

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  COMPREHENSIVE RENAL CARE MUNSTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CALUMET AVE MUNSTER, IN 46321
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V000000	<p>This was a federal ERSD [CORE] recertification survey.</p> <p>Survey dates: 9/10/14 - 9/16/14</p> <p>Facility number: 010128</p> <p>Medicaid number: 200315330E</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Census: 132 Patients Inpatient Hemodialysis : 127 Home Peritoneal Dialysis: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 3, 2014</p>	V000000		
V000111	<p>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.</p>			

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>Based on observation, facility policy and procedure review, and interview, the facility failed to ensure visible blood was cleaned as required in 1 of 1 observation of a blood spill and followed its own policy and procedure for clean and dirty areas for 1 of 1 dialysis facility creating the potential to affect all 127 inpatient hemodialysis patients and 25 staff members. (Patient 11 and observations 1 and 5)</p> <p>Findings include:</p> <p>Regarding a blood spill</p> <p>1. At station 10 on 9/15/14 at 11:00 AM, there was an observation of discontinuation of dialysis and post dialysis access care by Employee P, patient care technician. At 11:11 AM, blood from the Patient #11's right arm access spilled from beneath the pressure - applied gauze onto an attached side table by the arm rest and onto the side of the chair and onto the floor. Approximately 5 cubic centimeters [cc] of blood spilled onto the floor and 10 - 15 cc of blood spilled onto the attached table and chair. Patient #11 alerted Employee U. Employee U applied a new dressing to the bleeding access and then washed the patient's arm with paper towels and</p>	V000111	<p>V111 Overflowing Trash was immediately changed, and emergency cart cleaned. Facility Administrator (FA) on 9/15/2014 purchased 5 new containers with Neon Pink Lids to be used for making and storing 1:10 Bleach Solution. FA labeled Neon Pink Lids with instruction for preparing 1:10 solution, attached label for documenting TM Initials, Time and Expiration Date, and attached HMIG Label. FA held mandatory in-service for all Clinical Teammates (TMs) on 9/15/2014 and 9/16/2014. In-service included but was not limited to: <i>Review of Policy &amp; Procedure # 1-05-08 : Bleach Policy and Policy &amp; Procedure # 4-03-05 Biohazardous Cleanup</i>, Introduction of the new containers with neon pink lids for 1:10 Bleach Solution, emphasizing: 1) TMs must be able to identify difference between need for 1:100 &amp; 1:10 bleach solutions. 2) TMs must prepare in the morning prior to patient arrival each day 1:100 Bleach Solution using containers with Blue Lids label for 1:100 bleach solutions, and 1:10 Bleach Solution using containers with Neon Pink Lids labeled for 1:10 bleach solution. 3) TMs will have available 1:100 &amp; 1:10 Bleach Solution in each POD. 4) TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection tasks emphasizing for visible blood or gross blood spills a 1:10 bleach</p>	10/16/2014

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	<p>water. The patient left the station at 11:18 AM. Then Employee U cleaned the rest of the blood spill with a bleach solution of 1:100 applied to towels. He only cleaned the area where the blood spill had happened once. There was no 1:10 bleach solution available on the floor and no 1:10 bleach solution had been made to clean up this blood spill.</p> <p>2. On 9/15/14 at 11:28 AM, Employee U indicated the bleach solution was 1:100 and no 1:10 bleach solution was available on the treatment floor. Employee U indicated cleaning this blood spill once with 1:100 bleach solution.</p> <p>3. On 9/15/14 at 11:30 AM, Employee O, Registered Nurse, indicated blood spills were to be cleaned with a 1:10 bleach solution and this bleach solution had not been made or used to clean this blood spill occurrence in finding #1.</p> <p>4. On 9/15/14 at 12:20 PM, Employee Y, clinical services specialist, indicated blood spills are to be cleaned with 1:10 bleach and this was not available on the floor.</p> <p>Regarding clean and dirty areas clearly defined on the treatment floor</p>		<p>solution must be utilized. After blood is cleaned with 1:10 bleach solution TMs must use new disposable towel soaked with 1:10 bleach solution and clean a second time. Verification of attendance at in-service evidenced by TMs signature on in-service sheet. FA on 9/15/2014 purchased 3M Command adhesive backed tape. FA Attached adhesive to each Phoenix meter holder and mounted the Phoenix Meter Holders in designated clean area clear from splash zone. On 9/15/2014 and 9/16/2014 FA held In-service with all clinical TMs to discuss new process for storing Phoenix Meters at each POD in designated area. TMs were instructed to Disinfect Phoenix meter prior to returning to holder. Phoenix Meters are to be returned to mounted holder between uses. Verification of attendance at in-service evidenced by TMs signature on in-service sheet. FA on 9/15/2014 obtained additional garbage can with foot operated lid and placed it under the sink at the Nurse's Medication Station. On 9/15/2014 and 9/16/2014 an in-service was held instructing all clinical TMs facility must remain clean, uncluttered, and organized. All clinical TMs are responsible to verify the garbage does not overflow and empty garbage as necessary to prevent overflowing, and clean emergency cart at a</p>				

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	<p>5. On 9/10/14 at 3:20 PM, at observation #1 of the treatment floor, it was observed that the reverse osmosis water in a semi opaque 1 liter container kept on the treatment floor had a hose that discharged water into the clean sink at pod #3 on the incenter treatment floor. 3 of 3 phoenix meters kept at pods #1 - #3 were stored behind the clean sinks where some splashing during staff handwashing occurred and the phoenix meters were exposed to this splashed water.</p> <p>6. On 9/15/14 at 12:35 PM, at observation #5 of the treatment floor it was observed that an overflowing trash can full of paper waste including used paper towels to dry staff member's hands was near the medication preparation area on the treatment floor. This trash can was approximately two feet high and the paper waste was touching the counter of the medication preparation area. About 6 feet from this area was a red emergency cart which included the AED and suction machine and other supplies kept for emergencies. The emergency cart was covered with dust and did not appear clean.</p> <p>7. On 9/15/14 at 1 PM, Employee Y, Clinical Services Specialist, indicated the trash was considered soiled and should not touch the medication area which is</p>		<p>minimum of monthly. Infection Control Manager (ICM) or designee will conduct infection control audits daily on each patient shift x1 week, weekly x4 weeks, then monthly. FA will review audit results monthly with Medical Director during Facility Health Meetings (FHM), minutes will reflect FA is responsible for compliance with this plan of correction Completion date: 10/16/2014</p>		

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	<p>clean. Phoenix meters were disinfected as they are placed back into the clean areas and disinfected before use and should be kept clean. Clean areas and dirty areas need to be clearly defined.</p> <p>8. On 9/15/14 at 1:05 PM, the facility administrator indicated the phoenix meters would be hung up on the wall above the clean sinks so that this equipment remained clean.</p> <p>9. The policy titled "Infection Control for Dialysis Facilities" with a revision date of March 2014 stated, "40. Sinks should be easily accessible and readily available in the treatment are and in other appropriate areas .... handwashing sinks should be dedicated only for hand washing purposes and remain clean. Avoid placing, cleaning or draining used items in handwashing sinks ... 48. Clean areas should be clearly designated for the preparation, handling, and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas ... Cleaning and / or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or other potentially infectious materials. Use an appropriate disinfectant such as 1:100 [one to one hundred] bleach solution for</p>				

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V000113	<p>environmental surfaces. For visible blood or gross blood spills, a 1:10 [one to ten] bleach solution must be utilized. After all visible blood is cleaned with the 1:10 ... bleach solution, teammates are to use a new disposable towel soaked with 1:10 ... bleach solution and clean area a second time."</p> <p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure staff members followed the facility infection control policies during the initiation of dialysis treatments in 1 of 2 observations (Patient #2) of the initiation of dialysis with a arteriovenous fistula (Employee C).</p> <p>The findings include:</p> <p>1. The agency policy titled "AV Fistula or Graft Cannulation with Safety Fistula Needles [SFN] and administration of Heparin" with revision date of March 2014 stated, "Have patient wash access site with appropriate antibacterial soap, if able. If patient unable to wash access</p>	V000113	V113 FA held mandatory in-service for all Clinical TMs on 9/15/2014 and 9/16/2014. In-service included but was not limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure #1-05-01B: Hand Washing, and Policy & Procedure #1-04-01E: AV Fistula or Graft Cannulation with Medisystem Safety Fistula Needles (SFN) and Administration of Heparin, emphasizing 1) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station; 2) TMs must perform hand hygiene every time gloves are removed; 3) Once cannulation site has been cleaned it must not be touched, otherwise area must be cleaned	10/16/2014

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	<p>site, patient care teammate will clean access extremity with skin cleaning agent and pat dry. 3. Place clean barrier under access extremity. 4. Prior to auscultating a bruit with a stethoscope, clean the diaphragm of the stethoscope first with an alcohol swab. 5. Perform inspection, auscultation and palpation on entire length of access. Determine presence of bruit and thrill ... 8. Locate and palpate the needle cannulation sites prior to skin preparation ... 10. With clean gloved hands, cleanse the site by applying a 70% alcohol prep using a circular rubbing motion 11. With clean - gloved hands, cleanse the site by applying a providine iodine prep using a circular rubbing motion for 1 minute, moving from the center out. Allow to dry for 2 - 3 minutes. ... 14. Repeat for second insertion site. Do not palpate insertion site once area has been prepped."</p> <p>2. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment for patient #2 on 9/12/14 at 10:25 AM. The PCT cleansed the patient's access and palpated the access site with a gloved finger and then inserted each needle into the patient's AVF sites. Employee C failed to change her gloves and cleanse her hands after washing the patient's access and locating the access site with her gloved finger in</p>		<p>per policy prior to cannulation; Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. ICM or designee will conduct infection control audits daily on each patient shift x1 week, weekly x4 weeks, then monthly. FA will review audit results monthly with Medical Director during FHM, minutes will reflect The FA is responsible for compliance with this plan of correction Completion date: 10/16/2014</p>	

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V000122	<p>preparation for cannulation of the AV access site.</p> <p>3. On 9/12/14 at 10:55 AM, Employee S, Registered Nurse, indicated the procedure for AV fistula initiation did not follow infection control policy.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure dialysis machines had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed (Employees C and G) creating the potential to affect all of the facility's 127 current incenter patients.</p> <p>The findings include:</p> <p>1. The facility policy titled "Infection Control" with a date of 1/5/01 stated, "50.</p>	V000122	<p>V122 FA held mandatory in-service for all Clinical TMs on 9/15/2014 and 9/16/2014. In-service included but was not limited to: review of Policy &amp; Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment. TMs must fully clean machine including top, sides, and bottom lip. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.  ICM or designee will conduct</p>	10/16/2014

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V000403	<p>Equipment including the dialysis delivery system ... will be wiped clean with a bleach solution ... after each treatment."</p> <p>2. On 9/11/14 at 11 AM, Employee G, patient care technician (PCT), was observed to clean the hemodialysis machine #35 at station #22. The PCT failed to clean the left side of the hemodialysis machine.</p> <p>3. On 9/12/14 at 10:20 AM, Employee C, PCT, was observed to clean hemodialysis machine #24 at station #14. The PCT failed to clean the left side of the hemodialysis machine.</p> <p>4. On 9/15/14 at 4:45 PM, Employee Y, clinical services specialist, indicated the dialysis machines should be cleaned after each treatment.</p> <p>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 preventative maintenance record and facility policy review and interview, the facility failed to ensure the glucometer monitor had been maintained</p>	V000403	<p>infection control audits daily on each patient shift x1week, weekly x4 weeks, then monthly. FA will review audit results monthly with Medical Director during FHM, minutes will reflect</p> <p>The FA is responsible for compliance with this plan of correction</p> <p>Completion date: 10/16/2014</p> <p>V403 Facility immediately obtained control solutions and initiated Quality Control Log. FA held mandatory in-service for Registered Nurse TMs on</p>	10/16/2014			

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	<p>according to policy for 1 of 1 observation of the clinic's glucometer with the potential to affect any patients with glucometer readings obtained.</p> <p>The findings</p> <p>1. The facility policy titled "Freestyle Precision H Blood Glucose Monitoring Quality Control" with a revision date of October 2012 stated, "In addition to the required daily control tests, glucose controls are used before using the meter for the very first time ... whenever there is a reason to question blood glucose results ... any time the test strips have been exposed to extremes in temperature ... a new box of strips is opened. 2. Verify the monitor is at room temperature. Check control solution expiration date ... Document results of low control solution test and the range for each control level on the Blood Glucose Quality Control log."</p> <p>2. On 9/15/14 at 1:10 PM, observed failed to evidence the facility had control solutions or a log to record the results of testing.</p> <p>3. On 9/15/14 at 1:10 PM, Employee R, Registered Nurse, indicated that no control solution was used to test monitor the glucometer monitor and that no</p>		<p>9/15/2014. In-service included but was not limited to: review of <i>Policy &amp; Procedure #1-08-06A: Freestyle Precision H Blood Glucose Monitoring: Quality Control (QC) and #1-08-06B: Freestyle Precision H Blood Glucose Testing</i>. RNs were instructed that facility must implement and maintain a program to ensure Freestyle H Blood Glucose Monitor is maintained and operated in accordance with manufacturer's recommendations. RNs must perform quality control daily before meter is used, whenever there is reason to question blood glucose results and any time the test strips have been exposed to extremes in temperature as well as when a new box of test strips is opened. RNs must document all control testing on Quality Control Log. RNs must ensure control solution is dated when opened and assure control solution and test strips are not expired. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Clinical Coordinator or designee will review Freestyle H Blood Glucose Monitor: QC Log Book daily to assure compliance. FA will review Log Book monthly with Medical Director during FHM, minutes will reflect The FA is responsible for compliance with this plan of correction Completion date: 10/16/2014</p>		

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V000543	<p>quality control log was present.</p> <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 review, policy review, and interview, the facility failed to ensure the Registered Nurse (RN) completed an assessment within 1 hour of starting dialysis for 2 of 8 incenter hemodialysis records reviewed (#5 and #7) and patients' blood pressures were monitored every 30 minutes for 2 of 8 incenter hemodialysis records reviewed (#1, #3 ).</p> <p>The findings</p> <p>Regarding blood pressures monitored every 30 minutes</p> <p>1. Clinical record #1 included treatment sheets that failed to evidence the patient's blood pressure had been checked at least every 30 minutes and the nurse had</p>	V000543	<p>V543 FA held mandatory in-service for all clinical TMs on 9/15/2014 and 9/16/2014. In-service included but was not limited to: review of <i>Policy &amp; Procedure #1-03-09 Intradialytic Treatment Monitoring, Policy &amp; Procedure #1-03-08: Treatment Initiation Patient Assessment</i>. TMs instructed using surveyor observations as examples to the following: 1) Treatment monitoring must be completed at a minimum of every 30 minutes, evaluation and documentation must include at a minimum patient's blood pressure, heart rate, blood and dialysate flows, arterial and venous pressures, fluid removal and/or replacement, vascular access status and subjective well-being. 2) TMs must report and document any significant changes to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow</p>	10/16/2014

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	<p>assessed the patient within 1 hour of starting dialysis.</p> <p>a. The treatment sheet dated 8/8/14 with dialysis initiation at 12:26 PM and terminated at 4:30 PM evidenced the blood pressure was assessed at 2:01 PM and not again until 2:46 PM during the treatment time.</p> <p>b. The treatment sheet dated 9/10/14 evidenced the blood pressure was assessed at 1:30 PM and then not again until 2:31 PM. Then the blood pressure was assessed at 3:01 PM and not again until 3:49 PM. Dialysis was initiated at 12:35 PM and terminated at 4:04 PM.</p> <p>2. Clinical record #3 included treatment sheets that failed to evidence the patient's blood pressure had been checked at least every 30 minutes. The treatment sheet dated 8/11/14 with dialysis initiation at 12:45 PM and terminated at 4:54 PM evidenced the blood pressure was assessed at 2 PM and then not again until 3 PM.</p> <p>Regarding the nurse assessing within the hour of dialysis initiation</p> <p>3. Clinical record #5 included a treatment sheet that evidenced the RN failed to</p>		<p>physician orders. 3) RN must complete pre-treatment assessment and document within 1 (one) hour of treatment initiation time. Charge nurse is responsible for daily monitoring. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. RN or designee will complete post treatment sheet audits for 25% of treatments x 4 weeks, then 10% of treatments monthly ongoing. FA will review results of all audits with Medical Director during monthly FHM, minutes will reflect. The FA is responsible for compliance with this plan of correction. Completion date: 10/16/2014</p>		

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	<p>assess the patient within 1 hour of the initiation of dialysis treatment. The treatment sheet dated 8/11/14 evidenced the dialysis treatment started at 1:18 PM but the RN failed to assess the patient until 3:27 PM.</p> <p>4. Clinical record #7 included a treatment sheet that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment. The treatment sheet dated 9/10/14 evidenced the dialysis treatment started at 2:21 PM, but the RN failed to assess the patient until 3:36 PM.</p> <p>5. On 9/15/14 at 3:50 PM, the facility administrator indicated the documentation needed to be shored up since documentation was missing from the records.</p> <p>6. The agency policy titled "Intradialytic Treatment Monitoring" with a date of 1/3/09 stated, "To provide an effective, safe and comfortable dialysis treatment to every patient in accordance with his / her individual plan of care ... Treatment checks should be completed every 30 minutes 2. At a minimum, obtain and document the following: blood pressure, heart rate."</p>			

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V000544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record review and interview, the facility failed to ensure the blood flow rate prescription was followed for 1 of 8 incenter hemodialysis records (#7) reviewed with the potential to affect all patients of the facility.</p> <p>Findings</p> <p>1. Clinical record #7 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute. The flow sheet dated 9/3/14 evidenced BFRs of 350, 100, and 250 through the treatment with no explanation as to why the BFR was not followed.</p>	V000544	<p>V544 FA held mandatory in-service for all clinical TMs on 9/15/2014 and 9/16/2014. In-service included but was not limited to: reviewing <i>Policy &amp; Procedure #1-03-09: Intradialytic Treatment Monitoring, Policy &amp; Procedure #1-03-08: Treatment Initiation Patient Assessment</i> emphasizing TMs must verify patient prescriptions and set all treatments as prescribed. 1) TMs must verify dialysis prescription, prescribed dose of dialysis, and perform safety checks prior to each treatment initiation, Nurses are responsible for ensuring patients are achieving prescribed dose of dialysis and physician orders are followed, 2) TMs must monitor patient's blood flow &amp; dialysate flow rates at a minimum of every</p>	10/16/2014

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V000587	<p>2. On 9/16/14 at 2:30 PM, the facility administrator indicated the BFR was not as prescribed.</p> <p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record.</p> <p>Based on policy review, clinical record review, and staff interview, the agency failed to ensure that 1 of 2 home dialysis</p>	V000587	<p>30 minutes, report and document flow rates outside of ordered parameters to licensed nurse,licensed nurse must take appropriate action, contact physician if warranted,and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Charge nurse is responsible for daily monitoring. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. RN or designee will conduct daily audits on 25% of patient treatment sheets x 4 weeks, then 10% of treatments monthly. Results of audits will be discussed with the Medical Director during monthly FHM meetings, minutes will reflect. The FA is responsible for compliance with this plan of correction Completion date: 10/16/2014</p> <p>V587 FA held mandatory in-service for PD clinical TMs on 9/16/2014. In-service included but was not limited to: review of <i>Policy &amp; Procedure#5-01-29:</i></p>	10/16/2014	

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	<p>records reviewed (Clinical record # 10) maintained patient flow sheets in the clinical record with the potential to affect all 5 home dialysis patients.</p> <p>Findings</p> <p>1. The agency policy titled "Daily Home Treatment Record" with an origination date of September 2006 and revision date of March 2011 stated, "1. Each peritoneal dialysis patient will be instructed to complete documentation of each treatment procedure on the Daily Home Treatment record or by means of an electronic data card ... All Daily Home treatment records will be maintained as a part of the patient's medical record. In absence of Home records, the nurse will review the importance of home records."</p> <p>2. Clinical record #10, with a date of first dialysis on 7/5/11, evidenced the patient was an active peritoneal dialysis patient with no home records in the chart since January 2014. The last care plan meeting failed to evidence any documentation about the lack of flow sheets and no documentation was found that explained the lack of flow sheets.</p> <p>3. On 9/11/14 at 4:50 PM Employee L, home training nurse manager, indicated flow sheets were not in patient #10's</p>		<p><i>Daily Home Treatment Record</i> emphasizing 1) Each peritoneal dialysis patient must be instructed to complete documentation of each treatment procedure on the Daily Home Treatment record. 2) All Daily Home Treatment records must be maintained as a part of the patient's medical record. 3) Patient and/or home care caregiver must be instructed to bring all completed Daily Home Treatment Records to the facility for each clinic visit. 4) In the absence of Home Records, the licensed nurse teammate must review the importance of home records, the patient's responsibility to provide them and issue new record sheets and document. Educational attempts must be documented in the medical record. Plans of care for identified non-compliant patients will be established to address adherence issues. Peritoneal Dialysis nurse is responsible for monitoring. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. Peritoneal Dialysis Nurse or designee will perform monthly audits verifying home dialysis patients are bringing in their Home Treatment Records during their monthly clinic visit and those records are reviewed. Peritoneal Dialysis nurse will document patients not meeting compliance. Results will be discussed with the Medical Director during monthly</p>	

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	record since January 2014 and had not been reviewed since April 2014 and no care plan notation had been completed.		FHM meetings, minutes will reflect. The FA is responsible for compliance with this plan of correction. Completion date: 10/16/2014		