

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152574	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2015
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NAME OF PROVIDER OR SUPPLIER TELL CITY DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1602 MAIN ST TELL CITY, IN 47586
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V 000 Bldg. 00	This was a Federal ESRD [CORE] recertification survey. Survey Dates: 5-27-15, 5-28-15, & 5-29-15 Facility #: 002988 Medicaid Vendor #: 200315330H QR: JE 6/2/15	V 000		
V 122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [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-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, interview, and review of facility policy, the facility failed to ensure dialysis machines and stations had been cleaned and disinfected in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis machine and station observations completed. (employees A, B, and D)	V 122	V122 100% of clinical teammates were in-serviced on 6/3/2015 on Policy # 1-05-01 "Infection Control for Dialysis Facilities". Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Teammates will	07/03/2015

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

TITLE

(X6) DATE

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

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	<p>The findings include:</p> <p>1. Employee B, a registered nurse (RN), was observed to clean the dialysis machine at station number 1 on 5-27-15 at 2:35 PM. The RN was not observed to clean and disinfect the prime waste bucket or the dialysate hoses. The RN was not observed to clean the data entry station or the countertops around the dialysis station.</p> <p>The RN was observed to clean the dialysis chair at station number 1 after cleaning the dialysis machine. The RN was not observed to clean the fronts of the arms of the chair where patients place their hands.</p> <p>2. Employee D, a licensed practical nurse (LPN) was observed to clean the dialysis machine at station number 2 on 5-29-15 at 9:20 AM. The LPN was not observed to clean the dialysate hoses. The LPN was observed to drop the cloth being used to clean the dialysis machine on the floor. The LPN was observed to pick the cloth up, wrap it in another cloth, and continue to clean the front of the dialysis machine. The LPN was not observed to clean the data entry station or the countertops around the dialysis station.</p>		<p>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...</p> <p>2) Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates... 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, after spills of blood, throughout the work day, and after each treatment, and 3) Priming containers are to be emptied and flushed with water. The interior and exterior should be wiped down with 1:100 (one to one hundred) bleach solution and rinsed thoroughly with water before using on next patient treatment. The Charge Nurse is responsible for oversight of infection control practice daily. Instances of non-compliance will be addressed with the teammate immediately. The Facility Administrator (FA) or designee will conduct observational infection control audits on random shifts 3 x a week for 1 month, then monthly with the regularly scheduled infection control audits. Results of the audits will be reviewed with the</p>	

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	<p>Employee A, a RN, was observed to clean the dialysis chair at station number 2 at this time. The RN was not observed to clean the fronts of the arms of the chair where patients place their hands.</p> <p>3. The above-stated findings were discussed with the facility administrator, employee E, on 5-29-15 at 9:30 AM. The administrator indicated the employees had not cleaned and disinfected the dialysis machine and station in accordance with facility policy.</p> <p>4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "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 . . . Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates . . . as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of</p>		<p>Medical Director during the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this Plan of Correction (POC).</p> <p>Completion Date: 07/03/15</p>		

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V 260 Bldg. 00	<p>procedures, before being used on another patients, after spills of blood, throughout the work day, and after each treatment. Priming containers are to be empties and flushed with water. The interior and exterior should be wiped down with 1:100 (one to one hundred) bleach solution and rinsed thoroughly with water before using on next patient treatment."</p> <p>494.40(a) PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS 9 Personnel: training program/periodic audits A training program that includes quality testing, the risks and hazards of improperly prepared concentrate, and bacterial issues is mandatory.</p> <p>Operators should be trained in the use of the equipment by the manufacturer or should be trained using materials provided by the manufacturer.</p> <p>The training should be specific to the functions performed (i.e., mixing, disinfection, maintenance, and repairs).</p> <p>Periodic audits of the operators' compliance with procedures should be performed.</p> <p>The user should establish an ongoing training program designed to maintain the operator's knowledge and skills.</p> <p>Based on personnel file and facility document review and interview, the facility failed to ensure staff audits for the</p>	V 260	V260 Facility Administrator and Clinical Preceptor will complete Annual procedural skills verification	06/26/2015

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	<p>performance of bicarbonate and acid concentrate mixing had been completed at least annually in 4 (files A, C, D, and E) of 4 files reviewed of individuals that perform bicarbonate and acid concentrate preparation.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A identified the individual as a registered nurse (RN) with a hire date of 5-25-10. The file failed to evidence the individual had been audited for compliance with the facility's acid concentrate and bicarbonate preparation procedures at least annually. The file evidenced the RN had been audited on 4-30-13 for acid concentrate preparation and on 6-12-12 for bicarbonate preparation. 2. Personnel file C identified the individual as a licensed practical nurse (LPN) with a hire date of 12-1-13. The file failed to evidence the individual had been audited for compliance with the facility's acid concentrate procedures at least annually. The file evidenced the LPN had been audited on 7-31-13 for acid concentrate preparation. The file failed to evidence any audits had been completed for the preparation of bicarbonate since orientation. 		<p>checklists on all clinical teammates annually. Teammates were in-serviced on 6/3/2015 on periodic audits of teammate skills related to water start up, total chlorine testing, and bicarbonate mixing. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Annual verification on training of Acid and Bicarbonate mixing procedures. Teammate training on the water system, water room components, bicarbonate and acid concentrate mixing are conducted upon hire and annually. Annual training includes completion of skills checklists administered by the Biomedical Technician, as well as computer-based training and testing. Skills checklists and learning transcripts are placed in teammate file upon completion of training annually. The FA or designee will conduct an employee file audit on 100% of teammate files immediately to verify that any teammate performing water monitoring or bicarbonate mixing has an updated annual skills checklist. Ongoing compliance will be monitored by quarterly teammate file audits. Personnel A, C, D, and E will have a completed skills checklist for water start up, acid concentrate mixing, and bicarbonate mixing completed by 6/26/15. . Results of the audits will be reviewed with the Medical Director during the monthly FHM.</p>		

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	<p>3. Personnel file D identified the individual as an LPN with a hire date of 10-15-12. The file failed to evidence the individual had been audited for compliance with the facility's acid concentrate and bicarbonate preparation procedures at least annually. The file evidenced the LPN had been audited on 1-10-13 for both acid concentrate and bicarbonate preparation.</p> <p>4. Personnel file E identified the individual as a patient care technician (PCT) hired on 4-23-05. The failed to evidence the individual had been audited for compliance with the facility's acid concentrate and bicarbonate preparation procedures at least annually. The file evidenced the PCT had been audited on 4-30-13 for acid concentrate preparation and on 6-15-12 for bicarbonate preparation.</p> <p>5. The facility administrator, employee E, indicated, on 5-28-15 at 1:40 PM, the employees had not been audited at least annually for compliance with the facility's acid concentrate and bicarbonate preparation procedures.</p> <p>6. The facility administrator stated, on 5-28-15 at 2:00 PM, the audits were to be done annually. The administrator provided a copy of the facility's "Annual</p>		<p>The Facility Administrator is responsible for ongoing compliance with this POC.</p> <p>Completion Date: 6/26/15</p>				

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V 356 Bldg. 00	<p>Procedural Skills Verification Checklist" for both licensed personnel and dialysis technicians and indicated these were "facility policy."</p> <p>494.50(b)(1) RECORD ADV EVENTS/DIALYZER C/O LOG 13.2.3 Recording: adverse events dialyzer complaint log Any significant events such as the occurrence of symptoms listed in [AAMI] 13.2.1 and 13.2.2 should be recorded on an incident report form which would include the results of any evaluations conducted by the physician and others, and the event should be considered for reporting to the manufacturer(s) in accordance with the FDA's Medical Device User Reporting procedures. The resolution of actual or suspected problems caused by reprocessed dialyzers should be indicated. This form should be kept in the complaint investigation record file (see [AAMI] 4.5).</p> <p>4 Records 4.5 Complaint investigation record Records shall be kept of all complaints by patients and staff members about failures of preprocessed and reprocessed dialyzers or possible adverse reactions to any dialyzers; the results of a comprehensive investigation of these alleged problems; and, if appropriate, the corrective actions taken. The records shall be reviewed periodically for trends of adverse reactions. Compliance with the FDA's Medical Device User Reporting procedures shall be demonstrated.</p>			
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	<p>Based on reuse record and facility policy review and interview, the facility failed to ensure complaint investigation records had been completed as required in 4 (January, February, April, and May 2015) of 5 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's dialyzer failure log for January 2015 evidenced a failed dialyzer for patient number 5 on 1-19-15 due to "pressure" The complaint investigation log failed to evidence an investigation had been completed. 2. The facility's dialyzer failure log for February 2015 evidenced a failed dialyzer for patient number 3 on 2-2-15 due to "clotted" and patient number 7 on 2-23-15 due to "pressure". The complaint investigation log failed to evidence investigations had been completed. 3. The facility's dialyzer failure log for April 2015 evidenced a failed dialyzer for patient number 1 on 4-3-15 due to "clotted". The complaint investigation log failed to evidence an investigation had been completed. 4. The facility's dialyzer failure log for May 2015 evidenced a failed to dialyzer 	V 356	<p>V356</p> <p>100% of clinical teammates were in-serviced on 6/3/2015 on Policy # 6-01-13 "Complaint Investigation Record". Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) A Complaint Investigation Record is maintained that includes all patient and teammate complaints related to preprocessed and reprocessed dialyzers. A Complaint Investigation Record is completed for the following...Clotted (during dialysis treatment)...Pressure Failure, Visual Inspection.</p> <p>Facility Administrator or designee will audit Complaint Investigation Records weekly x 4 weeks and then monthly x 2 months. Reuse Tech will then continue to check monthly failed dialyzers to ensure that all complaint investigation records have been completed for month in review. All records will be discussed with Medical Director during Monthly FHM. Facility Administrator is responsible for ongoing compliance with this POC.</p> <p>Completion Date: 8/7/15</p>	08/07/2015

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V 401 Bldg. 00	<p>for patient number 8 for "pressure", for patient number 6 for "visual inspection", for patient number 9 for "pressure", and for patient number 10 for "pressure", all on 5-12-15. The log failed to evidence complaint investigations had been completed.</p> <p>5. The facility administrator, employee E, was unable to provide any additional documentation and/or information when asked on 5-28-15 at 3:00 PM.</p> <p>6. The facility's September 2013 "Complaint Investigation Record" policy number 6-01-13 states, "A Complaint Investigation Record is maintained that includes all patient and teammate complaints related to preprocessed and reprocessed dialyzers. A Complaint Investigation Record is completed for the following: . . . Clotted (during dialysis treatment) . . . Pressure Failure, Visual Inspection."</p> <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. Based on observation, interview, and</p>	V 401	V401	08/07/2015

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	<p>facility policy review, the facility failed to ensure the central solution delivery system had been maintained in 4 (#s 1, 2, 4, and 9) of 9 stations observed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 5-29-15 at 11:35 AM, observation noted 12 dialysis stations with chase cabinets lining the perimeter of the dialysis treatment floor. The cabinets housed the central solution delivery system and had countertops with doors that could be lifted to view the inside of the cabinets. The outside of the cabinets were inset with piping that delivered 2 types of acid concentrate, bicarbonate solution, and water. A small amount of a white, crystalline substance was noted on the 2K (potassium) 2.5 Ca (calcium) port at station number 1. A small amount of the substance was also noted on the floor in the cabinet. A small amount of a white, crystalline substance was noted on the 3K 2.5 Ca port at station number 2. A small amount of a white, crystalline substance was noted on the 3K 2.5 Ca port at station number 4. A large amount of the substance was noted on the floor in 		<p>100% of clinical teammates were in-serviced on 6/3/2015 on Policy # 8-04-01 "Physical Environment". Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using the surveyor observations as examples with emphasis on, but not limited to, the following: 1) the dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. Biomedical Technician (BMT) will check chase cabinets weekly x4 weeks. Ongoing compliance will be monitored by the BMT when performing the monthly disinfect. Teammates will also notify Biomed of any issues at the time they are noticed so repairs can be made in a timely manner. Facility Administrator will conduct observational audits of the chase cabinets monthly x 3 months. Results of audits will be reviewed with Medical Director during monthly FHM. The FA is responsible for ongoing compliance with this POC.</p> <p>Completion Date: 8/7/15</p>		

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V 550 Bldg. 00	<p>the cabinet.</p> <p>5. A small amount of a yellow gelatinous substance was noted on the 2K 2.5 port at station number 9. The biomedical technician, employee H, stated, "That is acid. There is a leak."</p> <p>6. The biomedical technician, employee H, stated, on 5-29-15 at 11:35 AM, "The white crystals are dried acid. I check these every month when I disinfect. They must have leaked since I checked them last."</p> <p>7. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other</p>						

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	<p>risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure staff had provided appropriate access care prior to the initiation of the dialysis treatment in 2 (#s 1 and 2) of 2 access of arteriovenous fistula (AVF) or graft (AVG) for initiation of dialysis observations completed. (Employees A and B)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee B, a registered nurse (RN), was observed to initiate the dialysis treatment on patient number 5 using an AVF on 5-27-15 at 10:05 AM. Observation noted the patient was brought into the treatment room via a wheelchair and then assisted to the dialysis chair. The RN was observed to initiate the treatment on the patient. The RN was not observed to wash the access with soap and water or ask the patient if the patient had washed the access with soap and water prior to starting the initiation procedure. Employee A, a RN, was observed to initiate the dialysis treatment on patient number 6 using an AVF on 5-27-15 at 11:25 AM. Observation noted the patient 	V 550	<p>V550</p> <p>100% of clinical teammates were in-serviced on 6/3/2015 on Policy # Policy 1-04-01 "Vascular Access Care" and Policy # 1-04-01E "AV Fistula or Graft Cannulation with NIPRO or Medisystems Safety Fistula Needles and Administration of Heparin". Verification of teammates in-service is evidenced by a signature sheet. Teammates were instructed using survey or observations as examples with emphasis on, but not limited to, the following: 1) Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry, and 2) Have patient wash access site with appropriate antibacterial soap, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry. The Facility Administrator or designee will conduct observational audits on random shifts 3 x per week for 4 weeks. Ongoing compliance will be monitored with the monthly infection control audit. Results of audits will reviewed with Medical Director during monthly FHM. The Facility Administrator is responsible for ongoing compliance with this POC.</p>	08/07/2015

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	<p>walked into the treatment room and proceeded to the dialysis chair. The RN was observed to initiate the treatment on the patient. The RN was not observed to wash the access with soap and water or ask the patient if the patient had washed the access with soap and water prior to starting the initiation procedure.</p> <p>3. The above-stated findings were discussed with the facility administrator, employee E, on 5-29-15 at 9:30 AM. The administrator indicated the employees had not initiated the dialysis treatments using an AVF in accordance with facility policy.</p> <p>4. The facility's March 2015 "Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care" policy number 1-04-01 states, "Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry."</p> <p>The facility's March 2015 "AV Fistula or Graft Cannulation with Nipro or Medisystem Safety Fistula Needles (SFN) and Administration of Heparin" procedure number 1-04-01E states,</p>		Completion Date: 8/7/15	

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NAME OF PROVIDER OR SUPPLIER TELL CITY DIALYSIS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1602 MAIN ST TELL CITY, IN 47586		
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V 559 Bldg. 00	<p>"Have patient wash access site with appropriate antibacterial soap, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry."</p> <p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the plan of care included an identification of barriers to reaching fluid volume goals and adjustments to address the identified barriers in 1 (# 3) of 4 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included physician orders dated 2-27-15 that</p>	V 559	<p>V559</p> <p>Interdisciplinary Team (IDT) was in-serviced on 6/3/2015 on Policy # 1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis". Verification of teammates in-service is evidenced by a signature sheet. Teammates were instructed using survey or observations as examples with emphasis on, but not limited to, the following: 1) In addition, if the expected outcome is not achieved, the interdisciplinary</p>	08/07/2015	

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	<p>identified the patient's estimated dry weight (EDW, the desired weight at the end of the dialysis treatment) was 84 kilograms (kg) and that the EDW had been increased to 85 kg on 5-15-15.</p> <p>A. A hemodialysis treatment flow sheet dated 5-3-15 evidenced the patient's weight at the end of the treatment was 86.7 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 5-4-15 evidenced 5.3 kg had been removed during the treatment (greater than 5% of the EDW).</p> <p>C. A hemodialysis treatment flow sheet dated 5-6-15 evidenced the patient's weight at the end of the treatment was 86.3 kg and that 5.5 kg (greater than 5% of the EDW) had been removed during the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 5-8-15 evidenced 4.8 kg (greater than 5% of the EDW) had been removed during the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 5-11-15 evidenced 5.5 kg (greater than 5% of the EDW) had been removed during the treatment.</p> <p>F. A hemodialysis treatment flow</p>		<p>team (or individual IDT member) will adjust the patient's plan of care to achieve the specified goal. When a patient is unable to achieve the desired outcomes, the team will:</p> <p>Adjust the plan of care to reflect the patient's current condition.</p> <p>Document in the patient's medical record the reasons why the patient is unable to achieve the goals.</p> <p>Implement plan of care changes to address the issues identified. The physician will be notified of each patient that is discharged from treatment >2 kilograms (Kg) above or below their prescribed dry weight for assessment and adjustment of the physician's order for dry weight.</p> <p>Each patient in the facility will be evaluated at least monthly by the Interdisciplinary team (IDT) during core team meeting to identify any potential patient concerns/needs including but not limited to adherence with fluid restrictions. Pt identified as Clinical Record #3 during the survey will have a re-assessment and plan of care completed by 7/1/15 to address the fluid volume goal and issues. The FA or designee will audit 100% post treatment flow sheets daily for one week, and then 25% of flow sheets weekly for 4weeks to verify that patients discharged from treatment >2 kilograms (Kg) above or below their prescribed dry weight are brought to the physician's attention. Ongoing compliance will be monitored by 10% of flow sheets monthly per the medical record</p>		

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	<p>sheet dated 5-13-15 evidenced the patient's weight at the end of the treatment was 85.8 kg.</p> <p>G. A hemodialysis treatment flow sheet dated 5-15-15 evidenced 6.6 kg (greater than 5% of the EDW) had been removed during the treatment.</p> <p>H. A hemodialysis treatment flow sheet dated 5-18-15 evidenced 6.2 kg (greater than 5% of the EDW) had been removed during the treatment and the patient's weight at the end of the treatment was 86.7 kg.</p> <p>I. A hemodialysis treatment flow sheet dated 5-20-15 evidenced 6.3 kg (greater than 5% of the EDW) had been removed during the treatment and that the patient's weight at the end of the treatment was 86.5 kg.</p> <p>J. A hemodialysis treatment flow sheet dated 5-22-15 evidenced 4.9 kg (greater than 5% of the EDW) had been removed during the treatment and that the patient's weight at the end of the treatment was 86.2 kg.</p> <p>2. Clinical record number 3 failed to evidence the interdisciplinary team had identified barriers preventing the patient from not having excessive intradialytic</p>		<p>audit. Results of audits will be reviewed with the Medical Director during the monthly FHM. The Facility Administrator is responsible for ongoing compliance with this POC.</p> <p>Completion Date: 8/7/15</p>		

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V 626 Bldg. 00	<p>fluid gain The record failed to evidence the plan of care had been updated with interventions to address any identified barriers.</p> <p>3. The facility administrator, employee E, was unable to provide any additional documentation and/or information when asked on 5-28-15 at 11:30 AM.</p> <p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "In addition, if the expected outcome is not achieved, the interdisciplinary team (or individual IDT member) will adjust the patient's plan of care to achieve the specified goal. When a patient is unable to achieve the desired outcomes, the team will: Adjust the plan of care to reflect the patient's current condition. Document in the patient's medical record the reasons why the patient was unable to achieve the goals. Implement plan of care changes to address the issues identified."</p> <p>494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of</p>			

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	<p>the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.</p> <p>Based on quality assessment and performance improvement (QAPI) documentation and facility policy review and interview, the facility failed to ensure all required QAPI committee members had participated in the monthly QAPI review in 4 (January, February, April, and May 2015) of 5 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's 1-16-15 and 2-20-15 QAPI committee meeting minutes failed to evidence the biomedical technician member had participated in the reviews. 2. The facility's 4-24-15 and 5-22-15 QAPI committee meeting minutes failed to evidence the medical social worker had participated in the reviews. 3. The facility administrator, employee E, was unable to provide any additional documentation and/or information when asked on 5-29-15 at 12:30 PM. 	V 626	<p>V626 IDT was in-serviced on 6/3/2015 on Policy: # 1-14-06 "Continuous Quality Improvement Program". Verification of teammates in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: ...Biomedical Technician...Social Worker...Facility Administrators (FAs) conduct periodic Facility Health Meetings...with the CQI committee to review issues and indicators regarding facility's management and performance. FHMs are conducted monthly. All members of the IDT are required to be present or attend via telephone at each monthly FHM. Facility Administrator will audit Facility Health record signature page</p>	08/07/2015

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	4. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: . . . Biomed Technician . . . Social Worker . . . Facility Administrators (FAs) conduct periodic Facility Health Meetings . . . with the CQI committee to review issues and indicators regarding facility's management and performance. FHMs are conducted monthly."		monthly x 3 months. Results of audit will be reviewed with Medical Director during monthly FHM. Facility Administrator is responsible for ongoing compliance with this POC. Completion Date: 8/7/15		