

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2014
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NAME OF PROVIDER OR SUPPLIER DUNELAND DIALYSIS - LAPORTE	STREET ADDRESS, CITY, STATE, ZIP CODE 103 WEST 18TH STREET LA PORTE, IN 46350
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V000000	<p>This was a Federal ESRD [Core] recertification survey.</p> <p>Survey dates: 9/18/14 - 9/30/14</p> <p>Facility #: 011219</p> <p>Medicaid Vendor: 200834980</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Census: 87 Inpatient Hemodialysis : 71 Home Peritoneal Dialysis: 16</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 14, 2014</p>	V000000		
V000122	<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</p>			

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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	<p>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 observation, staff interview, and review of policy and procedure, the facility failed to ensure surfaces were not contaminated with blood for 1 of 2 treatment floor observations on 9/18/14. (Patient 14)</p> <p>Findings</p> <ol style="list-style-type: none"> 1. On 9/18/14 at 2 PM, a small amount of blood approximately the size of a nickel was noted on the pillow of patient #14 at station #9. This pillow was resting on the right side of the patient. 2. On 9/18/14 at 2 PM, Employee A indicated the blood was there and had not been cleaned up immediately. 3. The agency policy titled "Infection Control Measures" with an effective date of 2/17/12 stated, "Environmental spills of blood ... must be immediately cleaned up with a bleach solution of 1:100 dilution." 	V000122	<p>Clinic Manager or designee will in-service all staff regarding Policy 494-30 "Infection Control Measures" by 10/31/14. The in-service will include but is not be limited to review of the proper method of disinfection regarding blood spills. The Clinic Manager or designee will monitor via the Infection Control Audit which includes monitoring proper disinfection of blood spills and/or splatters. This audit will be completed daily x 2 weeks or until 100% compliance is established, weekly x 4, and monthly x 2, then per the Quality Management Workbook audit schedule.</p> <p>Any staff found not to be in compliance with policy & procedure will be re-educated with future instances of non-adherence to policy resulting in progressive disciplinary action.</p> <p>Clinic Manager or designee will review all education, audit results, and discipline in the monthly QAPI and quarterly LGB meetings.</p>	10/31/2014

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V000147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on observations, staff interview, and review of policy and procedure, the</p>	V000147	<p>linic Manager in-serviced all staff including Empeoyees C & E on 9/18/14 regarding Policy 4a.300 Central Venous Catheter Care. The in-service included, but was not limited to, pre/post treatment care to ensure proper disinfection of the CVC hub with a clean field present. The Clinic Manager or designee will monitor all patients with a CVC including Pt. #1 & #6</p>	10/31/2014

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	<p>dialysis facility failed to ensure the patient care technician provided central venous catheter care in accordance with facility policy in 2 of 2 observations of care of patients with a central venous catheter completed by patient care technicians (C and E) on 9/18/14.</p> <p>Findings</p> <p>1. On 9/18/14 at 3:05 PM, Employee E, patient care technician, was observed to care for patient #1 at station #4 while initiating dialysis on a patient with a central venous catheter (CVC). Employee C did not wipe the venous hub prior to initiating disinfection.</p> <p>On 9/18/14 at 3:25 PM, Employee E indicated she may have left off this task while completing the initiation of dialysis with patient #1.</p> <p>2. On 9/18/14 at 6:50 PM, Employee C, patient care technician, was observed to care for patient #6 at station #5 while discontinuing dialysis on a patient with a central venous catheter (CVC). Employee C failed to put a clean field under the CVC ports. Employee C did not externally disinfect the exterior of the connections before connecting the hubs before applying the caps.</p>		<p>via the Infection Control-Staff Audit which includes monitoring pre/post treatment CVC care including, but not limited to, proper disinfection of hub and placement of clean field under CVC during pre/post care. This audit will be completed daily x 2 weeks or until 100% compliance is established, weekly x 4, and monthly x 2, then per the Quality Management Workbook schedule. Failure to perform care per policy will result in staff remedial education with future instances resulting in progressive disciplinary action. Clinic Manager or designee will review all education, audit results, and discipline in the monthly QAPI and quarterly LBG meetings.</p>	

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V000543	<p>On 9/19/14 at 4:30 PM, Employee A, clinic manager, and Employee O, home care manager, indicated Employee C did not follow the procedure for discontinuation of dialysis with a CVC.</p> <p>3. The agency policy titled "Central Venous Care" with a date of 2/27/12 stated, "ON PROCEDURE ... Catheter preparation ... perform catheter limbs scrub using preferred port disinfectant a. Alcavis i. Carefully place the ports in an Alcavis 50 saturated gauze pad and scrub the catheter ends and ports for 1 minute ... OFF PROCEDURE ... Perform catheter lumens scrub using, Alcavis. Following same scrub procedure as listed in 'On Procedure'."</p> <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 facility policy review and interview, the facility failed to ensure patients' abnormal blood</p>	V000543	Clinic Manager or designee will in-service all staff regarding Policy 4a.112 Patient Assessment by 10/31/14. The in-services will include, but not limited to, monitoring blood	10/31/2014	

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V000544	<p>pressure readings had been addressed in 1 (#5) of 9 records reviewed creating the potential to affect all of the facility's 53 current incenter patients.</p> <p>The findings include:</p> <p>1. Clinical record # 5 included hemodialysis treatment flow sheets that evidenced the patient had higher than normal (120/80) blood pressures throughout the treatments. The record failed to evidence the higher than normal blood pressures had been addressed.</p> <p>A. A hemodialysis treatment flow sheet dated 9/25/14 evidenced the blood pressure readings had increased to 194/92, 243/118, and 194/99 during the treatment. This was not addressed on the treatment sheet or in the progress notes. The physician was not contacted.</p> <p>B. On 9/29/14 at 3:06 PM, Employee A, clinical manager, indicated the physician should have been updated.</p> <p>2. The agency policy titled "Patient Assessment" with a date of 7/16/14 stated, "Notify the doctor of any significant findings."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of</p>		<p>pressures and notifying nurse in charge & physician (if applicable) of significant changes in vital signs; documentation of abnormal blood pressure readings and interventions. The Clinic Manager or designee will monitor via the Medical Records Audit section titled Bedside Flowsheet review which includes reviewing blood pressures. If significant changes in blood pressures are noted the auditor will further review flowsheet for documentation from dialysis care staff that nurse in charge & physician (if applicable) was informed & documentation exists related to any patient symptoms, notifications and interventions as ordered.</p> <p><small>This audit will be completed on a random sample of 50% of all patients treated daily X 2 weeks or until 100% compliance is established, weekly x 4, and monthly x 2, then per the Quality Management Workbook audit schedule. Any staff found not to be in compliance with policy & procedure will receive remedial education and future incidences will receive progressive disciplinary action. Clinic Manager or designee will review all education, audit results, and discipline in the monthly QAPI and quarterly LGB meetings.</small></p>		

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	<p>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. Based on clinical record review and interview, the facility failed to ensure the blood flow rate prescription was followed for 1 of 9 incenter hemodialysis records (#2) reviewed with the potential to affect all patients of the facility.</p> <p>Findings</p> <p>1. Clinical record #2 included hemodialysis orders that identified the blood flow rate (BFR) was to be 350 milliliters per minute. The flow sheet dated 9/1/14 evidenced BFRs of 321, 325, 275, and 230 through the treatment with no explanation as to why the BFR was not followed. The flow sheet dated 9/17/14 evidenced BFRs of 200, 300, 270, and 275 throughout the treatment with no explanation as to why the BFR was not followed.</p> <p>2. On 9/26/14 at 12 noon, Employee A, clinical manager, indicated the BFR was not as prescribed.</p> <p>3. The facility policy titled "Preparing and Operating the Fresenius 2008 K Utilizing Medisystems Streamline Airless System Set with Locksite Needleless</p>	V000544	<p>Clinic Manager or designee will in-service all staff regarding DSI Policy & Procedure 375-36: Initiation of Dialysis- Fresenius 2008 K/K2/T utilizing Medisystems Streamline Airless System Set with Locksite Needleless Access Sites by 10/31/14. The in-service will include but not be limited to monitoring the patients blood flow rate (BFR) at treatment initiation and at least every 30 minutes. Variances in BFR from prescribed rate must be documented and the nurse in charge notified.</p> <p>Clinic Manager or designee will monitor via the Initiation of Dialysis Audit for both AVF/AVG & CVC which includes monitoring that BFR is at prescribed rate with variances documented and nurse in charge notified.</p> <p>his audit will be completed on a random sample of 50% of all patients treated daily x 2 weeks or until 100% compliance is established, weekly x 4, and monthly x 2, then per the Quality Management Workbook audit schedule.</p> <p>Any staff found not to be in compliance with policy & procedure will receive remedial education and future instances will result in progressive disciplinary action.</p> <p>Clinic Manager or designee will review all education, audit results, and discipline in the monthly QAPI and quarterly LGB meetings.</p>	10/31/2014			

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V000550	<p>Access Site" with a date of 11/11/13 stated, "If no problems are noted, slowly increase the blood flow to the prescribed rate."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure pre - treatment access care had been provided in accordance with facility policy in 2 of 3 arteriovenous fistula or graft initiation of dialysis observations (#12 and #13) completed creating the potential to affect all of the facility's patients with fistulas and grafts. (Employees B and E, Patient Care Technicians)</p> <p>The findings include:</p>	V000550	<p>Clinic Manager or designee will in-service all staff including Employees E & B regarding Policy 4a.401 Needle Insertion/Cannulation of the Internal Vascular Access for Hemodialysis by 10/31/14. The in-service will include, but not limited to, proper cleansing of vascular access, followed by glove change and hand disinfection prior to needle insertion; if palpation of access occurs after the access has been disinfected, repeat cleansing will occur. Clinic Manager or designee will monitor via the Initiation of Dialysis Audit for a</p>	10/31/2014

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	<p>1. Employee E, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient # 13 who had an arteriovenous fistula (AVF) on 9/19/14 at 3:15 PM at station #4. The PCT was observed to cleanse the arterial and venous fistula sites with an antiseptic. The PCT palpated the arterial and venous needle sites with a gloved finger. She did not change her gloves or wash her hands before inserting the needles into the access sites.</p> <p>2. Employee B, a PCT, was observed to initiate the dialysis treatment on patient #12 who had an AVF on 9/19/14 at 3:30 PM at station #9. The PCT was observed to cleanse the arterial and venous fistula sites with an antiseptic. The PCT palpated the arterial and venous sites with a gloved finger. She did not change her gloves or wash her hands before inserting the needles into the access sites.</p> <p>3. On 9/19/14 at 3:40 PM, Employee O, Registered Nurse, indicated the sites were to be disinfected after the PCTs palpated the access site prior to cannulation.</p> <p>4. The agency policy "Needle Insertion / Cannulation of the Internal Vascular Access for Hemodialysis" with a date of</p>		<p>random 50% of all patients with a AVF/AVG including Pts. #12 & #13 which includes monitoring that access sites are properly cleansed and appropriate hand hygiene performed prior to cannulation of vascular access. This audit will be completed daily x 2 weeks or until 100% compliance is established, weekly x 4, and monthly x 2, then per the Quality Management Workbook audit schedule. Any staff found not to be in compliance will receive remedial instruction on policy with future instances resulting in progressive disciplinary action. Clinic Manager or designee will review all education, audit results, and discipline in the monthly QAPI and quarterly LGB meetings.</p>		

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	2/17/12 stated, "Use aseptic technique to access arterio - venous fistulas or grafts ... apply cleansing solution ... Do not touch site after it has been cleansed. Cleansing procedure must be repeated if site is touched."				