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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152610 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/17/2015 |
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| NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS LEBANON LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 2485 LEBANON ST LEBANON, IN 46052 |
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| V 000 Bldg. 00 | <p>This was a federal ESRD [CORE] recertification survey conducted 4/14/15-4/17/15</p> <p>Facility Number: 007817</p> <p>Medicaid Number: 200387680e</p> <p>Census InCenter HD: 30 Home HD: 1 HomePD: 3</p> <p>QA: JE 4/23/15</p> | V 000 | | |
| V 113 Bldg. 00 | <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 follow hand hygiene standards related to glove use in 3 out of 16 observations (patient #4 and # 6) creating the potential to affect the 30 incenter hemodialysis patients and staff.</p> <p>Findings:</p> | V 113 | <p>V 113</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene, Personal Protective Equipment and Infection Control Overview" policies to ensure a safe treatment environment that prevents cross contamination of</p> | 05/22/2015 |

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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| | <p>1. On April 15, 2015, at 10:00 A.M., discontinuation of dialysis and post dialysis access care of patient #4 was observed at station 8. The patient's left arm access site had been bleeding where the patient was holding pressure with an ungloved hand.</p> <p>A. In an interview with employee A on April 15, 2015, at 10:20 AM, the RN stated, "Yes, the patient should still be wearing a glove. We thought the bleeding had stopped."</p> <p>B. Facility policy FMS-CS-IC-II-155-090A, dated March 20, 2013, titled, "Hand Hygiene" states, "Gloves must be provided to patients when performing procedures which risk exposure to blood or bodily fluids, such as when self cannulating or holding access sites post treatment to achieve homeostasis."</p> <p>2. On April 15, 2015, at 11:40 AM, Employee A was observed holding a glove over the tips of his/her fingers to touch the control panel on the dialysis machine at station 9 where patient # 6 had been dialyzing..</p> <p>The May 2013 "Protocol for Hand Hygiene and Glove Use Observations", by the Centers for Disease Control and</p> | | <p>patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" with emphasis placed on appropriate glove usage and appropriate wearing of gloves, glove changes and hand hygiene using hand sanitizer. Emphasis during staff training will also be placed on providing patients with gloves when performing procedures which risk exposure to blood or other bodily fluids.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tools that are done via the QAI calendar which is monthly or 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</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> | | | | |

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| V 121 Bldg. 00 | <p>Prevention, states, "In general, gloves should be worn prior to contact with patients at the treatment station and potentially contaminated surfaces (e.g., dialysis machine, environmental surfaces) ... Holding a glove in one's hand instead of wearing it is not considered acceptable ... "</p> <p>494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [The facility must demonstrate that it follows standard infection control precautions by implementing-] (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the- (i) Handling, storage and disposal of potentially infectious waste; Based on observation, interview, and review of facility policy, the agency failed to maintain a sanitary environment by the manner in which storage of potentially-infectious bed linens were kept on the treatment floor and creating a potential for cross contamination to other staff for 1 of 1 observation of a dirty linen cart.</p> <p>Findings include:</p> | V 121 | <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> <p>V 121 On Friday April 24th 2015 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow FMS-CS-IC-II-155-110A "Cleaning and Disinfection" and Infection Control Overview" policies to ensure a safe treatment</p> | 05/22/2015 | | | |

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| | <p>1. An observation on the treatment floor on April 15, 2015, at 10:00 AM revealed a laundry cart spilling over with "dirty" linens that had been used on patient's treatment beds. The cart was not self contained.</p> <p>2. In an interview with the Director of operations, employee C, on April 15, 2015, at 5:00 PM, Employee C stated, "The laundry may need to be picked up more frequently, it does now one time a week."</p> <p>3. The FMS-CS-IC-II-155-110A, Cleaning and Disinfection Policy dated March 20, 2013, states, "The purpose of this policy is to provide guidelines to maintain a clean, safe, and aesthetically pleasant environment for patients staff, and visitors. To prevent the spread of infectious disease in accordance with appropriate regulations ... After use all equipment and supplies must be considered as potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded."</p> | | <p>environment that prevents cross contamination of patients and equipment</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies FMS-CS-IC-II-155-110A "Cleaning and Disinfection Policy" with emphasis placed on keeping linen carts self-contained to ensure the cart does not overflow.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical manager or designee will conduct audits via the QAI Infection Control audits and be monitored per the QAI calendar audit schedule which is monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> | |

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| V 122 Bldg. 00 | <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 observation, interview, and review of facility policy, the facility failed to demonstrate standard infection control precautions in 2 of 16 treatment practices with the potential to affect all 30 of the incenter hemodialysis patients. (station 3 and 2/4, employee A)</p> <p>Findings include:</p> <p>1. On April 15, 2015, at 11:00 AM, an observation of cleaning and disinfection of the dialysis station #3 revealed an omission of cleaning the prime waste container on the dialysis machine.</p> <p>2. In an interview with patient care technician, employee E, when asked whether it is policy to detach the container to clean it, responded, "Yes, I do usually dump it out and disinfect it."</p> <p>3. On April 15, at 12:20 PM, the</p> | V 122 | <p>V 122</p> <p>On Friday April 24th 2015 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow FMS-CS-IC-II-155-110A "Cleaning and Disinfection" and Infection Control Overview" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies FMS-CS-IC-II-155-110A "Cleaning and Disinfection Policy" with emphasis placed on disinfecting Oxygen Concentrators and Prime Waste Containers between dialysis</p> | 05/22/2015 |
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| V 403 Bldg. 00 | <p>Registered Nurse, employee A, took an oxygen concentrator from station 2 to station 4 without first thoroughly disinfecting it.</p> <p>4. Fresenius Medical Care Policy FMS-CS-IC-II-155-110A dated January 28, 2015, "Cleaning and Disinfecting" states, "After use, all equipment and supplies must be considered as potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded . . . All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glistening wet and let air dry unless otherwise specified by the manufacturer."</p> <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. Based on observation, facility document review, and interview, the facility failed</p> | V 403 | <p>treatments.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical manager or designee will conduct audits via the QAI Infection Control audits and be monitored per the QAI calendar audit schedule which is monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> | 05/22/2015 | | | |

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| | <p>to ensure all ancillary equipment was maintained for 1 of 1 facility creating the potential to effect all 30 incenter patients and staff.</p> <p>Findings include,</p> <p>1. In reviewing the Emergency Cart Daily Checklist on April 14, 2015. at 11:50 AM, the spare battery for the PowerHeart G3 Automated External Defibrillator [AED] was documented that it was present, though there was not one on the emergency cart.</p> <p>In an interview with the Clinic Manager, employee H, the Manager stated, "I believe we read that to mean that if the date of the installed battery was present on the AED, that is what we are documenting, indicating a date marked on the machine.</p> <p>2. The checklist for "Eyewash Inspection and Monitoring Record" failed to evidence documentation for the weeks from 6/10/14 to 8/8/14 and the current months 2015.</p> <p>A. The undated document titled "Eyewash Inspection and Monitoring Record" states, "Weekly . . . 1. Activate the eyewash station and test the flow of water through it (bump test) 2. Flush the</p> | | <p>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</p> <p>The Clinical Manager is responsible to ensure that staff complete correctly the Emergency Cart Daily Checklist as well as the Eyewash Inspection and Monitoring Records</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the Emergency Cart Daily Checklist and Eyewash Inspection and Monitoring Record with emphasis on proper documentation when completing</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical Manager will ensure the accuracy of all records by utilizing the QAI Technical audit tools that are done via the QAI calendar which is monthly or 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</p> | |

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| V 504 Bldg. 00 | <p>eyewash by allowing water to flow through it for at least three minutes 3. Record the results and initial 4. Report any faults or failures to the technical Department for corrective action."</p> <p>B. In an interview on 4/15/15 at 2:10 PM, employee G, the Biomed Tech, stated, "I don't know how that was missed, except it used to be part of an audit. It is not something we were checking weekly. We have two stations in case of an emergency."</p> <p>494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. Based on clinical record review and interview, the evaluation of the patients blood pressures and potential for the related intradialytic symptoms were not addressed in 2 (#1 and #3) of four records reviewed.</p> <p>Findings include: 1. Clinical record number 1 included a</p> | V 504 | <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> <p>V504 On Friday April 24th 2015 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow policies FMS-CS-IC-I-110-133A</p> | 05/22/2015 | |

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| | <p>hemodialysis treatment flowsheet dated 3/20/15 on which the Nurse, Employee I, documented, "Patient feels bad, b/p [blood pressure]88/55, 100 n/s [normal saline]." The clinical record failed to evidence the nursing staff had completed an assessment of the patient post treatment.</p> <p>Clinical record number 1 included a hemodialysis treatment flowsheet dated 4/17/14that failed to evidence the nursing staff had completed an assessment of the patient post treatment despite intradialytic concerns of which the physician was notified, such as tachycardia with the patients pulse at 7:21 AM at 164 BPM (beats per minute), and at 7:30, 163 and 7:46. The technician, employee E, wrote, "pt [patient] states starting to feel better", but the record failed to evidence any documentation of what the patient was feeling or their status. The clinical record failed to evidence the nursing staff had completed an assessment of the patient post treatment.</p> <p>2. Clinical record number 3 included a hemodialysis treatment flowsheet dated 3/23/15 that had failed to evidence the nursing staff had completed an assessment of the patient post treatment despite post treatment hypotension</p> | | <p>"Monitoring During Patient Treatment Policy" and FMS-CS-IC-I-110-132A " Patient Evaluation Post Treatment Policy"</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy" and FMS-CS-IC-I-110-132A " Patient Evaluation Post Treatment Policy" with emphasis placed on when to complete a Post Nursing Assessment when complications or unusual findings are noted in the patient's treatment record.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical manager or designee will conduct audits via the QAI Treatment Sheet Audit tool. These audits will be completed and monitored per the QAI calendar audit schedule which is monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> | |

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| V 506 Bldg. 00 | <p>(87/63) at 3:00 PM. At the start of dialysis, at 11:36 the patient's blood pressure was 193/87.</p> <p>Clinical record number 3 included a hemodialysis treatment flowsheet dated 3/30/15 that had failed to evidence the nursing staff had completed an assessment of the patient post treatment despite post treatment hypertension (201/102) and other parameters such as concerns from the patient.</p> <p>3. On 4/17/15 at 3:00 PM, the director of operations, employee C, indicated the lack of thorough nursing documentation could be improved and these issues were not in compliance with facility policy.</p> <p>494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. Based on clinical record review, interview, and facility policy review, the agency's interdisciplinary team failed to review and reconcile medications per policy in 1 out of 4 (# 4) patient records reviewed with the potential to affect all</p> | V 506 | <p>V506 On Friday April 24th 2015 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</p> | 05/22/2015 | | | |

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| | <p>of the facility's 30 patients.</p> <p>Findings include:</p> <p>1. Patient #4 clinical record revealed the newly admitted patient had a dialysis treatment on 4/9/15 and also dialyzed on 4/11/15, 4/14/15 and 4/16/16. The Home Medication report dated 4/16/15 states, "No results found."</p> <p>2. In an interview with the Director of Operations, employee C, on 4/16/15 at 10:30 AM, Employee C stated, "I'm sure the nurse is planning to review the medications and update them. We use the discharge medication list until then."</p> <p>3. FMS_CS IC-I-120-060A, HT-I230-030A, HTII-335-010A dated September 25, 2013, titled "Review and Reconciliation of Medications Taken by patients at Home Using MedReview-eRx, states, "Medication reconciliation of patients home medications are required within one week (3 treatments) for all newly admitted patients."</p> | | <p>resolution.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow policy FMS-CS-IC-I-120-060A-HT-1230-030A, HT-II-335-010A "Review and Reconciliation of Medications Taken by Patients at Home using "MedReview-eRX.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies FMS-CS-IC-I-120-060A, HT-1230-030A, HT-II-335-010A with emphasis placed on reconciling and entering the patient home medications within one week or "3" treatments for all newly admitted patients.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical manager or designee will conduct audits via the QAI Medical Records Audit tool. These audits will be completed and monitored per the QAI calendar audit schedule which is monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152610 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 04/17/2015 |
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| V 543 Bldg. 00 | <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record review and facility policy review, the facility failed to ensure the patient was assessed when there were issues with fluid management in 1 (#3) out of 4 records reviewed, creating the potential to affect the facilities 30 incenter hemodialysis patients.</p> <p>Findings:</p> <p>1. Clinical record review for patient number 3 included a dialysis treatment record dated 3/25/15 that revealed a</p> | V 543 | <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> <p>V543 On Friday April 24th 2015 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow policies FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy" and FMS-CS-IC-I-110-132A " Patient Evaluation Post Treatment Policy"</p> | 05/22/2015 | |

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| | <p>Blood pressure of 155/71 at 12:00 PM, Blood flow rate 400, Dialysate flow rate 800. The blood pressure had dropped to 102/53 at 12:37. At 13:05, the "UF off" per technician, employee J. There is not a note or assessment from the RN at this time. At 1:06 PM the blood pressure was 61/27.</p> <p>The RN, employee A, noted, "Patient alert, denies complaints, resting comfortably." The record failed to evidence a change in patient status. The blood pressure is not checked again for 28 minutes. The estimated dry weight is 69.6 kg and the post weight is 67.40. The weight change is 3.20 pounds below estimated dry weight. The RN marked a statement for a post assessment that stated, "No New Findings."</p> <p>A. The record for patient number 3 dialysis treatment dated 3/27/15 revealed a lack of nursing assessment, or collaboration among the interdisciplinary team, related to the patient's blood pressure. The Predialysis blood pressure was 190/88. The Post blood pressure was orthostatic at 116/66.</p> <p>B. The record for patient number 3 dialysis treatment dated 3/30/15 revealed a start time of 11:53 AM and notes from the patient care technician, employee E, at 11:59 AM that state, "Patient [Pt]</p> | | <p>FMS-CS-IC-I-131A " Patient Evaluation Pre Treatment"</p> <p>FMS-CS-IC-I-110-132C " Patient Evaluation Post Dialysis Treatment Procedure"</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy" and FMS-CS-IC-I-110-132A "Patient Evaluation Post Treatment Policy"</p> <p>FMS-CS-IC-I-110-131A " Patient Evaluation Pre Treatment FMS-CS-IC-I-110-132C " Patient Evaluation Post Dialysis Treatment Procedure" with emphasis placed on when to complete a Pre or Post Nursing Assessment when complications or unusual findings are noted in the patient's treatment record.</p> <p>Training will be completed by Friday May 22nd 2015 and an in-service attendance sheet is available in the facility for review</p> <p>The Clinical manager or designee will conduct audits via the QAI Treatment Sheet Audit tool. These audits will be completed and monitored per the QAI calendar audit schedule which is monthly.</p> <p>The Clinical Manager is responsible to review, analyze and trend all</p> | |

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| | <p>demanded to be set for a post weight of 70.2 kg. Pt gained 2.8 kg since last tx of goal set for .8 kg [kilogram] per pt demand. pt threatened to stop tx [treatment] if his weight goes below 70.2 kg. CM [clinical manager] notified." At 12:00 PM the technician notes the patient's pre-tx weight is 70.4 kg, and pts bp [blood pressure] is high also. The nurse, employee I. documented an assessment within the first hour at 12:23 PM that states, "No unusual findings noted." Text notes stated, "HD [hemodialysis] settings verified. pt denies chest pains, falls and abnormal bleeding." The issues raised by the patient technician are not noted, assessed, or addressed by the nurse in the pretreatment evaluation. The dialysis treatment note fails to evidence a complete nursing assessment interdialytic or post treatment.</p> <p>4. Facility policy and procedure, FMS-CS-IC-1-110-131A revision dated 04-JUL-2012 states, "If the PCT/LPN notes any changes or abnormal finding in the patients condition or vascular access are observed or reported by the patient, or the patient was hospitalized, the patient care technician must report the changes in the patient's condition to a registered nurse who will further assess the patient prior to initiation of treatment ... "</p> | | <p>reports and present them monthly to the QAI Committee for review.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p> | | |

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| | <p>5. "Patient Monitoring During Patient Treatment policy number, FMS-CS-IC-1-110-133A dated 04-JUL-2012, states, "Vital signs will be monitored at the initiation of dialysis and every 30 minutes OR MORE FREQUENTLY, as needed. Observe for changes in the patient's respirations, heart rate and blood pressure. Verify and react to unusual findings such as atypical blood pressure readings. Monitor for trends such as hypotension and bradycardia. Respond to change in vital signs as indicated by patients symptoms, nursing judgment or as ordered by the physician, Check for any changes in mental status, level of consciousness . . . Appropriate interventions in response to alarms, changes in vital signs, treatment parameters, or machine adjustments shall be documented in the treatment record."</p> <p>6. Policy document number FMS-CS-IC-1-110-132C, dated 04-JUL-2012, Patient Evaluation Post Dialysis Treatment states, "Orthostatic hypotension is well recognized as a risk factor for falls, syncope, and cardiovascular events. All ambulatory patients should be evaluated for orthostatic hypotension post treatment ... Patient assessment is a nursing responsibility and cannot be delegated to</p> | | | |

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| V 715 Bldg. 00 | <p>unlicensed patient care staff. Nurses assess the patient post treatment as warranted by the patient condition ... "</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on clinical record and facility policy review and interview, the medical director failed to ensure all personnel had provided services in accordance with facility policies in 2 (# 1 and 3) of 4 records reviewed creating the potential to affect all of the facility's 30 current patients.</p> <p>The findings include: 1. The facilities policy, FMS-CS-IC-110-133A, titled Patient</p> | V 715 | <p>V715 The Director of Operations met with the Medical Director on Friday April 24th 2015 to review her requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individual who treat patients in the facility emphasizing adherence to hand hygiene, cleaning and disinfecting of dialysis equipment, patient education, emergency procedures and safety cart,</p> | 05/22/2015 |

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| | <p>Monitoring During Treatment, dated July 4, 2014, states, "Vital signs will be monitored at the initiation of dialysis and every thirty minutes, or more frequently, as needed."</p> <p>A. Clinical record number 3 included a hemodialysis treatment flow sheets dated 4/1/15 that failed to evidence the facility staff had checked the patient at least every 30 minutes.</p> <p>B. The treatment flowsheet dated 4/1/15 evidenced facility staff had checked the patient's vital signs at 1:00 PM and not again until 2:04 PM, a period of 64 minutes between treatment checks.</p> <p>2. FMS-CS-IC-I-110-132C Policy and Procedure dated July 4, 2012, titled "Patient Evaluation Post Dialysis Treatment Procedure" states, "Guidelines for performing a post treatment assessment may include: Changes in the patients condition reported by the unlicensed patient care staff. Observations or changes in the patient's condition as noted and reported by the patient care staff. Symptoms or problems reported by the patient."</p> <p>A. Clinical record number 1 included a a hemodialysis treatment flowsheet dated 3/20/15 in which the Nurse,</p> | | <p>reconciliation and review of medications, pre and post dialysis treatment assessments and patient monitoring during dialysis.</p> <p>The Director of Operations will also review the Plan of Correction that is instituted to correct these issues.</p> <p>The Medical Director will then approve and direct the implementation of the plan as noted below.</p> <p>The facility's patient care staff will be educated and in-serviced on the following policies,</p> <p>"Hand Hygiene" "Patient Monitoring During Patient Treatment" "Emergency Supplies Management and Equipment Monitoring" "Reconciliation and Review of Patient Home Medications" "Pre and Post Treatment Nursing Assessments. By May 22nd 2015 by education or designee with a record of training reviewed by the QAI committee.</p> <p>The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the</p> | | |

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| | <p>Employee I, documented at 7:51 AM "Patient feels bad, b/p [blood pressure] 88/55 ... 100 n/s [normal saline]." The clinical record failed to evidence the nursing staff had completed an assessment of the patient post treatment.</p> <p>B. Clinical record number 1 included a hemodialysis treatment flowsheet dated 4/17/14 that failed to evidence the nursing staff had completed an assessment of the patient post treatment despite intradialytic concerns in which the physician was notified, such as tachycardia with the patients pulse at 7:21 AM at 164 BPM [beats per minute], at 7:30, 163 and 7:46. The technician, employee E, wrote, "Pt [patient] states starting to feel better", but there is not any documentation of what the patient was feeling. The clinical record failed to evidence the nursing staff had completed an assessment of the patient post treatment.</p> <p>C. Clinical record number 3 included a hemodialysis treatment flowsheet dated 3/23/15 that had failed to evidence the nursing staff had completed an assessment of the patient post treatment despite post treatment hypotension (87/63) at 3:00 PM. At the start of dialysis at 11:36 AM, the patient's blood pressure was 193/87.</p> | | <p>Medical Director during the monthly QAI Committee Meeting.</p> <p>The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p> | | |

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| | <p>D. Clinical record number 3 included a hemodialysis treatment flowsheet dated 3/30/15 that failed to evidence the nursing staff had completed an assessment of the patient post treatment despite post treatment hypertension (201/102) and other parameters such as concerns from the patient.</p> <p>3. On 4/17/15 at 3:00 PM, the director of operations, employee C, indicated the lack of thorough nursing documentation could be improved and that these issues were not in compliance with facility policy.</p> | | | | |