

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152642	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2015
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NAME OF PROVIDER OR SUPPLIER  HOOSIER HILLS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 143 S KINGSTON DR BLOOMINGTON, IN 47408
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V 0000  Bldg. 00	This was a Federal ESRD [CORE] survey.  Survey Dates: 8-12-15, 8-13-15, & 8-14-15  Facility #: 012211  Medicaid Vendor #: 200982260A  QA; LD, R.N.	V 0000		
V 0113  Bldg. 00	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.  7. On 8-13-15 at 2:35 PM, employee O, a registered nurse (RN), was observed to obtain a blood sample from patient number 11 in the home therapy department. The RN was observed to cleanse her hands and don clean gloves. The RN then palpated the antecubital space on the patient's right arm. The RN, without cleansing her hands and changing her gloves, then cleansed the site and inserted a butterfly needle with tubing and obtained the blood sample.	V 0113	V113  Facility Administrator (FA) will hold a mandatory in-service for all clinical teammates (TMs) on 8/31/2015, regarding infection control practices. In-service will include review of Policy 1-05-01: Infection Control for Dialysis Facilities emphasizing 1) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with the same patient, between each patient and station; 2) TMs must remove gloves	09/14/2015

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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V 0245  Bldg. 00	494.40(a) ACID CONC DIST-CONC LABELED & COLOR-CODED RED 5.5.3 Acid concentrate distribution systems: labeled & color-coded red Acid concentrate delivery piping should be labeled and color-coded red at the point of		andperform hand hygiene before entering clean supply area; 3) TMs must performhand hygiene every time gloves are removed Verification of attendance at inservice will be evidenced by TM's signature on in service sign in sheet.  Infection Control Managerwill conduct infection control audits every shift x 1 week, if compliance is achieved,audits will be conducted weekly x 3 weeks, then monthly. Facility Infection Managerwill review findings at home room meetings and audit results will be reviewedwith Medical Director during monthly Facility Health Meetings (FHM), minuteswill reflect.  The FA is responsible forcompliance with this plan of correction  Completion date: 9/14/2015	

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	<p>use (at the jug filling station or the dialysis machine connection).</p> <p>All joints should be sealed to prevent leakage of concentrate. If the acid system remains intact, no rinsing or disinfection is necessary.</p> <p>More than one type of acid concentrate may be delivered, and each line should clearly indicate the type of acid concentrate it contains.</p> <p>Based on observation and interview the facility failed to ensure wall boxes with acid concentrate delivery piping had been clearly labeled in 6 (#s 2, 3, 5, 7, 9, 12) of 12 dialysis stations observed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 8-12-15 at 1:15 PM, observation noted 2 different acid concentrate holding tanks in the water room. One tank was labeled 2K 2.5 Ca and the other 3K 2.5 Ca.</li> <li>2. On 8-12-15 at 2:30 PM, observation noted 2 different acid concentrate outlets in the chase cabinets at each of the dialysis stations numbered 1 through 12. Labels on the outlets at stations 2, 3, 5, 7, 9 and 12 were noted to be worn and illegible.</li> </ol>	V 0245	<p>Biomedical supervisor contacted on 8/12/2015, informed of faded labelson outlets at identified stations. Biomedical Technician inspected labels onchase, new color coded labels ordered. New labels will be placed on thecabinet/chase upon arrival to the clinic; labels will be identified by colorand easy to read so that acid concentrations at each station are able to be determined.</p> <p>Biomedical Technician will conduct monthly observational physical plantaudits to ensure facility is in good repair. FA will review results of allaudits with Medical Director during monthly FHM, minutes will reflect.</p> <p>The FA is responsible for compliance with this plan of correction</p> <p>Completion date: 09/14/2015</p>	09/14/2015

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V 0401 Bldg. 00	<p>3 The facility manager, employee K, agreed on 8/14/2015 at 10:22 AM that the outlets needed to be relabeled so the the acid concentrations at each station were able to be read.</p> <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. Based on observation, interview, and facility policy review, the facility failed to ensure the treatment floor had been kept clean and orderly in 1 (#1) of 3 days observed.</p> <p>The findings include:</p> <p>1. Upon arrival to the facility, on 8-12-15, a tour was completed of the treatment floor area at 1:25 PM. The following was observed:</p> <p>A. A tissue, an alcohol pad wrapper, a blue glove, and a strip of white paper</p>	V 0401	<p>TMs immediately picked up identified trash/debris of floor and identified fluid on floor immediately cleaned.</p> <p>FA will hold a mandatory in-service for all clinical TMs on 8/31/2015 reviewing of Policy 8-04-01 Physical Environment emphasizing all TMs are responsible for providing a sanitary and safe environment in the treatment area, and throughout facility. Treatment floor must remain clean, free of trash/debris, spills/fluid immediately cleaned in a timely manner to ensure patient safety. Verification of attendance at in</p>	09/14/2015

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V 0413  Bldg. 00	<p>approximately 2 inches by 6 inches was observed on the floor at station number 12.</p> <p>B. A 4 x 4 gauze package and an opaque plastic tube approximately 2 inches long was observed to the floor at station number 11.</p> <p>C. A moderate amount of a clean fluid was observed on the floor at station number 6 beside and under the dialysis chair.</p> <p>2. Employee E, a patient care technician (PCT), stated, on 8-12-15 at 1:35 PM, "We try to sweep the floor after every shift."</p> <p>3. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p> <p>494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and</p>				<p>service will be evidenced by TM's signature on in service sign in sheet.</p> <p>Infection Control Manager will conduct infection control audits every shift x 1 week, if compliance is achieved, audits will be conducted weekly x 3 weeks, then monthly.</p> <p>Facility Infection Manager will review findings at home room meetings and audit results will be reviewed with Medical Director during monthly FHM, minutes will reflect.</p> <p>The FA is responsible for compliance with this plan of correction</p> <p>Completion date: 9/14/2015</p>		

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	<p>emergency drugs, must be on the premises at all times and immediately available. Based on observation and interview, the facility failed to ensure emergency equipment was accessible in 1 (#1) of 3 days observation.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 8-12-15 at 1:45 PM, observation noted the emergency equipment, to include an AED (automated external defibrillator), oxygen, and suction, was located in a red cart against a wall in the corner of the medication preparation area. An intravenous pole, portable blood pressure equipment, and a CPR board were located in front of the cart and would need to be moved in order to get the cart out of the area and to a patient in need.</li> <li>The clinic manager, employee K, indicated, on 8-13-15 at 12:55 PM, the emergency equipment would be made accessible.</li> </ol>	V 0413	<p>TMs immediately picked up identified trash/debris of floor and identified fluid on floor immediately cleaned.</p> <p>FA will hold a mandatory in-service for all clinical TMs on 8/31/2015 reviewing of Policy 8-04-01 Physical Environment emphasizing all TMs are responsible for providing a sanitary and safe environment in the treatment area, and throughout facility. Treatment floor must remain clean, free of trash/debris, spills/fluid immediately cleaned in a timely manner to ensure patient safety. Verification of attendance at in service will be evidenced by TM's signature on in service sign in sheet.</p> <p>Infection Control Manager will conduct infection control audits every shift x 1 week, if compliance is achieved, audits will be conducted weekly x 3 weeks, then monthly. Facility Infection Manager will review findings at home room meetings and audit results will be reviewed with Medical Director during monthly FHM, minutes will reflect.</p> <p>The FA is responsible for compliance with this plan of correction</p> <p>Completion date: 9/14/2015</p>	09/14/2015	

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V 0543 Bldg. 00	<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; Based on clinical record and facility policy review and interview, the facility failed to ensure the necessary care and services had been provided to manage the patient's fluid volume in 1 (#1) of 5 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 failed to evidence the physician ordered estimated dry weight (EDW, the desired weight at the end of the treatment) had been achieved. The record included physician orders dated, 7-10-15 and 7-17-15, that identified an estimated dry weight (EDW, the desired weight at the completion of the treatment) of 70 kilograms (kg). The record included physician orders dated 10-10-11 that include instructions to follow the facility's "Adequacy Management Protocol." The record failed to evidenced the physician had been notified and the EDW adjusted.</p> <p>A. A hemodialysis treatment flow sheet dated 7-24-15 evidenced the</p>	V 0543	<p>V543</p> <p>Interdisciplinary Team (IDT) will initiate individualized plan of careupdate for Patient #1 to reflect evaluation of patient's current fluid volumestatus including estimated dry weight, and adjust plan of care to meet theneeds of the patient.</p> <p>FA will hold mandatory in-service with all clinical TMs by 8/31/2015,in-service will include review of Policy #1-07-03 Adequacy Management Guidance,Policy #1-03-12 Post Treatment Patient Assessment emphasizing TMs must reportand document any significant changes in target weight identified for eachpatient or failure to achieve estimated dry weight greater or less thanphysician's hemodialysis prescription to licensed nurse, licensed nurse musttake appropriate action, contact physician if warranted, and follow physicianorders. Examples given using surveyor observations for patients consistentlynot meeting estimated dry weight and team did not address. Verification ofattendance at in service will be</p>	09/14/2015

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	<p>patient's weight at the end of the treatment was 72.7 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 7-22-15 evidenced the patient's weight at the end of the treatment was 74.6 kg.</p> <p>C. A hemodialysis treatment flow sheet dated 7-27-15 evidenced the patient's weight at the end of the treatment was 75.1 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 7-29-15 evidenced the patient's weight at the end of the treatment was 72.6 kg.</p> <p>E. A hemodialysis treatment flow sheet dated 7-31-15 evidenced the patient's weight at the end of the treatment was 71.5 kg.</p> <p>F A hemodialysis treatment flow sheet dated 8-3-15 evidenced the patient's weight at the end of the treatment was 72.5 kg.</p> <p>G. A hemodialysis treatment flow sheet dated 8-5-15 evidenced the patient's weight at the end of the treatment was 71.9 kg.</p> <p>H. A hemodialysis treatment flow</p>		<p>evidenced by TM's signature on in service signin sheet.</p> <p>FA or designee will conduct audits on 10% of patient treatment sheetsdaily x 1 week, weekly x 4weeks, then monthly. FA will review results of allaudits with Medical Director during monthly FHM, minutes will reflect</p> <p>FA is responsible for compliance with this plan of correction.</p> <p>Completion date: 9/14/2015</p>	

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V 0587 Bldg. 00	<p>sheet dated 8-10-15 evidenced the patient's weight at the end of the treatment was 75 kg.</p> <p>I. A hemodialysis treatment flow sheet dated 8-11-15 evidenced the patient's weight at the end of the treatment was 72.6 kg.</p> <p>2. The facility administrator, employee K, was unable to provide any additional documentation and/or information regarding the above-stated findings when asked on 8-13-15 at 12:55 PM.</p> <p>3. The facility's March 2015 "Adequacy Management Guidance" policy number 1-07-03 states, "Target weight (TW) . . . If post weight is consistently different than the TW by 1 kg or more (+/- 1 kg), adjust TW as needed per physician order."</p> <p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record. Based on clinical record and facility policy review and interview, the facility</p>	V 0587	V587  IDT and home therapy nurse met	09/14/2015			

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	<p>failed to ensure self-monitoring records had been reviewed for completeness and accuracy in 1 (#4) of 2 home program records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included physician orders dated 7-14-15 that identified Epogen 3300 units (a red blood cell production stimulating medication) was to be administered every 9 days. The record identified the patient self-administered the medication at home.</p> <p>A. The record included "Daily Home Continuous Cycler Peritoneal Dialysis Records" for the month of July 2015. The records evidenced the patient had administered the ordered Epogen on 7-11-15 and not again until 7-29-15.</p> <p>B. The record included a signed attestation by the patient dated 8-11-15 that identifies the patient had performed the prescribed PD treatments and home administration of Epogen since the last clinic visit on 7-9-15.</p> <p>C. The record included a registered nurse (RN) "Progress Note", dated 8-12-15, that identified the RN had reviewed the home records. The progress</p>		<p>with home patient #4 on 8/26/2015, educating patient to the necessity of completing Daily Home Treatment records to provide continuity of care, Patients instructed to document medications given at home, including Epogen as prescribed; provide home therapy RN the records during clinic visit, any missed doses must be reflected and home patient must notify home therapy nurse of any missed doses, documentation of meeting and education placed in patient's medical record.</p> <p>FA to hold mandatory in-service by 8/31/2015 with home nurses reviewing Policy #5-01-29 Daily Home Treatment Record. Home therapy nurses will be instructed that all Daily Home Treatment Records must be maintained as a part of the patient's medical record and record must be reviewed for accuracy. Patients must bring in completed records to each clinic visit and TMs must review the document for accuracy and verify medications were given with patient to ensure verify no missed doses. Plans of care for identified non-compliant patients will be established to address adherence issues. Verification of attendance at in service will be evidenced by TM's signature on in service sign in sheet.</p> <p>FA or designee will conduct flow sheets audits monthly on 10% of PD patient daily home treatment</p>	

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	<p>note failed to evidence the RN had addressed the missed dose of Epogen on the home self-monitoring records.</p> <p>2. The RN, employee O, was unable to provide any additional documentation and/or information when asked on 8-13-15 at 2:45 PM.</p> <p>3. The facility's March 2011 "DAILY HOME TREATMENT RECORD" policy number 5-01-29 states, "Home training teammate will review completed Daily Home Treatment Records to assist in evaluating the patient's progress and self-care decision making process. This review will be verified by the home training nurse documenting review in the medical record."</p>		<p>records. FA will review results of all audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction.</p> <p>Completion date: 9/14/2015</p>		