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 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELL CITY DIALYSIS CENTER	1602 MAIN ST TELL CITY, IN 47586

(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
V0000	This was a federal ESRD recertification survey. Facility #: 002988 Survey Dates: 8-1-12, 8-2-12, and 8-3-12 Medicaid Vendor #: 200315330H Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN August 8, 2012	V0000		

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

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

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V0111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation and staff interview, the facility failed to ensure the treatment floor had been kept free of trash in 2 (day 1 and day 3) of 3 days of observation creating the potential to affect all of the facility's 29 patients. The findings include: 1. On 8-1-12 at 10:20 AM, observation noted a small white piece of paper 1" by 1/2 ", a blue plastic IV bag seal, and a bottle of test strips on the floor between stations 11 and 12. At station # 10, a 1 1/2 strip yellow paper and a white piece of paper (corner of envelope) was observed on the floor, and a 1/2" by 1/2" piece of white paper was observed under the chair at station 9. 2. On 08/03/2012 at 9:10 AM, observation noted an alcohol swab on the floor at the medication preparation area, a test strip on the floor by the dialysis chair at station number 8 (Patient # 5 was in the chair), a 4x4 white gauze on the floor by the dialysis chair (Patient # 6 was in the chair), 2 opened betadine packages and a	V0111	Clinical Teammates (TMs) were in-serviced08/03/2012 in the following: Policy #01-05-01:Infection Control for Dialysis FacilitiesVerification of attendance at in-service is evidencedby a signature sheet. TMs were instructed usingsurveyor observations as examples with emphasison, but not limited to, the following: 1) keepingtreatment floor free of trash and 2) after eachtreatment, the floor area around chair andhemodialysis delivery systems will be evaluated andcleaned if necessary. The Charge Nurse (CN) isresponsible for oversight of infection controlpractice daily. Instances of non-compliance will beaddressed with the TM responsible immediately.The Facility Administrator (FA) or designee willconduct observational infection control audits onrandom shifts 3x a week for one month, thenmonthly with regularly scheduled infection controlaudits. Results of audits will be reviewed with theMedical Director during the monthly QIFMM(Quality Improvement & Facility ManagementMeeting) and continued frequency of auditsdetermined by the team	08/31/2012

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	betadine soaked 2x2 on the floor by the dialysis chair at station 10 (Patient # 7 was in the dialysis chair), a rubber band on the floor in front of station # 12 (There was no patient in the chair), a blue glove on the floor by the dialysis machine at station # 11 (Patient # 2 was in the chair), a blue rubber IV bag stopper on the floor at station # 1 (Patient # 8 was in the chair), and 2 pieces of white paper 2" by 1/2 " on the floor at station # 2 (There was no patient in the chair). 3. The Clinical Service Specialist, employee L, indicated, on 8-3-12 at 9:40 AM, the treatment floor had not been kept free of trash.		with supportingdocumentation included in the meeting minutes.The FA is responsible for compliance with this POC	

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V0115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on observation, policy review, and staff interview, the facility failed to ensure staff had properly donned protective gowns in 2 (day 1 and day 3) of 3 days of observation creating the potential to affect all of the facility's 29 current patients. The findings include: 1. On 8-1-12 at 11:39 AM, employee B, a registered nurse, was observed to provide care to patient number 6. The employee's protective gown was not buttoned and her uniform was exposed creating the potential for the transfer of disease causing organisms among the nurse and the patients. 2. On 8-3-12 at 9:37 AM, employee A, a registered nurse, was observed to be on the treatment floor going from station to station with her protective gown partially	V0115	Clinical Teammates (TMs) were in-serviced08/03/2012 in the following: Policy #1-05-01:.Infection Control for Dialysis FacilitiesVerification of attendance at in-service isevidenced by a signature sheet. TMs wereinstructed using surveyor observations as exampleswith emphasis on, but not limited to, the following:proper use of protective gowns. The Charge Nurse(CN) is responsible for oversight of infectioncontrol practice daily. Instances of non-compliancewill be addressed with the TM responsibleimmediately. The Facility Administrator (FA) ordesignee will conduct observational infectioncontrol audits on random shifts 3x a week for onemonth, then monthly with regularly scheduledinfection control audits. Results of audits will bereviewed with the Medical Director during themonthly QIFMM and continued frequency ofaudits determined by the team	08/31/2012

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	open exposing her uniform. This practice created the potential for the transfer of disease causing organisms among the nurse and the patients. 3. The facility's Clinical Services Specialist, employee L, indicated, on 8-3-12 at 10:00 AM, the employees' gowns should be completely buttoned from top to bottom while out on the treatment floor. 4. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Appropriate lab coats or gowns will be worn at all times when on the treatment floor."		with supportingdocumentation included in the meeting minutes.The FA is responsible for compliance with thisPOC.	

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V0124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. Based on administrative record and facility policy review and interview, the facility failed to ensure monthly hepatitis B antigen testing had been completed in 1 (# 8) of 14 hepatitis B susceptible patients reviewed creating the potential to affect all of the facility's hepatitis B susceptible patients. The findings include: 1. The facility's March 2011 "Hepatitis Surveillance, Vaccination and Infection Control Measures" policy number 1-05-02 states, "Monthly hepatitis B surface antigen (HBsAg) testing will be completed on patients who are susceptible or not immune to hepatitis B infection, including non-responders to the vaccine." 2. The facility's "Hepatitis Status and Compliance with CDC Recommendations	V0124	Clinical Teammates (TMs) were in-serviced on08/03/2012 in the following: Policy 01-05-02:Hepatitis Surveillance Vaccination and InfectionControl Measures. Verification on attendance atin-service is evidenced by a signature sheet. TMswere instructed using surveyor observations asexamples with emphasis on, but not limited to, theimportance of appropriate Hepatitis testing for allpatients without adequate Hepatitis B antibodies.The Charge Nurse (CN) is responsible foroversight of Hepatitis testing. Instances of noncompliancewill be addressed with the TMresponsible. The Facility Administrator (FA) ordesignee will conduct monthly Hepatitis auditsafter monthly lab is drawn. Results of audits willbe reviewed with the Medical Director during themonthly QIFMM and continued frequency ofaudits determined by	08/31/2012

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	for Hepatitis B Testing on ESRD Patients" printed 8/01/2012 evidenced monthly hepatitis B antigen testing had not been completed for patients who were known to be susceptible or whose antibody status was unknown. The hepatitis status report evidenced the antibody status for patient number 8 was less than 10. The report failed to evidence monthly antigen testing had been completed in March and April 2012. 3. The clinical services specialist, employee L, stated, on 8-3-12 at 11:55 AM, "We knew that."		the team with supportingdocumentation included in the meeting minutes.The FA is responsible for compliance with thisPOC.	

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V0318	494.50(b)(1) REPROCESSING AREA & VENTILATION ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1 8 Physical plant and environmental safety considerations 8.1 Reprocessing area and ventilation The reprocessing area should be designed to suit the operation carried out and maintain acceptable ambient concentrations of harmful substances (see Table 1). The area should be kept clean and sanitary. It may be part of the dialysis treatment area, as long as equipment used is properly designed and vented to meet the requirements for environmental safety (see [AAMI] 8.5). Table 1-OSHA environmental exposure limits (29 CFR 1910, 1 July 1998), except as indicated Substance/material Limits (PEL)a Acetic acid 10 ppm TWAb Chlorine dioxide (syn: chlorine oxide) 0.1 ppm TWA Citric acid None developed Formaldehyde 0.75 ppm TWA 2 ppm STELc(15 min) 0.5 ppm action level Glutaraldehyde 0.2 ppm ceiling NIOSH/OSHA Hydrogen peroxide 1 ppm TWA Peracetic acid None developed			

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	Phenol 5 ppm TWA ppm = parts per million a) PEL (permissible exposure limit) represents the limit of what employees can be exposed to; PELs can be TWAs or STELs. b) TWA (time-weighted average) represents the limit of what an employee can be exposed to in an eight-hour period. c) STEL (short-term exposure limit) represents the limit of what an employee can be exposed to in any 15-minute time period. Based on observation and staff interview, the facility failed to ensure the reuse room was properly ventilated to ensure the dispersal of harmful substances in the air in 1 of 1 days of reuse room observations completed. The findings include: 1. On 8-2-12 at 2:31 PM, a strong odor was detected in the reuse room. The reuse technician, employee F, indicated the odor was Renalin, the chemical used to clean and disinfect the used dialyzers during reprocessing. The air temperature in the room was observed to be 80 degrees. 2. The Chief Biomedical Technician, employee M, indicated, on 8-2-12 at 3:05 PM, there existed an issue with a "build-up of heat above the room" and	V0318	Air testing was performed on 08/02/12 when thestrong odor was reported in the reuse room. Airtesting results were within normal limits. ClinicalTeammates were in-serviced on 08/03/2012 in thefollowing: *Policy #02-09-02: Air Testing Policy. Verification of attendance at in-service isevidenced by a signature sheet. TMs wereinstructed on the importance of performing airtesting to monitor proper ventilation and dispersalof harmful substances in the air. The HVACsystem will be inspected to ensure properventilation. Reuse teammates will be re-educatedto notify the Facility Administrator (FA) ordesignee if the air temperature is outside theacceptable limits. The FA or designee will monitordocumented reuse room temperatures daily x 2weeks, weekly x 4 weeks, and then monthlyaccording to the Reuse Monthly CQI ReviewForm. The FA or designee will conduct*	08/31/2012

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	that might be affecting the ventilation in the reuse room.		*baselinevapor concentration testing weekly for 4 weeks,then monthly for 3 months, then quarterly aftersuccessful baseline testing is established. The FAwill be responsible for auditing these results.Results of audits will be reviewed with the MedicalDirector during the monthly QIFMM andcontinued frequency of audits determined by theteam with supporting documentation included inthe meeting minutes. The FA is responsible forcompliance with this POC.*	

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V0401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on administrative record and facility policy review and interview, the facility failed to ensure it had maintained the facility by completing monthly facility assessments and evaluations in 1 (July 2012) of 7 months reviewed creating the potential for an unsafe or unhealthy work environment. The findings include: 1. The facility's August 2006 "System for Hazard Assessment, Evaluation and Correction" policy number 4-08-03 states, "A monthly inspection of the facility will be completed using the 'Monthly OSHA and Safety Checklist.'" 2. The facility's administrative records failed to evidence the monthly assessment had been completed in July 2012. 3. The assistant facility administrator, employee E, stated, on 8-2-12 at 2:40 PM, "No, it has not been done in July."	V0401	Clinical Teammates were in-serviced on08/03/2012 in the following: Policy #04-08-03:System for Hazard Assessment Evaluation andCorrection. Verification of attendance at inserviceis evidenced by a signature sheet. TMswere instructed on the importance of completingmonthly facility assessments on the OSHA andSafety Checklist. The Safety Team Leader isdesignated to complete the monthly OSHA andSafety Checklist. In the event the Safety TeamLeader is unable to complete the monthlychecklist, the Facility Administrator (FA) orCharge Nurse (CN) will assign it to anotherteammate. Results of audits will be reviewed withthe Medical Director during the monthly QIFMMand addressed as necessary. The FA is responsiblefor compliance with this POC.	08/31/2012

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V0407	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). Based on clinical record review and facility policy review and interview, the facility failed to ensure patients had been monitored at least every 30 minutes in 2 (#s 1 and 2) of 5 records reviewed creating the potential to affect all of the facility's 29 current patients. The findings include: 1. The facility's March 2012 "Intradialytic Treatment Monitoring" policy number 1-03-09 states, "Treatment checks should be completed at least every thirty (30) minutes." 2. Clinical record number 1 failed to evidence treatment checks had been completed at least every 30 minutes. A. A post treatment flow sheet dated 7-9-12 evidenced a treatment check had been completed at 8:32 AM and not again until 9:32 AM, a period of 1 hour between treatment checks. B. A post treatment flow sheet dated 7-16-12 evidenced a treatment check had	V0407	TMs were in-serviced 08/03/2012 in the following:Policy #1-03-09: Intradialytic Treatment Monitoring.Verification of attendance at in-serviceis evidenced by a signature sheet. TMs wereinstructed on the importance of monitoring anddocumenting vital signs at least every 30 minutes.The Charge Nurse (CN) is responsible for oversightof patient monitoring. Instances of non-compliancewill be addressed with the TM responsibleimmediately. The FA or designee will audittreatment flowsheets of 50% for the first 4 weeks,then 10% weekly x4, then 10% monthly. Results ofaudits will be reviewed with the Medical Directorduring the monthly QIFMM and continuedfrequency of audits determined by the team withsupporting documentation included in the meetingminutes. The FA is responsible for compliance withthis POC.	08/31/2012

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	been completed at 8:45 AM and again at 9:34 AM, a period of 49 minutes. The flow sheet evidenced a treatment check was completed at 10:10 AM and not again until 10:54 AM, a period of 44 minutes between treatment checks. C. A post treatment flow sheet dated 7-23-12 evidenced a treatment check had been completed at 9:31 AM and not again until 10:30 AM, a period of 59 minutes between treatment checks. 3. Clinical record number 2 failed to evidence treatment checks had been completed at least every 30 minutes. A. A post treatment flow sheet dated 7-11-12 evidenced a treatment check had been completed at 7:47 AM and not again until 8:40 AM, a period of 53 minutes between treatment checks. B. A post treatment flow sheet dated 7-25-12 evidenced a treatment check had been completed at 10:42 AM and not again until 11:42 AM, a period of 1 hour between treatment checks. 4. The clinical services specialist, employee L, indicated, on 8-3-12 at 11:30 AM, treatment checks had not been completed at least every 30 minutes in records numbered 1 and 2.			

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V0516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. Based on clinical record and facility policy review and interview, the facility failed to ensure initial assessments had been completed within 30 calendar days in 1 (# 2) of 5 records reviewed creating the potential to affect all new admissions to the facility. The findings include: 1. Clinical record number 2 evidenced the patient's first date of dialysis at this facility was 10-13-11. The record evidenced the initial assessment had not been completed until 12-9-11. 2. The clinical services specialist, employee L, indicated, on 8-3-12 at 11:30 AM, the initial assessment found in record number 2 had not been completed within 30 days. 3. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "New patient . . . Assessment Within 30 days of admission to facility . .	V0516	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessment.and Plan of Care when Utilizing Falcon DialysisVerification of attendance at in-service isevidenced by a signature sheet. TMs wereinstructed using surveyor observations as exampleswith emphasis on, but not limited to, the following:ensuring initial assessments are completed within30 calendar days or 13 treatments. The IDT willmeet at minimum monthly to review Falconassessment work list. The Facility Administrator(FA) or designee will be responsible for notifyingall IDT members and updating the worklistwhenever there is an admission and for ensuringthat IDT meetings are scheduled. The FA ordesignee will conduct monthly audits ofassessments and plans of care on all new patientadmissions over the next 3 months. Results ofaudits will be reviewed with the Medical Directorduring the monthly QIFMM and continuedfrequency of audits determined by the team	08/31/2012

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 08/03/2012
NAME OF PROVIDER OR SUPPLIER TELL CITY DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1602 MAIN ST TELL CITY, IN 47586	

(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
	. Plan of Care Within 30 days of admission to facility."		withsupporting documentation included in the meetingminutes. The FA is responsible for compliancewith this POC.	

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 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TELL CITY DIALYSIS CENTER	1602 MAIN ST TELL CITY, IN 47586

(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
V0520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. Based on clinical record and facility policy review and staff interview, the facility failed to ensure comprehensive assessments had been completed monthly in 1 (# 5) of 1 unstable patient records reviewed creating the potential to affect all of the facility's 29 current patients. The findings include: 1. Clinical record number 5 included a comprehensive assessment/plan of care dated 9-2-11 that identifies the patient as unstable. The record failed to evidence the comprehensive assessment/plan of care had been reviewed again until 11-18-11. The record failed to evidence the comprehensive assessment/plan of care had been reviewed and updated	V0520	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessmentand Plan of Care when Utilizing Falcon DialysisVerification of attendance at in-service is evidencedby a signature sheet. TMs were instructed usingsurveyor observations as examples with emphasison, but not limited to, the following: ensuringassessments and plans of care on unstable patientsare completed monthly. The IDT will meet atminimum monthly to review Falcon assessmentwork list. The Facility Administrator (FA) ordesignee will be responsible for notifying all IDTmembers and updating the worklist whenever thereis an unstable patient and for ensuring	08/31/2012

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 08/03/2012

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	during October 2011. 2. The clinical services specialist, employee L, stated, on 08/03/2012 at 11:30 AM, " I do not see that a care plan or assessment was done in October." 3. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states with regards to timeframes for comprehensive assessments and plans of care, "Monthly (unstable patients). Monthly until patient is determined by interdisciplinary team to be stable."		that IDTmeetings are scheduled. The FA or designee willconduct monthly audits of assessments and plans ofcare on all unstable patients over the next 3 months.Results of audits will be reviewed with the MedicalDirector during the monthly QIFMM and continuedfrequency of audits determined by the team withsupporting documentation included in the meetingminutes. The FA is responsible for compliance withthis POC.	

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V0543	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; 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 pressures in 2 (#s 2 and 5) of 5 records reviewed. The findings include: 1. Clinical record number 2 evidenced the patient received dialysis treatments 3 times per week for 4 hours and 30 minutes each treatment. Hemodialysis treatment flow sheets failed to evidence that lower than normal (120/80) blood pressures during the treatments had been addressed. A. A post treatment flow sheet dated 7-16-12 evidenced the patient's blood pressure ranged from 102/58 to 81/49 during the treatment. The flow sheet states, "Goal down to 4000 due to c/o nausea and BP dropping." B. A post treatment flow sheet dated 7-18-12 evidenced the patient's blood	V0543	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessmentand Plan of Care when Utilizing Falcon Dialysiswith special focus on ensuring the plan of careaddresses dose of dialysis. Verification ofattendance at in-service is evidenced by a signaturesheet. TMs were instructed on the importance ofensuring the necessary care and services areprovided to manage patients' blood pressure andvolume status. Emphasis was placed on addressingblood pressures that are outside of normal limitsand documenting the events in the medical record.The Charge Nurse (CN) is responsible for theoversight of daily blood pressure and volume statusmonitoring. The Facility Administrator (FA) ordesignee will audit treatment flowsheets of 50% forthe first 4 weeks, then 10% weekly x4, then 10%monthly. Results of audits will be reviewed withthe Medical Director during the monthly QIFMMand continued frequency of audits determined bythe team	08/31/2012

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 08/03/2012
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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	pressure decreased to 97/52 and 85/47 during the treatment. The flow sheet states, "Goal down to 3290 and 200 cc NS given." C. A post treatment flow sheet dated 7-20-12 evidenced the patient's blood pressure ranged from 96/49 to 89/49 30 minutes after the treatment had been discontinued. The flow sheet evidenced the patient's blood pressure standing at the end of the treatment was 93/44. D. A post treatment flow sheet dated 7-23-12 evidenced the patient's standing blood pressure at the end of the treatment was 98/57. E. A post treatment flow sheet dated 7-27-12 evidenced the patient's blood pressure ranged from 101/26 to 78/31 the last 40 minutes of the treatment with a standing end of treatment blood pressure reading of 103/40. The flow sheet states, "Pt c/o [complaint of] lightheaded turn goal to UF rate 300." F. A post treatment flow sheet dated 7-30-12 evidenced the patient's blood pressure was 101/57 and 99/43 the last 20 minutes of the treatment. G. During an interview with the patient, on 8-1-12 at 11:17 AM, the		with supporting documentation includedin the meeting minutes. The FA is responsible forcompliance with this POC.	

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	patient stated, "They give me extra fluid at the end of my treatment. My dry wt [weight] is 139.5. The doctor wants me to be at 138; the last few days I have not been able to do it." 2. Clinical record number 5 evidenced the patient received dialysis treatments 3 times per week for 3 hours and 45 minutes each treatment. Hemodialysis treatment flow sheets failed to evidence that lower than normal (120/80) blood pressures during the treatments had been addressed. A. A post treatment flow sheet dated 7-11-12 evidenced the patient's blood pressure had ranged from 90/46 to 75/28 the last 1 hour of the treatment. The flow sheet states, "Reports being dizzy." B. A post treatment flow sheet dated 7-13-12 evidenced the patient's blood pressure had ranged from 103/52 to 72/35 during the treatment. The flow sheet states, "Goal reduced to 2.5 for low BP." C. A post treatment flow sheet dated 7-16-12 evidenced the patient's blood pressure had ranged from 117/53 to 86/43 during the treatment. The flow sheet evidenced 100 milliliters of normal saline was administered "for low BP."			

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	D. A post treatment flow sheet dated 7-18-12 evidenced the patient's blood pressure ranged from 110/55 to 90/42 during the treatment. The flow sheet states, "c/o cramping. 200 cc NS given." E. A post treatment flow sheet dated 7-20-12 evidenced the patient's blood pressure ranged from 92/48 to 58/31 the last 40 minutes of the treatment. The flow sheet states, "100 cc NS flush given for low BP." F. A post treatment flow sheet dated 7-30-12 evidenced the patient's blood pressure ranged from 113/54 to 81/38 throughout the treatment. The flow sheet states, "Pt resting, c/o fingers starting to cramp, cont to monitor." 3. The clinical services specialist, employee L, was unable to provide any additional documentation and/or information when asked on 8-3-12 at 11:30 AM. 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."			

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V0551	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. Based on clinical record and facility policy review and staff interview, the facility failed to ensure plans of care provided for monitoring of patient's vascular accesses in 2 (#s 3 and 4) of 5 records reviewed creating the potential to affect all of the facility's 29 current patients. The findings include: 1. Clinical record number 3 included a plan of care dated 7-17-12 that identified the patient had a central venous catheter (CVC) as the primary access. The plan of care failed to evidence interventions to monitor and maintain the CVC. 2. Clinical record number 4 included a plan of care dated 6-26-12 that identified the patient had a fistula as the primary access. The plan of care failed to evidence interventions to monitor and maintain the fistula. 3. The clinical services specialist, employee L, was unable to provide any additional documentation and/or	V0551	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessment and Plan of Care when Utilizing Falcon Dialysis,*with special focus on ensuring the plan of careincludes interventions for monitoring the patient'svascular access. Verification of attendance at inserviceis evidenced by a signature sheet. TMs wereinstructed using surveyor observations as exampleswith emphasis on, but not limited to, the following:ensure vascular accesses are monitored to preventaccess failure, including monitoring ofarteriovenous grafts and fistulas, and CVCs.Teammates were re-educated on proper method ofdocumenting vascular access monitoring in Falcon.The Charge Nurse (CN) is responsible for oversightof access monitoring. The Facility Administrator(FA) or designee will conduct monthly audits ofplans of care to monitor adherence ofdocumentation for 3 months. Results of audits willbe reviewed with the Medical Director during themonthly QIFMM and continued frequency*	08/31/2012

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	information when asked on 8-3-12 at 11:30 AM. 4. The facility's September 2011 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "The plan of care will address, but not be limited to, the following: . . . When indicated, vascular access which addresses vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access . . . When indicated, the patient's vascular access will be monitored to prevent access failure and detect symptoms of stenosis in graft and fistulae."		*of auditsdetermined by the team with supportingdocumentation included in the meeting minutes.The FA is responsible for compliance with thisPOC.*	

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V0552	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. Based on clinical record and facility policy review and staff interview, the facility failed to ensure plans of care provided for monitoring of patients' psychosocial status in 2 (#s 3 and 4) of 5 records reviewed creating the potential to affect all of the facility's 29 current patients. The findings include: 1. Clinical record number 3 included a plan of care dated 7-17-12. The plan of care failed to evidence interventions to monitor the patient's psychosocial status. 2. Clinical record number 4 included a plan of care dated 6-26-12. The plan of care failed to evidence interventions to monitor the patient's psychosocial status. 3. The clinical services specialist, employee L, was unable to provide any	V0552	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessmentand Plan of Care when Utilizing Falcon Dialysiswith special focus on ensuring plans of care providefor monitoring of patients' psychosocial status.Verification of attendance at in-service is evidencedby a signature sheet. TMs were instructed usingsurveyor observations as examples with emphasison, but not limited to, the following: ensure thepatient's psychosocial status is monitored byincluding interventions from the social worker.Teammates were re-educated on proper method ofdocumenting interventions to monitor the patients'psychosocial status in Falcon. The FacilityAdministrator (FA) or designee will conductmonthly audits of plans of care to monitoradherence of documentation for 3 months.	08/31/2012

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	additional documentation and/or information when asked on 8-3-12 at 11:30 AM. 4. The facility's September 2011 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "The plan of care will address, but not be limited to, the following: . . .Psychosocial status which addresses necessary monitoring and social work interventions."		Resultsof audits will be reviewed with the MedicalDirector during the monthly QIFMM and continuedfrequency of audits determined by the team withsupporting documentation included in the meetingminutes. The FA is responsible for compliance withthis POC.	

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V0557	494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. Based on clinical record and facility policy review and interview, the facility failed to ensure initial plans of care had been implemented within 30 calendar days in 1 (# 2) of 5 records reviewed creating the potential to affect all new admissions to the facility. The findings include: 1. Clinical record number 2 evidenced the patient's first date of dialysis at this facility was 10-13-11. The record evidenced the initial plan of care had not been completed and implemented until 12-9-11. 2. The clinical services specialist, employee L, indicated, on 8-3-12 at 11:30 AM, the initial plan of care found in record number 2 had not been completed within 30 days. 3. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "New patient . . . Assessment	V0557	Clinical Teammates (TMs) and InterdisciplinaryTeam (IDT) were in-serviced 08/03/2012 in thefollowing: Policy #1-01-14: Patient Assessmentand Plan of Care when Utilizing Falcon Dialysis.Verification of attendance at in-service isevidenced by a signature sheet. TMs wereinstructed using surveyor observations as exampleswith emphasis on, but not limited to, the following:ensuring initial plans of care are completed within30 calendar days or 13 treatments. The IDT willmeet at minimum monthly to review Falconassessment work list. The FA or designee will beresponsible for notifying all IDT members andupdating the worklist whenever there is anadmission and for ensuring that IDT meetings arescheduled. The Facility Administrator (FA) ordesignee will conduct monthly audits ofassessments and plans of care on all new patientadmissions over the next 3 months. Results ofaudits will be reviewed with the Medical Directorduring the monthly QIFMM and continuedfrequency of audits determined by the team	08/31/2012

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	Within 30 days of admission to facility . . . Plan of Care Within 30 days of admission to facility."		withsupporting documentation included in the meetingminutes. The FA is responsible for compliancewith this POC.	

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V0715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on clinical record and facility policy review, observation, and interview, the medical director failed to ensure facility staff had provided care in accordance with the facility's patient monitoring policy in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed and with the facility's central venous catheter dressing change policy in 1 of 1 observation creating the potential to affect all of the facility's 29 current patients. The findings include: Regarding post treatment assessments: 1. The facility's March 2011 "Post Treatment Patient Assessment" policy number 1-03-12 states, "The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings . . . Assessment data includes the following: Weight, Temperature, Blood Pressure, Cardiac status, respiratory status, peripheral edema, vascular access, mental status,	V0715	Post-Treatment Assessment: TMs were inserviced08-03-2012 in the following: Policy#1-03-12: Post Treatment Patient AssessmentVerification of attendance at in-service isevidenced by a signature sheet. All RNs wereinstructed on the importance of obtaining basicdata on each patient post dialysis and comparingto pre-dialysis findings. The Charge Nurse (CN)is responsible for oversight of patient monitoring.Instances of non-compliance will be addressedwith the TM responsible immediately. The FA ordesignee will audit treatment flowsheets of 50%for the first 4 weeks, then 10% weekly x4, then10% monthly. Results of audits will be reviewedwith the Medical Director during the monthlyQIFMM and continued frequency of auditsdetermined by the team with supportingdocumentation included in the meeting minutes.The FA and Medical Director are responsible forcompliance with this POC.CVC Cleaning and Dressing Change:	08/31/2012

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 08/03/2012
NAME OF PROVIDER OR SUPPLIER TELL CITY DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1602 MAIN ST TELL CITY, IN 47586	

(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
	ambulatory status." 2. Clinical record number 1 included post treatment flow sheets dated 7/20/2012, 7-23-12, and 7/27/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed. 3. Clinical record number 2 included post treatment flow sheets dated 07/13/2012, 07/18/2012, 07/20/2012, and 07/27/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed. 4. Clinical record number 3 included post treatment flow sheets dated 07/12/2012, 07/24/2012, and 07/28/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed. 5. Clinical record number 4 included post treatment flow sheets dated 07/12/2012, 07/24/2012, and 07/28/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed. 6. Clinical record number 5 included post treatment flow sheets dated 07/13/2012, 07/20/2012, and 08/01/2012 that failed to evidence a post treatment assessment that		TMs werein-serviced 08-03-2012 in the following: Policy#1-04-02C: Central Venous Catheter Cleaningand Dressing Change. Verification of attendanceat in-service is evidenced by a signature sheet.TMs were instructed using surveyor observationsas examples with emphasis on, but not limited to,the following: to ensure catheter limbs arecleaned starting at exit site and cleaning entirelength of limbs. The Charge Nurse (CN) isresponsible for oversight of CVC dressingchanges. The Facility Administrator (FA) ordesignee will audit CVC dressing changes weeklyx 4 weeks. The infection control manager willaudit this monthly with the infection control audit.Results of audits will be reviewed with theMedical Director during the monthly QIFMM andcontinued frequency of audits determined by theteam with supporting documentation included inthe meeting minutes. The FA and MedicalDirector are responsible for compliance with thisPOC.	

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	included all of the required data had been completed. 7. The clinical services specialist, employee L, was unable to provide any additional documentation and/or information when asked on 8-3-12 at 11:30 AM. Regarding central venous catheter (CVC) dressing changes: 1. The facility's March 2011 "Central Venous Catheter (CVC) Cleaning and Dressing Change" procedure number 1-04-02C states, "Using fresh germicidal moistened gauze, clean catheter limbs, starting at exit site and cleaning entire length of limbs." 2. On 8-3-12 at 9:22 AM, employee D, a licensed practical nurse (LPN), was observed to change the CVC dressing on patient number 6. The LPN failed to cleanse the catheter limbs after cleansing the insertion site as required by the facility's procedure. 3. The clinical services specialist, employee L, indicated, on 8-3-12 at 8:50 AM, cleansing the CVC limbs was a required part of the procedure.			

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