

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V0000	<p>This visit was for an ESRD recertification survey.</p> <p>Survey dates: 10/15/12 - 10/18/12</p> <p>Facility #: 5980</p> <p>Medicaid vendor #: 200315330</p> <p>Surveyors: Ingrid Miller, RN, PHNS Susan Sparks, RN, PHNS</p> <p>Census: 181 incenter hemodialysis patients 18 Peritoneal dialysis patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 23, 2012</p>	V0000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0111	<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. Based on observations, staff interview, and review of policies and procedures, the facility failed to ensure that 1 of 1 emergency evaluation cart was clean and supplies were not expired with the potential to affect all the facility's 181 active hemodialysis patients.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. 10/17/2012 11 AM, an emergency evacuation cart was observed on the dialysis clinic's hemodialysis treatment floor. The top of the cart was covered in dust which covered the surface of the cart and the uncovered suction machine which was on the top of this cart. The cart evidenced 7 expired Yankauer Suction vents with expiration dates of 06/2012 on each. 2. On 10/17/12 at 11 AM, Employee G, Registered Nurse, indicated the vents were expired and the suction machine had visible dust on its surface. 3. On 10/1712 at 11:15 AM, Employee A, facility administrator, indicated the 	V0111	Expired supplies immediately removed from emergency cart and replaced with new non-expired supplies, and emergency cart deep cleaned and covered. Facility Administrator (FA) held mandatory in-service with all Teammates (TMs) on 10-26-2012. In-service included but was not limited to: review of <i>Policy & Procedure #01-02-08 Emergency Equipment Checks</i> , following equipment checks must be performed by a licensed nurse, TM must verify designated equipment is available and functional: Weekly: Oxygen supply is adequate with at least 1 tank on or next to crash cart, airways are available, suction is operational, AED is operational and pads are compatible with device, ambu bag operational, emergency cart is clean, operational, and supplies have not expired, TMs must conduct and document monthly checks on evacuation kits to ensure kits is complete and supplies have not expired. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will ensure compliance by conducting daily	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>vents were expired on the emergency evacuation cart and the top of the cart and suction machine were dusty.</p> <p>4. The facility policy titled "Emergency Equipment checks" with an effective date of 1/2/08 stated, "Emergency cart (crash cart) is clean, operational and supplies have not expired."</p>		<p>audits reviewing emergency equipment logs x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with Medical Director during monthly Quality Improvement Facility Management Meeting (QIFMM), minutes will reflect. FA is responsible for compliance with this Plan of Correction (POC).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0122	<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 observations, staff interview, and review of policies and procedures, the facility failed to ensure that 1 of 1 emergency evaluation cart was clean and supplies were not expired with the potential to affect all the facility's 181 active hemodialysis patients.</p> <p>Findings</p> <p>1. 10/17/2012 11 AM, an emergency evacuation cart was observed on the dialysis clinic's hemodialysis treatment floor. The top of the cart was covered in dust which covered the surface of the cart and the uncovered suction machine which was on the top of this cart. The cart evidenced 7 expired Yankauer Suction vents with expiration dates of 06/2012 on each.</p> <p>2. On 10/17/12 at 11 AM, Employee G, Registered Nurse, indicated the vents</p>	V0122	<p>Expired supplies immediately removed from emergency cart and replaced with new non-expired supplies, and emergency cart deep cleaned and covered.</p> <p>Facility Administrator (FA) held mandatory in-service with all Teammates (TMs) on 10-26-2012. In-service included but was not limited to: review of <i>Policy & Procedure #01-02-08 Emergency Equipment Checks</i>, following equipment checks must be performed by a licensed nurse, TM must verify designated equipment is available and functional: Weekly: Oxygen supply is adequate with at least 1 tank on or next to crash cart, airways are available, suction is operational, AED is operational and pads are compatible with device, ambu bag operational, emergency cart is clean, operational, and supplies have not expired, TMs must conduct and document monthly checks on</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>were expired and the suction machine had visible dust on its surface.</p> <p>3. On 10/17/12 at 11:15 AM, Employee A, facility administrator, indicated the vents were expired on the emergency evacuation cart and the top of the cart and suction machine were dusty.</p> <p>4. The facility policy titled "Emergency Equipment checks" with an effective date of 1/2/08 stated, "Emergency cart (crash cart) is clean, operational and supplies have not expired."</p>		<p>evacuation kits to ensure kits is complete and supplies have not expired. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>FA or designee will ensure compliance by conducting daily audits reviewing emergency equipment logs x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with Medical Director during monthly Quality Improvement Facility Management Meeting (QIFMM), minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction (POC).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0142	<p>494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P The facility must-</p> <p>(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit;</p> <p>Based on personnel file review, policy review, and interview, the facility failed to ensure employees had annual tuberculosis screenings as required by facility policy for 2 of 17 personnel files (E and J) reviewed with the potential to affect all the patients of the dialysis clinic.</p> <p>Findings</p> <p>1. The agency policy titled "Tuberculosis Monitoring and Follow-up" with an origination date of August 2006 and revision dates of September 2008, September 2009, and March 2011 stated, "The tuberculosis monitoring and follow-up consist of the following: Baseline and Annual TST [Tuberculosis Screening Test] ... Follow up TB [tuberculosis] screening using TST will occur on an annual basis, from the date of the last TST using a one step method based ... Indications for a two-step and one - step ... Teammate situation ... negative TST on baseline or annual</p>	V0142	<p>Annual TB Screening conducted for TMs E and J per Policy & Procedure # 4-06-05: Tuberculosis Monitoring and Follow-Up on 10/19/2012 and 10/24/2012, documentation placed in personnel record.</p> <p>FA has developed and initiated tickler system that will be reviewed monthly to ensure ongoing compliance with TMs annual health screening requirements including ensuring Tuberculosis monitoring is complete and documentation is verified in personnel record. FA will review audit results monthly with Medical Director during QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>screening ... Type of screening and monitoring ... annual single-step TST."</p> <p>2. Personnel file E, date of hire (DOH) 9/27/10, failed to evidence an annual tuberculosis screening was completed for 2012. The file evidenced the last screening was completed 4/21/11.</p> <p>3. Personnel file J, DOH 5/1/95, failed to evidence an annual tuberculosis screening was completed for 2012. The file evidenced the last tuberculosis screening had been completed on 7/18/11.</p> <p>4. On 10/18/12 at 1:50 PM, Employee Q, Registered Nurse and Facility Health Nurse, indicated the annual tuberculosis screenings were missing from files E and J.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0199	<p>494.40(a) RO-MEETS AAMI/MONITORED, RECORDED ON LOG 5.2.7 Reverse osmosis: meets AAMI/monitored/recorded on log Refer to RD62:2001, 4.3.7 Reverse osmosis: When used to prepare water for hemodialysis applications, either alone or as the last stage in a purification cascade, reverse osmosis systems shall be shown to be capable, at installation, of meeting the requirements of Table 1, when tested with the typical feed water of the user, in accordance with the methods of [AAMI] 5.2.2.</p> <p>5.2.7 Reverse osmosis Users should carefully follow the manufacturer's instructions for feed water treatment and monitoring to ensure that the RO is operated within its design parameters.</p> <p>6.2.7 Reverse osmosis All results of measurements of RO performance should be recorded daily in an operating log that permits trending and historical review. Based on interview and review of policy and administrative documents, the facility failed to ensure the reverse osmosis reject water flow rate was evaluated and monitored, documentation evidenced an acceptable reverse osmosis reject water flow rate, and the biomedical supervisor and administrator were appropriately notified of the unacceptable water flow rate for 1 of 1 facility with the potential to affect all dialysis patients.</p>	V0199	<p>Biomedical Technician (BMT) held mandatory in-service for all clinical TMs on 10/26/2012. In-service included but was not limited to: review of <i>Policy & Procedure # 2-07-02: Daily Water Treatment System Monitoring</i>. TMs educated that all observations and test results must be recorded on the approved Daily Water Treatment Log including but not be limited to RO reject/waste water flow rate, acceptable parameters for RO reject water flow rate, TMs must</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings</p> <p>1. The facility document titled "Water Treatment Log" evidenced RO [reverse osmosis] water flow rate needed to be at an acceptable level of 7 - 13 GPM [Gallons per minute] per facility level. Entries made between 9/3/12 - 9/8/12 and 9/10/12 - 9/12/12 indicated values at 5.02 GPM for each date which were below the facility acceptable level. These entries were recorded by Employee C, water technician, and Employee G, Registered Nurse (RN) on 9/3/12; by Employee L, RN, and Employee F, Water technician, on 9/4/12, 9/6/12, and 9/8/23; and by Employees F and G on 9/5/12 and 9/7/12, 9/10/12, and 9/12/12; and Employees G and H, RN, on 9/11/12. On each of these dates, the employees failed to notify the biomedical supervisor and / or administrator of these water flow rates which were below the acceptable level.</p> <p>2. On 10/16/12 at 9:25 AM, Employee D, Biomedical supervisor, indicated these rates were not within the specified water flow rate and the Biomedical supervisor and administrator had not been notified per policy by the nurses or the water technicians.</p> <p>3. The facility policy titled "Daily Water Treatment System Monitoring" with an</p>		<p>report any parameter outside of range to Biomed Technician at the time it is noted out of range. BMT or designee must take appropriate action and documentation must support actions taken and any necessary follow-up. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>FA or designee will conduct Daily Water Treatment Log audits x 2 weeks, then weekly x 4 weeks, then monthly. Results of audits will be reviewed with the Medical Director during monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>effective date of 2/7/02 stated, "All observations and test results will be within the limits specified on the Daily Water Treatment Log. If observations or test results are found outside the specified limits, follow the instructions given on the water treatment log for the parameters in question. In Addition to following the log form instructions, the teammate will notify the facility administrator / designee and Biomed teammate assigned to the facility of any observation or test result found outside the limit specified on the Daily Water Treatment Log ... a licensed nurse reviews the "Daily Water Treatment Log" for completeness and verifies the parameters are within specified limits. Upon satisfactory completion of this review, the licensed nurse initials and signs the log form where indicated."</p> <p>4. The facility document titled "Daily Water Treatment Log Explanation" with an origination date of August 2008 stated, "RO Reject Water Flow Rate (Facility specific) RO Monitor or flow Meter ... Enter the RO Product Water Flow Rate value displayed on the RO Monitor or indicated Flow meter. I f the observed water flow rate is outside the acceptable limits immediately contact the biomedical team for direction and assistance."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0401	<p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>Based on observations, staff interview, and review of policies and procedures, the facility failed to ensure a safe treatment environment in that 1 of 1 emergency evaluation cart was clean and supplies were not expired with the potential to affect all the facility's 181 active hemodialysis patients.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. 10/17/2012 11 AM, an emergency evacuation cart was observed on the dialysis clinic's hemodialysis treatment floor. The top of the cart was covered in dust which covered the surface of the cart and the uncovered suction machine which was on the top of this cart. The cart evidenced 7 expired Yankauer Suction vents with expiration dates of 06/2012 on each. 2. On 10/17/12 at 11 AM, Employee G, Registered Nurse, indicated the vents were expired and the suction machine had visible dust on its surface. 	V0401	<p>Expired supplies immediately removed from emergency cart and replaced with new non-expired supplies, and emergency cart deep cleaned and covered.</p> <p>Facility Administrator (FA) held mandatory in-service with all Teammates (TMs) on 10-26-2012. In-service included but was not limited to: review of <i>Policy & Procedure #01-02-08 Emergency Equipment Checks</i>, following equipment checks must be performed by a licensed nurse, TM must verify designated equipment is available and functional: Weekly: Oxygen supply is adequate with at least 1 tank on or next to crash cart, airways are available, suction is operational, AED is operational and pads are compatible with device, ambu bag operational, emergency cart is clean, operational, and supplies have not expired, TMs must conduct and document monthly checks on evacuation kits to ensure kits is complete and supplies have not expired. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p>	11/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. On 10/17/12 at 11:15 AM, Employee A, facility administrator, indicated the vents were expired on the emergency evacuation cart and the top of the cart and suction machine were dusty.</p> <p>4. The facility policy titled "Emergency Equipment checks" with an effective date of 1/2/08 stated, "Emergency cart (crash cart) is clean, operational and supplies have not expired."</p>		<p>FA or designee will ensure compliance by conducting daily audits reviewing emergency equipment logs x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with Medical Director during monthly Quality Improvement Facility Management Meeting (QIFMM), minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction (POC).</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0403	<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.</p> <p>Based on observation, policy review, and interview, the facility failed to change the diasafe filters on the dialysis machines in a timely manner for 2 of 40 machines (#23 and #45) observed with the potential to effect all 181 patients.</p> <p>Findings</p> <p>1. On 10/15/12 at 12:30 PM, Machine #23 and Machine #45 were observed with a diasafe filter date of 7/10/12. These machines were labeled Fresenius A 2008 K.</p> <p>2. The agency policy titled "Fresenius A2008K, K 2 Automated Diasafe Plus filter integrity test post chemical rinse cycle" with an origination date of September 2010 and revision dates of September 2011 and March 2012 stated, "The use of a Diasafe Plus Filter is not to exceed 90 days."</p>	V0403	<p>Diasafe filters changed and tested on machines 23 and 45 on 10/16/2012.</p> <p>Area Biomed Supervisor (ABS) held mandatory in-service for BMT on 10/25/2012 and 10/26/2012. In-service included review of <i>Policy & Procedure # 2-01-09 Preventative Maintenance Schedule for Equipment, Policy & Procedure # 2-02-01S Fresenius A2008 K, K2 Automated Diasafe Plus Filter Integrity Test Post Chemical rinse Cycle 1</i>) BMT will develop and implement revised ancillary equipment preventative maintenance (PM) schedule for 2012 which will include all ancillary equipment including Machine Diasafe Plus Filters. 2) The use of a Diasafe Plus Filter is not to exceed 90 days, BMT must replace Diasafe Plus filter at a minimum of every 90 days and document change PM records. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>ABS or designee will conduct</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3. On 10/16/12 at 1:25 PM, the administrator indicated the diasafe filter on Machine #23 and #45 had exceeded 90 days.		observational audits and review of facility PM logs and monitor compliance with PM schedule monthly x 3, then at a minimum of quarterly. Results of audit will be reviewed with Medical Director during monthly QIFMM, minutes will reflect. FA is responsible for compliance with this POC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0501	<p>494.80 PA-IDT MEMBERS/RESPONSIBILITIES The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.</p> <p>Based on staff interview, clinical record review, and policy and procedure review, the facility failed to ensure each patient had a individualized and comprehensive assessment to meet their needs in 2 of 3 records reviewed of patients who been hospitalized or who had changed between peritoneal dialysis and hemodialysis with the potential to affect all patients who are hospitalized or change treatment types. (2 and 14)</p> <p>Findings:</p> <p>1. Clinical record 2, with a plan of care date of 3/19/12, failed to evidence an assessment by any of the disciplines.</p> <p>On 10/18/2012 12:54 PM, the Facility Administrator, employee A, indicated the assessments had been missed when the patient changed the method of dialysis.</p>	V0501	<p>Interdisciplinary Team (IDT) will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patients #2 and 14 to ensure all members of IDT participate in care planning process, reflect evaluation of patient's current health status, method of dialysis, recent hospitalizations, and reflect resolution of any identified unstable issues, and document patient stable vs. unstable.</p> <p>FA will hold mandatory in-service for members of Interdisciplinary Team on 10/26/2012. In-service will include but not be limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care when Utilizing Falcon Dialysis and Policy & Procedure #1-01-07 Patient Assessment and Plan of Care When Utilizing Duck</i>, emphasizing 1) IDT is responsible for providing each</p>	11/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Clinical record 14 failed to evidence a plan of care or assessments by any of the disciplines after an extended hospitalization. The Treatment Log evidenced at least 10 treatments for five consecutive months.</p> <p>On 10/18/2012 1:08 PM, the Facility Administrator, Employee A, indicated the assessments were not done and the plan of care had not been generated. The facility had gone to the new software Falcon in June, and this patient had not been entered manually as required.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Duck", Policy:1-01-07, September 2012, stated, "4. A comprehensive assessment will be conducted on all new patients within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with the first outpatient dialysis treatment or per state guidelines. ...7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: ... At least monthly for unstable patients including, but not limited to, patients with: Extended or frequent hospitalizations."</p>		<p>patient with an individualized and comprehensive assessment documenting his/her needs. 2) The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. 3) The plan of care must specify the services necessary to address patient's needs as identified in the comprehensive assessment and changes in patient condition including change in treatment modality and extended hospitalization. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>FA or designee will conduct a Medical Record Audit for 100% of new admissions, 100% patients that have changed treatment modalities or had extended hospitalization to ensure current individualized Comprehensive Assessments and Plan of Care are in place, up-to-date, and documentation appropriate. FA will review audit results monthly with Medical Director during QIFMM and continued frequency of audits will be determined by team. QIFMM Minutes will reflect.</p> <p>The FA is responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0520	<p>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-</p> <p>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 staff interview, clinical record review, and policies and procedure review, the facility failed to ensure a monthly comprehensive reassessment was done for 1 of 2 records of unstable patients with an extended hospitalization with the potential to affect all patients who are hospitalized. (14)</p> <p>Findings:</p> <p>1. Clinical record 14 failed to evidence monthly plans of care or assessments by any of the disciplines after the patient had an extended hospitalization. The Treatment Log did evidence at least 10 treatments for five consecutive months.</p> <p>2. On 10/18/2012 1:08 PM: The Facility</p>	V0520	<p>IDT will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patients #14 to reflect evaluation of patient's current health status, recent extended hospitalization, and reflect resolution of any identified unstable issues, and document patient stable vs. unstable.</p> <p>FA will hold mandatory in-service for members of Interdisciplinary Team on 10/26/2012. In-service will include but not be limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care when Utilizing Falcon Dialysis and Policy & Procedure #1-01-07 Patient Assessment and Plan of Care When Utilizing Duck</i>, emphasizing 1) IDT is responsible for providing each patient with an</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Administrator, Employee A, indicated the monthly assessments were not done and the plans of care had not been generated. The facility had gone to the new software Falcon in June, and this patient had not been entered manually as required.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Duck", Policy:1-01-07, September 2012, stated: "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: ... At least monthly for unstable patients including, but not limited to, patients with: Extended or frequent hospitalizations."</p>		<p>individualized and comprehensive assessment documenting his/her needs. 2) The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. 3) The plan of care must specify the services necessary to address patient's needs as identified in the comprehensive assessment and changes in patient condition including change in treatment modality and extended hospitalization, 4) Review of unstable criteria. 5) Patients deemed unstable will have comprehensive assessment followed by a plan of care completed monthly until deemed stable, stable comprehensive assessment and plan of care will reflect resolution of unstable issues. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>FA or designee will conduct a Medical Record Audit for 100% of new admissions, 100% patients deemed unstable monthly to ensure current individualized Comprehensive Assessments and Plan of Care are in place, up-to-date, and documentation appropriate. FA will review audit results monthly with Medical Director during QIFMM and continued frequency of audits will be determined by team. QIFMM Minutes will reflect.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The FA is responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012	
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY				STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0587	<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 3 home dialysis records (Clinical record # 3) maintained patient flow sheets in the clinical record with the potential to affect all 18 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 #3 with a date of first</p>	V0587	<p>IDT met with Home patient #3 on 10/24/2012; Nephrologist along with other IDT members re-educated patient to the necessity of completing Daily Home treatment records for IDT to provide a continuity of care, patient instructed to complete documentation of each treatment procedure on the Daily Home Treatment Record and to provide PD RN with the documents. Documentation of meeting and re-education placed in patient's medical record.</p> <p>FA held in-service with home modality TMs on 10/26/2012 reviewing <i>Policy & Procedure #5-01-29 Daily Home Treatment Record</i>. TMs educated to 1) instruct patients that they must complete documentation of every treatment on the "Daily Home Treatment Record" which includes BPs, weight, heart rate, 2) instruct patients to bring completed records to each clinic visit, 3) review, evaluate, and initial the data recorded on the "Daily Home Treatment Record" and document findings in the</p>	11/18/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dialysis on 10/27/10 evidenced the patient is an active peritoneal dialysis patient with no home records in the chart since February 22, 2012. 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 10/17/12 at 2:45 PM, Employee B, home training nurse manager, indicated no flow sheets were in patient #3's record and no care plan notation had been completed.</p>		<p>medical record, and 4) to alert the FA if patient fails to meet recording requirements and document findings. A medical record audit of all PD patients was performed. Patients that are non-compliance with documentation have been identified. Those patients will be given additional education with a requirement to re-sign the agreement for completing and bringing in treatment records. Educational attempts will be documented in the medical record. Plans of care for the identified non-compliant patients will be established to address adherence issues. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>Home Modalities Coordinator will perform monthly audits by utilizing the "Daily Home Treatment Record Tracker." Results of audits will be reviewed with the Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.</p> <p>The FA is responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (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 personnel file review, policy review, and interview, the medical director failed to ensure all employees had annual tuberculosis testing as required per policy for 2 of 17 personnel files (E and J) reviewed with the potential to affect all the facility's patients.</p> <p>Findings</p> <p>1. The agency policy titled "Tuberculosis Monitoring and Follow-up" with an origination date of August 2006 and revision dates of September 2008, September 2009, and March 2011 stated, "The tuberculosis monitoring and follow-up consist of the following: Baseline and Annual TST [Tuberculosis Screening Test] ... Follow up TB [tuberculosis] screening using TST will occur on an annual basis, from the date of the last TST using a one step method based ... Indications for a two-step and one - step ... Teammate situation ... negative TST on baseline or annual screening ... Type of screening and</p>	V0715	<p>Annual TB Screening conducted for TMs E and J per Policy & Procedure # 4-06-05: <i>Tuberculosis Monitoring and Follow-Up</i> on 10/19/2012 and 10/24/2012, documentation placed in personnel record.</p> <p>FA has developed and initiated tickler system that will be reviewed monthly to ensure ongoing compliance with TMs annual health screening requirements including ensuring Tuberculosis monitoring is complete and documentation is verified in personnel record. FA will review audit results monthly with Medical Director during QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>	11/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY			STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>monitoring ... annual single-step TST."</p> <p>2. Personnel file E, date of hire (DOH) 9/27/10, failed to evidence an annual tuberculosis screening was completed for 2012. The file evidenced the last screening was completed 4/21/11.</p> <p>3. Personnel file J, DOH 5/1/95, failed to evidence an annual tuberculosis screening was completed for 2012. The file evidenced the last tuberculosis screening had been completed on 7/18/11.</p> <p>4. On 10/18/12 at 1:50 PM, Employee Q, Registered Nurse and Facility Health Nurse, indicated the annual tuberculosis screenings were missing from files E and J.</p>				