STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DSI LAFAYETTE DIALYSIS	915 MEZZANINE DR LAFAYETTE, IN 47905

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V000000	This visit was for a federal recertification survey. Survey Dates: May 7, 8, and 9, 2014 Facility #: 012040 Medicaid Vendor #: 200930200 Surveyors: Bridget Boston, RN, PH Nurse Surveyor Michelle Weiss, RN, PH Nurse Surveyor, observer Census: 49 Quality Review: Joyce Elder, MSN, BSN, RN May 15, 2014	V000000	Please see V628 & V634 for Plan of Correction	
V000628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. Based on quality assurance performance improvement (QAPI) document,	V000628	The Director of Operations will educate the Clinic Manager & all members of the QAPI committee	06/09/2014

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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	University of Michigan report, and facility policy review and interview, the facility failed to ensure its QAPI program included monitoring of fluid and blood pressure management, a review and evaluation of all patient deaths, and the percent of eligible patients completing the KDQOL in 6 (November 2013 through April 2014) of 6 months reviewed creating the potential to affect all of the facility's 49 current patients. The findings include: 1. The facility QAPI meeting minutes dated 11/26/13, 12/30/13, 1/28/14, 2/25/14, 3/25/14, and 4/22/14 failed to evidence the facility had monitored fluid and blood pressure management by the review and evaluation of the percentage of Intradialytic weight loss, blood pressure variances pre and post dialysis, and Intradialytic symptoms of depletion. The administrator indicated on 5/9/14 at 3 PM that fluid and blood pressure management was not reviewed by the QAPI team and not part of the program. 2. The facility QAPI meeting minutes dated 11/26/13, 12/30/13, 1/28/14, 2/25/14, 3/25/14, and 4/22/14 failed to evidence the facility had reviewed and evaluated all patient deaths and had		by 5/30/14 regarding Policy & Procedure: #900-01: Quality Assessment and Performance Improvement Program (QAPI) which included but was not limited to monitoring of fluid & blood pressure management, review & evaluation of all patient deaths as well as the goal & expectations for KDQOL completion. This review included instruction for documentation in the monthly QAPI meeting minutes.1 & 4: The DSI Quality Manager will in-service the CM regarding current available reports for reviewing intradialytic weight loss percentages, BP variances & fluid management as well as the requirement to document this in the monthly QAPI meeting minutes which is in addition to the individual review that is already documented in each individual patients POC/chart.The Director of Operations or designee to review all QAPI meeting minutes to ensure documentation of discussions about fluid & blood pressure management monthly X 3 or until 100% compliance is achieved. The Director of Operations or designee will review all education & auditing in the monthly QAPI & Local Governing Body meeting.2 & 4: The DSI Quality Manager will in-service the CM regarding the requirement to not only review the number of deaths but also the cause(s) for patient deaths to	

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	analyzed trends in causes of patient deaths. A. The University of Michigan 2013 Dialysis Facility Report evidenced the facility's standardized mortality ratio was 1.06 for 2009 - 2012 with the U.S. average being 1.00. B. The facility administrator indicated on 5/9/14 at 3 PM the QAPI meeting minutes do not evidence documentation all patient deaths had been analyzed for trends in causes of patient deaths. 3. The facility QAPI meeting minutes dated 11/26/13, 12/30/13, 1/28/14, 2/25/14, 3/25/14, and 4/22/14 failed to evidence the facility had reviewed the percent of eligible patients that had completed the KDQOL. The facility's only social worker indicated on 5/8/14 at 2:11 PM 55 % of the eligible patients had completed the KDQOL and there was not a facility goal to meet. 4. The facility policy titled "Continuous Quality Improvement Program (QAPI)" revision date January 9, 2013, policy number 900-01 stated, "The scope of the QAPI program must be facility wide: all services. ... Purpose: To develop,		identify any trends as well as the requirement to document this in the monthly QAPI meeting minutes. This will be in addition to the individual review that is already being discussed during QAPI in which the treatment data from the last 3 treatments, labs, and anything else on record such as hospital discharge summary(s) are reviewed.The Director of Operations or designee to review all QAPI meeting minutes to ensure documentation of discussions about the number of deaths as well as the causes monthly X 3 or until 100% compliance is achieved. The Director of Operations or designee will review all education & auditing in the monthly QAPI & Local Governing Body meeting.3 & 4: The DSI Quality Manager will in-service the CM & MSW regarding the requirement related to KDQOL and that the goal is 100% of existing patients & those on dialysis >90 days must have a KDQOL completed at 90 days and annually thereafter. The in-service will also include documentation & review of this in the monthly QAPI meeting minutes.The Director of Operations or designee to review all QAPI meeting minutes to ensure documentation of the percentage of eligible patients who have completed the KDQOL monthly X 3 or until 100% compliance achieved. The Director of Operations or	

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	implement, maintain, and evaluate an effective data driven quality assessment and performance improvement program that reflects the complexity of the dialysis facilities patient population and its processes of care with participation by the professional members of the interdisciplinary team. This program looks at facility aggregate data and requires facility based assessment and improvement of care. ... The QAPI committee will meet at least monthly. ... The scope of the QAPI program at minimum includes: To set measurable goals in consideration of current standards as outlined by K-DOQI, local Network chapters, legitimate Nephrology research and Federal, State, and local regulations addressing at least: ... Access ... Reduce incidence of access related infections ... Medical injuries and medical errors identification. Review all incident reports to minimize the number of occurrences and limit the number of patients / staff who are adversely affected. Review should not be limited to: Deaths, cardiac arrests, hospitalizations, ... medical errors, ... treatment prescription errors. Infection Control - Analyze and document the incidence of infections to identify trends and establish baseline information on infection incidence. ... Infections - Date of onset, site of infection, infecting		designee will review all education & auditing in the monthly QAPI & Local Governing Body meeting.	

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	organism, antimicrobial susceptibility results, if available. ... Physical and mental functioning - KDQOL - 36 survey annually and after initial 90 days - report aggregate data and percent of patients completing survey. ... Patient Survival. ... To identify specific areas of patient care that necessitates improvement. CMS generated data reports (Dialysis Facility Reports and other Crown Web provided reports) should be used to compare facility performance. ... To conduct the QAPI Program in a manner in which the results are reflective of the true clinical picture. This will be accomplished by creating an evaluation system that is objective, highly structured and comprehensive."			
V000634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. Based on quality assurance performance improvement (QAPI) document, University of Michigan report, and facility policy review and interview, the facility failed to ensure the QAPI	V000634	The Director of Operations will educate the Clinic Manager & all members of the QAPI committee by 6/9/14 regarding Policy & Procedure: #900-01: Quality Assessment and Performance Improvement Program (QAPI)	06/09/2014

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	program included a review and evaluation of adverse events and medical errors and hospitalizations in 6 (November and December 2013 and January, February, March, and April 2014) of 6 months reviewed creating the potential to affect all of the facility's 49 current patients. The findings include: 1. The facility's list of Adverse Events included the number of infiltrations per month: 1 in November 2013, 4 in March 2014, and 1 in April 2014. Included on the list was one incident in which a patient received the wrong prescription in February 2014 and 7 episodes in the last 6 months of patients transferred to the hospital. 2. The hospitalization log for the time period 7/3/13 through 4/14/14 evidenced 121 hospitalizations with 50 occurring less than 30 days from a previous hospitalization and a re-hospitalization rate of 41.3 %. 3. The facility QAPI meeting minutes, dated 11/26/13, 12/30/13, 1/28/14, 2/25/14, 3/25/14, and 4/22/14, failed to evidence the facility had investigated the adverse events and hospitalizations to determine root causes and to formulate		which included but was not limited to review of all incident reports to identify trends & evaluate root causes in order to minimize the number of occurrences and limit the number of patients/staff who are adversely affected. This review also included the importance of reviewing hospital readmissions in order to identify trends and prevent reoccurrence. This review included instruction for documentation in the monthly QAPI meeting minutes.#'s 1, 3, 4 & 6: The DSI Quality Manager will in-service the CM regarding performing root cause analysis related to adverse events, available tools to aid in root cause analysis well as the requirement to document this in the monthly QAPI meeting minutes.The Director of Operations or designee to review all QAPI meeting minutes to ensure documentation of discussions about adverse events, trend identification as well as analysis of root cause(s) of adverse events monthly X 3 or until 100% compliance achieved. The Director of Operations or designee will review all education & auditing in the monthly QAPI & Local Governing Body meeting.#'s 2, 3, 4, 5 & 6: An enhancement to PEARL (Electronic Medical Record) has been requested & is in progress to create a hospital log report that not only calculates the # days	

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	and implement a plan to address any identified reasons and prevent future occurrences. 4. On 5/9/14 at 3 PM, the facility administrator indicated the meeting minutes did not evidence discussion of the adverse events and hospitalizations. She indicated the supporting documents are reviewed and discussed although not documented. 5. The University of Michigan 2013 Dialysis Facility Report evidenced the facility's hospitalization rate for congestive heart failure was 37.9 % while the United States average is 21.8 %. The facility's hospitalization rate for cardiac dysrhythmia was 25.8 % with the U.S. average being 13.1%. The facility's hospitalization rate for cardiac arrest was 6.1 % with the U.S. average being 1.5%. The facility's hospitalization readmission rate was 35.0% with the US average being 31.1%. 6. The facility policy titled "Continuous Quality Improvement Program (QAPI)" revision date January 9, 2013, policy number 900-01 stated, "The scope of the QAPI program must be facility wide: all services. ... Purpose: To develop, implement, maintain, and evaluate an effective data driven quality assessment		between hospitalizations but also calculates an overall readmission rate in order to not only effectively capture the readmission rate but to also identify trends among patients in order to prevent reoccurrence(s). The Director of Operations or designee to review all QAPI meeting minutes to ensure documentation of discussions about the number of deaths as well as the causes monthly X 3 or until 100% compliance is achieved. The Director of Operations or designee will review all education & auditing in the monthly QAPI & Local Governing Body meeting.	

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	and performance improvement program that reflects the complexity of the dialysis facilities patient population and its processes of care with participation by the professional members of the interdisciplinary team. This program looks at facility aggregate data and requires facility based assessment and improvement of care. ... The QAPI committee will meet at least monthly. ... The scope of the QAPI program at minimum includes: To set measurable goals in consideration of current standards as outlined by K-DOQI, local Network chapters, legitimate Nephrology research and Federal, State, and local regulations addressing at least: ... Medical injuries and medical errors identification. Review all incident reports to minimize the number of occurrences and limit the number of patients / staff who are adversely affected. Review should not be limited to: Deaths, cardiac arrests, hospitalizations, ... medical errors, ... treatment prescription errors. Infection Control - Analyze and document the incidence of infections to identify trends and establish baseline information on infection incidence. ... Infections - Date of onset, site of infection, infecting organism, antimicrobial susceptibility results, if available. ... Patient Survival. ... To identify specific areas of patient			

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	care that necessitates improvement. CMS generated data reports (Dialysis Facility Reports and other Crown Web provided reports) should be used to compare facility performance. ... To conduct the QAPI Program in a manner in which the results are reflective of the true clinical picture. This will be accomplished by creating an evaluation system that is objective, highly structured and comprehensive."			