

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152589		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/19/2012	
NAME OF PROVIDER OR SUPPLIER  NEW ALBANY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 2669 E CHARLESTON RD NEW ALBANY, IN 47150			
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 7-17-12, 7-18-12, and 7-19-12</p> <p>Facility #: 004226</p> <p>Medicaid Vendor #: 200024860E</p> <p>Surveyors: Vicki Harmon, RN, PHNS Team Leader Dawn Snider, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 25, 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.

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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.</p> <p>Based on observation and staff interview, the facility failed to ensure a sanitary environment had been maintained by failing to provide for the protection of clean supplies used to initiate and discontinue dialysis treatments in 3 of 3 (#s 1, 2, and 3) environmental observations completed creating the potential for the transmission of disease causing organisms among staff and all of the facility's 33 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation number 1: On 7-18-12 at 9:45 AM, employee A, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 7. Observation noted the PCT placed the supplies to be used on the table attached to the dialysis chair without using a barrier to protect the supplies from possible contamination.</li> <li>2. Observation number 2: On 7-18-12 at 9:50 AM, employee K, a registered nurse (RN), was observed to discontinue the dialysis treatment for patient number 8.</li> </ol>	V0111	<p>Teammates (TM's) were in-services 7/20/2012 with exit findings on the following: When initiating or discontinuing treatment any clean supplies will not be placed directly on bedside table. A second chux/barrier will be included in the packs and any supplies necessary for said patient will be used to protect the supplies from possible contamination. An additional in-service will be completed on August 14-15, 2012 on Policy 1-04-01 "Infection Control for Dialysis Facilities" with all teammates by the Clinical Service Specialist with focus on treatment and placement of clean supplies and will be evidenced by a signature sheeet. Daily compliance will be monitored b Charge Nurse and or Facility Administrator and this will be added to the Infection Control Audit tool. The Facility Administrator and or designee will conduct observation infection control audits on random shifts daily for one week, then 3x week for one month, then 2xs weekly for one month, then monthly with regulary scheduled infection control audits. The results will be reported in the monthly QIFFM</p>	08/14/2012			

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	<p>The employee placed the supplied to be used to discontinue the treatment on the table attached to the dialysis chair without using a barrier to protect the supplies from possible contamination.</p> <p>3. Observation number 3: On 7-19-12 at 9:40 AM, employee L, an RN, was observed to initiate the dialysis treatment on patient number 5. The RN placed the supplies to be used to initiate the treatment on the table attached to the dialysis chair without using a barrier to protect the supplies from possible contamination.</p> <p>4. The facility administrator, employee M, indicated, on 7-19-12 at 4:30 PM, a barrier should have been used to protect the supplies from possible contamination .</p>		meeting and any negative findings will be reported to the Governing Body if deemed necessary. Teammates failing to follow these guidlesines will be subject to corrective action. The FA is responsible for compliance with the POC.		

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V0113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure staff followed the facility's infection control policies and procedures in 3 of 5 (#s 1, 2, and 3) patient care observations creating the potential for the transmission of disease causing organisms among staff and all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. Observation number 1: On 7-18-12 at 9:08 AM, employee C, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 6. The PCT failed to change her gloves and cleanse her hands after touching a dirty area, the dialysis machine and tubing, and then touching the patient's needle insertion sites. The PCT was observed to touch the dialysis machine and the tubing and then obtain 2 packages of gauze, open the package, and then remove the first needle from the patient's access site. The PCT placed the gauze over the insertion site and then repeated the process for the second</p>	V0113	<p>Clinical Teammates were in-serviced on 7/20/2012 in the following: Policy # 1-05-01: Infection Control for Dialysis Facilities. An additional in-service will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. Teammates were instructed using gloves and performing hand hygiene whenever gloves are removed. The August 14-15, 2012 in-services will include surveyor observations as examples with emphasis on, but not limited to, the following: 1) to remove gloves and wash hands between dirty and clean tasks, 2) to perform hand hygiene whenever gloves are removed and 3) to wear gloves for all machine contact. The Charge Nurse (CN) is responsible for oversight of infection control practice daily. Instances of non-compliance will be addressed with the TM responsible immediately. The Facility Adminsitrator or designee will conduct observation infection control audits on random shifts daily for one week, then 3x week for one month, then 2x week for one month, then monthly with</p>	08/31/2012			

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	<p>needle.</p> <p>2. Observation number 2: On 7-18-12 at 9:45 AM, employee A, a PCT, was observed to initiate the dialysis treatment on patient number 7. The PCT was observed to draw up 1000 units of bolus heparin and 700 units of maintenance heparin into 2 syringes at the medication preparation station. The PCT brought the medications to the patient's chairside and donned clean gloves without cleansing her hands. The PCT administered the heparin, removed her gloves, and cleansed her hands. The PCT then touched the computer keyboard and donned clean gloves without cleansing her hands.</p> <p>3. Observation number 3: On 7-18-12 at 9:40 AM, employee L, a registered nurse, was observed to initiate treatment on patient number 5. The employee touched the machine, tubing, and IV bag and then connected the patient to the machine without cleansing her hands or changing her gloves.</p> <p>4. The facility administrator, employee M, indicated, on 7-19-12 at 4:30 PM, employees A, C, and L had not followed the facility's infection control policies and procedures.</p>		regularly scheduled infection control audits. Results of audits will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits determined by the team with supporting documentation included in the meeting minutes. The FA is responsible for compliance with POC.				

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	<p>5. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "The Centers for Disease Control (CDC) 'Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients' (Dialysis Precautions) will be followed when caring for all patients . . . Hand hygiene is to be performed upon entering the facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area."</p> <p>6. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of</p>						

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	the patient. Decontaminate hands after removing gloves."			

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V0124	<p>494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B</p> <p>The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit.</p> <p>Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure monthly hepatitis B antigen testing had been completed in 8 (#s 3, 9, 10, 11, 12, 13, 14, and 15) of 14 hepatitis B susceptible patient records reviewed creating the potential to affect all of the facility's hepatitis B susceptible patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's March 2011 "Hepatitis Surveillance, Vaccination and Infection Control Measures" policy number 1-05-02 states, "Monthly hepatitis B surface antigen (HBsAg) testing will be completed on patients who are susceptible or not immune to hepatitis B infection, including non-responders to the vaccine."</li> <li>2. The facility's "Hepatitis Status and</li> </ol>	V0124	<p>All current patients will be reviewed on the Hepatitis Audit for their Hepatitis B Status, appropriate lab testing and administration of Hepatitis B Vaccine dosing per physician's order. Clinical Teammates were in-serviced on 7/20/2012 in the following: Policy # 1-05-02 stating "Monthly hepatitis B surface antigen ( HBsAG) testing will be completed on patients who are susceptible or not immune to hepatitis B infection including non-responders to the vaccine. " An addition in-service on policy # 1-05-02: Hepatitis Surveillance Vaccination and Infection Control Measures will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. The Charge Nurse and or Facility Administrator will be responsible to ascertain all patients susceptible or not immune will</p>	08/31/2012			

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	<p>Compliance with CDC Recommendations for Hepatitis B Testing on ESRD Patients" printed 7/17/2012 evidenced monthly hepatitis B antigen testing had not been completed for patients who were known to be susceptible or whose antibody status was unknown.</p> <p>A. The hepatitis status report evidenced the antibody status for patient number 3 was less than 10. The report failed to evidence monthly antigen testing had been completed in April and June 2012.</p> <p>B. The hepatitis status report evidenced the antibody status for patient number 9 was less than 10. The report failed to evidence monthly antigen testing had been completed in June 2012.</p> <p>C. The hepatitis status report evidenced the antibody status for patient number 10 was less than 10. The report failed to evidence monthly antigen testing had been completed in March and June 2012.</p> <p>D. The hepatitis status report evidenced the antibody status for patient number 11 was less than 10. The report failed to evidence monthly antigen testing had been completed in February 2012.</p>		<p>have monthly HBsAG tesing performed. The Hepatitis Audit will be reviewed after monthly labs each month to assure all patients susceptible or non immune are tested, including those patients missing treatments due to hospitalization or non-adherence during schedule monthly lab draws. Missing labs will be re-scheduled to ensure monthly monitoring. All findings will be reviewed with the Medical Director during monthly QIFFM meetings, and addressed as needed. The FA is responsible for the compliance with this POC.</p>		

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	<p>E. The hepatitis status report evidenced the antibody status for patient number 12 was less than 10. The report failed to evidence monthly antigen testing had been completed in May 2012.</p> <p>F. The hepatitis status report evidenced the antibody status for patient number 13 was less than 10. The report failed to evidence monthly antigen testing had been completed in June 2012.</p> <p>G. The hepatitis status report evidenced the antibody status for patient number 14 was less than 10. The report failed to evidence monthly antigen testing had been completed in March 2012.</p> <p>H. The hepatitis status report evidenced the antibody status for patient number 15 was less than 10. The report failed to evidence monthly antigen testing had been completed in May or June 2012.</p> <p>3. The facility administrator, employee M, indicated, on 7-19-12 at 5:00 PM, monthly antigen testing had not been done on all susceptible patients.</p>				

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V0196	<p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure total chlorine testing had been completed in accordance with facility procedure in 1 of 1 water test observed creating the potential to affect all of the facility's 33 current patients.</p>	V0196	On July 20, 2012 all Clinical Teammates were in-serviced on Policy and Procedure # 2-07-04J which states "Materials required when testing for free chlorine, chloramines or total chlorine require the following: "Personal Protective Equipment (PPE) including face protection,	08/31/2012			

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>On 7-18-12 at 3:15 PM, employee C, a patient care technician (PCT), was observed to perform a total chlorine test. The PCT failed to don gloves or wear face protection while performing the test.</li> <li>On 07/18/2012 at 3:42 PM, the facility administrator, employee M, stated "They should wear gowns, gloves, and a shield when performing water checks. That's the way I learned it."</li> <li>The facility's March 2010 "Total Chlorine Test Using Stericheck Total Chlorine Test Kit" procedure number 2-07-04J states, "Materials required: . . . PPE - personal protective equipment (faces protection, disposable gloves, fluid resistant / fluid impervious barrier garment) . . . Put on PPE."</li> </ol>				<p>disposable gloves, fluid resistant/fluid impervious barrier garments". An additional in-serive will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. The FA or designee will audit teammates when performing water testing weekly x 3 in addition to the monthly audit completed by the Biomed Tech. Finding of audit will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits determined by the team supporting documentation including in the meeting minutes. The FA is responsible fo compliceance with this POC.</p>		

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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 and staff interview, the facility failed to ensure only current medications were available for use in 2 of 10 medications reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a tour of the medication preparation area on 7-17-12 at 9:20 AM, observation noted 25 vials of Lidocaine with an expiration date of February 2012.</li> <li>2. Observation noted 2 vials of flu vaccine with an expiration date of June 2012 in the medication refrigerator.</li> <li>3. Employee K, a registered nurse, stated, on 7 /18/12 flu at 9:20 AM, "The meds are reviewed at the end of the month. I am not sure why the expired meds are still in the cabinet and the refrigerator. I am not here all the time."</li> </ol>	V0401	<p>On July 20, 2012 all Clinical Teammates were in-serviced on Policy and Procedure #1-06-01 Medication Policy with emphasis on checking medication expiration dates. An additional in-service will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. The FA or designee will audit the medication refrigerator and other medication storage areas for expired meds at the end of each month and a double-check system will be intitated with the medication count log books to document said medication are in date. The results will be reviewed with the Medical Director during the monthly QIFFM and addressed as needed. The FA is responsible for compliance with this POC.</p>	08/31/2012	

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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 document review and staff interview, the facility failed to ensure the automated defibrillator (AED) had been checked daily as required in 6 (January, February, March, April, June, and July) of 7 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's "Daily AED Log" evidenced daily checks had not been done on January 4 and 17, 2012; February 4, 14, 18, 21, and 24, 2012; March 3, 2012; April 3, 18, 25, 26, and 27, 2012; June 2, 2012; and July 12 and 16, 2012.</li> <li>2. The facility administrator, employee M, indicated, on 7-19-12 at 4:30 PM, the daily AED checks had not been done as required.</li> </ol>	V0403	<p>An in-service will be conducted on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet regarding appropriate equipment maintenance per manufacturers's recommendation. Emphasis on the importance of documenting the daily checks to the automated debrillator (AED) on the Daily AED log will be reviewed. An audit will be performed weekly x 6 weeks and all results will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits determined by the team with the supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC.</p>	08/31/2012	

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V0410	<p>494.60(d)(1) PE-PT CARE STAFF-CURRENT CPR CERT Staff training must be provided and evaluated at least annually and include the following: Ensuring that, at a minimum, patient care staff maintain current CPR certification</p> <p>Based on personnel file review and staff interview, the facility failed to ensure all patient care staff were CPR certified in 1 (file J) of 6 patient care staff files reviewed creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file J evidenced the individual had been hired on 4/21/2010 as the facility's medical director. The file failed to evidence documentation of CPR certification.</li> <li>2. The facility administrator, employee M, indicated, on 07/19/2012 5:18 PM, the file did not evidence the medical director was CPR certified. The administrator stated, "It is expired."</li> </ol>	V0410	<p>For clarification, the Medical Director and attending physicians are not employees of the facility so therefore are not required to have information on file at the facility. This facility is complying by choice. Audits are performed for all teammates employed by Davita Inc. on a quarterly basis. The Medical Director identified in review will be in compliance no later than August 31, 2012. All audits will be performed quarterly and the results will be reviewed with the Medical Director during the monthly QIFFM, and addressed as needed. The FA is responsible for compliance with this POC.</p>	08/31/2012

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V0412	<p>494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.</p> <p>Based on staff and patient interview and clinical record review, the facility failed to ensure patients and/or caregivers had been provided with disaster preparedness training in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 evidenced the patient's first date of dialysis at the facility was 11/11/2011. The record failed to evidence any disaster preparedness education had been provided to the patient and/or caregivers.</li> <li>2. Clinical record number 2 evidenced the patient's first date of dialysis at the facility was 11/04/2011. The record failed to evidence any disaster preparedness education had been provided to the patient and/or caregivers.</li> </ol> <p>During an interview with patient number 2, on 7/19/2012 at 10:31 AM, the patient indicated the facility had not provided the patient with any education</p>			V0412	<p>Clinical Teammates were in-serviced on 7/20/2012 on Emergency and Disaster Preparedness for all patients and teammates in Dialysis facilities. An additional in-service will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. Upon admission, all patients will be educated on emergency preparedness and disaster planning. Disaster and emergency preparedness education will be included in the admission package and a confirmation of receipt will be maintained in the patient record. The team will educate all patients quarterly on emergency evacuation and annually on disaster preparedness. Documentaion of patient education will be maintained in the medical record. An audit will be performed monthly by FA or designee x 3 months and all results will be reviewed with the Medical Director during the monthly QIFFM meeting and continued frequency of audits determined by the team with supporting document included in the meeting minutes. The FA is responsible for compliance with</p>		08/31/2012

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	<p>regarding disaster preparedness.</p> <p>3. Clinical record number 3 evidenced the patient's first date of dialysis at the facility was 04/16/2010. The record failed to evidence any disaster preparedness education had been provided to the patient and/or caregivers.</p> <p>4. Clinical record number 4 evidenced the patient's first date of dialysis at the facility was 10/03/2011. The record failed to evidence any disaster preparedness education had been provided to the patient and/or caregivers.</p> <p>5. Clinical record number 5 evidenced the patient's first date of dialysis at the facility was 09/30/2010. The record failed to evidence any disaster preparedness education had been provided to the patient and/or caregivers.</p> <p>6. The facility administrator, employee M, was unable to provide any documentation patients numbered 1 through 5 had received disaster preparedness education when asked on 7/18/2012 at 5:51 PM. The administrator stated, "I cant find it."</p>		this POC.				

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V0543	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the necessary care and services had been provided to manage the patients' volume status by failing to ensure physician ordered dry weights had been achieved in 4 (#s 1, 2, 3, and 5) of 5 records reviewed creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced physician orders dated 6-28-12 that identified the desired dry weight was 62.3 kilograms (kg).</p> <p>A. A post treatment flow sheet dated 7-7-12 evidenced the dry weight was 63.4 kg at the end of the treatment.</p> <p>B. A post treatment flow sheet dated 7-10-12 evidenced the dry weight was 63.3 kg at end of the treatment.</p> <p>C. A post treatment flow sheet dated</p>	V0543	<p>Clinical Teammates were in-serviced on 7/20/2012 in the following: Policy # 1-01-14 Patient assessment and plan of care when utilizing Falcon Dialysis stating "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patients volume and estimated dry weight status. An additional in-service with focus on the importance of patient's achieving dry weight and notifying the physician as indicated will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. The CN is responsible for oversight of patient monitoring and achieving patient treatment as ordered. The volume status will be evaluated with the IDT and any inability to achieve order as prescribed will be documented both in Snappy and Falcon electronic systems. The patients risks will be identified if unable to achieve prescribed volume status and if warranted the patient will be offered additional treatments if medical ordered and /or risk identified and noted</p>	08/31/2012			

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	<p>7-12-12 evidenced the dry weight was 63.5 kg at end of the treatment. The flow sheet evidenced the patient had complained of "right hand cramping" 1 1/2 hour into the treatment.</p> <p>D. A post treatment flow sheet dated 7-14-12 evidenced the dry weight was 62.9 kg at the end of the treatment.</p> <p>2. Clinical record number 2 evidenced physician orders dated 06/12/2012 that identified the desired dry weight was 82.5 kg.</p> <p>A. A post treatment flow sheet dated 06/26/2012 evidenced the dry weight was 83.5 kg at the end of the treatment.</p> <p>B. A post treatment flow sheet dated 06/28/2012 evidenced the dry weight was 83 kg at the end of the treatment.</p> <p>C. A post treatment flow sheet dated 06/30/2012 evidenced the dry weight was 83.2 kg at the end of the treatment.</p> <p>D. A post treatment flow sheet dated 07/03/2012 evidenced the dry weight was 83.3 at the end of the treatment.</p> <p>E. A post treatment flow sheet dated 07/07/2012 evidenced the dry weight was 83.1 at the end of the treatment.</p>		<p>understanding by Charge Nurse if patients refuses additional treatments as ordered. The CN will monitor flowsheets daily to ensure EDW's are met and documentation is in place. Instance of non-compliance will be addressed with the TM responsible immediatley. The FA or designee will audit 50% of treatment flowsheets 2 x /week x 4 weeks, then 10% weekly x 5, then 10% monthly. Results of audits will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits deteremined by the team with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC.</p>				

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	<p>F. A post treatment flow sheet dated 07/10/2012 evidenced the dry weight was 85.2 at the end of the treatment.</p> <p>G. A post treatment flow sheet dated 07/12/2012 evidenced the dry weight was 84.5 at the end of the treatment.</p> <p>H. A post treatment flow sheet dated 07/14/2012 evidenced the dry weight was 85 at the end of the treatment.</p> <p>I. A post treatment flow sheet dated 07/17/2012 evidenced the dry weight was 86.1 at the end of the treatment.</p> <p>3. Clinical record number 3 evidenced physician orders dated 4-23-12 that identified the desired dry weight was 69 kg.</p> <p>A. A post treatment flow sheet dated 06/25/2012 evidenced the dry weight at the end of the treatment was 69.9 kg at the end of the treatment.</p> <p>B. A post treatment flow sheet dated 06/29/2012 evidenced the dry weight at the end of the treatment was 70.6 kg at the end of the treatment.</p> <p>C. A post treatment flow sheet dated 07/02/2012 evidenced the dry weight was</p>			

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	<p>70.6 kg at the end of the treatment.</p> <p>4. Clinical record number 5 evidenced physician orders dated 6/28/2012 that identified the desired dry weight was 108 kg.</p> <p>A. A post treatment flow sheet dated 06/26/2012 evidenced the dry weight was 109.4 at the end of the treatment.</p> <p>B. A post treatment flow sheet dated 07/03/2012 evidenced the dry weight was 109.9 kg at the end of the treatment.</p> <p>C. Physician orders dated 07/05/2012 evidenced the dry weight had been increased to 109 kg. A post treatment flow sheet evidenced the dry weight was 111 kg at the end of the treatment.</p> <p>D. A post treatment flow sheet dated 07/10/2012 evidenced the dry weight was 110 kg at the end of the treatment.</p> <p>E. A post treatment flow sheet dated 07/12/2012 evidenced the dry weight was 110 kg at the end of the treatment.</p> <p>5. The facility administrator, employee M, was unable to provide any additional documentation and/or information when asked on 7/19/2012 at 4:30 PM.</p>			

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	6. The facility's September 2011 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status."			

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V0544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure patients had achieved and sustained the prescribed dose of dialysis by failing to ensure continuous heparin had been administered as ordered in 4 (#s 1, 2, 4, and 5) of 4 records reviewed of patients that had continuous maintenance heparin ordered and by failing to ensure blood flow rates (BFR) and dialysate flow rates (DFR) had been maintained as ordered in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>Regarding continuous maintenance heparin:</p> <p>1. Clinical record number 1 included physician orders dated 03/31/2012 that evidenced a total of 900 units of continuous heparin was to be administered during each treatment.</p> <p>A. A post treatment flow sheet dated</p>	V0544	<p>Clinical Teammates were in-seviced on 7/20/2012 regarding appropriate delivery of MD prescription to patient and deviation of said prescription regarding Blood Flow Rate (BFR), Dialysate Flow Rate (DFR) and heparin delivery. An additional in-service will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. The CN is responsible for oversight of patient monitoring and achieving patient treatment as ordered. Instances of non-compliance will be addressed with the TM responsible immediately. The heparin deliver, BFR and DFR will be evaluated within 30 minutes of patient initiation. Failure to achieve prescribed order will be documented with reason noted of inability to achieve prescribed order i.e. needle position, needle gauge, arterial pressure, incomplete treatment thus incomplete heparin delivered. Repetitive prescription variation will be evaluated with the IDT and any inability to achieve order as prescribed will be documented</p>	08/31/2012			

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	<p>6-26-12 evidenced a total of 700 units had been administered during the treatment.</p> <p>B. A post treatment flow sheet dated 6-30-12 evidenced a total of 1200 units had been administered during the treatment.</p> <p>C. A post treatment flow sheet dated 7-10-12 evidenced a total of 1000 units had been administered during the treatment.</p> <p>C. A post treatment flow sheet dated 7/17/2012 evidenced a total of 800 units had been administered during the treatment.</p> <p>2. Clinical record number 2 included physician orders dated 06/30/2012 that evidenced a total of 2000 units of continuous maintenance heparin was to be administered during each treatment.</p> <p>A post treatment flow sheet dated 06/26/2012 evidenced a total of 1600 units of heparin had been administered during the treatment.</p> <p>3. Clinical record number 4 included physician orders dated 06/23/2012 that evidenced a total of 1800 units of continuous heparin was to be administered during each treatment.</p>		<p>both in Snappy and Falcon electronic systems. Failure to achieve adequate dialysis will be evaluated by kinetic modeling via Kt/V and URR an rinse of extracorporeal circuit if heparin is not delivered as ordered. The FA or designee will audit 50% of treatment flow sheets 2 x weekly x 4 weeks, then 10% weekly x 4, the 10% monthly. Results of audits will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits determined by the team with supporting documentation included in the meeting minutes . The FA is responsible fo compliance with the POC.</p>		

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	<p>A. A post treatment flow sheet dated 06/26/2012 evidenced a total of 1200 units had been administered during the treatment.</p> <p>B. A post treatment flow sheet dated 06/30/2012 evidenced a total of 1300 units had been administered during the treatment.</p> <p>C. A post treatment flow sheet dated 07/05/2012 evidenced a total of 600 units had been administered during the treatment.</p> <p>D. A post treatment flow sheet dated 07/10/2012 evidenced a total of 2100 units had been administered during the treatment.</p> <p>E. A post treatment flow sheet dated 07/12/2012 evidenced a total of 1600 units had been administered during the treatment.</p> <p>4. Clinical record number 5 included physician orders dated 06/12/2012 that evidenced a total of 1100 units of continuous heparin was to be administered during each treatment.</p> <p>A. A post treatment flow sheet dated 06/30/2012 evidenced a total of 2000</p>				

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	<p>units had been administered.</p> <p>B. A post treatment flow sheet dated 07/10/2012 evidenced a total of 2000 units had been administered during the treatment.</p> <p>C. A post treatment flow sheet dated 07/14/2012 evidenced a total of 1000 units had been administered during the treatment.</p> <p>5. The facility administrator, employee M, was unable to provide any additional documentation and/or information when asked on 7/19/2012 at 4:30 PM.</p> <p>Regarding BFR and DFR:</p> <p>1. Clinical record number 1 included physician orders dated 03/31/2012 that evidenced the BFR was to run at 450 cubic centimeters (cc) per minute and the DFR at 700 cc per minute.</p> <p>A. A post treatment flow sheet dated 6-26-12 evidenced the BFR ran at 400 and the DFR ran at 600 cc per minute.</p> <p>B. A post treatment flow sheet dated 7-12-12 evidenced the BFR ran at 400 and the DFR ran at 600 cc per minute</p>						

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	<p>2. Clinical record number 2 included physician orders that evidenced the BFR was to run at 500 and the DFR at 800 cc per minute.</p> <p>A. A post treatment flow sheet dated 06/28/2012 evidenced the BFR ran at 400 and the DFR ran at 600 cc per minute.</p> <p>B. A post treatment flow sheet dated 06/30/2012 evidenced the DFR ran at 500 cc per minute.</p> <p>C. A post treatment flow sheet dated 07/03/2012 evidenced the BFR ran at 300 and the DFR ran at 500 cc per minute.</p> <p>D. A post treatment flow sheet dated 07/05/2012 evidenced the BFR ran at 450 and the DFR ran at 700 cc per minute.</p> <p>E. A post treatment flow sheet dated 07/12/2012 evidenced the BFR ran at 420 and the DFR ran at 700 cc per minute.</p> <p>3. Clinical record number 4 included physician orders dated 06/23/2012 that evidenced the BFR was to run at 400 and the DFR was to run at 800 cc per minute.</p> <p>A. A post treatment flow sheet dated 06/26/2012 evidenced the BFR ran at 450</p>						

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NAME OF PROVIDER OR SUPPLIER  NEW ALBANY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 2669 E CHARLESTON RD NEW ALBANY, IN 47150		
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	<p>and the DFR ran at 700 cc per minute.</p> <p>B. A post treatment flow sheet dated 06/30/2012 evidenced the BFR ran at 255 and the DFR ran at 500 cc per minute.</p> <p>C. A post treatment flow sheet dated 07/05/2012 evidenced the BFR ran at 455 and the DFR ran at 700 cc per minute.</p> <p>D. A post treatment flow sheet dated 07/07/2012 evidenced the BFR ran at 450 and the DFR ran at 700 cc per minute.</p> <p>E. A post treatment flow sheet dated 07/10/2012 evidenced the DFR ran at 600 cc per minute.</p> <p>F. A post treatment flow sheet dated 07/12/2012 evidenced the BFR ran at 450 and the DFR ran at 700 cc per minute</p> <p>4. Clinical record number 5 included physician orders dated 06/30/2012 that evidenced the BFR was to run at 500 and the DFR at 800 cc per minute.</p> <p>A. A post treatment flow sheet dated 06/26/2012 evidenced the BFR ran at 350 and the DFR ran at 600 cc per minute.</p> <p>B. A post treatment flow sheet dated 07/05/2012 evidenced the BFR ran at 450 and the DFR at 700 cc per minute.</p>				

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	5. The facility administrator, employee M, was unable to provide any additional documentation and/or information when asked on 7/19/2012 at 4:30 PM.			

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V0562	<p>494.90(d) POC-PT/FAMILY EDUCATION &amp; TRAINING The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.</p> <p>Based on clinical record review and staff and patient interview, the facility failed to ensure plans of care addressed infection control education and training in 5 (#s 1, 2, 3, 4 &amp; 5) of 5 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included a plan of care dated 01/10/2012. The plan of care failed to address and provide for infection control education and training.</li> <li>2. Clinical record number 2 included a plan of care dated 01/31/2012. The plan of care failed to address and provide for infection control education and training.</li> </ol> <p>During an interview with patient number 2, on 7/19/2012 at 10:31 AM, the patient indicated the facility had not provided any infection control education and training to the patient or family.</p> <ol style="list-style-type: none"> <li>3. Clinical record number 3 included a</li> </ol>	V0562	<p>Clinical Teammates were in-serviced on 7/20/2012 in the following: All patients will be educated at least annually on infection control. An additional in-service regarding infection control patient education will be completed on August 14-15, 2012 with all teammates by the Clinical Service Specialist and will be evidenced by a signature sheet. A monthly tickler file will be initiated which will ascertain all patients receive the monthly education provided via the company standardized patient education calendar which includes infection control and other ESRD education pertinent to the dialysis patient. The tickler file will be used as check off tool for those patients that may be hospitalized or non-adherent to treatment to ascertain education is received upon return to facility if patient was absent on scheduled Education days. An audit will be performed monthly by FA or designee and all results will be reviewed with the Medical Director during the monthly</p>	08/31/2012			

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	<p>plan of care dated 08/12/2011. The plan of care failed to address and provide for infection control education and training.</p> <p>4. Clinical record number 4 included a plan of care dated 12/27/2011. The plan of care failed to address and provide for infection control education and training.</p> <p>5. Clinical record number 5 included a plan of care dated 01/31/2012. The plan of care failed to address and provide for infection control education and training.</p> <p>6. The facility administrator, employee M, was unable to provide any documentation patients numbered 1 through 5 had received infection control education and training when asked on 7/18/2012 at 5:51 PM. The administrator stated, I cant find it."</p>		<p>QIFFM meeing and continue frequency of audits determined by the team with supporting documentation included in the meeting minutes. The FA is responsible for compliance with the POC.</p>		

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>Based on clinical record and facility policy review and interview, the medical director failed to ensure facility staff had provided care in accordance with the facility's patient monitoring policy in 4 (#s 1, 2, 4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. The facility's March 2011 "Post Treatment Patient Assessment" policy number 1-03-12 states, "The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings . . . Assessment data includes the following: Weight, Temperature, Blood Pressure, Cardiac status, respiratory status, peripheral edema, vascular access, mental status, ambulatory status."</p> <p>2. Clinical record number 1 included post treatment flow sheets dated 7/05/2012 and 7/10/2012 that failed to evidence a</p>	V0715	<p>An in-service will be conducted on August 14-15, 2012 on Policy 1-03-12 Post Treatment Assessment for all clinical teammates with verification of attendance at in-serviced evidenced by a signature sheet. Emphasis will be placed on the importance of obtaining and documenting the patients assessment post treatment in order to verify patients stability, discharge status, and effectiveness of treatment . The Charge Nurse (CN) is responsible for daily oversight of patient monitoring. The CN will monitor flowsheets to ensure documenation is in place. Instance of non-compliance will be addressed with the TM responsible immediatley. The FA or designee will audit 50% of treatment flowsheets 2 x/ week x 4 weeks the 10% weekly x 4, then 10% monthly. Results of audits will be reviewed with the Medical Director during the monthly QIFFM and continued frequency of audits determined by the team with supporting documenation included in the meeting minutes.</p>	08/31/2012			

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	<p>post treatment assessment that included all of the required data had been completed.</p> <p>3. Clinical record number 2 included post treatment flow sheets dated 06/28/2012, 07/03/2012, 07/05/2012, and 07/12/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed.</p> <p>4. Clinical record number 4 included post treatment flow sheets dated 06/28/2012, 07/03/2012, 07/07/2012, and 07/14/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed.</p> <p>5. Clinical record number 5 included post treatment flow sheets dated 07/03/2012, 07/05/2012, 07/10/2012, 07/12/2012, and 07/14/2012 that failed to evidence a post treatment assessment that included all of the required data had been completed.</p> <p>6. The facility administrator, employee M, indicated, on 07/19/2012 at 4:30 PM, post treatment assessments were to be completed after each treatment.</p>		The FA is responsible for compliance with this POC.		