STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152539	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAD COUNTIES DIALYSIS	528 N GRANDSTAFF DR AUBURN, IN 46706

(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
V0000		V0000		

This was a federal ESRD recertification survey.

Survey Dates: 2/20/13 - 2/22/13

Facility #: 9710

Medicaid Vendor #: 200117050A

Surveyors: Ingrid Miller, RN, Public Health Nurse Surveyor

Census by Service Type:

Number of In-Center Hemodialysis Patients: 24
Number of Peritoneal Dialysis Patients: 0
Number of home hemodialysis patients: 0

Quality Review: Joyce Elder, MSN, BSN, RN
February 27, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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V0111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, interview and review of facility policies and procedures and documents, the facility failed to ensure sanitary policies were followed in 3 of 3 observations creating the potential to affect all of the facility's 24 patients. Findings Concerning a bleach container 1. On 2/20/12 at 10:40 AM, in the middle section of the dialysis treatment room, an opaque covered container was observed next to a handwashing sink on a counter area near patient stations #4 - 6. This unmarked opaque container held approximately 2 liters of liquid. 2. On 2/20/12 at 11:15 AM, Employee L, licensed practical nurse, indicated this container contained a bleach solution with 1 part bleach to 100 parts of water that had been made around 6 AM and that she had forgotten to mark the bleach with a label with the date, time, and her initials.	V0111	Facility Administrator (FA) immediately disposed of identified bleach solutions, prepared new bleach solution and correctly labeled container with expiration date, time and initials. Bleach containers marked for ease of mixing. Soiled Red Biohazard Container wiped down with bleach solution, and removed from treatment floor. Biohazard room thoroughly cleaned, and free of debris, tape will be placed on biohazard room floor dividing plastic storage pallets into two sections for empty and full containers, FA posted sign on the entry door to identify where empty and full containers are to be stored. FA will conduct mandatory in-service for all clinical Teammates (TMs) by 3/20/2013. In-service will include but not be limited to: review of *Policy& Procedure #1-05-08A Preparation of 1:10 Bleach Solution, Policy& Procedure #1-05-08B Preparation of 1:100 Bleach Solution, Policy & Procedure #1-05-01 Infection Control for Dialysis Facilities,* emphasizing 1) proper measuring, labeling and mixing of 1:10 and 1:100 bleach solutions	03/22/2013

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	3. The agency procedure titled "Preparation of 1:100 Bleach Solution" with an origination date of September 2007 and revision date of September 2008 stated, "Label container with the expiration date, time, initials, and hazard communication label. The solution is good for 24 hours only." Concerning the biohazard containers 4. On 2/20/13 at 10:40 AM, a large soiled red colored biohazard container with wheels on the base was noted near station #3 and the handwashing sink and treatment counter on the patient treatment floor. The container was covered in a brown substance. 5. On 2/20/13 at 1:25 PM, observation evidenced a small room to the rear of the dialysis clinic that stored both dirty and clean biohazard containers. (The clean containers are moved to the floor for use.) This room was observed to contain 6 biohazard containers with lids off on the left side of the room and 6 biohazard containers with lids on the right side of the room. The containers on the left side were speckled with mud and dust and had dark discoloration over the red color of the containers. The containers were stored on pallets. Staff wearing a gown who enter the room could contaminate the		with demo and return demonstration; 2) TMs must ensure biohazard containers do not come into direct contact with clean areas/supplies/surfaces, and equipment in patient station in efforts to prevent cross contamination. Any container identified as visibly soiled must be wiped with appropriate bleach solution and removed from treatment floor storing in biohazard room. 3) review of Blood Borne Pathogens; TMs must keep biohazard room clean, empty containers must be clearly separated from full containers; Ensuring clean areas are clearly designated and maintained; 4) TMs are to wear appropriate PPE whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces; TMs instructed that care must be taken to prevent PPE gown from touching floor or other dirty supplies/equipment to assist in preventing cross contamination; 5) TMs must perform hand hygiene every time gloves are removed. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. Infection Control Manager (ICM) will conduct infection control audits weekly x4 weeks, then monthly. FA will review audit results monthly with Medical	

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	gown as it could touch the containers on the floor. 6. On 2/20/13 at 1:25 PM, Employee D, the biomedical technician, indicated the small rear room housed the clean and dirty containers that were brought and hauled away by Stericycle, a collector of medical waste. Employee D indicated the clean containers on the left side of the room were soiled with mud and dust in the back storage room and one of the containers on the treatment floor also appeared soiled. The containers on the right side of the room were full and ready to be hauled away. The clean containers were moved to the floor for use. 7. The dialysis facility document titled "Medical Waste Management Document" with a date of 11/14/12 and signature of Employee B, facility administrator, stated, "The facility administrator ... is responsible for ensuring exposures to infectious agents are minimized throughout the process of handling and disposing of medical waste. This includes, but is not limited to, the use of protocols, procedures and training, personal protective equipment, and physical containment ... Off treatment / disposal location and method of treatment / disposal Treatment site .. Stericycle - Gary ... Treatment method: Autoclaved."		Director during Quality Improvement Facility Management Meetings (QIFMM), continued frequency of audits will be determined by the team. QIFMM Minutes will reflect. FA is responsible for compliance with this Plan of Correction (POC)	

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	Concerning handwashing after removing gloves 8. On 2/22/13 at 10:17 AM, Employee F, patient care technician, was observed with patient #1 to connect sterile syringes to each port and flush with sterile saline. After flushing, she removed her gloves and did not wash her hands. 9. On 2/22/13 at 2:25 PM, the facility administrator indicated that when gloves are removed hands should be washed. 10. The facility policy titled "Infection Control for Dialysis Facilities" with an effective date of 1/5/01 and revised date of March 2012 stated, "Hand hygiene is to be performed ... after removal of gloves."			

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V0113	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. Based on observation, policy review, and interview, the facility failed to ensure staff performed hand hygiene appropriately after removing gloves during the provision of care in 1 of 3 observations of care on the treatment floor creating the potential to affect all of the facility's 24 patients. Findings 1. On 2/22/13 at 10:17 AM, Employee F, patient care technician, was observed with patient #1 to connect sterile syringes to each port and flush with sterile saline. After flushing, she removed her gloves and did not wash her hands. 2. On 2/22/13 at 2:25 PM, the facility administrator indicated hands should be washed after gloves are removed. 3. The facility policy titled "Infection Control for Dialysis Facilities" with an effective date of 1/5/01 and revised date of March 2012 stated, "Hand hygiene is to be performed ... after removal of gloves."	V0113	FA will conduct mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities,* emphasizing 1) TMs must wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station.; 2) TMs must remove gloves and perform hand hygiene between each patient and station; 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart; 4) TMs must perform hand hygiene every time gloves are removed. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. ICM will conduct infection control audits, weekly x4 weeks, and then monthly. FA will review audit results monthly with Medical Director during QIFMM, continued frequency of audits will be determined by the team. QIFMM Minutes will reflect. FA is responsible for compliance with this Plan of Correction	03/22/2013

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V0121	494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [The facility must demonstrate that it follows standard infection control precautions by implementing-] (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the- (i) Handling, storage and disposal of potentially infectious waste; Based on observation, interview, and review of facility documents, the facility failed to ensure potentially infectious waste containers were clean and stored properly in 1 of 3 observations and 1 of 1 observation of the biohazard room creating the potential to affect all of the facility's 24 patients. Findings 1. On 2/20/13 at 10:40 AM, a large soiled red colored biohazard container with wheels on the base was noted near station #3 and the handwashing sink and treatment counter on the patient treatment floor. The container was covered in a brown substance. 2. On 2/20/13 at 1:25 PM, observation evidenced a small room to the rear of the dialysis clinic that stored both dirty and	V0121	Soiled Red Biohazard Container wiped down with bleach solution, and removed from treatment floor. Biohazard room thoroughly cleaned, and free of debris, tape will be placed on biohazard room floor dividing plastic storage pallets into two sections for empty and full containers, FA posted sign on the entry door to identify where empty and full containers are to be stored. FA will conduct mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy & Procedure #1-05-01 Infection Control for Dialysis Facilities,* emphasizing 1) TMs must ensure biohazard containers do not come into direct contact with clean areas/supplies/surfaces, and equipment in patient station in efforts to prevent cross contamination. Any container identified as visibly soiled must be wiped with appropriate bleach solution and removed from treatment floor storing in	03/22/2013

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	clean biohazard containers. (The clean containers are moved to the floor for use.) This room was observed to contain 6 biohazard containers with lids off on the left side of the room and 6 biohazard containers with lids in place on the right side of the room. The containers on the left side were speckled with mud and dust and had dark discoloration over the red color of the containers. The containers were stored on pallets. Staff wearing a gown who enter the room could contaminate the gown as it could touch the containers on the floor. 3. On 2/20/13 at 1:25 PM, Employee D, the biomedical technician, indicated the small rear room housed the clean and dirty containers that were brought and hauled away by Stericycle, a collector of medical waste. Employee D indicated the clean containers on the left side of the room were soiled with mud and dust in the back storage room and one of the containers on the treatment floor also appeared soiled. The containers on the right side of the room were full and ready to be hauled away. The clean containers were moved to the floor for use. 4. The dialysis facility document titled "Medical Waste Management Document" with a date of 11/14/12 and signature of Employee B, facility administrator, stated,		biohazard room. 2) review of Blood Borne Pathogens; TMs must keep biohazard room clean, empty containers must be clearly separated from full containers; Ensuring clean areas are clearly designated and maintained; 4) TMs are to wear appropriate PPE whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces; TMs instructed that care must be taken to prevent PPE gown from touching floor or other dirty supplies/equipment to assist in preventing cross contamination; Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. ICM will conduct infection control audits, weekly x4 weeks, and then monthly. FA will review audit results monthly with Medical Director during QIFMM, continued frequency of audits will be determined by the team. QIFMM Minutes will reflect. FA is responsible for compliance with this Plan of Correction	

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	"The facility administrator ... is responsible for ensuring exposures to infectious agents are minimized throughout the process of handling and disposing of medical waste. This includes, but is not limited to, the use of protocols, procedures and training, personal protective equipment, and physical containment ... Off treatment / disposal location and method of treatment / disposal Treatment site .. Stericycle - Gary ... Treatment method: Autoclaved."			

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V0196	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. Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet. 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. Based on observation, interview, and review of procedures, the facility failed to ensure the chlorine testing had been completed in accordance with facility policy and procedure in 1 of 2 water tests observed creating the potential to affect	V0196	Clock with second hand placed in water room for use during chlorine checks. Biomedical Technician (BMT) will hold mandatory in-service for all TMs responsible for water treatment monitoring by 3/20/2013. In-service will include	03/22/2013

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	all of the facility's 24 patients. The findings include 1. On 2/20/13 at 12:55 PM, Employee G, patient care technician, was observed to complete a routine water test for chlorine using a Hach Pocket Colorimeter by adding the contents of the N, N-diethyl-p-phenylene-diamine (DPD) Total Chlorine Reagent Powder Pillow to the reverse osmosis water sample in a small glass container, putting a cap on the sample, and then gently shaking the water and powder in the capped container for unknown amount of time. She conducted the water test without using a timing device to ensure the contents of the sample and powder were thoroughly mixed for 20 seconds. 2. On 2/20/13 at 12:55 PM, Employee G indicated counting to 23 seconds in her head for the required 20 seconds while mixing the DPD Total Chlorine Reagent Powder with the reverse osmosis water sample. 3. On 2/20/13 at 1 PM, Employee C, Registered Nurse, indicated Employee G should count the required 20 seconds with a timing device while mixing the DPD Total Chlorine Reagent Powder with the reverse osmosis water sample.		but not be limited to: review *of Policy& Procedure # 2-07-04 Daily Water System Total Chlorine Monitoring, Policy & Procedure# 02-07-04D Total Chlorine Test Using HACH Pocket Colorimeter, and Routine Chlorine Testing Log*. TMs must use clock with second hand that is available in Water Room to ensure correct time during chlorine testing. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will conduct observational audits weekly x 2, then monthly. Results of the audits will be reviewed with Medical Director during monthly QIFMM, minutes will reflect. FA is responsible for compliance with this Plan of Correction	

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	4. The facility procedure titled "Total Chlorine Test Using Hach Pocket Colorimeter" with an origination date of 8/06 and revision date of September 2011 stated, "Open the pillow and form a spout by squeezing the side edges, pour the pillow contents into the sample cell cap, and gently shake the sample and DPD powder for 20 seconds."			

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V0226	494.40(a) MIX SYS-DFU/MONITOR/PM/LOG/SANITIZE 5.4.4.1 Mixing systems: follow DFU/monitor/PM/log/sanitization If a concentrate mixing system is used, the preparer should follow the manufacturer's instructions for mixing the powder with the correct amount of water. If a concentrate mixing system is used, the number of bags or the weight of powder added should be determined and recorded. Manufacturer's recommendations should be followed regarding any preventive maintenance and sanitization procedures. Records should be maintained indicating the date, time, person performing the procedure, and results (if applicable). 6.4.1 Mixing systems: Systems for preparing either bicarbonate or acid concentrate from powder should be monitored according to the manufacturer's instructions. Based on document review, interview, and policy review, the facility failed to ensure the bicarbonate concentrate system mixing was completed as required by the manufacturer's instructions and per policy for 1 of 1 observation of the bicarb concentrate mixing system with the potential to affect all 24 patients of the facility. Findings	V0226	The measurement of 95L marked with a bold black line on the side of the bicarbonate tank was removed per Biomed. FA will conduct mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy & Procedure #2-04-01 Bicarbonate Concentrate System Mixing.* TMs must perform all bicarbonate concentrate mixing in accordance with the bicarbonate manufacturer's recommendations. TMs educated	03/22/2013

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	1. On 2/22/13 at 7:46 AM, Employee L, licensed practical nurse, was observed to add 90 liters of dialysis quality water to a translucent tank in the bicarb mixing room and then added one bag of 45X Naturalyte 4000 Rx - 12 dry pack for bicarbonate dialysis to a tank with 95 liters of water. This amount of water did not meet the manufacturer's requirement of 96 liters. The measurements were noted on the side of the tank by one liter increments. The 95 liter mark was marked with a bold black line. 2. On 2/22/13 at 7:46 AM, Employee L indicated the 95 liter mark was used for this procedure. 3. The policy titled "Bicarbonate Concentrate System Mixing" with a date of 2/4/01 and review date of March 2012 stated, "Manufacturer's Direction for use [DFU] for central and noncentral bicarb mixing and delivery units for hemodialysis are to be followed. Current manufacturer's DFU are required to be present in the facility." 4. The bicarb base concentrate came in an undated bag titled "45 X Naturalyte 4000 RX - 12 dry pack for bicarbonate dialysis" that stated, "Directions for use ... Add water for a total volume of 96 liters."		that during bicarbonate concentrate mixing procedures quality water must be added for a total volume of 96 liters. TMs educated not performing bicarbonate concentrate mixing in accordance with the bicarbonate manufacturer's recommendations could have the potential to affect 100% of facility patient census. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will conduct observational audits weekly x 2, then monthly. Results of the audits will be reviewed with Medical Director during monthly QIFMM, minutes will reflect. FA is responsible for compliance with this Plan of Correction	

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V0401	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. Based on observation and interview, the facility failed to ensure medications were labeled correctly in 1 of 3 observations of the medication preparation area (2/20/13) and failed to ensure laboratory supplies were not expired in 1 of 1 observations of the laboratory area (2/20/13) creating the potential for an unsafe or healthy environment for the 24 active patients. Findings Regarding medications 1. Observation on 2/20/13 at 10:40 AM evidenced 4 - 3 milliliter syringes filled with Heparin for patients #7 and #8 were lying on a counter top in the medication preparation area. The heparin syringes failed to be labeled to identify the nurse who prepared the nurse who prepared the medication and the date / time drawn. Also, an Epogen vial with 2 milliliters of 20000 units of epogen was observed open without being labeled with a date and time and initials of who had opened the vial.	V0401	Expired Lab tubes were immediately discarded. Expiration dates on all facility supplies, and medications were verified not to be expired by FA. FA will conduct mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy & Procedure # 1-05-01 Infection Control for Dialysis Facilities, Policy & Procedure # 1-06-01 Medication Policy* emphasizing 1) TMs must properly label all opened medications vials with date, time, initials of person opening the vial. If medication is not immediately administered, the medication must be labeled with patient name, name of medication, date, time prepared, dose and initials of TM preparing medication; 2) importance of verifying all facility medications, solutions and supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs were educated that using expired items could have the potential to affect 100% of facility patient census. Attendance of in-service is evidenced by TMs	03/22/2013

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	2. On 2/20/13 at 10:35 AM, Employee J, Registered Nurse, indicated the above medications were not labeled correctly. Regarding the lab supplies 3. On 2/20/13 at 1:40 PM in the lab area, 18 bottles of BD Bactec Lytic 10 Anaerobic Culture were observed with an expiration date of 11/30/12 and 18 bottles of BD Bactec Plus Aerobic F Culture were observed with expiration dates of 11/30/12. 4. On 2/22/13 at 2:05 PM, the facility administrator indicated lab supplies should not be expired.		signature on the Clinical In-Service Form. FA or designee will conduct observational audits of medication draws weekly x 2, then monthly. FA or designee will check facility inventory monthly to verify all facility medications, solutions and supplies are checked for expiration in stock or available for use on treatment floor. Compliance will be assured by FA/designee audit of facility monthly logs. Results of audits will be reviewed with Medical Director during QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. FA is responsible for compliance with this Plan of Correction	

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V0403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. Based on document review, policy review, and interview, the dialysis facility failed to ensure the the phoenix meter was calibrated daily for 2 of 2 phoenix meters (instrument used to measure pH and conductivity of dialysate) with the potential to affect all of the dialysis hemodialysis patients. Findings 1. The dialysis facility document titled "Phoenix Meter Log" with an effective date of February 2013 failed to evidence the phoenix meter had been calibrated on 2/18/13 and 2/20/13 (treatment dates of the facility). 2. On 2/20/13 at 10:50 AM, the facility administrator indicated the phoenix meter calibration had not been logged on the two dates noted in finding #1. 3. The facility policy titled "Phoenix meter disinfection and calibration	V0403	BMT will hold mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy & Procedure #2-04-06I Phoenix Meter Disinfection and Calibration Verification*, emphasizing the Phoenix Meter must be disinfected and verified prior to daily use, after disinfection, calibration of the Phoenix Meter is verified prior to daily use or whenever inaccurate readings are suspected. TMs must ensure proper documentation of calibration on Phoenix Meter Log. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will conduct daily audit review of Phoenix Meter Log x 1 week, then weekly to ensure proper calibration and documentation in accordance to manufacturer standards. Results of audits will be reviewed with Medical Director during QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect.	03/22/2013

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	verification"with an origination date of August 2006 and revision date of March 2012 stated, "After disinfection, calibration of the Phoenix meter is verified prior to daily use or whenever inaccurate readings are suspected."		FA is responsible for compliance with this Plan of Correction	

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V0715	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 review, interview, and policy review, the medical director failed to policies related to treatment initiation were followed for 2 of 5 (2 and 4) clinical records reviewed with the potential to affect all 24 hemodialysis patients. Findings 1. Clinical record #2 included a hemodialysis flow sheet that evidenced Employee G, patient care technician (PCT), completed the pretreatment assessment and placed the patient on hemodialysis treatment on 1/30/13 at 11:09 AM. Employee B, Registered Nurse, completed the pretreatment data collection assessment at 12:30 PM on the same day. This was more than 1 hour after the initiation of dialysis treatment. 2. Clinical record #4 included a hemodialysis flow sheet that evidenced Employee F, PCT, completed the pretreatment assessment and placed the	V0715	FA will conduct mandatory in-service for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of *Policy& Procedure # 1-03-08: Treatment Initiation Patient Assessments,* 1) patient care staff must obtain and document basic data on each patient pre dialysis, findings that may preclude the initiation of dialysis must be reported to licensed nurse, licensed nurse determines the need to intervene, assesses patient immediately collecting any additional data needed; 2) Assessment data includes: Weight, Temperature, Blood Pressure, Cardiac status, Respiratory Status, Peripheral Edema, Vascular Access, Mental Status, and Ambulatory Status, Recent hospitalization or outpatient facility visits; 3) All findings, interventions and patient response will be documented in patient's medical record, 4) Data must be compared to previous findings, and licensed nurse must contact physician if indicated of changes in patient status. Charge nurse is responsible for daily	03/22/2013

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	patient on hemodialyis treatment on 2/15/13 at 3:19 PM. The pretreatment data collection assessment completed by Employee B, Registered Nurse, occurred at 4:26 PM on the same day. This was more than 1 hour after the initiation of dialysis treatment. 3. On 2/22/13 at 2 PM, the facility administrator indicated the registered nurse completed the above assessments late. 4. The policy titled "Treatment Initiation patient assessment" with a revision date of March 2011 stated, "The licensed nurse determines the need to intervene and assess the patient immediately or allowable by state law completes the assessment within the first hour of dialysis and collects any additional data needed." Indiana does not have a state law allowing the nurse to complete the assessment within the first hour.		monitoring. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will perform audits for 25% of treatment sheets weekly x 4 weeks, then monthly. Results of audits will be reviewed with Medical Director QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. FA is responsible for compliance with this Plan of Correction	