

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152545	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2013
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NAME OF PROVIDER OR SUPPLIER BLUE RIVER VALLEY RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST STE 106 SHELBYVILLE, IN 46176
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V000000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 8-5-13, 8-6-13, and 8-7-13</p> <p>Facility #: 010000</p> <p>Medicaid Vendor #: 200827250D</p> <p>Surveyors: Vicki Harmon, RN, PHNS Team Leader Miriam Bennett, RN, PHNS</p> <p>Blue River Valley Renal Center was found to be out of compliance with the Conditions for Coverage 42 CFR 494.90 Patient Plan of Care, 494.30 Infection Control, and 494.110 Quality Assessment and Performance Improvement.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 16, 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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V000110	<p>494.30 CFC-INFECTION CONTROL</p> <p>Based on observation, policy review and interview, it was determined the dialysis facility failed to ensure staff followed infection control policies and procedures for 6 of 14 observations with the potential to affect all the facility's patients (See V 113); failed to ensure clean sink area had soap and paper towels available for 1 of 1 facility (see V 114); failed to ensure staff cleaned equipment between each patient use prior to returning to clean area for 2 of 14 observations with the potential to affect all the facility's patients(see V 116); failed to ensure clean equipment was not stored in dirty areas in 4 of 14 observations with the potential to affect all the facility's patients (See V 117); failed to ensure the clean supply cart was located a sufficient distance from patient care areas to prevent potential contamination from body fluids for 1 of 1 supply cart observed with the potential to affect all the facility's patients (see V 119); failed to ensure staff disposed of bloody PPE in biohazard receptacle for 1 of 14 observations with the potential to affect all the facility's patients (see V 121); and failed to ensure staff cleaned blood spill immediately and effectively for 2 of 3 observations related to cleaning spills and equipment with the potential to affect all the agency's patients (see V</p>	V000110	<p>DaVita Blue River Valley takes the conditions of coverage very seriously. Immediate steps were taken to ensure the facility provides a sanitary environment to minimize any transmission of infectious agents in the facility. These actions are outlined in depth in the Plan of Correction for V113, V114, V116, V117, V119, V121, and V122.</p> <p>Governing Body (GB) meeting was held on 08/23/2013 to review the deficiencies as a result of a survey concluded on 08/07/2013. Members of the GB including the Medical Director, Group Facility Administrator (GFA), and Divisional Vice President (DVP) have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 1) Ensuring facility provides and monitors for sanitary environment to minimize transmission of infections; 2) Teammates (TMs) are compliant with infection control practices; 3) Ample soap and towels are available at clean sinks to facilitate proper hand washing. 4) Ensuring clean items taken into the dialysis station should either be disposed of or cleaned and disinfected before being taken to a common clean area or used on another patient. 5) Ensuring unused supplies taken to the patient's station</p>	09/06/2013			

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	122). The cumulative effect of these systematic problems resulted in the facility's inability to meet the requirements of the Condition for Coverage 494.30: Infection Control.		should be used only for that patient and should not be returned to a common clean area. 6) Ensuring clean areas are clearly separated from contaminated areas where used supplies and equipment are handled. 7) Ensuring clean supplies are stored at a sufficient distance to prevent contamination. 8) Ensuring proper handling and disposal of potentially infectious waste. 9) Ensuring the cleaning and disinfection of contaminated surfaces, medical devices and equipment. GB will review Quality Improvement Facility Management Meeting (QIFMM) minutes to ensure action plans are evaluated for effectiveness, new plans developed as applicable. Once compliance is achieved, Plan of Correction will be monitored during GB meeting at a minimum of quarterly. This Plan of Correction will also be reviewed during QIFMM and the GFA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.		

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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>8. On 8-7-13 at 10:00 AM, employee I, a registered nurse (RN), was observed to initiate the dialysis treatment via fistula on patient number 8. The employee cleansed the insertion sites with alcohol and then with betadine. Upon application of the Betadine the patient indicated an allergy to the Betadine. Without removing her gloves or cleansing her hands, the RN obtained a bottle of ExSept cleanser from the clean supply cart, poured a small amount in a cup, poured the cleanser onto a clean 4x4, and then cleansed the insertion site with the ExSept soaked gauze.</p> <p>A. Without changing her gloves or cleansing her hands, the RN then inserted the first needle. The RN then palpated the insertion site and, without again cleansing the insertion site, inserted the second needle and initiated the dialysis treatment.</p> <p>B. The facility's March 2013 AV Fistula or Graft Cannulation with Safety Fistula Needles (SFN) and Administration of Heparin" procedure number 1-04-01A</p>	V000113	<p>GFA will hold mandatory in-service for all clinical TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure 1-05-01A: Use of Alcohol-Based Hand Rubs, and Policy & Procedure 1-05-01B: Hand washing, Policy & Procedure # 1-04-01A The AV Fistula or Graft Cannulation with Safety Fistula Needles</i>, TMs instructed using surveyor observations as examples to the following: 1) TMs must wear disposable gloves appropriately when caring for 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 each station. 3) Effective contact time for alcohol is 1 minute, when using alcohol as the cleaning agent the alcohol must remain wet for cannulation and 4 alcohol pads are used per cannulation site for cleaning. Once cannulation site has been cleaned it must not be touched, otherwise area must be cleaned per policy prior to cannulation. Air drying time when using ExSept</p>	09/06/2013			

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	states, "For patients who have an allergy to povidone iodine or other skin antiseptic agents, necessitating alcohol alone, apply alcohol using a circular rubbing motion, center out for 1 minute immediately prior to cannulation. Repeat for second insertion site. Do not palpate insertion site once area has been prepped."		Plus is 2 minutes prior to cannulation. 4) TMs must wear gloves when there is a potential for exposure to blood, dialysate and other potentially infectious substances. TMs must wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and must remove gloves and perform hand hygiene between each patient and/or station. 5) Appropriate PPE must be worn whenever there is the potential for contact with the body fluids, hazardous chemicals, contaminated equipment and environmental surfaces. 6) TMs must perform hand hygiene prior to donning gloves and every time gloves are removed. 7) TMs must ensure clean barrier is placed between the machine/chairs and supplies. 8) PPE must be removed as soon as possible if contaminated and placed in a designated biohazard waste bin. 9) TMs must wash hands at designated "clean sinks". 10) TMs educated on proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment: TMs must completely recline and open chair foot rest to clean in the crevasses of chair with 1:100 bleach solution after each patient treatment, cleaning chair demonstrated to all TMs to cover all the chair surfaces. 11) Cleaning and/or disinfection of		

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	Based on observation, policy review, and interview, the facility failed to ensure staff followed infection control policies and procedures for 6 of 14 observations		<p>equipment and work surfaces must be performed immediately following exposure to blood or other potentially infectious materials. Use 1:100 (one to one hundred) bleach solution for environmental surfaces. For visible blood or gross blood spills, a 1:10 (one to ten) bleach solution must be utilized. After all visible blood is cleaned with the 1:10 bleach solution, TMs must use a new disposable towel soaked with 1:10 bleach solution and clean area a second time. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>Clinic Nurse Manager (CNM) or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and 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>The GFA and Medical Director are responsible for compliance with this POC</p>		

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	<p>with the potential to affect all the facility's patients. (Employees A, B, C, and I)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During an observation 8/5/13 at 1:35 PM, employee I was discontinuing dialysis on a Central Venous Catheter (CVC) patient (#2) at station 12. Employee I failed to change gloves throughout the process. The employee left the station to obtain new supplies from the clean supply cart and returned to the station but failed to change gloves or perform hand hygiene. 2. During an observation on 8/5/13 at 2:10 PM, employee I was observed providing Arterial/Venous Fistula (AVF) Graft post care to patient #6 at station 7. The following was observed: <ol style="list-style-type: none"> a. Employee I attempted to change pressure dressing on right thigh arterial site due to saturation with blood. Employee I removed blood covered gloves, failed to perform hand hygiene, walked over to clean supply cart to obtain more 2 x 2 dressings and returned to station but failed to perform hand hygiene prior to donning clean gloves. b. Employee I proceeded to fold the 2 x 2 dressing on the arm of the chair and 			

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	<p>placed the side touching the chair directly onto the arterial site.</p> <p>c. Blood spurted onto employee's gown, gloves, and onto floor spanning across 3 floor tiles. Employee I removed the bloody gloves and then the gown, but failed to place them in the biohazard receptacle. The articles were placed in the regular trash.</p> <p>d. Employee I walked over to wash hands, stepped in the blood on the floor, and used the dirty sink to wash hands.</p> <p>e. Employee I returned to station 7, donned clean gloves, left the station and went to the dirty sink area, and gathered a wet disposable towel to provide to patient to clean blood from leg. The employee failed to change gloves and perform hand hygiene. The employee stepped in the blood on the floor.</p> <p>f. Employee I failed to clean the blood from the floor. At 2:20 PM, employee C cleaned the blood on the floor, but failed to clean it a second time per policy.</p> <p>3. During an observation on 8/7/13 at 10:25 AM, employee I was observed cleaning the dialysis chair at station 2. Employee I failed to fully recline the chair. Employee I was cleaning the right</p>			

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	<p>inside cushion and arm of the chair, which had a moderate sized area of a brownish substance, when the towel became saturated. Employee I threw it away but failed to change the gloves before obtaining a new towel and dipping it into the bleach solution and returning to the station. At 10:30 AM, employee I washed hands at the dirty sink.</p> <p>4. During an observation on 8/7/13 at 11:40 AM, employee A was observed preparing dressings for an AVF on patient #8 at station 1. Employee A carried the open dressing packages to the clean supply cart, poured a solution into a cup on the nurses' station ledge, poured this solution into the clean dressing packages above the clean supplies, and returned to station 1. Employee A failed to change gloves and perform hand hygiene.</p> <p>5. During an observation on 8/7/13 at 10:45 AM, employee B was observed initiating dialysis on a CVC patient (#3) at station 12. Employee B carried open dressing packages to the clean supply cart, poured a solution into a cup on the nurses' station ledge, poured this solution into the clean dressing packages above the clean supplies, and returned to station 12. Employee B failed to change gloves or perform hand hygiene. Employee B then went to the clean supply again to obtain</p>			

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	<p>two masks and returned back to station 12, failing to change the gloves again.</p> <p>6. During interview on 8/7/13 at 10:05 AM, employee A indicated the solution the staff used to clean patient access sites is called ExSept Plus. It is a cleaner/disinfectant. The staff have to wait 3 minutes once they use it before accessing sites.</p> <p>7. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "1. Hand hygiene is to be performed ... prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area. ... 8. Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. ... 10. Glove should be changed when: ... When going from a "dirty" area or task to a "clean" area or task. ... 12. All personal protective equipment (PPE) is to be removed as soon as possible if overtly</p>			

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	contaminated and is to be placed in a biohazard waste container. ... 30. If electronic thermometers and/or blood glucose meter are used, measures will be taken to prevent cross contamination between patients. For example, the thermometer should not be placed on potentially contaminated such as the dialysis delivery system. If the potential for contamination exists, the device outercasting is wiped with an appropriate disinfectant before being returned to clean area or using on another patient. ... 39. Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient. ... 40. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment. ... 44. If a common supply cart is used to store clean supplies in the patient treatment area, ... Only teammates with clean hands may remove items from the supply cart. ... 46. Cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or other potentially infectious materials. ... For visible blood			

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	or gross blood spills, a 1:10 (one to ten) bleach solution must be utilized. After all visible blood is cleaned with the 1:10 (one to ten) bleach solution, teammates are to use a new disposable towel soaked with 1:10 (one to ten) bleach solution and clean area a second time. 47. Equipment including the dialysis delivery system, the interior and the exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices ... IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, ... and after each treatment."			

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V000114	<p>494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.</p> <p>Based on observation, interview, and policy review, the facility failed to ensure the appropriate supplies were readily available for patients and staff to wash hands for 1 of 1 facility with the potential to affect all the facility's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During an observation on 8/5/13 at 1:00 PM, surveyor went to wash hands at clean sink. This clean sink area failed to contain soap and paper towels. Staff indicated the soap and paper towels were located on the wall to the right of the dirty sink area. 2. During interview on 8/7/13 at 2:10 PM, employee J indicated the clean sink was just relocated to that area a few months ago and paper towels and soap were there. Employee J was not sure where they went. 3. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "37. Sinks should be easily accessible and readily available in the treatment area and in other appropriate areas ... The facility 	V000114	<p>Paper towel holder and soap dispenser located by dirty sink removed. Soap dispenser placed at designated clean sink on 8/8/2013 along with paper towel holder.</p> <p>GFA will hold mandatory in-service for all clinical TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>, TMs educated on clean vs. dirty sinks, hand washing must only occur at clean sinks; clean sinks must have soap and paper towels located at sink. CNM will be responsible to conduct daily audit to ensure availability and document on daily audit forms. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to</p>	09/06/2013			

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	should have a sink available for patients to wash their access sites prior to treatment and their hands after treatment. ... Soap and a supply of paper towels protected from contamination must be available at each sink."		monitor ongoing compliance. The GFA and Medical Director are responsible for compliance with this POC	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V000116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>Based on observation, interview, and policy review, the facility failed to ensure staff are disinfecting nondisposable items before returning to clean areas for 2 of 14 observations with the potential to affect all the facility's patients.</p> <p>Findings include</p> <p>1. During an observation on 8/5/13 at 2:30 PM, employee I checked a temperature on patient #5 at station 4. Employee I failed to clean or disinfect the thermometer prior to returning it to the clean area.</p> <p>2. During an observation on 8/7/13 at 11:40 AM, employee B obtained a Phoenix meter from its base at the dirty</p>	V000116	GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i> . TMs educated that items taken to dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Dirty supplies must not be placed in areas designated for clean items only. TMs must disinfect thermometers by wiping outer casing with 1:100 bleach solution after each patient use, and prior to returning thermometer to clean area; Phoenix Meters must be disinfected with 1:100 bleach	09/06/2013	

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	<p>sink area and took it to station 2. Phoenix meter gave a different reading than dialysate machine so employee B returned it to the dirty sink area and obtained a second Phoenix meter from station 6 but failed to disinfect or clean the meter before using at station 2. Employee B then failed to clean or disinfect this second meter before returning it to the storage area by the dirty sink.</p> <p>3. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "30. If electronic thermometers and/or blood glucose meter are used, measures will be taken to prevent cross contamination between patients. For example, the thermometer should not be placed on potentially contaminated such as the dialysis delivery system. If the potential for contamination exists, the device outercasting is wiped with an appropriate disinfectant before being returned to clean area or using on another patient. ... 39. Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient. ... 40. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime</p>		<p>solution after each patient use and prior to returning to clean area. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and 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>The GFA and Medical Director are responsible for compliance with this POC</p>				

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	container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment."			

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V000117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation and policy review, the facility failed to ensure clean equipment was not stored in dirty areas in 4 of 14 observations with the potential to affect all the facility's patients.</p> <p>Findings include</p> <p>1. During an observation on 8/5/13 at 1:00 PM, the Phoenix meters, bleach solution for cleaning machines, and the clean disposable towels used for cleaning</p>	V000117	<p>Identified bleach and towels discarded and new clean bleach solution, towels, and phoenix meters relocated to designated clean area.</p> <p>GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i> with focus on review of facility clean and dirty areas, maintaining designated clean</p>	09/06/2013			

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	<p>dialysis machines were observed stored in the area labeled "dirty."</p> <p>2. During an observation on 8/7/13 at 11:40 AM, employee B obtained a Phoenix meter from its base at the dirty sink area and took it to station 2. Phoenix meter gave a different reading than dialysate machine so employee B returned it to the dirty sink area and obtained a second Phoenix meter from station 6 but failed to disinfect or clean the meter before using at station 2. Employee B then failed to clean or disinfect this second meter before returning it to the storage area by the dirty sink.</p> <p>3. During an observation on 8/5/13 at 2:10 PM, employee I was observed discontinuing dialysis and providing Arterial/Venous Fistula (AVF) Graft post care to patient #6 at station 7. Employee I walked over to wash hands at the dirty sink.</p> <p>4. During an observation on 8/7/13 at 10:25 AM, employee I was observed cleaning the dialysis chair at station 2. Employee I failed to fully recline the chair. Employee I was cleaning the right inside cushion and arm of the chair which had a moderate sized area of a brownish substance when the towel became saturated. Employee I threw it away, but</p>		<p>areas. TMs instructed using surveyor observations as examples to the following: 1) Items taken to dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Phoenix Meters must be disinfected with 1:100 bleach solution after each patient use and prior to returning to clean area. 2) TMs must wash hands in designated clean sinks only. 3) Chairs must be fully reclined and sides open to be cleaned, if a second towel is needed, TM is to remove gloves, conduct hand hygiene, re-glove, and obtain new bleach cloth. 4) Patients must be instructed to wash their accesses prior to treatment at designated clean sink. 5) Clean areas are designated for storage of unused supplies and equipment and separated from contaminated areas. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be</p>				

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	<p>failed to change gloves before obtaining a new towel and dipping it into the bleach solution at the dirty sink area. At 10:30 AM, employee I washed hands at the dirty sink.</p> <p>5. During interview on 8/7/13 at 10:05 AM, employee A indicated that when patients wash their access sites at the facility, they wash them at the clean sink. At 10:20 AM, employee A indicated that patients wash access sites at the dirty sink because the sites are considered dirty when they come in for treatment.</p> <p>6. During interview on 8/7/13 at 2:15 PM, employee J indicated the patients wash their access sites at the clean sink.</p> <p>7. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "10. Glove should be changed when: ... When going from a "dirty" area or task to a "clean" area or task. ... 30. If electronic thermometers and/or blood glucose meter are used, measures will be taken to prevent cross contamination between patients. For example, the thermometer should not be placed on potentially contaminated such as the dialysis delivery system. If the potential for contamination exists, the device outercasting is wiped with an appropriate disinfectant before</p>		<p>reviewed during GB meetings to monitor ongoing compliance.</p> <p>The GFA and Medical Director are responsible for compliance with this POC</p>		

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	being returned to clean area or using on another patient. ... 39. Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient. 45. Clean areas should be clearly designated for ... storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled."			

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V000119	<p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. Based on observation, interview, and policy review, the facility failed to ensure the clean supply cart was located a sufficient distance from patient care areas to prevent potential contamination from body fluids for 1 of 1 supply cart observed with the potential to affect all the facility's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8/5/13 at 1:00 PM, surveyor noted the clean supply cart was located in front of nurses' station, directly across from dialysis stations 5 and 6, at a space of 4 tiles from the patient care area. During interview on 8/7/13 at 2:10 PM, employee J indicated they don't know where they can move the supply cart due to space. The facility's policy titled "Infection 	V000119	<p>Common clean supply cart was replaced by a closed system to prevent cross-contamination.</p> <p>GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs instructed on designated clean supply areas which are located at a sufficient distance to avoid contamination. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be</p>	09/06/2013	

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	Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "44. If a common supply cart is used to store clean supplies in the patient treatment area, this cart is to remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood."		reviewed during GB meetings to monitor ongoing compliance. The GFA and Medical Director are responsible for compliance with this POC	

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V000121	<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-</p> <p>(i) Handling, storage and disposal of potentially infectious waste; Based on policy review, observation, and interview, the facility failed to ensure staff followed infection control policies for soiled Personal Protective Equipment (PPE) for 1 of 14 observations with the potential to affect all the facility's patients.</p> <p>Findings include</p> <p>1. During an observation on 8/5/13 at 2:10 PM, employee I was observed providing Arterial/Venous Fistula (AVF) Graft post care to patient #6 at station 7. Blood spurted onto employee gown, gloves, and onto floor spanning across 3 floor tiles. Employee I removed the bloody gloves and then the gown, but failed to place them in the biohazard receptacle. The employee placed them in the regular trash.</p> <p>2. During interview on 8/7/13 at 1:30 PM, employee J indicated the nurse should have placed the bloody gown and</p>	V000121	<p>GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs instructed if Personal Protective Equipment (PPE) becomes visibly soiled, PPE must be discarded, conduct hand hygiene and don new PPE. TMs must place blood contaminated PPE in designated biohazard containers only, not regular trash. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p>	09/06/2013	

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	gloves in the biohazard container, not the regular trash. 3. The facility ' s policy titled " Infection Control for Dialysis Facilities " # 1-05-01, revised March 2013 states, " 12. All personal protective equipment (PPE) is to be removed as soon as possible if overtly contaminated and is to be placed in a biohazard waste container. "		The GFA and Medical Director are responsible for compliance with this POC	

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V000122	<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 policy review, the facility failed to ensure staff followed infection control policies for 2 of 3 observations related to cleaning spills and equipment with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. During an observation on 8/5/13 at 2:10 PM, employee I was observed providing Arterial/Venous Fistula (AVF) Graft post care to patient #6 at station 7. Blood spurted onto employee gown, gloves, and onto floor spanning across 3 floor tiles. Employee I walked over to wash hands, stepped in the blood on the floor. Employee I returned to station 7, donned clean gloves then left the station and went to the dirty sink area, gathered a wet paper towel to provide to patient to clean blood from leg and stepped in the blood on the floor. Employee I failed to</p>	V000122	<p>GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs instructed using surveyor observations as examples to the following: 1) Blood spills must be cleaned immediately with appropriate bleach solution, if PPE becomes visibly soiled, PPE must be discarded, conduct hand hygiene and don new PPE. TMs must place blood contaminated PPE in designated biohazard containers only 2) Cleaning and/or disinfection of equipment and work surfaces will be performed immediately following exposure to blood or other potentially infectious materials. TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection tasks emphasizing for visible blood or gross blood spills a 1:10 bleach solution must be utilized. After</p>	09/06/2013	

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	<p>clean the blood from the floor. At 2:20 PM, employee C cleaned the blood on the floor, but failed to clean it a second time per policy.</p> <p>2. During an observation on 8/5/13 at 2:00 PM, employee I was cleaning and disinfecting the dialysis machine and chair at station 7. Employee I failed to clean the sides of the machine, jug of bicarb, IV pole, and computer keyboard. Employee I failed to fully recline the chair for cleaning.</p> <p>3. During interview on 8/7/13 at 1:40 PM, employee J indicated the dialysis chairs should be fully reclined for cleaning.</p> <p>4. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised March 2013 states, "40. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment. ... 47. Equipment including the dialysis delivery system, the interior and the exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices ... IV poles, as well as all work surfaces will be</p>		<p>blood is cleaned with 1:10 bleach solution TMs must use new disposable towel soaked with 1:10 bleach solution and clean a second time. 3) Proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment including sides of machine, fully reclining chair to clean crevices, all non-disposable items and equipment including jugs of bicarbonate, IV poles, computer keyboards, blood pressure cuffs, and clamps must be wiped with a bleach solution in between patients. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>CNM or designee will conduct infection control audits daily x 2 weeks, then weekly x 2 weeks, then monthly. GFA/Charge nurse will review results of all audits with TMs during home room meetings and 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>The GFA and Medical Director are responsible for compliance with this POC</p>				

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	wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, ... and after each treatment."			

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V000228	<p>494.40(a) MIXING SYSTEMS-LABELING 5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine.</p> <p>Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until the tank has been emptied.</p> <p>Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents.</p> <p>Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure individual containers used to dispense the bicarbonate portion of the dialysate solution had been labeled in 5 (#s 1-5) of 5 machines observed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <p>1. During a tour of the facility, on 8-5-13</p>	V000228	<p>All individual bicarbonate jugs labeled with manufacture information that indicates concentrates formula on 08/06/2013.</p> <p>GFA will hold mandatory in-service for all clinical TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure 2-04-01 Bicarbonate Concentrate System Mixing</i> emphasizing individual bicarbonate containers must have manufacturing label attached</p>	09/06/2013			

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	<p>at 1:20 PM, observation noted individual jugs of bicarbonate solution on each of the dialysis machines used by patients numbered 1, 2, 3, 4, and 5. The jugs failed to evidence any labeling to identify the concentration of the solution, the date and time the solution was mixed, and who had mixed it.</p> <p>2. The facility's March 2012 "Bicarbonate Concentrate System Mixing" policy number 2-04-01 states, "If individual bicarbonate containers are used to supply dialysis delivery systems, the containers must be labeled with the date and time that the bicarbonate was mixed."</p> <p>3. The Group Facility Administrator, employee J, acknowledged, on 8-7-13 at 2:45 PM, the containers were not labeled when observed on 8-5-13 at 1:20 PM.</p>		<p>identifying chemical composition. TMs must ensure individual bicarbonate containers are labeled with the date and time bicarbonate was mixed. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>CNM or designee will conduct observational audits daily x 2 weeks, then weekly to ensure compliance. GFA/Charge nurse will review results of all audits with TMs during home room meetings and 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>The GFA and Medical Director are responsible for compliance with this POC</p>		

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V000401	<p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>Based on observation and interview, the facility failed to ensure it had maintained the water treatment and dialysate mixing area in a clean and safe manner creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> During a tour of the facility, on 8-5-13 at 1:20 PM, observation of the water treatment and dialysate mixing area noted multiple pieces of trash, including chlorine test strips, other pieces of paper, and very small black bead-like pieces on the floor and around the drain in the floor. Observation also noted a large white paper stained with multiple black dots on a cart under the equipment used to complete the chlorine testing of the water. The facility administrator, employee A, acknowledged the condition of the water and dialysate preparation area on 8-5-13 at 1:20 PM during the tour. The facility administrator was unable to provide any information as to why the 	V000401	<p>Water Treatment and Dialysate Mixing Area along with cart utilized for testing chlorine were immediately cleaned. Designated TM assigned to clean water/dialysate area, and verification of task added to RN daily check list.</p> <p>GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i> emphasizing all TMs are responsible for providing a sanitary and safe environment in the treatment area, and throughout facility. Water and Dialysate Mixing Area must remain clean, floors free of debris or trash, equipment clean and free from debris. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>CNM or designee will conduct observational audits daily x 2 weeks, then weekly to ensure compliance. GFA/Charge nurse will review results of all audits with TMs during home room</p>	09/06/2013

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	area was not clean.		meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. The GFA and Medical Director are responsible for compliance with this POC		

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V000408	<p>494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on administrative record and facility policy review, observation, and interview, the facility failed to ensure the emergency evacuation kit was complete and had been maintained creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <p>1. The facility's March 2011 "Evacuation Kit" policy number 4-07-02 states, "Each facility will maintain an evacuation kit(s) with specified patient care supplies for use in case of an emergency evacuation . . . The contents of the evacuation kit(s) should include, at a minimum, enough supplies to provide care for a full shift of patients including home patients likely to be present in the facility at any one time . . . A designated person is to review the contents of the kit(s) and replace missing or expired supplies at least monthly."</p>	V000408	<p>Expired supplies were immediately discarded and all missing supplies were placed in evacuation kit on 08/06/2013. GFA will hold mandatory in-service for all clinic TMs by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #4-07-02 Evacuation Kit</i>. TMs instructed Evacuation kit must be maintained with specified patient care supplies for use in case of an emergency evacuation. Contents at minimum should have enough supplies to provide care for one shift of patients and all items included on <i>Policy & Procedure #4-07-02A Emergency Evacuation Kit Checklist</i>. Designated TM will be assigned monthly to complete <i>Emergency Evacuation Kit Checklist</i>; TM will review contents of kit and must replace missing or expired supplies. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p>	09/06/2013	

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	<p>The facility's March 2010 "Emergency Evacuation Kit Checklist "procedure number 4-07-02A lists the supplies to be maintained in the evacuation kit as follows: "Copy of Disaster Plan . . . Map of local area to direct emergency transportation efforts, Blank flow sheets, paper, pens and pencils, PPE-face shields . . . Heparin 1:1000 units/ml . . . Scissors, Small sharps container . . . Bite block(s), Portable radio and batteries."</p> <p>2. Observation noted, on 8-7-13 at 9:15 AM, the emergency evacuation kit included 12 1000 milliliter bags of normal saline with an expiration date of June 2013. The evacuation failed to include a copy of the facility's Disaster Plan, a map of local area to direct emergency transportation efforts, blank flow sheets, paper, pens and pencils, PPE-face shields, Heparin 1:1000 units/ml, scissors, a small sharps container, bite block(s), or a portable radio and batteries.</p> <p>3. The facility's administrative records included an "Emergency Equipment Checklist" that evidenced the contents of the emergency evacuation kits had been checked weekly on 7-1-13, 7-8-13, 7-15-13, 7-22-13, 7-31-13, and 8-5-13. The checklist failed to evidence the expired normal saline bags had been</p>		<p>CNM or designee will conduct monthly checks on Evacuation Kit ensuring all contents and expiration dates. GFA will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. The GFA and Medical Director are responsible for compliance with this POC</p>				

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	<p>noted and replaced.</p> <p>4. The facility administrator, employee A, indicated, on 8-7-13 at 9:30 AM, the emergency evacuation kit did include 12 bags of expired normal saline, and failed to include a copy of the facility's Disaster Plan, a map of local area to direct emergency transportation efforts, blank flow sheets, paper, pens and pencils, PPE-face shields, Heparin 1:1000 units/ml, scissors, a small sharps container, bite block(s), or a portable radio and batteries.</p>			

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V000540	<p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on clinical record and facility policy review, interview, and observation, it was determined the facility failed to maintain compliance with this condition by failing to ensure patients' blood pressures had been monitored at least every 30 minutes in accordance with facility policy in 2 of 4 records reviewed and failed to ensure patients achieved physician ordered estimated dry weights (EDW) in 1 of 4 records reviewed creating the potential to affect all of the facility's 19 current patients (See V 543); by failing to ensure ensure prescribed blood flow rates (BFR) had been maintained as ordered in 2 of 4 patient observations completed creating the potential to affect all of the facility's 19 current patients (See V 544); and by failing to provide appropriate anemia management to maintain patient's hemoglobin at the desired level in 3 of 4 records reviewed creating the potential to affect all of the facility's 19 current patients (See V 547).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.90 Patient Plan of Care.</p>	V000540	<p>DaVita Blue River Valley takes the conditions of coverage very seriously, immediate step were taken to ensure patients safely receive prescribed dialysis treatments per physician orders, facility continuously assesses outcomes, updates patients plan of care with regard to dialysis prescription to meet goals, and all TMs follow policy & procedure. These actions are outlined in depth in the POC for V543, 544, and 547.</p> <p>GB meeting was held on 08/23/2013 to review the deficiencies as a result of a survey concluded on 08/07/2013. Members of the GB including the Medical Director, GFA, and DVP have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 1) Ensuring facility process in place to safely provide patients appropriate prescribed treatment per physician orders; 2) Ensuring Interdisciplinary Team (IDT) implements medical plan of care with regard to dialysis prescription, assesses 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. 3) Ensuring facility provides patients with appropriate anemia</p>	09/06/2013			

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			management to maintain Hemoglobin levels. 4) Ensuring TMs comply with all policies and procedures for intradialytic treatment monitoring. 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 correction will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the GFA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.		

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V000543	<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 and facility policy review and interview, the facility failed to ensure patients' blood pressures had been monitored at least every 30 minutes in accordance with facility policy in 2 (#s 1 & 4) of 4 records reviewed and failed to ensure patients achieved physician ordered estimated dry weights (EDW) in 1 (# 3) of 4 records reviewed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <p>Regarding blood pressure checks:</p> <p>1. The facility's March 2012 "Intradialytic Treatment Monitoring" policy number 1-03-09 states, "Treatment checks should be completed at least every thirty (30) minutes. At a minimum, obtain and document the following: Blood pressure, heart rate."</p> <p>2. Clinical record number 1 included post treatment flow sheets that evidenced the patient's blood pressure had not been</p>	V000543	<p>GFA/CSS will hold mandatory in-service for all clinical TMs and members of IDT by 08/28/2013. In-service will include but not be limited to: review of <i>Policy & Procedure#1-01-14 Patient Assessment and Plan of Care when Utilizing Falcon Dialysis, Policy & Procedure #1-03-09 Intradialytic Treatment Monitoring</i>. TMs instructed using surveyor observations as examples to the following: 1) Treatment monitoring must be completed at a minimum of every 30 minutes, evaluation and documentation will include at a minimum patient's blood pressure, heart rate, blood and dialysate flows, arterial and venous pressures, fluid removal and/or replacement, vascular access status and subjective well being. 2) TMs must report and document any significant changes in target weight identified for each patient or failure to achieve estimated dry weight greater or less than physician's hemodialysis prescription to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders.</p>	09/06/2013

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	<p>checked at least every 30 minutes.</p> <p>A. A post treatment flow sheet dated 7-15-13 evidenced the blood pressure had been checked at 7:32 AM and not again until 8:32 AM.</p> <p>B. A post treatment flow sheet dated 7-19-13 evidenced the blood pressure had been checked at 8:01 AM and not again until 9:02 AM.</p> <p>C. A post treatment flow sheet dated 7-22-13 evidenced the blood pressure had been checked at 8:02 AM and not again until 9:01 AM.</p> <p>3. Clinical record number 4 included post treatment flow sheets that evidenced the patient's blood pressure had not been checked at least every 30 minutes.</p> <p>A. A post treatment flow sheet dated 7-17-13 evidenced the blood pressure had been checked at 9:02 AM and not again until 10:01 AM.</p> <p>B. A post treatment flow sheet dated 7-19-13 evidenced the blood pressure had been checked at 9:31 AM and not again until 10:31 AM.</p> <p>C. A post treatment flow sheet dated 7-26-13 evidenced the blood pressure had</p>		<p>3) Patients individualized plan of care must address Dose of Dialysis which addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed dose of dialysis. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Examples given using surveyor observations for patients consistently not meeting estimated dry weight and IDT did not address. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet and signature on policies.</p> <p>CNM or designee is responsible for daily monitoring and will complete post treatment audits for 100% of treatments x 2 weeks, then 50% of treatments x 1 week, then 10% of treatments ongoing. GFA will review results of all audits 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>The GFA and Medical Director are responsible for compliance with this POC</p>		

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	<p>been checked at 7:01 AM and not again until 8:01 AM.</p> <p>D. A post treatment flow sheet dated 8-2-13 evidenced the blood pressure had been checked at 6:41 AM and not again until 7:31 AM.</p> <p>4. The Group Facility Administrator, employee J, stated, on 8-7-13 at 10:55 AM, "We just inserviced the staff on treatment checks every 30 minutes."</p> <p>Regarding estimated dry weights:</p> <p>1. Clinical record number 3 failed to evidence the facility had addressed the patient not reaching the physician ordered EDW. The record included physician orders dated 5-22-13 that evidenced the ordered EDW was 78.5 kilograms (kg).</p> <p>A. A post treatment flow sheet dated 7-12-13 evidenced the EDW at the end of the treatment was 81.0 kg. The flow sheet states, "Went home with 2.5 kg of fluid on. Pt is asymptomatic, advised caregiver to take pt to the hospital if SOB [shortness of breath] occurs. pt refused alternate treatment."</p> <p>B. A post treatment flow sheet dated 7-15-13 evidenced the EDW at the end of the treatment was 79.6 kg. The flow</p>			

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	<p>sheet evidenced the patient had complained of being "dizzy" and that the ultrafiltration had been "turned off" and "100 cc NS" had been administered 3 1/2 hours into the treatment.</p> <p>C. A post treatment flow sheet dated 7-22-13 evidenced the EDW at the end of the treatment was 80.5 kg.</p> <p>D. A post treatment flow sheet dated 7-26-13 evidenced the EDW at the end of the treatment was 79.2 kg.</p> <p>E. A post treatment flow sheet dated 7-29-13 evidenced the EDW at the end of the treatment was 80.3 kg. The record included a physician order dated 7-29-13 that evidenced the EDW had been raised to 79 kg.</p> <p>F. A post treatment flow sheet dated 7-31-13 evidenced the EDW at the end of the treatment was 82.3 kg. The flow sheet evidenced that 3 25 hours into the treatment, the patient's blood pressure dropped to 68/30 and that 200 milliliters of normal saline was administered. The blood pressure reading was 90/35 and 83/32 at the time the treatment was terminated.</p> <p>G. A post treatment flow sheet dated 8-5-13 evidenced the EDW at the end of</p>			

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	<p>the treatment was 81.8 kg.</p> <p>2. The Group Facility Administrator, employee J, was unable to provide any additional information and/or documentation when asked on 8-7-13 at 2:45 PM.</p> <p>3. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but is not limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status."</p>			

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V000544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record and facility policy review and interview, the facility failed to ensure prescribed blood flow rates (BFR) had been maintained as ordered in 2 (#s 3 and 5) of 4 patient observations completed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On 8-5-13 at 2:00 PM, observation noted the BFR to be 350 for patient number 3. Clinical record number 3 included physician orders dated 1-18-13 that evidenced the ordered BFR was 400. 2. On 8-5-13 at 2:00 PM, observation noted the BFR to be 350 for patient number 5. Clinical record number 5 included physician orders dated 6-5-13 that evidenced the ordered BFR was 450. 3. The Group Facility Administrator, employee J, was unable to provide any additional documentation and/or information when asked on 8-7-13 at 2:45 	V000544	<p>GFA/CSS will hold mandatory in-service by 08/28/2013 for all clinical TMs and members of IDT. In-service will include but not be limited to: review of <i>Policy & Procedure#1-01-14 Patient Assessment and Plan of Care when Utilizing Falcon Dialysis</i> emphasizing blood flow rates must be set as prescribed. 1) TMs must verify dialysis prescription, prescribed dose of dialysis, and perform safety checks prior to each treatment initiation. Nurses are responsible for ensuring patients are achieving prescribed dose of dialysis and physician orders are followed. TMs must monitor patient's blood flow rates at a minimum of every 30 minutes, any identified variance in prescribed treatment must immediately be addressed including notifying licensed nurse of findings. Licensed nurse must take appropriate action, assess patient, contacting physician if warranted and follow physician orders, all findings and interventions and patient's response must be documented in patient's medical record; 2) Patients individualized plan of</p>	09/06/2013			

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	<p>PM.</p> <p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed dose of dialysis."</p>		<p>care must address Dose of Dialysis which addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed dose of dialysis. The IDT should review the Kt/V results to determine if the patient's adequacy values attain goal; if not IDT should compare treatment orders and dialysis treatment records to determine if prescribed dose of dialysis is being delivered. If the patient is not receiving an adequate treatment, the IDT should develop a plan to address problem and attain goal to meet patient needs. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>CNM or designee is responsible for daily monitoring and will complete post treatment audits for 100% of treatments x 2 weeks, then 50% of treatments x 1 week, then 10% of treatments ongoing. GFA will review results of all audits 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>The GFA and Medical Director are responsible for compliance with this POC</p>		

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V000547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO</p> <p>The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs. Based on clinical record and facility policy review and interview, the facility failed to provide appropriate anemia management to maintain patient's hemoglobin at the desired level in 3 (#s 2, 3, & 4) of 4 records reviewed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included physician orders dated 5-6-13 that identified Epogen (a medication used to treat anemia) was to be administered in accordance with the "HD Davita SHAPE Epoetin Alfa IV MDV Protocol." <p>A. The record evidenced a physician order dated 5-17-13 for Epogen 10,000 units 3 times per week and that the hemoglobin level was 8.1 grams per deciliter (gm/dL) on 5-8-13.</p>	V000547	<p>New Anemia Manager governed in on 08/07/2013; anemia management will be handled remotely by another CNM trained in anemia management. TM will be responsible until CNM at Blue River Valley facility is adequately trained and governed in.</p> <p>GFA contacted physician on 08/07/2013 to address (Patients #2, 3, and 4) lab values, Epogen doses, and obtained/implemented new orders for Epogen therapy per SHAPE Protocol 5.1. IDT will complete plan of care updates to include detailed evaluation of factors associated with anemia management and treatment plan.</p> <p>GFA will conduct mandatory in-service for CNM and members of IDT by 08/28/2013 emphasizing the facility must establish targets in anemia management that reflect professionally-accepted clinical practice standards. The IDT must have a plan for managing patients' anemia. The laboratory</p>	09/06/2013			

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	<p>B. The record included laboratory results dated 6-3-13 that evidenced the hemoglobin level was 8.0 g/dL. The record failed to evidence an Epogen dosage change had been initiated per the protocol. The protocol indicates that if the current hemoglobin level was less than 9 and the current Epogen dosage was 10,000, then the new dosage should be 14,300 unities of Epogen three times per week.</p> <p>C. The record included laboratory results dated 7-1-13 that evidenced the hemoglobin level was 9.5. The record failed to evidence an Epogen dosage change had been initiated per the protocol. According to the protocol, the dosage should have been decreased to 11,000 units three times per week.</p> <p>D. The record included laboratory results dated 7-15-13 that evidenced the hemoglobin level was 9.9. According to the protocol, the dosage should have remained at 11,000 units three times per week.</p> <p>E. The Clinical Services Specialists, employee K, reviewed the above-stated findings on 8-6-13 at 1:10 PM. The employee stated, "We make dosage changes every 2 weeks according to the hemoglobin results." The employee</p>		<p>reports, orders for ESAs and medication administration records must be considered as a part of the anemia management program. Facilities that use medication algorithms or protocols for managing anemia must ensure that the care for each patient is individualized. The physician or a non physician practitioner (i.e., advanced practice registered nurse, or physician assistant) is responsible for ordering medications and laboratory tests and may or may not use standing orders or a standard algorithm. Each patient's laboratory values must be monitored and values outside the target levels must be addressed, doses adjusted, and ESAs administered as ordered. This facility uses DaVita SHAPE Protocol 5.1. Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis will be reviewed, with attention that the IDT or individual IDT member must develop and implement a written, individualized comprehensive plan of care that must include measurable and expected outcomes and timetables for achieving goals including anemia regarding Hgb. values. IDT must identify reasons for patient not meeting goal, ensuring goals and plans and interventions are patient specific. IDT must follow up and readjust plan of care as necessary and document as such</p>				

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	<p>indicated the Epogen dosage changes should have been made as stated above and that the anemia management nurse, employee A, had not followed the protocol.</p> <p>2. Clinical record number 3 included physician orders dated 6-11-12 that identified Epogen (a medication used to treat anemia) was to be administered in accordance with the "HD Davita SHAPE Epoetin Alfa IV MDV Protocol."</p> <p>A. The record evidenced Epogen 10,000 units had been ordered by the physician on 1-3-13 and had been stopped on 6-26-13. The record included laboratory results that evidenced the hemoglobin level was 12.4 on 7-1-13 and had dropped to 11.5 on 7-22-13.</p> <p>A. The record evidenced the anemia management nurse, employee A, had initiated Epogen at 6000 units three times per week on 7-22-13. According to the protocol, Epogen 11,000 units was to be started.</p> <p>B. The anemia management nurse, employee A, stated, on 8-6-13 at 2:10 PM, "I used the no change column to determine the dosage. It says 6600. I did 6000 because that is easier than drawing up 6.6. We have single dose vials."</p>		<p>in patient's medical record. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>SHAPE protocol will be followed without fail and all adjustments to protocol will be reviewed with Medical Director and GFA weekly for 6 weeks, then at a minimum of monthly. Verification can be found on weekly SHAPE summaries with physician initialing all changes. Anemia Manager will be responsible to attend monthly QIFMM meetings to review anemia management with Medical Director. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>The GFA and Medical Director are responsible for compliance with this POC</p>		

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	<p>C. The Group Facility Administrator, employee J, indicated, on 8-6-13 at 2:15 PM, the anemia management nurse, employee A, apparently did not understand the protocol. The administrator indicated employee A had received training on how to use SHAPE protocol and had indicated she did understand and could implement the protocol appropriately.</p> <p>3. Clinical record number 4 included physician orders dated 6-20-12 that identified Epogen (a medication used to treat anemia) was to be administered in accordance with the "HD Davita SHAPE Epoetin Alfa IV MDV Protocol."</p> <p>A. The record evidenced Epogen had been initiated by the anemia manager, employee A, on 6-25-13 at 6000 units three times per week. According to the protocol, Epogen is to be started "for Hgb [hemoglobin] 9.0 to 9.9 g/dL at 75 units/kg [kilogram] IV per treatment 3 times weekly." The record included laboratory results that evidenced the hemoglobin level was 9.9 on 6-24-13 and that the patient's estimated dry weight was 100 kg. According to the SHAPE protocol, the initial dose was to be 7500 units.</p>			

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	<p>B. The Clinical Services Specialist, employee K, indicated, on 8-6-13 at 2:30 PM, the anemia management nurse, employee A, did not follow the protocol to initiate the Epogen dosing.</p> <p>4. The medical director, employee G, stated, on 8-7-13 at 10:30 AM, "I was not aware the protocol was not being followed. It is my responsibility."</p> <p>5. The facility's March 2013 "Adjusting Medication Doses Pursuant to Protocols" policy number 1-06-09 states, "Protocols are drafted so that the exact dose (dosage and frequency) that has been ordered for the patient can be determined, verified and replicated without requiring or allowing the exercise of discretion on the part of center teammates or requiring further confirmation or additional input from the physician of AHP. Protocols are not simply practice guidelines, they are patient specific and when ordered by a physician or AHP, the protocol becomes part of the order."</p>			

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V000625	<p>494.110 CFC-QAPI</p> <p>Based on quality assurance performance improvement (QAPI) document review, facility policy review, and interview, the facility failed to maintain compliance with this condition by failing to ensure its QAPI program included monitoring of fluid and blood pressure management in 6 of 6 months reviewed creating the potential to affect all of the facility's 19 current patients (See V 628); by failing to ensure its QAPI program included monitoring and investigation of root causes of low hemoglobin values in 6 of 6 months reviewed creating the potential to affect all of the facility's 19 current patients (See V 632); and by failing to ensure its infection surveillance included monitoring of staff infection control practice trends in 6 of 6 months reviewed creating the potential to affect all of the facility's 19 current patients (See V 637).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.110 Quality Assessment and Performance Improvement.</p>	V000625	<p>DaVita Blue River Valley takes the conditions of coverage very seriously. Immediate steps were taken to ensure the facility immediate steps were taken to ensure facilities QAPI Program analyzes data, develops plans/interventions for improvement of care, and re-evaluates focusing on health outcomes and safety of patients. These actions are outlined in depth in the Plan of Correction for V628, V632, and V637.</p> <p>GB meeting was held on 08/23/2013 to review the deficiencies as a result of a survey concluded on 08/07/2013. Members of the GB including the Medical Director, GFA, and DVP have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 1) Ensuring that facilities QAPI program reviews, measures, analyzes, and tracks quality indicators including fluid and blood pressure management 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. 2) Ensuring that QAPI program monitors and investigates root causes of low</p>	09/06/2013			

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			hemoglobin values and addresses with protocol and/ or physician order as indicated. 3) Ensuring QAPI program reviews trends with infection surveillance and monitors and tracks infection practices. 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 Correction will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the GFA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.	

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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 and interview, the facility failed to ensure its QAPI program included monitoring of fluid and blood pressure management in 6 (February through July 2013) of 6 months reviewed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QAPI meeting minutes, dated 2-22-13, 3-15-13, 4-29-13, 5-24-13, 6-26-13, and 7-17-13 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 Group Facility Administrator, employee J, indicated, on 8-7-13 at 1:15 PM, the facility's QAPI committee did not monitor fluid and blood pressure 	V000628	<p>CSS will conduct in-service for all QIFMM members by 09/06/2013. In-service will include but not be limited to: Review of <i>Policy & Procedure 1-14-06: Continuous Quality Improvement Program</i> with emphasis that QIFMM Team must set measurable goals, timelines, conduct ongoing monitoring/evaluation, and initiate interventions for quality indicators including fluid and blood pressure management by reviewing percentage of intradialytic weight loss including review of trends of adverse occurrences. QIFMM team must review any identified underperformance and analyze to identify root causes and have action plan identified that will include a timeline and result in performance improvement, and will track change in performance over time to ensure improvements are sustained. QIFMM minutes must reflect discussion, actions and evaluation by team. Verification of attendance at in-service will be evidenced by teammate's</p>	09/06/2013	

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	management.		signature on in-service sheet. CSS will attend QIFMM or review meeting minutes for the next 3 months to ensure IDT remains in compliance, minutes are comprehensive, and reflective of actions taken. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. The GFA and Medical Director are responsible for compliance with this POC		

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V000632	<p>494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management.</p> <p>Based on quality assurance performance improvement (QAPI) document review, facility policy review, and interview, the facility failed to ensure its QAPI program included monitoring and investigation of root causes of low hemoglobin values in 6 (February through July 2013) of 6 months reviewed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <p>1. The facility's QAPI meeting minutes, dated 2-22-13, 3-15-13, 4-29-13, 5-24-13, 6-26-13, and 7-17-13 failed to evidence the facility had monitored incidence and prevalence of patients with hemoglobin levels of less than 10.</p> <p>A. The meeting minutes all include the percentage of patients with hemoglobin values greater than 12. The meeting minutes failed to evidence the percentage of patients with hemoglobin values of less than 12 had been monitored and evaluated.</p> <p>B. The meeting minutes all include the same plans to monitor and evaluate</p>	V000632	<p>CSS will conduct in-service for all QIFMM members by 09/06/2013. In-service will include but not be limited to: Review of <i>Policy & Procedure 1-14-06: Continuous Quality Improvement Program</i> with emphasis that QIFMM Team must set measurable goals, timelines, conduct ongoing monitoring/evaluation, and initiate interventions for quality indicators including Anemia Management which includes Hemoglobin goals. Any identified underperformance including patients with hemoglobin levels not meeting goal must be reviewed to identify root causes and will have action plan identified that will result in performance improvement, and must track change in performance over time to ensure improvements are sustained. Action plans must be re-evaluated for effectiveness with new interventions initiated as needed. QIFMM minutes must reflect discussion, actions and evaluation by team. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. CSS will attend QIFMM or review meeting minutes for the next 3 months to ensure IDT remains in compliance, minutes are</p>	09/06/2013			

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	<p>the hemoglobin levels. The minutes all state, "Prior Months Plan: Continue SHAPE monitoring for anemia management for all patients. Adjust Epogen as indicated by protocol. Weekly HGB [hemoglobin] if Epogen is on HOLD all other patients biweekly lab draw . . . Revision to Plan/New Plan: Continue Shape monitoring for anemia management for all patients. continue to adjust Epogen as indicated by protocol. Weekly HGB if Epogen is on HOLD all other patients biweekly lab draw."</p> <p>2. The meeting minutes failed to evidence the facility had reviewed and evaluated the anemia management program. Three of 4 records reviewed failed to evidence the facility had provided the appropriate anemia management to maintain patient's hemoglobin at the desired level. (See G 547).</p> <p>3. The Group Facility Administrator, employee J, indicated, on 8-7-13 at 1:15 PM, the meeting minutes did not evidence the committee had analyzed and evaluated the root causes for hemoglobin values of less than 10.</p> <p>4. The facility's March 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "The facility will</p>		<p>comprehensive, and reflective of actions taken. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>The GFA and Medical Director are responsible for compliance with this POC</p>				

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	measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following: . . . Anemia Management."			

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V000637	<p>494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must-</p> <p>(A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents.</p> <p>Based on quality assurance performance improvement (QAPI) document and facility policy review and interview, the facility failed to ensure its infection surveillance included monitoring of staff infection control practice trends in 6 (February through July 2013) of 6 months reviewed creating the potential to affect all of the facility's 19 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QAPI meeting minutes, dated 2-22-13, 3-15-13, 4-29-13, 5-24-13, 6-26-13, and 7-17-13, failed to evidence the facility had monitored and analyzed trends in staff infection control practice deviations. 2. The Group Facility Administrator, employee J, indicated, on 8-7-13 at 1:25 PM, trends in deviation from expected infection control practices were not 	V000637	<p>CSS will conduct in-service for all QIFMM members by 09/06/2013. In-service will include but not be limited to: Review of <i>Policy & Procedure 1-14-06: Continuous Quality Improvement Program</i> with emphasis that QIFMM team must ensure facility monitoring and identify problems such as TM non-compliance with policies and procedures related to Infection Control by analyzing data collected including facility internal audits, conducting evaluation of trends and areas not meeting facility goals, identifying root causes for underperformance, develop recommendations and action plans to minimize infection transmission. QIFMM Team must review current action plans in place, evaluate effectiveness, and initiate new plans as needed to meet goals along with tracking performance over time to ensure improvements are sustained. QIFMM minutes must reflect</p>	09/06/2013	

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	<p>analyzed and tracked. The administrator indicated the deviations were addressed on an individual basis as they occurred.</p> <p>3. The facility's March 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following: . . . Infection Control."</p>		<p>discussion, actions and evaluation by team. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. CSS will attend QIFMM or review meeting minutes for the next 3 months to ensure IDT remains in compliance, minutes are comprehensive, and reflective of actions taken. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>The GFA and Medical Director are responsible for compliance with this POC</p>		

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V000715	<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 the facility's new patient pre-treatment policy and procedure had been implemented in 2 (#s 2 and 4) of 2 records reviewed of patients on service for less than 90 days creating the potential to affect all new facility patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's September 2010 "New Patient Pre-Treatment Evaluation" policy number 1-03-07 states, "A registered nurse (RN) as required by federal regulations will perform an initial pre-treatment evaluation of all new patients prior to the initiation of their first treatment at the facility." 2. Clinical record number 2 evidenced the patient's first date of dialysis at this facility was 5-6-13. The record failed to evidence the RN had performed an initial pre-treatment evaluation. 	V000715	<p>GFA will hold mandatory in-service for all RNs and Administrative Assistants on <i>Policy & Procedure #01-03-07 New Patient Pre-Treatment Evaluation</i> emphasizing Registered Nurse must perform initial pre-treatment evaluation of all new patients prior to initiation of first treatment at facility, pre-treatment evaluation must be documented on the New Patient Pre-Treatment Evaluation Form. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet.</p> <p>GFA or designee will conduct monthly Medical Record audit on 100% of new patient admissions to ensure the Initial RN Assessment is completed prior to first treatment and documentation placed in patient medical record. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to</p>	09/06/2013			

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	<p>3. Clinical record number 4 evidenced the patient's first date of dialysis at this facility was 6-13-13. The record failed to evidence the RN had performed an initial pre-treatment evaluation.</p> <p>4. Employee K, the Clinical Services Specialist, indicated, on 8-7-13 at 1:10 PM, records numbered 2 and 4 did not evidence the RN had performed an initial pre-treatment evaluation.</p>		<p>monitor ongoing compliance.</p> <p>The GFA and Medical Director are responsible for compliance with this POC</p>	