

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	<p>This was a federal recertification survey.</p> <p>Survey Dates: 2-29-12, 3-1-12, and 3-2-12</p> <p>Facility #; 012010</p> <p>Medicaid Vendor #: 200934060</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Facility Census: 8 Incenter hemodialysis patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>March 13, 2012</p>	V0000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0365	<p>494.50(b)(1) QA AUDITS-REPROCESSING SUPPLIES 2X/YR 14.6 Reprocessing supplies: audit semiannually Designated staff members should audit the provisions of [AAMI] section 9]: Reprocessing supplies: Specifications and testing, and inventory control] at least semiannually.</p> <p>Based on reuse quality assurance record and facility policy review and interview, the facility failed to ensure semi-annual audits of the facility's reuse supply testing and inventory control had been completed in 1 (2012) of 2 years reviewed creating the potential to affect all of the agency's 7 current patients with reuse being practiced.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's reuse quality assurance audit records evidenced a semi-annual audit of the facility's reuse supply testing and inventory had been completed on 1-31-11 and 7-28-11. The records failed to evidence any further audits of the facility's reuse supply testing and inventory control. 2. The facility administrator, employee F, stated, on 3-1-12 at 10:40 AM, "It looks like it got missed." 3. The facility's September 2011 "Reuse 	V0365	<p>V365Semi-Annual Reuse Audit completed on 2/29/2012. Facility Administrator (FA) held in-service for Teammates (TMs) on 3/2/2012. In-service included but was not limited to: review of Improvement CQI Plan, facilities reuse supply testing and inventory control, and must report audit results as part of Quality Improvement Facility Management Meeting (QIFMM) activities. Audit will include review of reuse records to verify: Reuse procedures are followed as written, Reuse supplies are used on first in, first out basis, verify "Incoming Reuse Supply Log" is maintained for reuse supplies, all reuse cleaning and disinfectant solutions are USP grade, EPA, or FDA certified. Reuse Technician and FA reorganized the Reuse CQI book to include blank reuse audit forms to be done in scheduled months. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will verify reuse audits are completed as scheduled monthly. Results of audits will be reviewed with</p>	04/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	Continuous Quality Improvement (CQI) Plan" policy number 6-01-12 states, "Semi-annual review of reuse records is performed to verify the records reflect the following: Reuse procedures are followed as written, Reuse supplies are used on first in, first out basis, Confirm that 'Incoming Reuse Supply Log' is maintained for reuse supplies, All reuse cleaning and disinfectant solutions are USP grade, EPA, or FDA certified."		Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this plan of correction (POC). Completion date 4/2/12 <i>Policy & Procedure#6-01-12 Reuse Continuous Quality Reuse Technician must conduct Semi-Annual Reuse Audit of</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0407	<p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>Based on observation and interview, the facility failed to ensure patients' accesses were in view at all times in 2 (#s 1 and 2) of 2 access observations completed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation noted, on 2-29-12 at 8:50 AM, the accesses of patients at stations numbered 3, 8, and 10 were not visible. The patient at station number 10 was completely covered with a blanket, including the access, face, and head. 2. Observation noted, on 3-2-12 at 9:20 AM, the accesses of patients at stations numbered 8 and 10 were not visible. 3. The facility administrator, employee F, indicated, on 3-2-12 at 9:55 AM, the accesses should be visible at all times. 	V0407	<p>FA informed TMs of deficiency on 3/1/2012. FA will hold mandatory in-service for all Clinical TMs. In-service will include but not be limited to: review of 1-04-11 Vascular Access Monitoring and Surveillance, treatment, access sites are to remain visible at all times during treatment to ensure or minimize the risk of needle dislodgement during treatment, TMs must visualize patient's vascular access at a minimum of every 30 minutes, documenting if access is visible or not, and if access is not visible, document action taken including re-educating the patient and requesting that the patient uncover the access, involving Social Worker and MD as necessary. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Clinical Coordinator will re-educate the importance of access visibility with patients and provide educational sheet on uncovering access by 3/30/2012. Acknowledgement of education will be placed in patient medical record. FA or designee will conduct observational audits weekly x 4 weeks, then monthly. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. The FA is responsible for compliance with this POC. <i>Policy & Procedure #during a patient hemodialysis</i></p>	04/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0466	<p>494.70(a)(15) PR-INFORMED OF EXTERNAL GRIEVANCE PROCESSES The patient has the right to-</p> <p>(15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency;</p> <p>Based on clinical record review and interview, the facility failed to ensure patients had been informed of the toll-free hotline numbers for the State agency in 5 (#s 1, 2, 3, 4, & 5) of 5 records and failed to ensure patients had been informed of the ESRD Network toll-free hotline numbers in 5 (#s 1-5) of 5 records reviewed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced the patient had acknowledged the receipt of the facility's "Patient Grievance Procedure" on 12-14-11. The grievance procedure failed to include the Indiana State Department of Health (ISDH) toll-free hotline number to be used to file a complaint with the ISDH. 2. Clinical record number 2 evidenced the patient had acknowledged the receipt of the facility's "Patient Grievance Procedure" on 5-13-11. The grievance 	V0466	<p>FA ensured contact information including mailing address and toll-free complaint hot line numbers for the ESRD Network and Indiana State Department of Health were added to grievance forms. Updated Grievance Procedure posted in patient lobby. 100% of patient census have been re-educated on Grievance Procedures including toll-free complaint hot line numbers for the ESRD Network and Indiana State Department of Health. Verification of patient education will be documented in patient's medical record. FA or designee will conduct Medical Records Audits monthly 10% of current patient census to ensure documentation is present to support external grievance mechanisms. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. The FA is responsible for compliance with this POC.</p>	03/07/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012	
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265			
(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			
	<p>procedure failed to include the ISDH toll-free hotline numbered to be used to file a complaint with the ISDH.</p> <p>3. Clinical record number 3 evidenced the patient had acknowledged the receipt of the facility's "Patient Grievance Procedure" on 10-30-09 and 12-22-09. The grievance procedure failed to include the ISDH or the ESRD Network toll-free hotline numbers to be used to file a complaint with the ISDH or the Renal Network.</p> <p>4. Clinical record number 4 evidenced the patient had acknowledged receipt of the facility's "Patient Grievance Procedure" on 5-16-11. The grievance procedure failed to include the ISDH toll-free hotline number to be used to file a complaint with the ISDH.</p> <p>5. Clinical record number 5 evidenced the patient's guardian had acknowledged receipt of the facility's "Patient Grievance Procedure" on 5-20-09. The grievance procedure failed to include the ISDH or the ESRD Network toll-free hotline number to be used to file a complaint with the ISDH or the Renal Network.</p> <p>6. The facility administrator, employee F, was unable to provide any additional information and/or documentation</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>7. The medical social worker, employee D, indicated, on 3-1-12 at 9:15 AM, patients were provided with the grievance procedure and sign a receipt of the procedure. The medical social worker indicated the records did not evidence the patients had been provided with the ISDH and/or ESRD Network toll-free numbers.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(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
V0541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included measurable outcomes and estimated timetables to achieve desired goals in 2 (#s 2 and 4) of 5 records reviewed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included an interdisciplinary plan of care (PoC) dated 8-29-11. The PoC identified a psychosocial goal for the patient "to afford monthly household and tx [treatment] needs." The PoC failed to evidence an estimated timetable to achieve the stated goal.</p>	V0541	<p>Interdisciplinary Team (IDT) will initiate and develop Comprehensive Re-Assessments followed by Individualized Plans of Care for Patients #2, and #4 to include measurable goals and timetables in POC specific to patient identified psychosocial, and PTH control goals. FA will hold mandatory in-service for all members of IDT on 3/26/2012. In-service will include but not be limited to: review of The FA is responsible for compliance with this POC</p> <p><i>Policy & Procedure 1-01-07 Patient Assessment and Plan of Care When Utilizing Duck, with attention to the IDT or individual IDT member must: 1) develop and implement a written, individualized comprehensive plan of care that will include measurable and expected outcomes and timetables for achieving goals, 2) IDT will follow up and readjust plan of care as necessary and document as such in patients medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Medical Records Audits monthly for 100% of completed plans of care to ensure patient's individualized plan of care includes measureable goals</i></p>	04/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(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
	<p>2. Clinical record number 4 included an interdisciplinary PoC dated 8-29-11. The PoC identified the patient's "pth [parathyroid hormone (PTH)] low at 108. pt [patient] not on vit [vitamin] d analog." The plan failed to evidence a measurable outcome for the PTH level and failed to evidence an estimated timetable to achieve the desired outcome.</p> <p>3. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>4. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that . . . will include measurable and expected outcomes and estimated timetables to achieve these outcomes."</p>		<p><i>and timetables specific to patients needs. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect.</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012	
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265			
(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			
V0543	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the necessary care and services had been provided to manage the patients' blood pressure and volume status by failing to ensure high and low blood pressures had been addressed in 2 (#s 1 and 2) of 5 records reviewed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient's blood pressure (BP) fluctuated above and below the desired level of 120/80 throughout the treatments as follows:</p> <p>A. A post treatment flow sheet dated 2-8-12 evidenced the patient's BP had ranged from 91/53 to 110/66 throughout the treatment with a post treatment standing BP of 104/59.</p> <p>B. A post treatment flow sheet dated 2-10-12 evidenced the patient's BP had</p>	V0543	<p>IDT will initiate and develop Comprehensive Re-Assessments followed by Individualized Plan of Care for Patients #1 and #2 to reflect evaluation and management of patient's current fluid volume status, and dialysis treatment blood pressures. FA will hold mandatory in-service for all members of IDT on 3/26/2012. In-service will include but not limited to: review of Assessment and Plan of Care When Utilizing Duck, IDT member that Plan of Care must address Dose of Dialysis, IDT must provide the necessary care and services to manage patient's volume status. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Examples given using surveyor observations for patient consistently having high and low blood pressure during treatments and plan of care did not address. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA will hold mandatory in-service for all <i>Policy 1</i> clinical TMs on 3/26/2012. In-service will</p>	04/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012	
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265			
(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			
	<p>ranged from 120/71 to 163/99 throughout the treatment with a post treatment sitting BP of 163/108.</p> <p>C. A post treatment flow sheet dated 2-15-12 evidenced the patient's BP had ranged from 84/63 to 155/99 throughout the treatment with a post treatment standing BP of 129/110.</p> <p>D. A post treatment flow sheet dated 2-17-12 evidenced the treatment had been ended early due to "pt [patient] feeling bad". The flow sheet states, "Tx [treatment] ended early, BP low." The recorded BP at the time the treatment was ended was 77/63.</p> <p>E. A post treatment flow sheet dated 2-20-12 evidenced the patient's BP had ranged from 145/94 to 196/115 during the treatment.</p> <p>F. A post treatment flow sheet dated 2-22-12 evidenced the patient's BP had ranged from 94/59 to 144/86 throughout the treatment.</p> <p>G. A post treatment flow sheet dated 2-27-12 evidenced the patient's BP had ranged from 140/92 to 162/104 throughout the treatment.</p> <p>2. Clinical record number 2 evidenced</p>		<p>include but not be limited to: review o& Procedures: # 1-03-10: Pre-Post Dialysis Treatment Data Collection, # 1-03-12: PostTreatment Patient Assessment, #1-03-09: Intradialytic Treatment Monitoring, Patient's Blood Pressures must be evaluated and monitored Pre-Treatment, DuringTreatment at a minimum of every 30 minutes, and Post-Treatment along with patient statusand subjective well being, 2) TMs must report and document any significant changes orpatient's blood pressure outside of ordered parameters to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physicianorders. All findings, interventions and patient response will be documented in patient'smedical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Medical RecordsAudits on 25% of current patient census to ensure assessments and plans of care are inplace, current, needs of patient including fluid volume and blood pressure management areevaluated/addressed, and documentation of action plans and response to interventions are present. Clinical Coordinator or designee will conduct audit on 4 post treatment records daily x 2</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>the patient's BP fluctuated above the desired level of 120/88 throughout the treatments as follows:</p> <p>A. A post treatment flow sheet dated 2-3-12 evidenced the patient's BP had ranged from 114/55 to 171/77 with a standing post treatment reading of 142/116.</p> <p>B. A post treatment flow sheet dated 2-6-12 evidenced the patient's BP had ranged from 104/84 to 190/138 throughout the treatment with a standing post treatment reading of 140/97.</p> <p>C. A post treatment flow sheet dated 2-8-12 evidenced the patient's BP had ranged from 111/79 to 178/108 throughout the treatment with a standing post treatment reading of 189/109.</p> <p>D. A post treatment flow sheet dated 2-10-12 evidenced the patient's BP had ranged from 08/84 to 212/141 throughout the treatment with a standing post treatment reading of 161/114.</p> <p>E. A post treatment flow sheet dated 2-13-12 evidenced the patient's BP had ranged from 94/56 to 131/71 throughout the treatment with a standing post treatment reading of 121/106.</p>		<p>weeks, then 2 post treatment records x 2 weeks, then 2 post treatment records monthly to ensure blood pressures outside of ordered parameter are addressed appropriately. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. FA is responsible for compliance with this POC. <i>Policy & Procedure # 1-01-07 Patient with attention to the IDT or individual</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012	
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265			
(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			
	<p>F. A post treatment flow sheet dated 2-15-12 evidenced the patient's BP had ranged from 89/60 to 163/101 throughout the treatment.</p> <p>G. A post treatment flow sheet dated 2-20-12 evidenced the patient's BP had ranged from 114/26 to 215/77 throughout the treatment.</p> <p>H. A post treatment flow sheet dated 2-22-12 evidenced the patient's BP had ranged from 110/73 to 201/95 throughout the treatment with a standing post treatment reading of 145/113.</p> <p>I. A post treatment flow sheet dated 2-24-12 evidenced the patient's BP had ranged from 120/79 to 202/144 throughout the treatment with a standing post treatment reading of 189/91.</p> <p>J. A post treatment flow sheet dated 2-27-12 evidenced the patient's BP had ranged from 121/91 to 234/100 throughout the treatment with a standing post treatment reading of 143/97.</p> <p>3. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(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
	4. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(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
V0544	<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 and facility policy review and interview, the facility failed to ensure patients achieved the prescribed dose of dialysis by ensuring blood flow and dialysate flow rates had been maintained as ordered by the physician in 2 (#s 1 and 2) of 5 records reviewed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included physician orders dated 12-14-11 that identified the blood flow rate (BFR) was to run at 500 milliliters (ml) per hour and the dialysate flow rate (DFR) at 800 ml per hour.</p> <p>A. A post treatment flow sheet dated 2-3-12 evidenced the BFR had run at 400 ml per hour and the DFR at 600 ml per hour.</p> <p>B. A post treatment flow sheet dated 2-6-12 evidenced the BFR had run at 300 ml per hour and the DFR at 500 ml per</p>	V0544	<p>IDT will initiate and develop Comprehensive Re-Assessments followed by Individualized Plan of Care for Patients #1 and #2 to address care and services to achieve and sustain prescribed dose of dialysis including blood and dialysate flow rates. FA will hold mandatory in-service for all members of IDT on 3/26/2012. In-service will include but not limited to: review of Policy & Procedure # 1-01-07 Patient Assessment and Plan of Care When Utilizing Duck, with attention to the IDT or individual IDT member that Plan of Care must address Dose of Dialysis, IDT must provide the necessary care and services to manage prescribed dose of dialysis including patient blood and dialysate flow rates . IDT must follow-up and readjust plan of care to address changes in dialysis prescription. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA will hold mandatory in-service for all <i>Policy 1) TMs must verify dialysis prescription, prescribed clinical TMs on 3/26/2012. In-service will include but not be limited to: review of & Procedure # 1-03-02: Prescription Verification and Safety Checks, #1-03-09: Intradialytic Treatment Monitoring, dose of dialysis, and perform safety checks prior to each treatment initiation, 2) Nurses are responsible for ensuring patients are</i></p>	04/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>hour.</p> <p>C. A post treatment flow sheet dated 2-10-12 evidenced the BFR had run at 400 ml per hour and the DFR at 600 ml per hour.</p> <p>D. A post treatment flow sheet dated 2-13-12 evidenced the BFR had run at 445 ml per hour and the DFR at 700 ml per hour.</p> <p>E. A post treatment flow sheet dated 2-15-12 evidenced the BFR had run at 450 ml per hour and the DFR at 700 ml per hour.</p> <p>F. A post treatment flow sheet dated 2-27-12 evidenced the BFR had run at 450 to 475 ml per hour.</p> <p>G. Post treatment flow sheets, dated 2-20-12 and 2-27-12, evidenced the BFR had run at 400 ml per hour.</p> <p>H. A post treatment flow sheet dated 2-22-12 evidenced the BFR had run at 350 ml per hour.</p> <p>I. A post treatment flow sheet dated 2-24-12 evidenced the BFR had run at 455 ml per hour.</p> <p>2. Clinical record number 2 included</p>		<p>achieving prescribed dose of dialysis and physician orders are followed, 3) TMs must monitor patient's blood flow and dialysate flow rates at a minimum of every 30 minutes, report and document flow rates outside of ordered parameters to licensed nurse, licensed nurse must take appropriate action. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Medical Records Audits on 25% of current patient census to ensure care and services are addressed to achieve and sustain prescribed dose of dialysis including blood and dialysate flow rates. Clinical Coordinator or designee will conduct audit on 4 post treatment records daily x 2 weeks, then 2 post treatment records x 2 weeks, then 2 post treatment records monthly to ensure blood pressures outside of ordered parameter are addressed appropriately. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. FA is responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(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
	<p>physician orders dated 1-19-12 that identified the BFR was to run at 500 ml per hour and the DFR at 800 ml per hour.</p> <p>A. A post treatment flow sheet dated 2-13-12 evidenced the BFR had run at 450 ml per hour.</p> <p>B. Post treatment flow sheets dated, 2-15-12 and 2-17-12, evidenced the BFR had run at 400 ml per hour.</p> <p>C. A post treatment flow sheet dated 2-22-12 evidenced the BFR had run at 475 ml per hour.</p> <p>D. A post treatment flow sheet dated 2-24-12 evidenced the BFR had run between 200 to 420 ml per hour.</p> <p>3. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>4. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to . . . achieve and sustain the prescribed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	dose of dialysis."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0551	<p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care provided for the monitoring of accesses in 2 (#s 2 and 4) of 5 records reviewed creating the potential to affect all of the facility's 8 current patients.</p> <p>The findings include;</p> <p>1. Clinical record number 2 included a plan of care (PoC) dated 8-29-11 that identified the patient had an arteriovenous fistula in the left upper arm. The plan failed to provide for the monitoring of the access to prevent failure.</p> <p>Monthly "Patient Progress Notes", from October 17, 2011, to February 6, 2012, identify continued problems with the fistula with surgeries to correct abnormalities to the access.</p> <p>2. Clinical record number 4 included a PoC dated 8-29-11 that identified the patient had an arteriovenous graft in the right lower arm. The plan of care failed to provide the monitoring of the access to</p>	V0551	<p>IDT will initiate and develop Comprehensive Re-Assessments followed by Individualized Plans of Care for Patients #2, and #4 to ensure vascular access problems are evaluated, addressed, and provide updated monitoring of vascular access to detect symptoms of access problems and assist in preventing failure.</p> <p>FA will hold mandatory in-service for all members of IDT on 3/26/2012. In-service will include but not be limited to: review of Assessment and Plan of Care When Utilizing Duck, patients vascular access including vascular access monitoring and surveillance to detect symptoms of access problems and assist in preventing failure. Vascular Access Manager is responsible for updating IDT of patient's vascular access status and needs.</p> <p>Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Medical Records Audits monthly for 100% of completed plans of care to ensure patient's individualized plan of care includes vascular access monitoring. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. The FA is responsible for compliance with this POC <i>Policy & Procedure 1-01-07 Patientplan of care will include/address</i></p>	04/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>prevent failure.</p> <p>Monthly "Patient Progress Notes", from November 26, 2011, to February 27, 2012, identify continued problems with the graft with a central venous catheter placed on 2-20-12.</p> <p>3. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>4. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The plan of care will address, but not be limited to, the following: . . . When indicated, vascular access which addresses vascular access monitoring . . . When indicated, the patient's vascular access will be monitored to prevent access failure and detect symptoms of stenosis in graft and fistulae."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0552	<p>494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care provided for monitoring of patients' psychosocial status in 5 (#s 1, 2, 3, 4, & 5) of 5 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care (PoC) dated 1-30-12. The plan of care failed to evidence interventions to monitor the patient's psychosocial status. 2. Clinical record number 2 included a PoC dated 8-29-11. The PoC failed to evidence interventions to monitor the patient's psychosocial status. 3. Clinical record number 3 included a PoC dated 2-21-11. The PoC failed to evidence interventions to monitor the 	V0552	<p>Social Worker will initiate individualized plan of care updates for Patients (#1, 2, 3, 4, and 5) to include evaluation and monitoring of patient's psychosocial status. FA will hold mandatory in-service for all members of IDT on 3/26/2012. In-service will include but not be limited to: review of <i>and Plan of Care When Utilizing Duck, IDT or individual IDT member must: 1) develop and implement a written, individualized comprehensive plan of care that will include measurable and expected outcomes, interventions to achieve goal and timetables for achieving goals related to patient's psychosocial status, 2) Social Worker will follow up and readjust plan of care as necessary, document interventions to monitor the patient's psychosocial status. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Medical Records Audits monthly for 100% of completed plans of care to ensure patient's individualized plan of care includes appropriate, measurable goals for patient's psychosocial status. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team.</i></p>	04/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>patient's psychosocial status.</p> <p>4. Clinical record number 4 included a PoC dated 8-29-11. The PoC failed to evidence interventions to monitor the patient's psychosocial status.</p> <p>5. Clinical record number 5 included a PoC dated 4-25-11. The PoC failed to evidence interventions to monitor the patient's psychosocial status.</p> <p>6. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>7. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The plan of care will address, but not be limited to, the following: . . . Psychosocial status which addresses necessary monitoring and social work interventions.</p>		<p>QIFMM minutes will reflect. The FA is responsible for compliance with this POC.</p> <p><i>Policy & Procedure 1-01-07 Patient Assessment</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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 clinical record and facility policy review and interview, the medical director failed to ensure adherence to the facility's policy regarding new patient pre-treatment evaluations in 2 (#s 3 and 5) of 5 records reviewed creating the potential to affect all new admissions to the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 3 evidenced the patient's first date of dialysis at this facility was 10-26-09. The record failed to evidence an initial evaluation to determine any immediate needs by the registered nurse (RN) prior to the initiation of the treatment. 2. Clinical record number 5 evidenced the patient's first date of dialysis at this facility was 5-18-09. The record failed to evidence an initial evaluation to determine any immediate needs by the RN prior to the initiation of the treatment. 	V0715	<p>FA will hold mandatory in-service for all Registered Nurses and Patient Care Technicians on Evaluation.</p> <p>patients prior to initiation of first treatment at facility; pre-treatment evaluation will be documented on the New Patient Pre-Treatment Evaluation Form.</p> <p>Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct monthly Medical Record audit on 100% of new patient admissions to ensure the Initial RN Assessment is completed prior to first treatment and documentation placed in patient medical record. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. FA & Medical Director are responsible for compliance with this POC <i>Policy & Procedure #01-03-07 New Patient Pre-Treatment Registered Nurse must perform initial pre-treatment evaluation of all new</i></p>	04/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER NORTH VERNON DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265		
(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	
	<p>3. The facility administrator, employee F, was unable to provide any additional information and/or documentation regarding these findings when asked on 3-2-12 at 9:55 AM and just prior to the exit conference on 3-2-12 at 12:15 PM.</p> <p>4. The facility's September 2010 (origination date September 2007) "New Patient Pre-Treatment Evaluation" policy number 1-03-07 states, "A registered nurse (RN) as required by federal regulation will perform an initial pre-treatment evaluation of all new patients prior to the initiation of their first treatment at the facility."</p> <p>5. The facility's September 2010 (origination date September 2008) "Medical Director Qualifications and Responsibilities" policy number 3-03-71 states, "MD responsibilities include, but are not limited to: . . . Ensuring that 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 non-physician providers."</p>				