

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2012
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NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 8/20/2012, 8/21/2012, and 8/22/2012</p> <p>Facility #: 005157</p> <p>Medicaid Vendor #: 100172360D</p> <p>Surveyor: Kelly Ennis, RN, BSN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 96 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 0</p> <p>Total: 96</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 24, 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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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 4 of 4 Patient Care Technicians (PCT) (employees C, D, H, and I) observed provided care in compliance with infection control policies and procedures creating the potential to spread infection causing agents among facility staff and all 96 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/20/12 at 10:25 AM, employee H, Patient Care Technician (PCT), was at station #6, patient # 6, preparing to initiate treatment. With gloves on, the PCT sprayed "Pain Ease Spray" onto the first access site and inserted needle #1 with no glove change prior. The PCT then sprayed the "Pain Ease Spray" onto the second access site and inserted needle #2 with no glove change prior. On 8/20/12 at 10:40 AM, employee C, PCT, was at station #5, patient #1, preparing to initiate treatment. With gloves on, the PCT sprayed "Pain Ease 	V0113	<p>Clinic Nurse Manager (CNM) held an incenter meeting on 8-22-2012 and FacilityManager (FA) held a mandatory in-service for all Clinical Teammates (TMs) on 8-30-2012. In-service included but was not limited to: review of Policy and Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure # 1-04-01C: Administration of Pain Ease Spray Prior to AV Fistula or Graft Cannulation, Policy & Procedure #1-04-02C: Central Venous Catheter (CVC) Cleaning and Dressing Change, TMs instructed using surveyor observations as examples to the following: 1) TMs must wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. 2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station. 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart. 4) TMs will perform hand hygiene everytime gloves are removed. 5) Pain ease spray must never be placed down at thepatient station. Verification of attendance at in-service will be</p>	09/22/2012			

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	<p>Spray" onto the first access site and inserted needle #1 with no glove change prior. The PCT then sprayed the "Pain Ease Spray" onto the second access site and inserted needle #2 with no glove change prior. The patient then asked the PCT if he was done with the spray and the PCT replied "yes". The patient then took the bottle and placed it back into his bag.</p> <p>3. On 8/21/12 at 10:15 AM, employee D, PCT, was at station #1, patient #3, preparing to initiate treatment. The patient placed the bottle of "Pain Ease Spray" onto their lap. The PCT then picked up the bottle of "Pain Ease Spray" and placed it on the chair side table by the clean supplies. The PCT then placed a tourniquet around the patient's arm, applied the "Pain Ease Spray", and inserted needle #1 with no glove change prior. The PCT then removed her gloves, applied gel, and then applied new gloves. She then picked up the bottle of "Pain Ease Spray" and sprayed it onto the patient's arm and then inserted needle #2 with no glove change prior.</p> <p>4. On 8/21/12 at 10:40 AM, employee I, PCT, was at station #4, patient #12, preparing to do a dressing change on a patient who had a Central Venous Catheter (CVC). The PCT removed the old catheter dressing and cleansed around</p>		evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) will conduct infection control audits on every shift daily x1 week, weekly x4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), minutes will reflect. The FA is responsible for compliance with this Plan of Correction (POC).				

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	<p>the catheter site. The PCT then applied the new dressing with no glove change prior.</p> <p>5. On 8/21/12 at 4:45 PM, employee A, Facility Administrator (FA), indicated the patients bring in their own bottle of Pain Ease spray from home. Employee A indicated gloves should be changed after touching the bottle of Pain Ease spray and before cannulating the patient.</p> <p>6. On 8/22/12 at 12:20 PM, employee A, FA, indicated that during a CVC dressing change, a glove change should be done before applying a new dressing.</p> <p>7. Facility policy titled "Control for Dialysis Facilities" policy number 1-05-01, revised March 2012 states, "Gloves should be changed when ... going from a "dirty" area or task to a "clean" area or task."</p> <p>8. Facility policy titled "Administration of Pain Ease Spray prior to AV Fistula or Graft Cannulation" procedure number 1-04-01C, origination date September 2011 states, "With clean-gloved hands, go to designated area where Pain Ease Spray is kept and return to patient ... Spray Pain Ease to each cannulation site for 4 to 10 seconds from a distance of 3 to 7 inches until the skin begins to blanch. When the</p>			

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	<p>skin begins to turn white, the numbing has taken effect and it is time to stop spraying. Do not frost the skin. Return can of Pain Ease spray immediately to designated area ... With clean-gloved hands, follow remainder of existing procedure AV Fistula or Graft Cannulation with Safety Needles (SFN) and Administration of Heparin."</p> <p>9. Facility policy titled "Central Venous Catheter (CVC) Cleaning and Dressing Change" procedure number 1-04-02C, revised March 2011, states, "With clean, gloves hands remove old dressing and discard without reaching over patient and/or contaminating clean field ... remove gloves and discard. Wash hands or use hand gel as long as there is no visible blood or body fluids on hands. Re-glove."</p>			

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V0146	<p>494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure 1 of 2 Patient Care Technicians (PCT) (employee I) observed providing central venous catheter care provided care in compliance with central venous catheter policies and procedures creating the potential to spread infectious and communicable disease which could affect all patients with a central venous catheter (CVC).</p>	V0146	CNM held an in-center meeting on 8-22-2012 and on 8-30-2012 FA held amandatory in-service for all clinical Teammates. In-service included but was not limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure #1-04-02C: Central Venous Catheter (CVC) Cleaning and Dressing Change, dressing change TMs must 1) set-up clean field with supplies. With clean gloved hands remove old dressing and discard without	09/22/2012

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	<p>The findings include:</p> <ol style="list-style-type: none"> On 8/21/12 at 10:40 AM, employee I, PCT, was at station #4, patient #12, preparing to do a dressing change on a patient who had a Central Venous Catheter (CVC). The PCT removed the old catheter dressing and cleansed around the catheter site. The PCT then applied the new dressing with no glove change prior. On 8/21/12 at 4:45 PM, employee A, Facility Administrator (FA), indicated the patients bring in their own bottle of Pain Ease spray from home. Employee A indicated gloves should be changed after touching the bottle of Pain Ease spray and before cannulating the patient. On 8/22/12 at 12:20 PM, employee A, FA, indicated during a CVC dressing change, a glove change should be done before applying new dressing. Facility policy titled "Control for Dialysis Facilities" policy number 1-05-01, revised March 2012 states, "Gloves should be changed when ... going from a "dirty" area or task to a "clean" area or task." Facility policy titled "Central Venous 		<p>reaching over patient and contaminating clean field, assess CVC exit site for infection 2) Remove and discard gloves, conduct hand hygiene, don new gloves, 3) Holding catheter with non dominant hand using aseptic technique, clean exit site, 4) Remove and discard gloves, conduct hand hygiene, don new gloves, 5) Place sterile gauze over catheter and exit site leaving catheter limbs accessible. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. ICM will conduct infection control audits on every shift daily x1 week, weekly x4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect. The FA is responsible for compliance with this POC.</p>	

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	Catheter (CVC) Cleaning and Dressing Change" procedure number 1-04-02C, revised March 2011 states, "With clean, gloves hands remove old dressing and discard without reaching over patient and/or contaminating clean field ... remove gloves and discard. Wash hands or use hand gel as long as there is no visible blood or body fluids on hands. Re-glove."			

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V0190	<p>494.40(a) SOFTENERS-AUTO REGENERATE/TIMERS/SALT LVL 5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution.</p> <p>5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration.</p> <p>The face of the timers used to control the regeneration cycle should be visible to the user.</p> <p>6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated.</p> <p>The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and pistons and clog orifices in the softener</p>						

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	<p>control head. Based on administrative document review, staff interview, and policy and procedure review, the facility failed to ensure the salt level check was completed and accurately recorded in the daily water treatment system monitoring log in 6 of 6 months of treatment logs reviewed, creating the potential of a contaminated water supply which could affect all 96 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Administrative document titled "DaVita Daily Water Treatment Log" item number 10 states, "Salt Level in Brine Tank? (Y/N)" On 2/4/12, 2/9/12, 2/21/12, 3/6/12, 3/12/12, 4/2/12, 4/4/12, 4/6/12, 4/10/12, 4/14/12, 5/14/12, 5/17/12, 5/21/12, 6/11/12, 6/18/12, 7/2/12, 7/5/12, 7/9/12, 7/25/12, 7/30 1, 8/13/12, and 8/15/12, "No" was recorded. However, there was no action recorded. On 8/20/12 at 5:35 PM, employee A, Facility Administrator, indicated their former policy under DSI did not require them to indicate action taken, and this was a new DaVita policy. She indicated she would instruct her staff to indicate what action was taken when "No" was answered. 	V0190	<p>Biomed held mandatory in-services for all clinical TMs responsible for watertreatment testing on 8-30-2012. In-service included but was not limited to: review of <i>Policy & Procedure # 2-07-02: Daily Water Treatment System Monitoring, Policy & Procedure # 2-07-02A Daily Water Treatment Log emphasizing TMs must verify daily at the start of each operation day that softener brine tanks salt level is above half full, TMs must document Yes on the Daily Water Treatment Log to indicate appropriate salt level, or No if level is not half full, and fill brine tank with salt to the appropriate level ensuring to document action taken on daily log. Re-validation of skills conducted on all clinical TMs on water treatment monitoring using the Dialysis Quality Water Monitoring and Testing Skills Checklist. Verification of attendance at in-service will be evidenced by TMs signature on inservice sheet. FA or designee will conduct Daily Water Treatment Log audits. Results of audits will be reviewed with the Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC</i></p>	09/22/2012	

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	<p>3. Facility policy titled "Daily Water Treatment System Monitoring" policy number 2-07-02, revised March 2011, states, "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 limiters, follow the instructions given on the Daily water Treatment Log for the parameter(s) in question."</p> <p>4. Facility document titled "Daily Water Treatment Log Explanation" log #2-07-02A, revised March 2010 states, "10. "Salt Level in Brine Tank? (Y/N)" ... At the start of each operation day, check salt level in the brine tank. If the salt level is above half full in the brine tank enter 'Y' (YES) to indicate salt level is appropriate. If 'Y' is entered, no other user action is required for that day. If the level is not half full, enter 'N' (NO). Fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary contact the Biomed Team for direction and assistance."</p>				

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V0191	<p>494.40(a) SOFTENERS: TESTING HARDNESS/LOG 6.2.4 Softeners: Testing hardness/log Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total hardness monitoring requirements of the reverse osmosis machine manufacturer. Total hardness of the water exiting the water softener should be measured at the end of each treatment day.</p> <p>Water hardness test results should be recorded in a water softener log.</p> <p>Based on administrative document review, staff interview, and policy and procedure review, the facility failed to ensure the water hardness test was completed and recorded in the daily water treatment system monitoring log in 4 of 6 months of treatment logs reviewed, creating the potential of a contaminated water supply which could affect all 96 current in-center patients.</p> <p>The findings include:</p> <p>1. Administrative document titled "DaVita Daily Water Treatment Log" item number 30 states, "End of Day Hardness Test Result" and item number 31 states, "Time and Initials of Teammate Performing End of Day Hardness Test." No entry for test result, time, or initials was made for 2/25/12, 4/3/12, 6/5/12, 7/5/12, 7/17/12, 7/18/12, 7/20/12,</p>	V0191	<p>Biomed held mandatory in-services for all clinical TMs responsible for watertreatment testing on 8-30-2012. In-service included but was not be limited to: review of Policy & Procedure # 2-07-02: Daily Water Treatment System Monitoring, Policy & Procedure # 2-07-02C Total Hardness - Using Hach 5B Hardness Test Kit, Policy & Procedure # 2-07-02A Daily Water Treatment Log emphasizing the requirement to record end of the day waterhardness testing result on the Daily Water Treatment Log including time, initials and results. Re-validation of skills conducted on all clinical TMs on water treatment monitoring using the Dialysis Quality Water Monitoring and Testing Skills Checklist. Verification of attendance at inservice will be evidenced by TMs signature on in-service sheet.FA or designee will conduct Daily Water Treatment Log audits. Results of auditswill be</p>	09/22/2012	

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	<p>7/21/12, or 7/23/12.</p> <p>2. On 8/20/12 at 3:15 PM, Employee J, Area Biomedical Supervisor, indicated the water hardness tests should be completed at the end of each treatment day.</p> <p>3. Facility policy titled "Daily Water Treatment System Monitoring" policy number 2-07-02, revised March 2011, states, "The initials and signature of the teammate performing and recording all observations and test results are entered where indicated on the Daily Water Treatment Log. A separate entry of time and initials is provided for the teammate performing end of day hardness testing."</p> <p>4. Facility document titled "Daily Water Treatment Log Explanation" log #2-07-02A, revised March 2010, states, "30. "End of Day Hardness Test Result" ... At the end of the treatment day, perform the unit specific Hardness test on treated water collected from the designated Post Softener Sample Port. Enter the Hardness Test Result in the space provided. If the Hardness Test Result is less than (<) or equal to (=) 1 Grain (gr) of hardness, no additional user action is required. If the Hardness Test Result is equal to or greater than 1 Grain (gr) contact the Biomedical Team for direction and assistance. 31.</p>		<p>reviewed with the Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2012
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NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
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	<p>"Initials of Teammate Performing End of Day Hardness Test" ... The Teammate entering End of Day Hardness test result is listed above and needs to enter the time and their initials."</p> <p>5. Facility policy titled "Total Hardness -- Using Hach 5B Hardness Test Kit" procedure #2-07-02C, origination date August 2006, states, "Hardness testing is done on water leaving the water softener at the end of treatment day. Results of this testing are documented on the Daily Water Treatment Log."</p>			

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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. Based on observation, staff interview, and policy and procedure review, the facility failed to ensure all residual bleach test strips were in date for 2 of 4 bottles observed, creating the potential for contaminated dialysate which could affect all 96 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/20/12 at 12:40 PM, 4 bottles of Residual Chlorine test strips were observed in the clean supply area. Two 2/4 bottles of residual chlorine strips were expired with expiration dates of 1/12 and 6/12. On 8/20/12 at 2:20 PM, employee K, Biomedical technician, indicated the residual chlorine test strips located on the treatment floor are used to test for residual chlorine after he bleaches the machines. Once he was informed the 2/4 bottles were expired, he indicated this was not good and all the bottles should be current to ensure accuracy. 	V0403	Expired items were immediately discarded and replaced with new. All Expiration dates on facility supplies were verified not to be expired by FA on 8-20-2012.FA held mandatory in-service for all TMs on 8-30-2012. In-service included but was not limited to: review of Policy and Procedure # 1-05-01 Infection Control for Dialysis Facilities, importance of verifying all facility medications, solutions and supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs educated that using expired items could have the potential to affect 100% of facility patient census.Verification of attendance at in-service will be evidenced by TMs signature on inservice sheet. CNM added Residual Bleach Test Strips to emergency evacuation cart to be checked monthly, and will audit facility inventory monthly to verify all facility medications, solutions and supplies are checked for expiration in stock or available for use on treatment floor. Results of audits will be reviewed with Medical Director during QIFMM,	09/22/2012			

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	3. Facility policy titled "Residual Bleach Testing Using Serim Residual Chlorine (Bleach) Test Strips" procedure #2-04-10B, revised September 2011, states, "These strips are intended for use in testing Bleach levels in the water. Do not use strips if vial is found loosely capped or cap is missing. Verify that strips are in date. The expiration date is printed on the bottom of the vial ... improper strip activation and color interpretation may result in patient injury."		minutes will reflect. The FA is responsible for compliance with this POC.	