

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152514	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/03/2013
NAME OF PROVIDER OR SUPPLIER  MADISON DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 CLIFTY DR VILLAGE SQ STE K MADISON, IN 47250		
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V000000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 5/29, 5/30, 5/31, and 6/3/2013</p> <p>Facility #: 005159</p> <p>Medicaid Vendor #: 200024860D</p> <p>Surveyor: Dawn Snider, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>June 7, 2013</p>	V000000			

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

TITLE

(X6) DATE

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

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V000113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation and review of policy and procedure, the facility failed to ensure the dialysis treatment area was maintained to minimize the transmission of infectious agents for 1 of 6 (# 4) patient care observations with the potential to transmit disease causing organisms to all the facility's patients and staff.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 5/29/13 at 2:50 PM, employee E, a licensed practical nurse, was observed to discontinue the dialysis treatment for patient number 4 at station #4, machine # 9. The employee discarded the hemodialysis lines in a hazardous waste can, went back to the patient and removed the blood pressure cuff, and then touched the machine without changing her gloves and completing hand hygiene.</li> <li>Facility policy "Infection Control for Dialysis Facilities" with a revision date March 2012 policy number 1-05-01 states, "The Centers for Disease Control (CDC) 'Recommendations for Preventing</li> </ol>	V000113	<p>FA reviewed P&amp;P 1-05-01"Hand hygiene is to be performed upon entering facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area. All teammates to be inserviced and in compliance by 6/19/2013. FA will do infection control audit weekly times 3 weeks then montly as required to ensure compliance. Breaking of technique will be addressed when observed and failure to comply will result in additional education and further corrective action.</p>	06/19/2013			

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	<p>Transmission of Infections Among Chronic Hemodialysis Patients' (Dialysis Precautions) will be followed when caring for all patients . . . Hand hygiene is to be performed upon entering the facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area."</p> <p>3. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p>				

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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 facility policy review, observation, and interview, the facility failed to ensure staff cleaned and disinfected equipment as required during 2 of 2 days of observations creating the potential to spread infectious and communicable disease to all 19 in-center patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "INFECTION CONTROL FOR DIALYSIS FACILITIES" policy number 1-05-01 with a revision date of March 2013 states, " 47. Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables ... IV poles, as well as all work surfaces will be wiped clean with a bleach solution of appropriate strength after completion of procedures, before</p>	V000122	<p>On 6/14/13, FA reviewed P &amp; P 1-05-01: Infection Control for Dialysis Facilities with emphasis on the importance of cleaning all surfaces in the patient station between patients, including but not limited to the IV pole. Verification of attendance at in-service is evidenced by a signature sheet. Teammates verbalized understanding. FA or designee will do infection control audit weekly for 4 weeks then monthly to ensure compliance. Variances from policy will be addressed with the teammate involved. Audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will be addressed as necessary. The FA is responsible for compliance with the plan of correction (POC).</p>	07/03/2013	

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	<p>being used on another patient, after spills of blood, throughout the work day, and after each treatment."</p> <p>2. On 5/29/13 at 2 PM , employee F, patient care technician (PCT), was observed to clean machine #15. The PCT failed to clean the IV pole.</p> <p>3. On 5/29/13 at 2:50 PM, employee E, licensed practical nurse (LPN), was observed to clean machine #8. The LPN failed to clean the IV pole.</p> <p>4. On 5/29/13 at 3:03 PM, employee F, PCT, was observed to clean machine #9. The PCT failed to clean the IV pole.</p> <p>5. On 6/3/13 at 4:20 PM, employee C, the facility administrator, indicated all IV poles are supposed to be cleaned after each treatment.</p>				

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V000126	<p>494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Hepatitis B Vaccination</p> <p>Vaccinate all susceptible patients and staff members against hepatitis B.</p> <p>Based on personnel file review and staff interview, the facility failed to ensure all patient care staff had evidence of being vaccinated for Hepatitis B and or the serologic immune status in 1 (file K) of 9 personnel files reviewed of employees providing patient care with the potential to affect all Hepatitis B susceptible staff and patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file K, the Medical Director, failed to evidence documentation of being vaccinated for Hepatitis B or an immune status.</li> <li>2. On 6/5/13 at 3:20 PM, the facility administrator, employee C, indicated the medical director did not have any evidence of serologic testing or vaccination.</li> </ol>	V000126	<p>The FA has reviewed the standard of V126 and discussed with the Medical Director on 6/17/13. The FA will audit 100% of medical staff files to ensure documentation of vaccination for Hepatitis B or an immune status. FA will notify the medical staff of the requirement and obtain the required documentation of any medical staff member as needed. Medical staff files will be audited quarterly with the teammate files. The audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will be addressed as necessary. The FA is responsible for compliance with the plan of correction (POC).</p>	07/26/2013	

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V000147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on policy review and observation, the facility failed to ensure 2 of 2 employees (A and E) observed treating a patient with a central venous catheter (CVC) provided care in compliance with</p>	V000147	FA in-serviced teammates on 6/14/13 on policy 1-04-02C: Central Venous Catheter (CVC) Cleaning and Dressing Change with emphasis on the importance of using a clean, moisture proof barrier @ patients chair side table to put supplies on.	07/03/2013	

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	<p>central venous catheter policy creating the potential to spread infectious and communicable disease to all patients with a CVC.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "CENTRAL VENOUS CATHETER (CVC) CLEANING AND DRESSING CHANGE" policy number 1-04-02C with a revision date of March 2013 states, "Materials required: Clean, moisture proof barrier ... 5. Patient should be in comfortable supine position. Place non-sterile barrier under catheter to prevent contamination."</li> <li>2. On 5/30/2013 at 11:00 AM, employee E, a licensed practical nurse, was observed to perform a CVC dressing change on patient #10 at station #1. Employee E did not place supplies for the CVC on an opened moisture proof barrier. The supplies were kept folded up on the side table.</li> <li>3. On 5/31/13 at 3:00 PM, employee A, a registered nurse, was observed to perform a CVC dressing change on patient #8 at station #9. Employee A did not place supplies for the CVC on an opened moisture proof barrier.</li> </ol>		<p>Verification of attendance is evidenced by a signature sheet. Teammates verbalized understanding. FA or designee to perform random infection control audit weekly for 4 weeks then monthly to ensure compliance. Variances from policy will be addressed with the teammate involved. Audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will be addressed as necessary. The FA is responsible for compliance with the plan of correction (POC).</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2013

FORM APPROVED

OMB NO. 0938-0391

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V000196	<p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure total chlorine testing had been completed in accordance with facility procedure in 1 of 1 water test observed creating the potential to affect all of the</p>	V000196	On 6/14/13, the FA in-serviced teammates on policy 2-07-04J: Total Chlorine Test Using Stericheck Total Chlorine Test Kit with emphasis on the importance of wearing the required PPE including face protection, disposable gloves, fluid resistant/ fluid impervious barrier	07/03/2013	

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	<p>facility's 19 current patients.</p> <p>The findings include:</p> <p>1. On 5/31/13 at 1:00 PM , employee F, a patient care technician (PCT), was observed to perform a total chlorine test. The PCT failed to don gloves while performing the test. Employee F indicated she was supposed to wear gloves during the test.</p> <p>2. Facility policy "Total Chlorine Test Using Stericheck Total Chlorine Test Kit" with a revision date March 2010 policy number 2-07-04J states, "Materials required: . . . PPE - personal protective equipment (faces protection, disposable gloves, fluid resistant / fluid impervious barrier garment) . . . Put on PPE."</p>		<p>garment. Attendance is evidenced by a signature sheet. All teammates verbalized understanding. FA or designee to audit chlorine checks 3 times a week for 4 weeks then weekly for 4 weeks to assure compliance. On-going monitoring will be performed monthly with the biomed audit. Variances from policy will be addressed with the teammate involved. Audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will be addressed as necessary. The FA is responsible for compliance with the plan of correction (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 facility policy review, observation, and interview, the facility failed to ensure drugs and supplies were not expired and clinic staff followed facility policy and procedures to ensure expired medications and products were not available for use with the potential to affect all 19 patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "MEDICATION POLICY", policy number 1-06-01 with a revision March 2013, states, "27. All medications in the facility are checked monthly ... All medications are checked monthly for expiration dates. 29. Disposal of expired medications, including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations."</li> <li>2. On 5/31/13 at 9:05 AM, observation of the overhead cabinet located in the "Exam Room" identified 2 bottles of Fosrenol</li> </ol>	V000401	<p>All expired medications and supplies noted during the survey were disposed of immediately. All medications and supplies' expiration dates have been audited. The FA in-serviced teammates on 6/14/13 on policy 1-06-01: Medication Policy with emphasis on the importance of checking medications and nutritional product samples for expiration dates. Teammates were instructed that no other patient medications are to be kept in the facility except for the DaVita RX medications. Attendance verified by signature sheet. All teammates voiced understanding. The Clinical Coordinator has been designated to audit all medications, nutritional product samples, and emergency cart supplies for expiration dates monthly. The Administrative Assistant (AA) has been designated to audit lab supplies' expiration dates monthly. All supplies will be audited monthly with the facility's infection control audit. Audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will</p>	07/03/2013			

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	<p>1000 mg (milligram) 10 chewable tabs expired 2/2013, 1 box of Renvela 2.4 Gm (Gram) packets, labeled with a patient's name, 1 6 fluid ounce (oz) vanilla flavored Re Gen-Nutrabalance best used by 3/18/2011, 1 bottle of Requip 0.5 mg expired 9/2008, 1 box of Re Gen-Nutrabalance best used by 3/17/2011, 1 box containing 6 bottles with 7 tabs in each bottle of Sensipar 30 mg expired 10/12, 1 bottle of 1 fluid oz of Proteinex 100 calories expired 3/13, 1 bottle of Sensipar 90 mg 30 tabs labeled with a patient's name expired 5/12, 40 packets of Unifiber expired 9/09, 1 bottle of Kionex 454 Gms expired 7/2011, and 3 Sensipar 30 mg with 7 tabs in each expired 10/12.</p> <p>On 5/31/13 at 9:25 AM the facility administrator, employee C, indicated these were sample products that were expired and discarded.</p> <p>3. On 5/31/2013 at 3:09 PM observation of the emergency cart identified 16 individual Providine Iodine prep pads expired 2009.</p> <p>On 5/31/13 at 3:09 PM the facility administrator, employee C, indicated these were expired.</p> <p>4. On 5/31/2013 at 3:14 PM observation</p>		be addressed as necessary. The FA is responsible for compliance with the plan of correction (POC).		

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NAME OF PROVIDER OR SUPPLIER  MADISON DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 CLIFTY DR VILLAGE SQ STE K MADISON, IN 47250		
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	<p>of the overhead cabinet in the patient lab area identified 42 each 5 ml green top tubes expired 01/2010, 2 specimen containers for urine culture expired 11/2010.</p> <p>On 5/31/13 at 3:14 PM the facility administrator, employee C, indicated these were expired.</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.</p> <p>Based on clinical record review and facility policy review, the facility failed to ensure patients achieved the prescribed dose of dialysis by ensuring the ordered blood flow rate (BFR) was maintained in 1 (#1) of 5 records reviewed creating the potential to affect all of the facility's 19 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #1 included hemodialysis orders that identified the BFR was to be 400. The hemodialysis treatment flow sheet dated 5/17/13 evidenced a BFR of 350. The treatment flow sheet dated 5/29/13 evidenced a BFR of 325. There was no explanation documented for the variances in the BFR.</li> <li>Facility policy titled "INTRADIALYTIC TREATMENT MONITORING" policy number 1-03-09 with a revision date of March 2012 states, "9. The licensed nurse notifies the physician as needed of</li> </ol>	V000544	<p>FA in-serviced teammates on 6/14/13 on policy 1-03-09: Intradialytic Treatment Monitoring and policy 1-04-05: Blood Flow Problems with emphasis on notifying the nurse if unable to achieve the prescribed BFR and the importance of documenting findings, interventions, and the patient response in the medical record. Verification of attendance is evidenced by a signature sheet. FA or designee to audit post treatment 25% flowsheets daily for two weeks, then 25% weekly for four weeks, then 10% monthly for three months to ensure compliance. Audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and will be addressed as necessary. The FA is responsible for compliance with the plan of correction (POC).</p>	07/03/2013	

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	<p>changes in patient status. 10. All findings, interventions and patient response will be documented in the patient's medical record."</p> <p>3. Facility policy titled "BLOOD FLOW PROBLEMS" policy number 1-04-05 with a revision date of March 2011 states, "5. The licensed nurse will assess the patient, their vascular access and extracorporeal circuit for the above and include the following: Assess, the effectiveness of above interventions, Determine need to reduce blood flow and extend treatment time ... 6. Document findings and interventions in the patient's medical record."</p> <p>4. On 6/3/13 at 2:00 PM, the facility administrator, employee C, indicated documentation did not evidence the reason for the change in the BFR.</p>				

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V000715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on policy and procedure review, the medical director failed to ensure the facility had provided services in accordance with its own policies and procedures with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The medical director failed to ensure the facility followed its policy titled "INFECTION CONTROL FOR DIALYSIS FACILITIES" with a revision date March 2012 policy number 1-05-01 that states, "The Centers for Disease Control (CDC) 'Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients' (Dialysis Precautions) will be followed when caring for all patients . . . Hand hygiene is to be performed upon entering the facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact,</p>	V000715	<p>The Governing Body met on 6/17/13 to review the survey results and the plan of correction.</p> <p>V113-On 6/17/13, the FA reviewed P &amp; P 1-05-01: Infection Control for Dialysis Facilities with emphasis on the importance of appropriate glove changes and need to perform hand hygiene. The FA or designee will do infection control audit weekly times 4 weeks then monthly as required to ensure compliance.</p> <p>V122-On 6/14/13, the FA reviewed P &amp; P 1-05-01: Infection Control for Dialysis Facilities with emphasis on the importance of cleaning all surfaces in the patient station between patients, including but not limited to the IV pole. FA or designee will do infection control audit weekly for 4 weeks then monthly to ensure compliance.</p> <p>V126- The FA has reviewed the standard of V126 and discussed with the Medical Director on 6/17/13. The FA will audit 100% of medical staff files to ensure documentation of vaccination for Hepatitis B or an immune status. FA will notify the medical staff of the requirement and</p>	07/26/2013			

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	<p>between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area." (See V 113)</p> <p>2. The medical director failed to ensure the facility followed its policy titled "INFECTION CONTROL FOR DIALYSIS FACILITIES" policy number 1-05-01 with a revision date of March 2013 that states, "47. Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables ... IV poles, as well as all work surfaces will be wiped clean with a bleach solution of appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment." (See V 122)</p> <p>3. The medical director failed to ensure the facility followed its policy titled "CENTRAL VENOUS CATHETER (CVC) CLEANING AND DRESSING CHANGE" policy number 1-04-02C with a revision date of March 2013 that states, "Materials required: Clean, moisture proof barrier ... 5. Patient should be in comfortable supine position. Place non-sterile barrier under catheter to prevent contamination." (See V 126)</p>		<p>obtain the required documentation of any medical staff member as needed. Medical staff files will be audited quarterly with the teammate files.</p> <p>V196- All expired medications and supplies noted during the survey were disposed of immediately. All medications and supplies' expiration dates have been audited. The FA in-serviced teammates on 6/14/13 on policy 1-06-01: Medication Policy with emphasis on the importance of checking medications and nutritional product samples for expiration dates. Teammates were instructed that no other patient medications are to be kept in the facility except for the DaVita RX medications. The Clinical Coordinator has been designated to audit all medications, nutritional product samples, and emergency cart supplies for expiration dates monthly. The Administrative Assistant (AA) has been designated to audit lab supplies' expiration dates monthly. All supplies will be audited monthly with the facility's infection control audit.</p> <p>V544- FA in-serviced teammates on 6/14/13 on policy 1-03-09: Intradialytic Treatment Monitoring and policy 1-04-05: Blood Flow Problems with emphasis on notifying the nurse if unable to achieve the prescribed BFR and the importance of documenting findings, interventions, and the patient</p>				

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	<p>4. The medical director failed to ensure the facility followed its policy titled "Total Chlorine Test Using Stericheck Total Chlorine Test Kit" with a revision date March 2010 policy number 2-07-04J that states, "Materials required: . . . PPE - personal protective equipment (faces protection, disposable gloves, fluid resistant / fluid impervious barrier garment) . . . Put on PPE." (See V 196)</p> <p>5. The medical director failed to ensure the facility followed its policy titled "MEDICATION POLICY" policy number 1-06-01 with a revision March 2013 that states, " 27. All medications in the facility are checked monthly ... All medications are checked monthly for expiration dates. 29. Disposal of expired medications, including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations." (See V 401)</p> <p>6. The medical director failed to ensure the facility followed its policy titled "NTRADIALTIC TREATMENT MONITORING" policy number 1-03-09 with a revision date of March 2012 that states, "9. The licensed nurse notifies the physician as needed of changes in patient status. 10. All findings, interventions and patient response will be documented in</p>		<p>response in the medical record. Verification of attendance is evidenced by a signature sheet. FA or designee to audit post treatment 25% flowsheets daily for two weeks, then 25% weekly for four weeks, then 10% monthly for three months to ensure compliance. Verification of attendance at all in-services is evidenced by signature sheets. Teammates were allowed to ask questions and have verbalized understanding of policies. This plan of correction and all audit results will be reviewed in the Quality Improvement &amp; Facility Management Meeting (QIFMM) with the Medical Director and the FA will report progress, as well as any barriers to maintaining compliance, to the committee. The Medical Director is responsible for compliance with the plan of correction (POC).</p>		

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	<p>the patient's medical record." ( See V 544)</p> <p>7. The medical director failed to ensure the facility followed its policy titled "BLOOD FLOW PROBLEMS" policy number 1-04-05 with a revision date of March 2011 that states, "5. The licensed nurse will assess the patient, their vascular access and extracorporeal circuit for the above and include the following: Assess, the effectiveness of above interventions, Determine need to reduce blood flow and extend treatment time ...</p> <p>6. Document findings and interventions in the patient's medical record." (See V 544)</p>			