6-12 that identified the patient has a CVC as the primary access. The plan failed to provide for the monitoring of the CVC.</p> <p>During an interview with the patient, on 1-4-13 at 10:20 AM, the patient stated, "I had a fistula, it lasted approximately 6</p>		<p>FA or designee will conduct Medical Records Audits monthly 10% of patient census, to ensure individualized plans of care are in place, and include/address patient's vascular access including vascular access monitoring and surveillance. Results of audits will be reviewed with the 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.</p> <p>FA & Medical Director are responsible for compliance with this Plan of Correction.</p>	

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	<p>years, then it clotted, then I had a graft that lasted about 3 to 4 months. Now I have a CVC with plans for a new fistula."</p> <p>7. The group facility administrator, employee AA, indicated, on 1-8-13 at 11:30 AM, the plans of care did not include interventions to monitor the patients' accesses. The administrator stated, "The computer program only addresses an area if there is a problem. The nurses have to go in and revise the plan to include interventions to monitor the access."</p> <p>8. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "The plan of care will address, but not be limited to, the following: . . . When indicated, the patient's vascular access will be monitored to prevent access failure and detect symptoms of stenosis in graft and fistulae."</p>			

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V0559	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>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-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the interdisciplinary team (IDT) had addressed abnormal albumin and potassium levels in 2 (#s 3 and 7) of 7 records reviewed creating the potential to affect all of the facility's 74 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 failed to evidence the IDT had addressed lower than desired albumin levels and higher than desired potassium levels. The record failed to evidence the IDT had identified possible reasons for the abnormal levels and had adjusted the plan of care to address any identified reasons.</p>	V0559	V559 IDT will initiate and develop Comprehensive Assessments followed by Individualized Plan of Care for Patients (#3and 7) to address and include measureable goals and timetables in POC specific to patient identified issues with nutrition related to potassium and albumin levels. FA held mandatory in-service for all members of IDT on 1/22/3013 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i> , emphasizing to the IDT or individual IDT member that Plan of Care must evaluate and address current nutritional needs of patient including albumin and potassium levels to achieve and sustain effective nutritional status. IDT must develop, and implement, individualized comprehensive plan of care that will include	02/08/2013			

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	<p>A. The record included laboratory values for the months of October 2012 and November 2012 that identified the albumin levels were 3.5 and 3.6 milligrams per deciliter (mg/dL), respectively. These values are below the desired value of 4.0 mg/dL according to the Centers for Medicare and Medicaid Services (CMS) Measurement Assessment Tool (MAT).</p> <p>B. The laboratory values for the months of October 2012 and November 2012 identified a marked increase in the potassium levels. The level was 3.7 in October 2012 and increased to 5.5 in November 2012. The desired level is 3.6 to 5.0 milliequivalents per liter (mEq/L) according to the CMS MAT.</p> <p>C. The record included a "Care Notes Report" with an entry by the registered dietician (RD), employee F, on 12-12-12, that states, "Pt's albumin, K+ [potassium] and a1c [blood sugar related measurement] are within goal range."</p> <p>2. Clinical record number 7 failed to evidence the IDT had addressed higher than desired potassium levels. The record failed to evidence the IDT had identified possible reasons for the abnormal levels and had adjusted the plan of care to address any identified reasons.</p>		<p>measurable and expected outcomes and timetables for achieving goals, IDT must follow up and readjust plan of care as necessary and document as such in patient's medical record. Identified unstable patients must have monthly updated progress of interventions and response documented in medical record. TMs also in-serviced on new facility process "Scheduling Labs and Follow up". Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will audit RD progress notes monthly to ensure nutrition notes are completed, and appropriate interventions are documented to meet patient needs for indicators not meeting goal. FA or designee will conduct Medical Records Audits on 10% of current patient census monthly to ensure assessments and plans of care are in place, current, needs of patient including nutritional status are evaluated/addressed, and documentation of action plans and response to interventions are present. Results of audits will be discussed with the Medical Director during monthly meetings at QIFMM meetings, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA & Medical Director are responsible for compliance with this Plan of Correction.</p>		

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	<p>A. The record included laboratory results for the months of October and December 2012 that identified a marked increase in the potassium levels. The potassium level was 3.8 in October and had increased to 6.5 in December 2012. The desired potassium levels are 3.6 to 5.0 mEq/L according to the CMS MAT.</p> <p>B. The record included a "Care Notes Report" with an entry by the RD, employee F, on 12-27-12 that states, "RD contacted patient per phone to review monthly Dec. [December] labs. Patient did not answer so call was placed and talked with [parent]." The parent indicated the parent was not aware of the patient eating any high potassium foods. The note states, "Explained I would try to contact [the patient] later this afternoon." The record failed to evidence any further follow-up by the RD or IDT to address the elevated potassium level.</p> <p>C. Employee AA, the group facility administrator, indicated, on 1-8-13 at 10:59 AM, that the registered dietician had addressed the elevated potassium in her note but that record did not include documentation the RD had followed up with the patient or that the team had discussed the elevated lab value.</p>						

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	3. The facility's September 2012 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "In addition, if the expected outcome is not achieved, the interdisciplinary team (or individual team member) will adjust the patient's plan of care to achieve the specified goal. When a patient is unable to achieve the desired outcomes, the team will: Adjust the plan of care to reflect the patient's current condition, Document in the patient's medical record the reasons why the patient was unable to achieve the goals, Implement plan of care changes to address the issues identified."			