

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 180 E CARMEL DR CARMEL, IN 46032
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V000000	<p>This was a federal ESRD complaint investigation survey.</p> <p>Complaint #: IN00132083 - Unsubstantiated: Lack of sufficient evidence. Deficiencies unrelated to the complaint are cited.</p> <p>Survey Date: 8/14/13</p> <p>Medicaid Vendor #: 200890530A</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>Census: 32 In-Center hemodialysis patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 20, 2013</p>	V000000		

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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V000541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS 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, observation, and staff interview, the facility failed to evidence patients had been afforded the opportunity to participate in the development of the plans of care failed to ensure plans of care had been developed in 1 (# 1) of 5 records reviewed of patients with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. On 8/14/13 at 12 PM, a care plan for patient 1 with print date 8/9/13 was observed on the counter of the in-center unit. The care plan was without any signature of the IDT or the patient. When asked why the care plan was in location observed, employee E indicated that the clinic manager used to review with the</p>	V000541	V 541 Interdisciplinary Team (IDT) will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patient #1 to ensure all members of IDT including patient or patient's designated representative participate in care planning process when developing individualized plan of care, and all members' signatures are present verifying participation. If patient chooses not to sign the plan of care, the choice will be documented on the plan of care, along with the reason the signature was not provided. Deficiency discussed and reviewed by Medical Director during Quality Improvement Facility Management Meeting (QIFMM) on 8/23/2013. Facility Administrator (FA) held mandatory in-service for Interdisciplinary Team (IDT) on	09/14/2013			

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	<p>patients after the care plan meetings and indicated she did not complete this task. When asked, the employee indicated patient 1 was a current in-center patient and was dialyzing in station 7.</p> <p>Clinical record number 1 evidenced the start of care date 2/10/12. The record included a plan of care developed by the interdisciplinary team (IDT) on 7/2/12 and signed by the patient on 8/13/12. The record failed to evidence why the patient had not been included in the plan of care until 8/13/12. The record included a comprehensive re-assessment with the last entry date of 6/18/13. The clinical record failed to evidence the development and implementation of a new and current care plan.</p> <p>2. On 8/14/13 at 3 PM, the facility's interim administrator, employee A, indicated care plans and quality improvement meetings were held on the same day and the social worker took care of inviting patients to their care plan meetings. She was not aware of how this was done and documented.</p> <p>3. On 8/14/13 at 3 PM, the social worker indicated that there was no documentation that the patients were invited to participate in their care plans and the "current " care plan for patient 1 was</p>		<p>8/23/2013. In-service included but was not limited to: review of Policy & Procedure # 1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, emphasizing IDT consists of at a minimum: Physician treating the patient for ESRD, patient or patient's designated representative, Registered Nurse, Social Worker, and Renal Dietician. IDT must promote patient participation in developing the plan of care. If IDT member is unable to attend in person, they may attend telephonically. Plan of Care must be signed by entire IDT verifying participation in plan of care. If patient chooses not to sign the plan of care, the choice will be documented on the plan of care, along with the reason the signature was not provided. MSW will be responsible to give patients formal invite to their plan of care meetings in which patient will sign whether they will attend or decline. If patient declines all IDT members will meet with patient at chair side to discuss plan of care and goals within seven business days and all disciplines will sign plan of care at that time along with implement changes to plan of care to address issues to achieve specified goals. Verification of attendance at in- service will be evidenced by teammates (TMs) signature on in-service sheet. Assessment Manager will</p>				

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	<p>placed on the unit so that the registered nurse could review with the patient. The social worker indicated the care plan meeting for patient 1 was held during the last quality improvement meeting on 7/28/13.</p> <p>4. On 8/14/13 at 6:30 PM, employee A indicated there was no evidence a plan of care was developed by the IDT and implemented based on the comprehensive re-assessment dated 6/18/13 for patient # 1 and she did not know why.</p> <p>5. The facility failed to follow it's own policy by failing to ensure a plan of care was developed for each patient. The facility policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," revision date March 2013, Policy: 1-14-02, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients. ... The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specified the services necessary to address the patient's needs. ... The plan of care following reassessments must be completed within 15 days of completing the re-assessment. ... If patient wishes not to sign the plan of care, this choice</p>		<p>oversee process control of all Plans of Care from inception to completion of meetings and signatures obtained. FA or designee will conduct Medical Records Audits monthly for 10% of current patient census, to ensure plans of care are signed by all members of IDT including patient, or patient designated representative. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this Plan of Correction</p>		

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	will be documented on the plan of care, along with the reason the signature was not provided."				

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V000542	<p>494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. Based on clinical record and facility policy review, observation, and staff interview, the facility failed to evidence patients had been afforded the opportunity to participate in the development of the plans of care failed to ensure plans of care had been developed in 1 (# 1) of 5 records reviewed of patients with the potential to affect all patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/14/13 at 12 PM, a care plan for patient 1 with print date 8/9/13 was observed on the counter of the in-center unit. The care plan was without any signature of the IDT or the patient. When asked why the care plan was in location observed, employee E indicated that the clinic manager used to review with the patients after the care plan meetings and indicated she did not complete this task. When asked, the employee indicated patient 1 was a current in-center patient and was dialyzing in station 7. <p>Clinical record number 1 evidenced the start of care date 2/10/12. The record included a plan of care developed by the interdisciplinary team (IDT) on 7/2/12 and signed by the patient on 8/13/12. The</p>	V000542	<p>V 542 IDT will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patient #1 to ensure all members of IDT including patient or patient's designated representative participate in care planning process when developing individualized plan of care, and all members' signatures are present verifying participation. If patient chooses not to sign the plan of care, the choice will be documented on the plan of care, along with the reason the signature was not provided. Deficiency discussed and reviewed by Medical Director during QIFMM on 8/23/2013. FA held mandatory in-service for IDT on 8/23/2013. In-service included but was not limited to: review of Policy & Procedure # 1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, emphasizing IDT consists of at a minimum: Physician treating the patient for ESRD, patient or patient's designated representative, Registered Nurse, Social Worker, and Renal Dietician. IDT must promote patient participation in developing the plan of care. If IDT member is unable to attend in person, they may attend telephonically. Plan of Care must be signed by entire IDT verifying</p>	09/14/2013	

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	<p>record failed to evidence why the patient had not been included in the plan of care until 8/13/12. The record included a comprehensive re-assessment with the last entry date of 6/18/13. The clinical record failed to evidence the development and implementation of a new and current care plan.</p> <p>2. On 8/14/13 at 3 PM, the facility's interim administrator, employee A, indicated care plans and quality improvement meetings were held on the same day and the social worker took care of inviting patients to their care plan meetings. She was not aware of how this was done and documented.</p> <p>3. On 8/14/13 at 3 PM, the social worker indicated that there was no documentation that the patients were invited to participate in their care plans and the "current " care plan for patient 1 was placed on the unit so that the registered nurse could review with the patient. The social worker indicated the care plan meeting for patient 1 was held during the last quality improvement meeting on 7/28/13.</p> <p>4. On 8/14/13 at 6:30 PM, employee A indicated there was no evidence a plan of care was developed by the IDT and implemented based on the comprehensive</p>		<p>participation in plan of care. If patient chooses not to sign the plan of care, the choice will be documented on the plan of care, along with the reason the signature was not provided. MSW will be responsible to give patients formal invite to their plan of care meetings in which patient will sign whether they will attend or decline. If patient declines all IDT members will meet with patient at chair side to discuss plan of care and goals within seven business days and all disciplines will sign plan of care at that time along with implement changes to plan of care to address issues to achieve specified goals. Verification of attendance at in- service will be evidenced by TMs signature on in-service sheet. Assessment Manager will oversee process control of all Plans of Care from inception to completion of meetings and signatures obtained. FA or designee will conduct Medical Records Audits monthly for 10% of current patient census, to ensure plans of care are signed by all members of IDT including patient, or patient designated representative. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this Plan of Correction</p>		

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	<p>re-assessment dated 6/18/13 for patient # 1 and she did not know why.</p> <p>5. The facility failed to follow it's own policy by failing to ensure a plan of care was developed for each patient. The facility policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," revision date March 2013, Policy: 1-14-02, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients. ... The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specified the services necessary to address the patient's needs. ... The plan of care following reassessments must be completed within 15 days of completing the re-assessment. ... If patient wishes not to sign the plan of care, this choice will be documented on the plan of care, along with the reason the signature was not provided."</p>				

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V000559	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care were updated and changed when needs were identified and goals not attained in 1 (#s 6) of 5 records reviewed with care plans creating the potential to affect all of the facility's 32 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 evidenced a care plan dated 8/24/12 which identified the patient's blood pressure and fluids goals were not met and the goal was for the patient's pre treatment BP to be less than or equal to 140 / 90.</p> <p>A. The record evidenced the patient was treated in a hospital emergency room</p>	V000559	<p>V 559 IDT will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patient #6 addressing current fluid management needs of patient including evaluation of blood pressures, and unmet goals with adjustment to dialysis prescriptions and/or plan of care to meet the needs of the patients.</p> <p>Deficiency discussed and reviewed by Medical Director during QIFMM on 8/23/2013. FA held mandatory in-service for IDT on 8/23/2013. In-service included but was not limited to: review of Policy & Procedure # 1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, Policy & Procedure # 3-02-02 Medical Record Preparation and Charting Guidelines, emphasizing 1) IDT must provide the necessary care</p>	09/14/2013			

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	<p>on 6/9/13 with fluid overload. The record evidenced the patient returned to the same hospital emergency room on 6/26/2013 with the same blood pressure and fluid overload problems.</p> <p>B. The post treatment records evidenced the pre - treatment blood pressure sitting and standing, respectively, for the following dates:</p> <p>7/1/13 - 153 / 101 and 179 / 67 7/5/13 - 209 / 91 and 215 / 96 7/8/13 - 208 / 93 and 204 / 87 7/17/13 - 186 / 84 and 178 / 84 7/22/13 - 206 / 92 and 203 / 88 7/24/13 - 205 / 92 and 203 / 86 7/26/13 - 214 / 88 and 227 / 102 8/14/13 - 149 / 98 and 175 / 76</p> <p>C. The record failed to evidence the interdisciplinary team (IDT) had identified reasons for the patient's unmet goals and fluid overload and had adjusted the plan of care and addressed why the patient was not meeting the stated goals.</p> <p>2. On 8/14/13 at 8 PM, employee A indicated employee H documented in the electronic clinical record for patient #6 on 8/9/13 regarding the patients blood pressure and fluids and that the patient was reeducated. When asked how employee H educated the patient on</p>		<p>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, document reasons why patient unable to achieve goals, and implement changes to plan of care to address issues to achieve specified goals. 2) All documentation entries must be accurate, documentation must be completed at the time of service. If unable to chart immediately after rendering a service or at time of an observation, the teammate is to make appropriate entry as soon as possible. Documentation done within the same treatment day is not considered "Late Entry". Documentation done following day must have entry labeled as "Late Entry". 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 10% of current patient census, to ensure documentation is accurate; plans of care are in place, current, needs of patient including fluid volume management are evaluated/addressed, and documentation of action plans and response to interventions are present. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation</p>				

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	<p>8/9/13 as the employee was not working in the facility 8/9/13, employees A and H indicated employee H documented into the electronic medical record from a remote location while working in another facility. Employees A and H indicated the documentation of intervention was a summary of previous education and was not necessarily completed on the day of documentation. Employee H was unclear as to when she last spoke with and educated patient 6 and indicated the last date she was in the facility was July 28, 2013.</p> <p>3. The facility's policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," revision date March 2013, Policy: 1-14-02, states, "If expected outcomes is not achieved, the interdisciplinary team, including the patient's or personal representative and be signed by team members including the patient or patient's personal representative. If patient wishes not to sign the plan of care, this choice will be documented on the plan of care, along with the reason the signature was not provided."</p> <p>4. The facility policy titled "Medical Record Preparation and Charting Guidelines" stated, "Patient medical records are legal documents serving</p>		<p>included in the meeting minutes. FA is responsible for compliance with this Plan of Correction</p>				

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	<p>several important purposes: ...</p> <p>Facilitating medical care and treatment - enabling members of the treatment team and future caregivers to understand the patient's diagnosis, history, and course of treatment. ... Providing evidence that services were furnished when reasonable and necessary, ... Establishing compliance with applicable licensure requirements and conditions of participation in payer programs. ... All entries must be accurate. ...</p> <p>Documentation is to be completed at the time of service. ... Corrections to the Medical Record ... Late Entries - If unable to chart immediately after rendering a service or at time of an observation, the teammate is to make the appropriate entry as soon as possible. Documentation done within the same day would not be considered a 'Late Entry.' Documentation done the following day would need to have the entry labeled as "late entry."</p>						

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V000726	<p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. Based on clinical review and facility policy review, and interview, the facility failed to ensure medical records were accurately dated and included all pertinent information related to patient treatment in 1 of 5 (# 6) records reviewed with the potential to affect all the patients of the facility.</p> <p>The findings include:</p> <p>1. Clinical record number 6 evidenced a care plan dated 8/24/12 which identified the patient's blood pressure and fluids goals were not met and the goal was for the patient's pre treatment BP to be less than or equal to 140 / 90.</p> <p>A. The record evidenced the patient was treated in a hospital emergency room on 6/9/13 with fluid overload. The record evidenced the patient returned to the same hospital emergency room on 6/26/2013 with the same blood pressure and fluid overload problems.</p>	V000726	<p>V 726 IDT will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patient #6 addressing current fluid management needs of patient including evaluation of blood pressures, and unmet goals with adjustment to dialysis prescriptions and/or plan of care to meet the needs of the patients. Deficiency discussed and reviewed by Medical Director during QIFMM on 8/23/2013. FA held mandatory in-service for IDT on 8/23/2013. In-service included but was not limited to: review of Policy & Procedure # 1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, Policy & Procedure # 3-02-02 Medical Record Preparation and Charting Guidelines, emphasizing 1) 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</p>	09/14/2013			

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	<p>B. The post treatment records evidenced the pre - treatment blood pressure sitting and standing, respectively, for the following dates:</p> <p>7/1/13 - 153 / 101 and 179 / 67 7/5/13 - 209 / 91 and 215 / 96 7/8/13 - 208 / 93 and 204 / 87 7/17/13 - 186 / 84 and 178 / 84 7/22/13 - 206 / 92 and 203 / 88 7/24/13 - 205 / 92 and 203 / 86 7/26/13 - 214 / 88 and 227 / 102 8/14/13 - 149 / 98 and 175 / 76</p> <p>C. The record failed to evidence the interdisciplinary team (IDT) had identified reasons for the patient's unmet goals and fluid overload and had adjusted the plan of care and addressed why the patient was not meeting the stated goals.</p> <p>2. On 8/14/13 at 8 PM, employee A indicated employee H documented in the electronic clinical record for patient #6 on 8/9/13 regarding the patients blood pressure and fluids and that the patient was reeducated. When asked how employee H educated the patient on 8/9/13 as the employee was not working in the facility 8/9/13, employees A and H indicated employee H documented into the electronic medical record from a remote location while working in another</p>		<p>needs, document reasons why patient unable to achieve goals, and implement changes to plan of care to address issues to achieve specified goals. 2) All documentation entries must be accurate, documentation must be completed at the time of service. If unable to chart immediately after rendering a service or at time of an observation, the teammate is to make appropriate entry as soon as possible. Documentation done within the same treatment day is not considered "Late Entry". Documentation done following day must have entry labeled as "Late Entry". 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 10% of current patient census, to ensure documentation is accurate; plans of care are in place, current, needs of patient including fluid volume management are evaluated/addressed, and documentation of action plans and response to interventions are present. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this Plan of Correction</p>		

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	<p>facility. Employees A and H indicated the documentation of intervention was a summary of previous education and was not necessarily completed on the day of documentation. Employee H was unclear as to when she last spoke with and educated patient 6 and indicated the last date she was in the facility was July 28, 2013. Employee H indicated it was not the facility policy to document as the time of service.</p> <p>3. The facility policy titled "Medical Record Preparation and Charting Guidelines" stated, "Patient medical records are legal documents serving several important purposes: ... Facilitating medical care and treatment - enabling members of the treatment team and future caregivers to understand the patient's diagnosis, history, and course of treatment. ... Providing evidence that services were furnished when reasonable and necessary, ... Establishing compliance with applicable licensure requirements and conditions of participation in payer programs. ... All entries must be accurate. ... Documentation is to be completed at the time of service. ... Corrections to the Medical Record ... Late Entries - If unable to chart immediately after rendering a service or at time of an observation, the teammate is to make the</p>				

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	appropriate entry as soon as possible. Documentation done within the same day would not be considered a 'Late Entry.' Documentation done the following day would need to have the entry labeled as "late entry."			

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V000757	<p>494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS The governing body or designated person responsible must ensure that-</p> <p>(1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; Based on observation and interview, the governing body failed to ensure a clinic manager was present a sufficient amount of time to meet the needs of the patients creating the potential to affect all of the facility's current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Upon entering the facility, on 8/14/13 at 11:30 AM, the in-center door was propped open with the foot pedal from a wheelchair. 2. At 12:30 PM, the door of the in-center unit was still propped open and patient 8 entered from the outside the in-center unit, walked to the floor scales and weighed self, then returned to the waiting area through the same door. 3. On 8/14/13 at 12:40 PM, during a confidential interview with employee C, when asked, the employee indicated there had not been a clinic manager or facility administrator on-site since the end of July and indicated they were not aware of who 	V000757	<p>V 757 Deficiency discussed and reviewed by Medical Director during QIFMM on 8/23/2013. All TMs in serviced on 8/23/2013 that door to in center must remain closed at all times and must never be propped open.</p> <p>Governing Body Meeting held on 8/28/2013 and approved Facility Administrator/Clinical Nurse Manager (CNM) meeting Conditions for Coverage and facility, patient needs. FA/CNM is a fulltime employee at Carmel Dialysis. All TMs, and patients given written and verbal notification on 8/28/2013 of approved acting FA/CNM, availability and contact information. FA/CNM held homeroom meeting with all TMs on 8/28/2013 and introduced self to facility patients to discuss facility operations, and any concerns. FA/CNM/CN will hold homeroom meetings at a minimum of weekly to ensure patient and facility needs are met. Administrative Assistant or designee to be present at site every day facility open for business to greet patients and alert TMs that patients have</p>	09/14/2013			

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	<p>was currently in charge. The employee indicated the door was propped open because they did not have anyone at the front desk to notify the staff of patient's arrival and answer the phones. The employee indicated one registered nurse, one certified patient care technician, one new non-certified technician, and then either a nurse or patient care technician which is sent from the float pool is scheduled daily to provide treatment. The employee stated, "We were already in trouble for not answering the phones [when they rang]."</p> <p>4. Employee A, indicated, on 8/14/13 at 1 PM, she was the area Group Facility Manager and had six ESRD facilities that she managed. At the end of July 2013, employee H, the previous clinic manager and facility manager, was promoted and moved to another facility. Employee A indicated, since end of July, she was now the individual responsible for the day to day facility operations and was on-site and present in the facility every Monday, Wednesday, and Friday.</p> <p>5. On 8/14/13 at 8 PM, employee I, an administrative assistant, indicated this was a new position for her and that she does not work onsite at this facility, but she worked at the Eagle Creek facility site with employee A.</p>		<p>arrived. This plan of correction will be reviewed during QIFMM and the FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA & Medical Director are responsible for compliance with this Plan of Correction</p>				

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	<p>6. On 8/14/13 at 1:20 PM, during a confidential interview with employee E, the employee indicated there had not been a clinic manager or facility administrator on-site to work every day the facility is open (Monday, Wednesday, and Friday) since the end of July. The employee indicated they were not aware of who was in currently the clinic manager or in charge of the facility. When asked if any corporate managers or employees A or H had been to the facility since July, the employee shook his / her head, indicating the answer was no.</p> <p>7. At 2:15 PM, the in-center door was still propped open with wheelchair pedal. Employee A indicated the door should not be propped open, when asked.</p> <p>8. During an interview with patient 4, at 4:35 PM, the patient indicated he / she was not aware employee H had moved to another facility and said, "I wondered why I haven't seen her. I thought she was in her office." When asked if he / she knew who was in charge currently, the patient said, "I guess I don't, I haven ' t seen anyone else." When specifically asked if he / she knew employee A and offered the employees name, the patient said "no." The patient did know the names of all the regularly scheduled staff on the floor by</p>						

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	<p>name and discipline.</p> <p>9. Employee F, at 4:40 PM, stated, "I just don't get involved" and indicated he / she did not know who was currently managing the facility. The employee indicated generally working in the facility the three days a week it is open.</p> <p>10. At 8 PM, employee A indicated the staff should know who is in charge because she authorized their reported work hours for payroll.</p>						