

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
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V000000	<p>[CORE]</p> <p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: Novemeber 19, 20, and 21, 2013</p> <p>Facility #: 003256</p> <p>Medicaid Vendor #: 200378680</p> <p>Surveyors: Janet Brandt, RN, Public Health Nurse Surveyor, Team Leader Bridget Boston, RN, Public Health Nurse Surveyor, Team Member</p> <p>37 current patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 27, 2013</p>	V000000			

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

TITLE

(X6) DATE

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

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V000113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure staff members followed the facility infection control policies during the termination of dialysis treatments in 1 (Employee J) of 2 observations of access of arteriovenous fistula (AVF) for termination of dialysis creating the potential to affect all dialysis patients with AVFs.</p> <p>The findings include:</p> <p>1.. The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, After contact with inanimate objects near the patient, When moving from a contaminated body site to a clean body site of the same patient."</p>	V000113	<p>On 12/4/13, the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene and Personal Protective Equipment" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all nursing staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Personal Protective Equipment" FMS-CS-IC-II-155-080A with emphasis placed on appropriate hand hygiene after glove removal. Training will be completed on 11/21/13 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by 11/28/13. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks,</p>	12/04/2013			

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	<p>2. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloves hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>3. Employee J, a patient care technician, was observed to terminate the dialysis treatment for patient #6 at station 8 on 11-19-13 at 3:39 PM. The employee was observed to remove needles from fistula site with one gloved hand while lifting the blood lines with the opposite ungloved hand. The patient then held pressure against the needle site using a gauze. Employee J was observed to leave station #8, remove gloves, retrieve supplies from a drawer, entered station #9 without sanitizing hands prior to entering, hung up a package of clamps on a pole, and left,</p> <p>4. The clinic manager, employee A, indicated, on 11-21-13 at 10:10 AM, employee J had failed to follow agency protocol for hand hygiene.</p>		<p>weekly for 4 weeks, monthly for 3 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>				

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V000403	<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 agency document review, facility policy review and agency staff interview, the facility failed to ensure equipment used to perform conductivity tests of dialysis machines prior to patients receiving treatments were calibrated monthly according to agency policy for 1 of 1 maintenance record reviewed of equipment used to perform calibration on dialysis machines creating the potential to affect all of the facility's 38 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's document, "FMC Equipment Repair Record ER-1" for "Phoenix Meter # 1", form date 1994, failed to evidence the monthly Level 1 & 2 calibration was completed for October of 2013. Documentation indicated calibration had been done for June, July, August, and September 2013. 2. Employee O, indicated on 11-20-13 at 3:30 PM that there was no documentation 	V000403	<p>On 11/26/13, the Director of Operations met with the Technical Supervisor to discuss the identified technical deficiency, no documentation of the appropriate monthly Level 1 & 2 calibration of the Phoenix meter. On 11/26/13, processes have been put into place to ensure documentation is kept per policy ongoing. The Technical Supervisor is responsible to review all logs and checklists and present them to the Clinical Manager monthly for review, analysis and trending. The Technical Supervisor or their designee is responsible to present the data for review monthly in the technical portion of the QAI program. This will be monitored by the Director of Operations monthly, who will provide a summary of findings in QAI and compliance will be monitored by the QAI committee.</p>	11/26/2013	

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	<p>of the Phoenix meter #1 calibration for October of 2013. Employee O indicated that according to review of agency document, "Facility Equipment - Schedule #2", dated 12-2-11, the Phoenix meter Level 1 & 2 calibration was completed on October 30 and there was no sign-off verification by the technician that the task had been completed on that date.</p> <p>3. Review of agency policy "Phoenix Meter(s)", dated 12-2-2011, provided by Employee O on 11-20-13 at 3:30 PM states, "The phoenix meter(s) will be calibrated monthly by doing both Level 1 & Level 2 calibrations, with 1.0mS, 4.0pH, 7.0pH, 10.0pH, 14.0mS and 100.0mS Standard Solutions and documented on the ER-1 log."</p>			

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V000628	<p>494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS</p> <p>The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves.</p> <p>Based on quality assurance performance improvement (QAPI) document review, document review, and interview, the facility failed to ensure its QAPI program included monitoring of fluid and blood pressure management and a review and evaluation of all patient deaths in 4 (July through October 2013) of 4 months reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QAPI meeting minutes dated 7/30/13, 8/27/13, 9/24/13, and 10/29/13 failed to evidence the facility had monitored fluid and blood pressure management by the review and evaluation of the percentage of intradialytic weight loss, blood pressure variances pre and post dialysis, and intradialytic symptoms of depletion. 2. The facility's QAPI meeting minutes dated 7/30/13, 8/27/13, 9/24/13, and 	V000628	<p>On 11/26/13 the Director of Operations scheduled a meeting with all participants of the QAI committee for the purpose of reeducation on the "Quality Assessment and Performance Improvement Program" FMS-CS-IC-II-101-001A. This education included but was not limited to the following:QAI ProcessesIncluding tools with all minutes monthlyMortality analysis and trendingBlood pressure and fluid management monitoring and trending The Clinical Manager will review the Mortality summary log and trending tool. Reports will be evaluated to determine if any patient death was a result of the care provided by the facility. Fluid and blood pressure management will also be reviewed monthly and discussed in the clinical issues section within the QAI minutes. Any items identified as not meeting an outcome will have an action plan developed and followed monthly. The Clinical Manager is responsible to report a summary of findings monthly. The QAI Committee is</p>	11/26/2013			

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	<p>10/29/13 failed to evidenced the facility had reviewed and evaluated all patient deaths and had analyzed trends in causes of patient deaths.</p> <p>The University of Michigan 2013 Dialysis Facility Report evidenced the facility's standardized mortality ratio was 1.06 for 2009-2012 and 1.88 for 2012 compared to the the U.S. Standardized Mortality Ratio (SMR) of 1.00 for the previous four year average 2009 - 2012 and one year average for 2012 being 1.00.</p> <p>3. The clinic manager indicated on 11/21/13 at 11 AM the facility did not track fluid and blood pressure management and did not have a formal mortality review. The QAPI meeting minutes did not evidence documentation that all patient deaths were analyzed for trends in causes of patient deaths.</p>		<p>responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p>		