

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2012
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NAME OF PROVIDER OR SUPPLIER DAVISS COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 310 NE 14TH ST WASHINGTON, IN 47501
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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Facility #: 002590</p> <p>Survey Dates: 4-11-12, 4-12-12, 4-13-12, & 4-16-12</p> <p>Medicaid Vendor #: 200285170A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Census: 46 incenter hemodialysis, 0 home dialysis</p> <p>Daviess County Dialysis was found to be out of compliance with the Condition for Coverage 42 CFR 494.60 Physical Environment.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">April 20, 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, facility policy review, and interview, the facility failed to ensure staff followed the facility's infection control policy and procedure in 3 (#s 1, 3, 4,) of 6 patient care observations creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. 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</p>	V0111	<p>Surveyor observations were discussed in homeroom meetings during the week following the survey. Teammates (TMs) were formally in serviced 4/17/2012 & 4/18/2012 on <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs received specific instruction including but not limited to: 1) TMs must remove gloves and perform hand hygiene between each patient and station, even if the contact is casual. 2) TMs must remove gloves perform hand hygiene and don new gloves between dirty to clean tasks with same patient 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart. 4) TMs must perform hand hygiene prior to gloving, each time gloves are removed, and prior to leaving the treatment floor. Verification of attendance at in-service evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct daily infection control audits x 2 weeks, then weekly x 2 months, then monthly thereafter. Facility Administrator (FA) will review results of all audits with TMs during homeroom meetings and with Medical Director during</p>	05/16/2012

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	<p>care area."</p> <p>2. 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 the patient. Decontaminate hands after removing gloves."</p> <p>3. Patient care observation number 1 occurred on 4-11-12 at 1:05 PM. Employee E, a patient care technician (PCT), was observed to remove the patient from the dialysis machine and remove the needles upon completion of the treatment. The PCT was observed to remove her gloves and cleanse her hands. The PCT adjusted the blood pressure cuff on the patient's arm and donned clean gloves without cleansing her hands. The PCT observed the patient's blood pressure and removed the blood pressure cuff from the patient's arm. The PCT then changed</p>		<p>monthly Quality Improvement Facility Management Meetings (QIFMM), QIFMM minutes will reflect. FA is responsible for compliance with this POC.</p>		

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	<p>her gloves without cleansing her hands.</p> <p>A. The PCT cleaned the front of the dialysis machine, removed her gloves and cleansed her hands. The PCT obtained 2 new bags of normal saline, opened the bags and hung them on the machine. The PCT then obtained new tubing and opened the package and donned clean gloves without cleansing her hands.</p> <p>B. The PCT then removed her gloves, cleansed her hands, and obtained a roll of tape from the supply at the nurse's station. The PCT donned new gloves without cleansing her hands.</p> <p>4. Patient care observation number 3 occurred on 4-12-12 at 9:55 AM. Employee C, a registered nurse, was observed to initiate the dialysis treatment on patient number 3. The employee touched the dialysis machine and then connected the arterial tubing to the patient without changing her gloves or cleansing her hands. After placing a barrier under the patient's central venous catheter limbs, the employee changed her gloves and cleansed her hands. The employee then touched the front of the machine and connected the venous tubing to the patient without changing her gloves and cleansing her hands.</p>				

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	5. Patient care observation number 4 occurred on 4-13-12 at 9:10 AM. The dialysis needles had dislodged from patient number 7 and the facility administrator, employee A, was holding pressure on the insertion site with her gloved left hand. Employee A touched the machine with her right hand and then switched to her right hand to hold pressure on the insertion site without changing her glove or cleansing her hands.			

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V0112	<p>494.30(a) IC-CDC MMWR 2001 The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. 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 at 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>The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure staff followed the facility's infection control policy and procedure in</p>	V0112	Surveyor observations were discussed in homeroom meetings during the week following the survey. TMs were formally in serviced 4/17/2012 & 4/18/2012	05/16/2012			

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	<p>3 (#s 1, 3, 4,) of 6 patient care observations creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. 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>2. 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</p>		<p>on Policy & Procedure #1-05-01: <i>Infection Control for Dialysis Facilities</i>. 1) TMs must remove gloves and perform hand hygiene between each patient and station, even if the contact is casual. 2) TMs must remove gloves perform hand hygiene and don new gloves between dirty to clean tasks with same patient 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart. 4) TMs must perform hand hygiene prior to gloving, each time gloves are removed, and prior to leaving the treatment floor. Verification of attendance at in-service evidenced by TMs signature on in-service sheet.</p> <p>ICM or designee will conduct daily infection control audits x 2 week, then weekly x 2 months, then monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC</p>		

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	<p>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.</p> <p>Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Patient care observation number 1 occurred on 4-11-12 at 1:05 PM. Employee E, a patient care technician (PCT), was observed to remove the patient from the dialysis machine and remove the needles upon completion of the treatment. The PCT was observed to remove her gloves and cleanse her hands. The PCT adjusted the blood pressure cuff on the patient's arm and donned clean gloves without cleansing her hands. The PCT observed the patient's blood pressure and removed the blood pressure cuff from the patient's arm. The PCT then changed her gloves without cleansing her hands.</p> <p>A. The PCT cleaned the front of the dialysis machine, removed her gloves and cleansed her hands. The PCT obtained 2 new bags of normal saline, opened the bags and hung them on the machine. The PCT then obtained new tubing and opened the package and donned clean gloves without cleansing her hands.</p>			

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	<p>B. The PCT then removed her gloves, cleansed her hands, and obtained a roll of tape from the supply at the nurse's station. The PCT donned new gloves without cleansing her hands.</p> <p>4. Patient care observation number 3 occurred on 4-12-12 at 9:55 AM. Employee C, a registered nurse, was observed to initiate the dialysis treatment on patient number 3. The employee touched the dialysis machine and then connected the arterial tubing to the patient without changing her gloves or cleansing her hands. After placing a barrier under the patient's central venous catheter limbs, the employee changed her gloves and cleansed her hands. The employee then touched the front of the machine and connected the venous tubing to the patient without changing her gloves and cleansing her hands.</p> <p>5. Patient care observation number 4 occurred on 4-13-12 at 9:10 AM. The dialysis needles had dislodged from patient number 7 and the facility administrator, employee A, was holding pressure on the insertion site with her gloved left hand. Employee A touched the machine with her right hand and then switched to her right hand to hold pressure on the insertion site without</p>						

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	changing her glove or cleansing her hands.			

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V0122	<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 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, facility policy review, and interview, the facility failed to ensure it had followed its own cleaning and disinfection procedures in 4 (#s 1, 2, 3, and 4) of 4 cleaning observations completed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, tourniquet, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment . . . For visible blood or gross blood spills a 1:10 (one to ten) bleach solution must be utilized. After all visible blood is cleaned with the 1:10 (one to 10) bleach solution, teammates are to use a</p>	V0122	<p>Surveyor observations were discussed in homeroom meetings during the week following the survey. TMs were formally in serviced 4/17/2012 & 4/18/2012 on <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure # 1-05-08A: Preparation of 1:10 Bleach Solution, and Policy & Procedure # 1-05-08B Preparation of 1:100 Bleach Solution, emphasizing 1) TMs must fully clean machine including front, top, sides, bottom lip, and interior/exterior of prime container. 2) TMs must completely recline and open chair foot rest to clean in the crevasses of chair. 3) TMs instructed how to prepare 1:100 and 1: 10 bleach solutions 4) TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection tasks emphasizing for visible blood or gross blood spills a 1:10 bleach solution must be utilized. After blood is cleaned with 1:10 bleach solution TMs must use new disposable towel</i></p>	05/16/2012			

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	<p>new disposable towel soaked with 1:10 (one to ten) bleach solution and clean area a second time."</p> <p>2 Observation number 1 was completed on 4-11-12 at 1:15 PM. Employee E, a patient care technician (PCT) was observed to clean a dialysis machine after a dialysis treatment on patient number 1. The PCT was observed to use a cloth with 1:100 bleach solution to wipe down the front of the machine. The PCT was not observed to clean the entire area of the front of the machine. The PCT was not observed to clean the top or the sides of the machine.</p> <p>3. Observation number 2 was completed on 4-12-12 at 9:10 AM Central Time. The biomedical technician, employee J, brought a replacement dialysis machine out to the treatment floor for patient number 3. The biomedical technician indicated the machine had been sitting in the back of the facility in the biomedical technical area and had been disinfected on the inside less than 72 hours ago.</p> <p>Employee C, a registered nurse, was observed to clean the outside of the machine prior to connecting patient number 3. The employee was not observed to clean the entire surface of the front of the machine or to clean the back</p>		<p>soaked with 1:10 bleach solution and clean a second time. Bleach Solutions policies have been posted in treatment area where bleach solution preparations takes place. The Charge Nurse is responsible for monitoring daily. Verification of attendance at in-service evidenced by TMs signature on in-service sheet.</p> <p>ICM or designee will conduct daily infection control audits x 2 week, then weekly x 2 months, then monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC</p>				

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	<p>and sides of the machine.</p> <p>4. Observation number 3 was completed on 4-12-12 at 9:30 AM Central Time. Employee C, a registered nurse, was observed to clean the dialysis machine after patient number 6 had completed treatment. The employee was not observed to clean the entire surface area of the front of the machine. The employee was observed to clean the dialysis chair. The employee was not observed to clean the lower one-half of both sides of the chair or the back of the chair. A small droplet of a white substance was noted on the right bottom half of the side of the chair after the employee completed the cleaning.</p> <p>5. Observation number 4 was completed on 4-13-12 at 9:10 AM Central Time. Observation noted a needle had dislodged from patient number 7's access. A large amount of gross blood was noted on the patient's right arm, the arm of the chair, on the chair-side table, and the floor. Employee D was observed to clean the chair, the chair-side table, and the floor with a wet cloth. When asked what strength of bleach solution was being used to clean the blood spill, the employee replied, "I don't know." The employee then showed the surveyor what container the cloth had been immersed in</p>				

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	<p>and it read, "1:100 bleach solution."</p> <p>A. At 9:50 AM, after observation of employee P clean the entire chair and floor again, observation noted blood splatter on the floor under the dialysis chair in an area approximately 6 inches by 6 inches.</p> <p>B. The facility administrator, employee A, stated, on 4-13-12 at 10:35 AM Central Time, "The immediate cleaning of the gross blood spill at station number 10 was not done with 1:10 bleach."</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 observation, interview, and review of daily water log, the facility failed to ensure water hardness tests had been completed accurately in 3 (January, February, and March 2012) of 3 months reviewed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During review of the water treatment area, on 4-12-12 at 10:08 AM Central Time, observation noted the test strips used to perform the water hardness test had expired in December 2011. 2. The facility's daily water checklist for January, February, and March 2012 evidenced a daily check for water hardness had been completed at the end of each treatment day. 3. Employee E, a patient care technician, 	V0191	<p>TMs immediately discarded expired water hardness test strips. Patient care supply cabinets were deep cleaned by TMs on 4/12/2012. FA conducted mandatory in-service for all clinical TMs on 4/17/2012 & 4/18/2012. In-service included but was not limited to: review of <i>Policy and Procedure # 1-05-01 Infection Control for Dialysis Facilities</i>, 1.) expiration date must be checked on supplies before opening, and once opened TMs must label with signature and date. 2) TMs must verify all facility medications, solutions, and supplies are checked for expiration dates and discarded per <i>Policy and Procedure</i> if found, 3.) TMs will be assigned to clean supply drawers monthly. Verification of attendance at in-service evidenced by TMs signature on in-service sheet. Administrative Assistant (AA) or designee will conduct Monthly Inventory Audits to verify all facility medications, solutions</p>	05/16/2012			

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	stated, "I did not notice the strips were expired when I did the water hardness tests."		and supplies in stock or available for use are checked for expiration. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect. FA is responsible for compliance with this POC		

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V0244	<p>494.40(a) BICARB JUG MAINTENANCE/DISINFECTION 5.5.4 Bicarbonate concentrate distribution systems: jug disinfection When reusable concentrate jugs are used to distribute bicarbonate concentrate, they should be rinsed free of residual concentrate before disinfection.</p> <p>6.5 Concentrate distribution When reusable concentrate jugs are used to distribute bicarbonate concentrate, they should be disinfected at least weekly.</p> <p>7 Strategies for bacterial control 7.1 General Following disinfection, jugs should be drained, rinsed, and inverted to dry.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure the bicarbonate containers had been disinfected weekly in 3 (January, February, & March 2012) of 4 months reviewed.</p> <p>The findings include:</p> <p>1. The facility's March 2012 "Bicarbonate Concentrate System Mixing" policy number 2-04-01 states, "Additionally, the containers and wands will be disinfected with household bleach diluted to 1:100 (one to one hundred) solution and rinsed with dialysis quality water at least weekly and documented on the Bicarb Jugs and Wands Bleach</p>	V0244	<p>FA held mandatory in service for all Patient Care Technicians and Registered Nurses on 5/1/2012 & 5/2/2012. In service included but was not limited to: review of <i>Policy & Procedure 2-04-01, Bicarbonate Concentrate System Mixing</i>, emphasizing Individual bicarbonate containers, wands and caps must be rinsed with dialysis quality water at the end of the treatment day and stored inverted to dry. Additionally containers and wands must be disinfected with household bleach diluted to a 1:100 solution at least weekly, verified for absence of bleach and documented as complete on log. Verification of attendance at in-service evidenced by TMs signature on in-service sheet.</p>	05/16/2012			

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	<p>Disinfection Log."</p> <p>A. The facility's "Non-Central Bicarb System Bleach Disinfect Log" failed to evidence the bicarb jugs and wands had been disinfected during the month of January 2012.</p> <p>B. The log evidenced the jugs and wands had been disinfected 2 times during the month of February 2012, on 2-21-12 and 2-29-12.</p> <p>C. The log evidenced the jugs and wands had been disinfected 3 times during the month of March 2012, on 3-6-12, 3-13-12, and 3-20-12.</p> <p>2. The facility administrator, employee A, indicated, on 4-12-12 at 12:25 PM Central Time, the citric acid and bicarbonate containers, jugs, uptake wands, and caps had not been disinfected weekly as required. The administrator stated, "It's not been done."</p>		<p>FA or designee will conduct weekly audits of the Bicarbonate Jugs/Wands Bleach Disinfection Log x 2 weeks, then weekly x 2 months, then monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>		

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V0354	<p>494.50(b)(1) MONITOR-DIALYSIS/PT'S CLINICAL COURSE 13 Monitoring 13.1 Dialysis: patient's clinical course The clinical course of the patient should be observed and recorded during each dialysis to identify possible complications caused by new or reprocessed dialyzers. Dialyzer failures should be recorded and systematically evaluated. Applicable home dialysis patients and their assistants should be instructed in the appropriate observation, recording requirements, and reporting procedures.</p> <p>Based on reuse documentation and facility policy review and interview, the facility failed to ensure a complaint investigation record had been maintained for every dialyzer that was failed during reprocessing in 2 (February and April 2012) of 4 months reviewed creating the potential to affect all the facility's 41 current reuse patients.</p> <p>The findings include:</p> <p>1. The facility's September 2011 "Complaint Investigation Record" policy number 6-01-13 states, "A Complaint Investigation Record is maintained that includes all patient and teammate complaints related to reuse dialyzers . . . A Complaint Investigation Record is completed for the following: . . . pressure test failure."</p>	V0354	<p>Lead Reuse Technician conducted mandatory in-service for facility reuse technician on 4/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure # 6-01-13 Complaint Investigation Record Policy</i>, emphasizing Complaint Investigation Record must be completed for pressure test failures. Complaint Investigation and Reuse Communication Log must be reviewed monthly during QIFMM. . Verification of attendance at in-service evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will audit the complaint investigation record for pressure test failures weekly x 1 month, then monthly. Result of audits, Complaint Investigation Records and Reuse Communication Log will be reviewed monthly with Medical Director during QIFMM, QIFMM</p>	05/16/2012	

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	<p>2. The dialyzer failure logs for the months of February and April 2012 evidenced 1 dialyzer each month had been failed due to pressure. The log failed to evidence complaint investigation records had been completed for the failed dialyzers.</p> <p>3. The facility administrator, employee A, indicated, on 4-13-12 at 1:15 PM Central Time, the complaint investigations had not been done. The administrator stated, "The complaint investigations are not there."</p>		<p>minutes will reflect.</p> <p>The FA is responsible for compliance with this POC.</p>		

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V0400	<p>494.60 CFC-PHYSICAL ENVIRONMENT</p> <p>Based on observation, administrative and preventative maintenance record review, interview, and facility policy review, it was determined the facility failed to ensure a sanitary environment and failed to ensure patient care and ancillary equipment was maintained as required creating the potential for equipment failure and patient harm to all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure it had maintained a clean environment for patient care in 3 of 7 environmental observations completed. (See v 401). 2. The facility failed to ensure a preventative maintenance schedule was in place for the maintenance of ancillary building equipment in 6 of 6 months reviewed. (See V 402). 3. The facility failed to ensure preventative maintenance schedules had been developed and implemented in 4 of 16 preventative maintenance records reviewed. (See V 403). 4. The facility failed to ensure a patient was in full view of the staff during a 			V0400	<p>Daviess County Dialysis takes the condition of coverage very seriously; immediate steps were taken to ensure facility provides quality dialysis treatments to patients in a clean and safe environment. These actions are outlined in depth in the POC for V401, V402, V403, V407, and V416.</p> <p>Governing Body (GB) meeting held on 4/20/2012 to review the formal statement of deficiencies received as a result of this survey. Members of the GB including Medical Director, FA, and ROD have agreed to meet weekly to monitor the facility's ongoing progress toward compliance including but not limited to: 1) Providing clean and safe environment for patient care, 2) Ensuring preventative maintenance schedules are developed, in place, and implemented for maintenance of all equipment including ancillary building equipment, 3) Ensuring facility patients are in full view of TMs during treatments, 4) Facility notifies Local Disaster Agency of dialysis facility needs in the event of emergency. Once compliance is achieved, POC will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the FA will report progress, as well as any barriers</p>		05/16/2012

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	<p>treatment in 1 of 6 patient care observations completed. (See V 407).</p> <p>5. The facility failed to ensure the local disaster management agency at been notified of the dialysis facility needs in the event of an emergency in 2 of 2 years reviewed. (See V 416).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with Condition for Coverage 42 CFR 494.60 Physical Environment.</p>		to maintaining compliance, with supporting documentation included in the meeting minutes.		

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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 observation and interview, the facility failed to ensure it had maintained a clean environment for patient care in 3 (#s 1, 2, and 4) of 7 environmental observations completed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. On 4-11-12 at 12:00 PM Central Time, environmental observation number 1 included the dialysate mixing area. Observation noted a dried white substance that covered the bicarbonate mixer, all of the piping, the distribution pump, the pallets with supplies, and a cart on wheels with 3 shelves. The shelves of the cart were covered with stained, wrinkled, and dirty Chux. Three-ring binders were on the shelves and were covered in the dried, white, powdery substance. The trash can was observed sitting on the floor next to the cart and was overflowing with trash. A cover gown was laying over the binders on the top shelf of the cart.</p>	V0401	<p>Immediate Actions were taken by TMs: Dialysate Mixing Area was deep cleaned, removing white residual from mixer, pipes, distribution pump, pallets, and cart. Dirty chux, binders, PPE identified on shelves discarded, shelves deep cleaned. Overflowing trash container changed. TMs cleaned the dialysate mixing area and removed trash on floor. Treatment area floor swept removing trash.</p> <p>Biomedical Technician contacted a local contractor to obtain estimate and schedule repair of chipped concrete and paint.</p> <p>FA and CSS conducted mandatory in-service for all clinical TMs on 4/17/2012 & 4/18/2012. In-service included but was not limited to: review of <i>Policy and Procedure # 1-05-01 Infection Control for Dialysis Facilities</i>, emphasizing all TMs are responsible for providing a sanitary and safe environment in the treatment area, and throughout facility. 1) Facility must remain clean, uncluttered, and organized. 2) TMs must</p>	05/16/2012	

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	<p>There were multiple small pieces of trash strewn about on the floor that included used test strips, alcohol swabs, and alcohol swab packages. The concrete floor had multiple areas coated with the white, powdery substance. The floor evidenced multiple areas with chipped paint. Observation noted two areas of chipped concrete approximately the size of quarters.</p> <p>2. On 4-11-12 at 1:35 PM Central Time, environmental observation number 2 included observation of multiple pieces of trash on the floor at station number 1. There was a plastic spoon, 4 small pieces of white paper, and other pieces of trash on the floor.</p> <p>At 1:40 PM, observation noted an alcohol swab and package on the floor at station number 6.</p> <p>3. On 4-12-12 at 8:45 AM, environmental observation number 4 noted the floor of the dialysate mixing area evidenced multiple areas that were coated with a dried, white, powdery substance.</p> <p>4. The facility administrator, employee A, indicated on 4-12-12 at 8:45 AM, "[The dialysate mixing area] should have been cleaned."</p>		<p>immediately clean up any spills. 3) Dialysate Mixing Area and Equipment must remain free of concentrate build-up. 4) Facility floors must remain clean and free of debris or trash. 5) PPE must be stored in designated areas at all times. Daily cleaning assignments have been initiated and assigned to TMs to ensure facility maintains sanitary environment. Verification of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>ICM or designee will conduct daily infection control audits x 2 week, then weekly x 2 months, then monthly thereafter. Biomedical Technician will conduct monthly observational physical plant audits to ensure physical plant and equipment remains in good repair/condition. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>				

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V0402	<p>494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure a preventative maintenance schedule was in place for the maintenance of ancillary building equipment in 6 (November and December 2011 and January, February, March, and April 2012) of 6 months reviewed creating the potential for equipment malfunction and potential harm to all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's preventative maintenance records for November and December 2011 and January, February, March, and April 2012 failed to evidence a schedule for the maintenance of the heating and air conditioning system, the backflow preventor, the hot water heater, and the generator. 2. The biomedical technician stated, on 4-12-12 at 10:45 AM Central Time, "The hospital maintenance department takes care of all of the maintenance on the heating and air conditioning system, the 	V0402	<p>BMT contacted Daviess Community Hospital Maintenance department on 4/26/2012. Documentation was requested and provided for up to date preventative maintenance for HVAC, Backflow Preventer, Hot Water Heater, and Generator. Maintenance department agreed to provide dialysis facility with ongoing preventative maintenance documentation. ABS held mandatory in service for Biomedical Technician (BMT) on 5/1/2012. In-service included but was not limited to: review of <i>Policy & Procedure # 2-01-09 Preventative Maintenance Schedule for Equipment, Policy & Procedure #2-08-01 Back-up Generator Operational Checks, maintenance schedules. BMT will develop and implement revised ancillary equipment preventative maintenance (PM) schedule for 2012 which will include all ancillary equipment including HVAC, Backflow Preventer(s), Hot Water Heater, and Generator. All PM that is completed by designated hospital personnel must be tracked, verified monthly or per schedule as complete with supporting documentation provided and</i></p>	05/16/2012	

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	<p>backflow preventor, the hot water, and generator. I know its been done but I do not have a schedule for when they will do it."</p> <p>3. The facility's August 2006 "Back Up Generator Operational Checks" procedure number 2-08-01 states, "This procedure is performed by Biomed or designated personnel and should be performed monthly or immediately if the generator fails to cycle properly."</p>		<p><i>maintained in facility PMrecords. Verification of attendance at inservice evidenced by TMs signature on inservice sheet. 5/16/2012Area Biomed Technician or designee will audit compliance with PM schedules monthly. Results of audit will be reviewedwith Medical Director during monthlyQIFMM, QIFMM minutes will reflect.QIFMM minutes and activities will bereviewed during GB meetings to monitorongoing compliance.FA & Medical Director are responsible forcompliance with this POC.</i></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.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure preventative maintenance schedules had been developed and implemented in 4 (#s 5, 7, 15, & 16) of 16 preventative maintenance records reviewed creating the potential for equipment malfunction and patient harm to all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. The facility's March 2012 "Preventative Maintenance Schedules for Equipment" policy number 2-01-09 states, "Preventative maintenance (PM) schedules must be made in accordance with manufacturer's recommendation for all equipment used to perform a patient treatment. A copy of the equipment PM schedule must be filed in the appropriate Equipment Maintenance Manual . . . All miscellaneous equipment will receive PM at least annually or per manufacturer's recommendations. Examples of miscellaneous equipment may include,</p>	V0403	<p>On 4/24/2012 a break-away lock was placed on the emergency box. BMT conducted required preventative maintenance (PM) on Oxygen Concentrators per manufacturer recommendations on 4/26/12. BMT contacted outside vendor that completed PM on facility scale and obtained up to date PM documentation. ABS held mandatory in-service for BMT and clinical TMs on 5/2/2012. In-service included review of <i>Policy & Procedure # 2-01-09 Preventative Maintenance Schedules for Equipment</i>, preventative maintenance will be completed on miscellaneous equipment minimum of annually or per manufacturers recommendations, review of DeVilbiss Oxygen Concentrator Instruction Guide, New Life 10-Liter Oxygen Concentrator Manual, Invacare Oxygen Concentrator Operators Manual for required weekly service and Maintenance Log. TMs shown how to complete weekly Preventative Maintenance and document cleaning of filters, connectors as recommended per</p>	05/16/2012	

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	<p>but are not limited to: refrigerators, suction machines, oxygen concentrators, scales, infusion pumps, bicarb mixers and acid dissolution system."</p> <p>2. The facility's maintenance records failed to evidence a preventative maintenance schedule for the scales used to weigh patients before and after the dialysis treatments. (Preventative maintenance record number 7)</p> <p>The biomedical technician, employee J, indicated, on 4-12-12 at 10:25 AM Central Time, the preventative maintenance on the patient scales was done by an outside vendor. The employee indicated the preventative maintenance was to be completed two times per year per the facility's policy but was unable to provide a schedule for completion of the preventative maintenance.</p> <p>3. The facility's equipment maintenance records failed to evidence the Diasafe filter had been changed on machine number 13 every 90 days as required. (Preventative maintenance record number 15).</p> <p>A. The facility's March 2012 "Fresenius A2008K Automated Diasafe Plus Filter Integrity Test Post Chemical Rinse Cycle" procedure number 2-02-01S</p>		<p>manufacturer. FA held a mandatory in-service for all RN's on 5/1/2012 and 5/2/2012 reviewing <i>Policy & Procedure # 1-02-08 Emergency Equipment Checks</i>, emphasizing that during required equipment checks TM must verify emergency box is sealed with a breakaway lock. Break away lock is only to be opened in the event of an emergency situation or replacement of outdated items. ABS held mandatory in-service for BMT on 5/2/2012. In-service included <i>Policy & Procedure # 2-01-09 Preventative Maintenance Schedule for Equipment, Policy & Procedure # 2-02-01S Fresenius A2008 K, K2 Automated Diasafe Plus Filter Integrity Test Post Chemical rinse Cycle</i> 1) BMT will develop and implement revised ancillary equipment preventative maintenance (PM) schedule for 2012 which will include all ancillary equipment including Scale used to weigh patients, and Machine Diasafe Plus Filter. 2) All PM that is completed by outside contractors must be tracked, verified completed per schedule with supporting documentation provided and maintained in facility PM records. 3) The use of a Diasafe Plus Filter is not to exceed 90 days. BMT must replace Diasafe Plus filter at a minimum of every 90 days and document change PM</p>		

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	<p>states, "The use of a Diasafe Plus filter is not to exceed 90 days."</p> <p>B. The preventative maintenance records for machine number 13 evidenced the Diasafe Filter had been changed on 5-23-11 and not again until March 15, 2012.</p> <p>C. The biomedical technician, employee J, stated, on 4-12-12 at 11:10 AM Central Time, "We only have 1 machine that has a Diasafe Filter, number 13. The filter change was missed."</p> <p>4. The facility failed to maintain the emergency equipment box per the facility's own policy. (Preventative maintenance record number 16).</p> <p>A. On 4-12-12 at 1:55 PM, observation noted there was not a break-away lock on the emergency equipment box.</p> <p>B. The facility's Clinical Services Specialist, employee O, stated, on 4-12-12 at 3:00 PM Central Time, "That is not a break-away lock on the emergency box."</p> <p>C. The facility's March 2011 "Emergency Equipment Checks" policy number 1-02-08 states, "The part of the</p>		<p>records. Verification of attendance at all in-services evidenced by TMs signature on in service sheet. FA or designee will conduct observational audits and review of facility PM logs for ancillary equipment weekly x 1 month, then monthly. Area Biomed Technician or designee will audit compliance with PM schedules monthly. Results of audit will be reviewed with Medical Director during monthly QIFMM, QIFMM minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA & Medical Director are responsible for compliance with this POC.</p>		

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	<p>cart containing medications and other supplies will be sealed with a break away lock and is only to be opened in the event of an emergency situation or the replacement of an outdated item."</p> <p>5. The facility's preventative maintenance records failed to evidence weekly maintenance on the oxygen concentrators had been completed as required. (Preventative maintenance record number 5).</p> <p>A. The biomedical technician, employee J, indicated, on 4-12-12 at 10:25 AM Central Time, the facility had 4 different oxygen concentrators in use. The employee states, "I don't know if they are cleaning them weekly or not. We have 2 oxygen concentrators that are the same brand."</p> <p>B. The manufacturer's recommendations were received for the oxygen concentrators.</p> <p>1.) The NewLife 10-Liter Oxygen Concentrator manual states, "On a weekly basis, wash the air intake gross particle filter."</p> <p>2.) The DeVilbiss "Oxygen Concentrator Instruction Guide" states, "The air filter and connector should be</p>				

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	<p>cleaned at least once a week."</p> <p>3.) The Invacare oxygen concentrator "Operator's Manual" states, "There are two cabinet filters one located on each side of the cabinet. Remove each filter and clean at least once a week depending on environmental conditions."</p> <p>C. The facility administrator, employee A, stated, on 4-12-12 at 11:05 AM Central Time, "They've not been done weekly. They're supposed to be."</p>			

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V0407	<p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>Based on observation and interview, the facility failed to ensure a patient was in full view of the staff during a treatment in 1 (# 5) of 6 patient care observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 4-13-12 at 9:25 AM Central Time, observation noted patient number 8 on a cart connected to the dialysis machine and facing away from the nurse's station towards the wall. The patient's access was not visible. Closer inspection revealed the patient's access was in the groin area and was completely covered by clothing and blankets. Employee P, another facility administrator, stated, on 4-13-12 at 9:35 AM, "You are right. You cannot see the patient's face or access." 	V0407	<p>FA held mandatory in-service for all clinical TMs on 4/17/2012 & 4/18/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-04-11 Vascular Access Monitoring and Surveillance, Policy & Procedure # 1-04-01 Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care, Policy & Procedure #1-04-02 Central Venous Catheter (CVC) Care</i>, TMs educated that during a patient hemodialysis treatment, access sites are to remain visible at all times during treatment to ensure or minimize the risk of needle dislodgement during the treatments. TMs must visualize patient's vascular access at a minimum of every 30 minutes, documenting if access is visible or not, and if access is not visible, document action taken including re-educating the patient and requesting that the patient uncover the access. TMs also educated on <i>Policy & Procedure 1-02-09 Physical Environment</i>, TMs must be able to visualize patients at all times during hemodialysis treatments for patient safety. Charge Nurse is responsible for monitoring compliance daily, Instances of</p>	05/16/2012	

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			<p>non-compliance will be addressed immediately. Verification of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct observational audit of all patients on each patient shift daily x 2 weeks, weekly x 1 month, then monthly. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>	

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V0416	<p>494.60(d)(4)(iii) PE-CONTACT LOCAL EOC ANNUALLY The facility must-</p> <p>(iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency.</p> <p>Based on administrative record review and interview, the facility failed to ensure the local disaster management agency at been notified of the dialysis facility needs in the event of an emergency in 2 (2010 and 2011) of 2 years reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's administrative records failed to evidence the local disaster management agency had been notified of the facility's needs in the event of an emergency in 2010 or 2011. 2. The facility administrator, employee A, stated, on 4-12-12 at 1:55 PM Central Time, "I don't think we have contacted the local disaster management agency at all." 	V0416	<p>FA contacted Local Emergency and Disaster Management Agency on 5/02/2012 as a follow up to the letter sent on 4/13/2012 to notify agency of dialysis facility needs in the event of an emergency. FA requested, and agency agreed to send letter of conformation of notification. Task of Contacting Local Disaster Management Agency placed on facility calendar and will occur at least annually. Verification of contact will be reviewed with Medical Director during QIFMM and during GB meetings with supporting documentation included in the meeting minutes.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>	05/16/2012	

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V0502	<p>494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(1) Evaluation of current health status and medical condition, including co-morbid conditions.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure comprehensive assessments included a complete nursing assessment that evaluated the patient's current health status in 2 (#s 2 and 4) of 5 records reviewed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a comprehensive assessment completed by the registered nurse (RN), employee B, on 3-12-12. The assessment failed to include an evaluation of the patient's sensory, integument, cardiovascular, and respiratory systems. Clinical record number 4 included a comprehensive assessment completed by the registered nurse (RN), employee B, on 3-12-12. The assessment failed to include an evaluation of the patient's sensory, integument, cardiovascular, and 	V0502	<p>Interdisciplinary Team (IDT) will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patients #2, and #4 to reflect evaluation of patient's current health status including complete nursing assessment.</p> <p>FA held mandatory in-service for all members of IDT on 05/01/2012 & 5/02/2012 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, and CMS regulations surrounding patient assessments emphasizing IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. Assessment must include but not be limited to evaluation of current health status and medical condition including evaluation of a patient's sensory, integument, cardiovascular, and respiratory systems. Verification</p>	05/16/2012	

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	<p>respiratory systems.</p> <p>3. The facility administrator, employee A, indicated, on 4-16-12 at 9:55 AM Central Time, the assessments in records numbered 2 and 4 did not include complete nursing assessments with evaluations of the patient's current health status.</p> <p>4. The facility's September 2011 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "Assessment criteria will include, but not be limited to, evaluation of current health status and medical condition."</p>		<p>of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions, and 10% of current patient census to ensure current individualized Comprehensive Assessments and Plans of Care are in place, up-to-date, and documentation appropriate. Results of audit will be reviewed with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>		

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V0511	<p>494.80(a)(8) PA-DIALYSIS ACCESS TYPE & MAINTENANCE The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(8) Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts and peritoneal catheters).</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure comprehensive assessments included an evaluation of the patient's access type and maintenance in 2 (#s 2 and 4) of 5 records reviewed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a comprehensive assessment completed by the registered nurse (RN), employee B, on 3-12-12. The assessment failed to identify the type of access and its location in the patient's body. 2. Clinical record number 4 included a comprehensive assessment completed by the registered nurse (RN), employee B, on 3-12-12. The assessment failed to identify the type of access and its location in the patient's body. 	V0511	<p>IDT will initiate and develop Comprehensive Re-Assessment followed by Individualized Plan of Care for Patients #2, and #4 to reflect evaluation and identification of patient's current dialysis access type, location, and maintenance.</p> <p>FA held mandatory in-service for all members of IDT on 05/01/2012 & 5/2/2012 reviewing <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, and CMS regulations surrounding patient assessments emphasizing IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. Assessment must include but not be limited to evaluation of patient dialysis access, indentifying access type, location and maintenance of that access. RNs provided monthly tool to aid in</p>	05/16/2012	

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	<p>3. The facility administrator, employee A, indicated, on 4-16-12 at 9:55 AM Central Time, the assessments in records numbered 2 and 4 did not identify the types of accesses and their locations.</p> <p>4. The facility's September 2011 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-01-14 states, "Assessment criteria will include, but not be limited to, . . . Dialysis access type and performance."</p>		<p>documentation. Verification of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions, and 10% of current patient census to ensure current individualized Comprehensive Assessments and Plans of Care are in place, up-to-date, and documentation appropriate. Results of audit will be reviewed with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>		

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V0551	<p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included interventions to monitor dialysis accesses in 2 (#s 2 & 4) of 5 records reviewed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a plan of care dated 3-21-12. The plan of care included a goal to "maintain goal of fistula for HD [hemodialysis]." The plan of care failed to include any interventions to monitor the access and achieve the desired goal. 2. Clinical record number 4 included a plan of care dated 3-16-12. The plan of care included a goal to "maintain goal of fistula for HD [hemodialysis]." The plan of care failed to include any interventions to monitor the access and achieve the desired goal. 3. The facility administrator, employee A, indicated, on 4-16-12 at 9:55 AM 	V0551	<p>FA held mandatory in-service for all members of IDT on 05/01/2012& 5/2/2012. In-service included but was not limited to: review of <i>Policy & Procedure 1-01-14 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, plan of care will include/address patients vascular access including interventions for vascular access monitoring and surveillance to detect symptoms of access problems, assist in preventing failure, and achieve goals. Vascular Access Binder in place to document daily events to keep IDT informed of patients vascular access needs. Vascular Access Manager is responsible for ensuring IDT is utilizing tool, and maintain accurate medical information in patients' medical record. Vascular Access Manager will provide Medical Director with update in monthly QIFMM, supporting documentation will be included in the meeting minutes. Verification of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct Medical Record Audits monthly for 100% new admissions, and</p>	05/16/2012	

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	<p>Central Time, the plans of care found in records numbered 2 and 4 did not include interventions to monitor and maintain the patients' accesses.</p> <p>4. 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: . . . When indicated, the patient's vascular access will be monitored to prevent access failure and detect stenosis in graft and fistulae."</p>		<p>10% of current patient census to ensure patient's individualized plan of care includes interventions for vascular access monitoring. Results of audit will be reviewed with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC.</p>		

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V0552	<p>494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care provided for the monitoring of patients' psychosocial status in 5 (#s 1, 2, 3, 4, & 5) of 5 records reviewed creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care dated 2-17-12 that identified the patient resides in the patient's own home. An update to the plan of care dated 4-9-12, identified the patient had "significant changes in living situation." The plan identifies the patient was admitted to a skilled nursing facility for rehabilitation.</p> <p>The plan failed to include interventions related to monitoring the patient's psychosocial status related to the</p>	V0552	<p>IDT will initiate and develop Comprehensive Re-Assessments followed by Individualized Plans of Care for Patients (#s 1,2,3,4, & 5) to include interventions to monitor patient's psychosocial status in POC.</p> <p>FA held mandatory in-service for all members of IDT on 05/01/02 & 5/02/2012 In-service included but was not limited to: review of Policy & Procedure 1-01-14 <i>Patient Assessment and Plan of Care When Utilizing Falcon Dialysis</i>, IDT or individual IDT member must: 1) develop and implement a written, individualized comprehensive plan of care that will include measurable and expected outcomes, interventions to achieve goal and timetables for achieving goals related to patient's psychosocial status, 2) Social Worker must follow up and readjust plan of care as necessary, document patient specific interventions to achieve</p>	05/16/2012			

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	<p>significant change in the living situation and any possible effect on the patient's dialysis treatment regimen.</p> <p>2. Clinical record number 2 included a plan of care dated 3-21-12. The plan of care included psychosocial goals to "maintain stable support system", maintain stable or improved score in 5 categories", "maintain stable living situation", "maintain stable mood", "maintain stable living environment", "maintain open communication between patient and clinical team", and "maintain patient/family ability to verbalize understanding of end of life issues."</p> <p>The plan failed to include individualized, patient-specific interventions to achieve the desired outcomes and to monitor the patient's psychosocial status.</p> <p>3. Clinical record number 3 included a plan of care dated 12-15-11. The plan identified the patient had a "Hx [history] of depressive symptoms." The plan failed to include individualized, patient-specific interventions to monitor the patient's status.</p> <p>An update to the plan of care, completed by the medical social worker, employee G, on 3-313-12, states, "mood</p>		<p>desired outcomes and to monitor the patients' psychosocial status. Verification of attendance at in-service evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct Medical Records Audits monthly for 100% new admissions, and 10% of current patient census, to ensure interventions to achieve desired outcomes and monitor patient's psychosocial status are included in POC. Results of audit will be reviewed with Medical Director during monthly QIFMM, QIFMM minutes will reflect.</p> <p>FA is responsible for compliance with this POC</p>				

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	<p>fair" and that the patient had recently been hospitalized. The plan failed to include any interventions to monitor the patient's psychosocial status.</p> <p>4. Clinical record number 4 included a plan of care dated 3-16-12. The plan of care included psychosocial goals to "maintain stable support system", maintain stable or improved score in 5 categories", "maintain stable living situation", "maintain stable mood", "maintain stable living environment", "maintain open communication between patient and clinical team", and "maintain patient/family ability to verbalize understanding of end of life issues."</p> <p>A. The plan failed to include individualized, patient-specific interventions to achieve the desired outcomes and to monitor the patient's psychosocial status.</p> <p>B. Updates to the plan of care, completed by the medical social worker, employee G, on 3-29-12 and 4-9-12, identified the patient had "significant changes in living situation." The updates identify the patient was hospitalized for back pain and is now at a skilled nursing facility for rehabilitation.</p> <p>The plan failed to include</p>				

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	<p>interventions to monitor the patient's psychosocial status related to the significant change in the living situation and any possible effect on the patient's dialysis treatment regimen.</p> <p>5. Clinical record number 5 included a plan of care dated 10-21-11. The plan identified the patient resided in a skilled nursing home to receive rehabilitation services with the goal of returning home.</p> <p>A. The plan failed to include interventions by the medical social worker to monitor the patient's psychosocial status.</p> <p>B. An update to the plan of care, completed by the medical social worker, employee G, on 4-5-12, identifies the patient has had "significant changes in living situation." The update identifies the patient has lived in a skilled nursing facility "since amputation."</p> <p>The plan failed to include interventions to monitor the patient's psychosocial status related to the significant change in the living situation and any possible effect on the patient's dialysis treatment regimen.</p> <p>C. Updates to the plan of care, completed by the medical social worker,</p>			

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	<p>employee G, on 4-5-12, 4-6-12, and 4-12-12, identify a "deterioration in mental status or functioning." The updates state, "counseled on alternative activities besides eating to improve mood" and that the patient had been "referred to counseling."</p> <p>The plan of care failed to include any interventions to monitor the patient's psychosocial status.</p> <p>6. The medical social worker, employee G, indicated, on 4-12-12 at 12:55 PM Central Time, the plans of care did not include individualized, patient-specific interventions to monitor the patients' psychosocial status.</p> <p>7. 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: . . . Psychosocial status which addresses necessary monitoring and social work interventions."</p>				

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&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 observation, administrative record review, and interview, the medical director failed to ensure the facility had followed its own policies creating the potential to affect all of the facility's 42 current patients.</p> <p>The findings include:</p> <p>1. The facility's September 2010 "Renatron II 100/Renallog RM Cleaning With Institutional Formula 409 Cleaner/Degreaser" procedure number 6-02-02S states, "This procedure is divided into two (2) sections, Formula 409 cleaning, done at least every two weeks at the end of the treatment day after reprocessing activities are finished, and Formula 409 rinsing, done the next operating day after Formula 409 cleaning."</p> <p>A. The facility's "DaVita Reuse Daily Log Sheet" for the months of January 2012 through April 2012 failed to evidence the Formula 409 procedure had</p>	V0715	<p>Lead Reuse Technician conducted mandatory in-service for all clinical TMs on 4/25/2012 reviewing <i>Policy & Procedure # 6-02-02S Renatron II 100/Renallog RM Cleaning with Institutional Formula 409 Cleaner/Degreaser</i>. In- service included but was not limited to 1) TMs must complete Formula 409 cleaning every two weeks at the end of the treatment day after reprocessing activities are finished, 2) TMs must complete Formula 409 rinsing next operating day after Formula 409 cleaning. 3) TMs must document completion on Formula 409 Cleaning and Rinsing in appropriate sections of DaVita Reuse Daily Log. TMs must also document in Renalog RM that Renatron has been rinsed and sanitized.</p> <p>FA conducted mandatory in service for all nursing personnel 4/17/2012 reviewing <i>Policy & Procedure #1-04-02C Central Venous Catheter (CVC) Cleaning and Dressing Change</i>. In- service included but was not</p>	05/16/2012			

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	<p>been completed at least every 2 weeks. The log evidenced the cleaning had been completed on 2-11-12 and 3-17-12.</p> <p>B. Employee O, a corporate reuse person, stated, on 4-13-12 at 12:25 PM, "The 409 cleaning is supposed to be done every 2 weeks."</p> <p>2. The facility's March 2011 "Central Venous Catheter (CVC) Cleaning and Dressing Change" procedure number 1-04-02C states, "Both patient and teammate will wear face masks covering nose and mouth . . . clean exit site with germicidal moistened gauze, per manufacturer's recommendations . . . Using fresh germicidal moistened gauze, clean catheter limbs, starting at exit site and cleaning the entire length of catheter limbs."</p> <p>A. On 4-12-12 at 8:50 AM, employee C, a registered nurse, was observed to perform a central venous catheter dressing change on patient number 3.</p> <p>1.) The employee performed the dressing change without wearing a mask and without applying a mask to the patient.</p> <p>2.) The employee was observed to cleanse around the catheter exit site in a</p>		<p>limited to 1) Both patient and TM must wear face masks covering nose and mouth, 2) Clean exit site with germicidal moistened gauze, per manufacturer's recommendations, 3) Using fresh germicidal moistened gauze, clean catheter limbs, starting at exit site and cleaning the entire length of catheter limbs.</p> <p>Verification of attendance at in-services evidenced by TMs signature on in service sheet.</p> <p>FA or designee will conduct bi-weekly audits of Reuse Logs x 1 month, then monthly thereafter. ICM or designee will conduct daily infection control audits x 2 week, then weekly x 2 months, then monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly QIFMM, QIFMM minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

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	<p>circular motion and then apply a clean, dry dressing to the site. The employee was not observed to cleanse the catheter limbs per the facility's procedure.</p> <p>B. Employee C stated, on 4-12-12 at 9:06 AM Central Time, "I do usually wear a mask."</p>			