

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152581	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2015
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NAME OF PROVIDER OR SUPPLIER MERRILLVILLE DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 9223 TAFT MERRILLVILLE, IN 46410
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V 000 Bldg. 00	<p>This was a Federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: 4/8/15 - 4/14/15</p> <p>Facility #: 003230</p> <p>Medicaid Vendor #: 200315330G</p> <p>QR: JE 4/17/15</p>	V 000		
V 113 Bldg. 00	<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, interview, and review of facility policy, the facility failed to ensure staff (Employee F, patient care technician) had changed gloves and cleansed hands appropriately in 1 of 2 infection control observations on 4/9/15.</p>	V 113	<p>V113</p> <p>Facility Administrator (FA) will hold mandatory in-service for all clinical Teammates (TMs) by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities</p>	05/14/2015

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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	<p>The findings include:</p> <ol style="list-style-type: none"> On 4/9/15 at 1:40 PM, Employee F, a patient care technician (PCT), was observed to carry a 1 liter container which was approximately half full of clear fluid to a dirty sink between station #11 and #12. After she carried this container to the dirty sink, she proceeded to station #11 with patient #15 and touched the hemodialysis machine screen (Machine 8078163) without changing her gloves or washing hands. On 4/9/15 at 1:45 PM, Employee F indicated that she needed to wash her hands and change her gloves when she started the task at station #11. The facility policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and / or station." 		<p>emphasizing 1) TMs must wear disposable gloves appropriately 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 area; 4) TMs must perform hand hygiene every time gloves removed. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meeting (FHM), minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 5/14/2015</p>	

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V 117 Bldg. 00	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation and interview, the facility failed to ensure medications were kept secure and in a clean medication storage area in 1 of 1 observation of the peritoneal dialysis home department.</p> <p>Findings</p> <p>1. On 4/9/15 at 1 PM, a multi - dose vial of heparin was observed in a desk drawer</p>	V 117	<p>V117</p> <p>Heparin removed from identified unlocked drawer; and relocated to secured location. Locks scheduled to be applied on cabinetry and drawers for storage of medications in PD Home Department Training Room by 5/14/2015.</p> <p>FA will hold in-service for all clinical TMs by 5/9/2015. In-service</p>	05/14/2015

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V 121 Bldg. 00	<p>of the peritoneal home department patient training room. The drawer did not have a lock on it and could not be secured.</p> <p>2. On 4/9/15 at 1 PM, Employee H, the nurse manager of the peritoneal dialysis home department, indicated keeping the heparin in this drawer and indicated the room was never locked.</p> <p>3. On 4/9/15 at 1 PM, Employee A, the administrator of the dialysis clinic, indicated heparin should be kept in a locked and clean medication storage area.</p> <p>494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [The facility must demonstrate that it follows standard infection control precautions by implementing-]</p>		<p>will include but will not be limited to: review of Policy & Procedure # 5-07-01: Medication Policy for Peritoneal Dialysis emphasizing medications must be stored in a clean and secured area. RNs are responsible to verify all refrigerated medications are locked at the close of each business day or if not under supervision by licensed TM. Non-refrigerated medications are to be stored in locked cabinet(s) or drawer(s) and locked at close of each business day or if not under supervision by the licensed TM. RNs are responsible for daily monitoring. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct observational spot check audits daily x 2weeks, weekly x 2weeks, then monthly to verify compliance. FA will review results of audits with TMs during home room meetings and 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: 5/14/2015</p>		

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	<p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-</p> <p>(i) Handling, storage and disposal of potentially infectious waste;</p> <p>Based on observation, interview, and review of facility policies, the facility failed to ensure potentially infectious waste containers were stored properly in 1 of 1 observation of the biohazard room on 4/8/15 and a biohazard container on the floor was not overfilled in 1 of 2 infection control observations on 4/9/15.</p> <p>Findings</p> <p>1. On 4/8/15 at 10:30 AM, observation evidenced a small room near the rear entrance to the dialysis clinic of the dialysis clinic that stored used biohazard containers. This room was observed to contain 6 biohazard containers with the lids off and filled with full biohazard bags. There were approximately 5 gloves and a mask on the floor of the room.</p> <p>On 4/8/15 at 10:30 AM, Employee E, reuse technician, indicated the containers should be covered and no waste should be on the floor.</p> <p>2. On 4/9/15 at 1:20 PM, a biohazard container on the treatment floor was</p>	V 121	V121 Biohazard Storage room was immediately cleaned; removing trash from floor and securing lids to biohazard storage containers. Bio-hazardous materials hanging outside of container on treatment floor were placed inside; outside of container wiped with appropriate bleach solution. FA will hold in-service for all clinical TMs by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 4-03-07: Segregation of Medical Waste emphasizing the proper handling, storage and disposal of bio hazard waste. 1) All TMs must comply with policy and procedures for Medical Waste to be contained separately from other non-infectious waste generated in the facility; 2) Medical waste containers are defined as: A labeled plastic container with or without a foot mechanism to open the lid; 3) Following infection control practices need to be followed: Lid should be tight fitting. Gloves should always be worn when removing the lid. Lid should be put back on the plastic container after medical waste is disposed of and contaminated gloves removed. Hand hygiene is to be	05/14/2015

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	<p>observed to have discarded blood lines hanging out of the container from under the lid. There were approximately 1 foot of discarded blood line out of the biohazard container. This container was observed on the floor while patient care was occurring. Nearest to the container was patient #7 at station #10.</p> <p>On 4/9/15 at 1:25 PM, Employee J, patient care technician, indicated the blood lines were not contained in the biohazard container.</p> <p>3. The agency policy titled "Segregation of medical waste" with a date of March 2013 stated, "Medical waste is contained separately from other noninfectious waste in the facility ... lid should be tight fitting ... lid should be put back on the plastic container after medical waste is disposed of and contaminated gloves removed."</p> <p>4 The agency policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "All potentially infectious waste will be placed in sealable, leak proof biohazard waste bags that are clearly marked or colored. All extracorporeal disposable supplies such as blood lines will be placed in the red biohazard bags immediately after use ... all red disposal bags ... that are 3/4s full will be removed</p>		<p>performed after glove removal; 4) Labeled medical waste containers should be lined with red bags and placed in areas where medical waste is generated. Full bags are secured, tied with a center knot, not a dog eared knot, double bagged and placed in the designated medical waste receptacles daily and as necessary. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect. FA is responsible for compliance with this plan of correction Completion date: 5/14/2015</p>				

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V 122 Bldg. 00	<p>from the treatment area and placed in the labeled designated area and locked."</p> <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- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observations, staff interview, and review of policies and procedures, the facility failed to ensure that 1 of 1 emergency evaluation cart had supplies not expired.</p> <p>Findings</p> <p>1. On 4/13/15 at 11:30 AM, an emergency evacuation cart was observed in the hallway near the entrance to the the</p>	V 122	<p>V122</p> <p>Expired items identified in Emergency Evacuation Cart were immediately discarded and replaced with new non-expired supplies.</p> <p>FA will hold in-service for all clinical TMs by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure #4-07-02 Evacuation Kit, Policy & Procedure #4-07-02A Emergency</p>	05/14/2015	

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V 143 Bldg. 00	<p>dialysis clinic's hemodialysis treatment floor. The cart evidenced 2 expired Yankauer Suction vents with expiration dates of 1/15, 12 dialysis priming sets with expiration dates of June 2013, 4 hemodialysis fistula needle sets with expiration dates of 11/13, and 1 hemodialysis set with an expiration date of 10/14.</p> <p>2. On 4/13/15 at 11:30 AM, Employee A, administrator, indicated the emergency evacuation cart did have expired supplies in its contents.</p> <p>3. The policy titled "Evacuation Kit" with a date of September 2014 stated, "The Facility administrator or designee will review the contents of the kit [s] and replace missing or expired supplies at least monthly."</p> <p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-]</p>		<p>Evacuation Kit Checklist, Policy & Procedure # 1-02-08A: Utilization of Emergency Equipment Checklist emphasizing completing monthly checklist to verify all supplies are monitored monthly for expiration. FA or designee must review the contents of the emergency evacuation kit(s) and replace missing or expired supplies at least monthly. The date and initials of the TM checking the contents must be placed on a label outside the kit(s). Evacuation kit will be sealed with a breakaway lock and is only to be opened in the event of an emergency situation, monthly review, and/or the replacement of an outdated item. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct monthly audit to ensure Emergency Evacuation Kit Checklist is completed. FA will review results of all audits with TMs during home room meetings and 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: 5/14/2015</p>		

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	<p>(2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p> <p>Based on observation, interview, and review of policy, the facility failed to ensure medications were labeled with the date and time of opening and the initials of who had opened the medication for 1 of 1 facility with the potential to affect all the patients of the facility.</p> <p>Findings</p> <p>1. On 4/14/15 at 10:05 AM, a multi - dose vial of heparin was observed opened and not labeled with the time and date the medication had been opened.</p> <p>2. On 4/14/15 at 10:05 AM, Employee I, Registered Nurse, indicated opened multi - dose vials were to be labeled with the date and time when opened and the initials of the staff who had opened the medication.</p> <p>3. The agency policy titled "Medication Policy" with a date of March 2015, stated, "Each vial is labeled with the initials of the person opening the vial and the expiration date."</p>	V 143	<p>V143</p> <p>Identified open unlabeled bottle of Heparin immediately discarded.</p> <p>FA will hold in-service for all clinical TMs by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 5-07-01: Medication Policy emphasizing TMs must properly label all opened medications vials with date, time, initials of person opening the vial; multi-dose vials must include discard date. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct observational spot check audits daily x 2weeks, weekly x 2weeks, then monthly to verify compliance. FA will review results of all audits with TMs during home room meetings and 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: 5/14/2015</p>	05/14/2015

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V 401 Bldg. 00	<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, policy and document review, and clinical record review, the facility failed to ensure laboratory supplies were not expired in 1 of 1 observations of the laboratory area (4/13/15) and 1 of 8 incenter hemodialysis clinical records (#2) reviewed.</p> <p>Findings</p> <p>1. On 4/13/15 at 11:30 AM in the lab area, 2 urine vaccutainers were observed with expiration dates of 3/15, one bottle of BD Bactec Plus Aerobic F Culture was observed with an expiration date of 3/31/15, and 1 Fisher Finest transport swab was observed with an expiration date of March 18, 2015.</p> <p>2. Clinical record #2 evidenced a microbiology report dated 12/31/14 with a reported swab culture of a catheter wound collected on 12/29/14. This lab report comments stated, "Swab exp [expired] on October 11, 2014 ... specimen received in an expired swab ..."</p>	V 401	<p>V401</p> <p>Identified expired laboratory supplies immediately discarded.</p> <p>FA will hold in-service for all clinical TMS by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 1-08-02: Obtaining Patient Lab Specimens emphasizing importance of verifying all facility supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs were educated that using expired items could have the potential to affect 100% of facility patient census. TMs must verify the expiration date on all laboratory specimen tubes prior to collection. Expired laboratory specimen tubes are not to be used and are to be discarded in the sharps container. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>Designated TM will be assigned by FA to check facility inventory monthly and verify all supplies are checked for expiration, rotate stock, discard and or transfer out expired supplies as appropriate. Monthly</p>	05/14/2015

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V 407 Bldg. 00	<p>caution should be used when interpreting results. A specimen collected in expired media may lead to failure in recovery of a pathogen."</p> <p>3. On 4/13/15 at 11:30 AM, the facility administrator indicated lab supplies should not be expired.</p> <p>4. The clinic document titled "Support Services" with a date of March 2015 stated, "The facility teammates should monitor inventory levels of all clinical supplies [tubes, containers, etc.] and take care to rotate stock to avoid expired products."</p> <p>5. The policy titled "Obtaining Patient Lab Specimens" with a date of March 2015 stated, "Teammates are to verify the expiration date on all laboratory specimen tubes prior to be collection. Expired laboratory specimen tubes are not to be used."</p> <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). Based on observation, policy review, and</p>	V 407	<p>audit for supply and inventory to apply as stock enters and TMs rotate. FA or designee will conduct observational spot check audits daily x 2weeks, weekly x 2weeks, then monthly to verify compliance. FA will review results of audits with TMs during home room meetings and 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: 5/14/2015</p>	05/14/2015

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	<p>interview, the facility failed to ensure all access sites were visible during the hemodialysis treatment for 1 of 2 observations of incenter hemodialysis care (observation #1) on 4/8/15.</p> <p>The findings include</p> <ol style="list-style-type: none"> On 4/8/14 at 11:20 AM, patient #11 at station #11 was observed to have the blanket up around his / her neck. His / her access site which was a AV (arteriovenous) fistula on the left lower arm was not visible. This patient was receiving incenter hemodialysis. On 4/21/14 at 11:30 AM, patient #11 was observed to have a blanket up around his / her neck. The patient 's access site which was a AV fistula on the left lower arm was not visible while the patient was dialyzing. On 4/21/14 at 11:30 AM, Employee G, patient care technician, indicated the access site was to remain visible while treatment was occurring. The policy titled "Intradialytic Treatment Monitoring" with a date of March 2012 stated, "Each patient, including his / her face, vascular access site, and blood line connections, needs to be seen by a staff member throughout the 		<p>FA will hold in-service for all clinical TMs by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 1-03-09: Intradialytic Treatment Monitoring emphasizing 1) Treatment checks must be completed at least every thirty (30) minutes; 2) TMs must confirm and visually inspect vascular access visible and line connections intact; 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; 3) Each patient, including his/her face, vascular access site, and blood line connections, must be seen by a staff member throughout the dialysis treatment. Allowing patients to cover access sites and line connections provides an opportunity for accidental needle dislodgement or a line disconnection to go undetected. Rounding to be performed by RN and clinical TMs consistently to verify and educate patients on importance of compliance and safety measures. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct observational spot check audits daily x 2weeks, weekly x 2weeks, then monthly to verify compliance. FA will review results of all audits with TMs during home room meetings and with Medical Director during</p>	

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V 543 Bldg. 00	<p>dialysis treatment."</p> <p>5. The policy titled "Arteriovenous Fistula and Arteriovenous Graft Vascular Care" with a date of March 2015 stated, "Cannulation sites and blood tubing connections will ... remain visible throughout the treatment."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record and policy review, and interview, the facility failed to ensure the necessary care and services had been provided to manage the patients' blood pressures in 1 of 8 records reviewed (#1) and post assessments had been completed by the registered nurse in 1 of 8 records reviewed (#3).</p> <p>The findings</p> <p>Regarding higher than normal blood</p>	V 543	<p>monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 5/14/2015</p> <p>V543 FA will hold in-service for all clinical Teammates by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure 1-03-08 Treatment Initiation Patient Assessment, Policy & Procedure # 1-03-09: Intradialytic Treatment Monitoring, 1-03-12 Post Treatment Patient Assessment, emphasizing 1) TMs must obtain and document data collection on each patient Pre-Treatment, During Treatment, and Post-Treatment that includes but is not limited to blood pressure</p>	05/14/2015

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	<p>pressure and doctor notification</p> <p>1. Clinical record #1 evidenced the patient received dialysis treatments 3 times per week for 210 minutes per treatment. Higher than normal blood pressure (120 / 80) failed to be addressed.</p> <p>A. A post treatment flow sheet dated 3/23/15 evidenced a blood pressure at 197 / 107 during treatment and the post treatment assessment blood pressure 212 / 83 at 2:30 PM. These higher than normal blood pressure was not addressed with the physician.</p> <p>B. On 4/13/15 at 4:45 PM, the administrator indicated no documentation exists that shows the physician was notified of the high blood pressure.</p> <p>Regarding Post Assessment completed by the Registered Nurse (RN)</p> <p>2. Clinical record #3 evidenced the patient received dialysis treatments 3 times per week for 225 minutes per treatment. Post treatment assessments failed to occur by the RN when the patient experienced symptoms of not feeling well during the treatment.</p> <p>A. A post treatment flow sheet dated</p>		<p>monitoring along with patient status and subjective well-being;</p> <p>2) Pre and Post Assessments must be completed by clinical TM and RN. RN is responsible for making sure that all assessments are done prior to patient leaving the facility. TMs must report and document any significant changes in blood pressure and/or patients experiencing symptoms of hyper/hypotension to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct daily audits on 10% of patient treatments sheets daily x 2 week, then weekly x 2 weeks, then monthly to verify compliance. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect. FA is responsible for compliance with this plan of correction</p> <p>Completion date: 5/14/2015</p>	

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	<p>3/14/15 evidenced the patient complained of cramps during the treatment and RN being aware. At the end of treatment, no post assessment was completed by the RN.</p> <p>B. A post treatment flow sheet dated 3/19/15 evidenced the patient complained of cramps during the treatment. At the end of treatment, no post assessment was completed by the RN.</p> <p>c. A post treatment flow sheet dated 4/2/15 evidenced the patient complained of cramps during the treatment. At the end of treatment, no post assessment was completed by the RN.</p> <p>3. The policy titled "Pre and Post Treatment and data collection" with a date of September 2014 stated, "The licensed nurse teammate assesses the patient and documents findings on the patient flowsheet prior to treatment initiation and notifies the physician as needed of changes in the patient's status ... the licensed nurse notifies the physician as applicable of changes in the patient status or when the patient cannot tolerate treatment as ordered."</p> <p>4. The policy titled "Intradialytic Treatment Monitoring" with a date of March 2012 stated, "The licensed nurse</p>				

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V 544 Bldg. 00	<p>notifies the physician as needed of changes in patient status."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record review and interview, the facility failed to ensure the blood flow rate and dialysis flow rate on the prescription were followed for 3 of 8 incenter hemodialysis records (#2 , #4, and #5) reviewed.</p> <p>Findings</p> <p>1. Clinical record #2 included hemodialysis orders that identified the blood flow rate (BFR) was to be 350 milliliters per minute.</p> <p>A. The flow sheet dated 3/12/15</p>	V 544	<p>V544</p> <p>FA will hold in-service for all clinical TMs by 5/9/2015. In-service will include but will not be limited to: review of Policy & Procedure # 1-03-09: Intradialytic Treatment Monitoring emphasizing TMs must verify patient prescriptions and set all treatments as prescribed including blood flow rate, and dialysate flow rate. RN is responsible for verifying patients are achieving prescribed dose of dialysis and physician orders are followed. TMs must monitor patient's blood flow & dialysate flow rates at a minimum of every 30</p>	05/14/2015

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	<p>evidenced BFRs of 330, 300, and 270 through the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 3/31/15 evidenced BFRs of 300 and 200 through the treatment with no explanation as to why the BFR was not followed.</p> <p>2. Clinical record #4 included hemodialysis orders that identified the BFR was to be 350 milliliters per minute and the Dialysis Flow Rate (DFR) was to be 600 milliliters per minute.</p> <p>A. The flow sheet dated 3/16/15 evidenced BFRs of 300 and 400 through the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 3/18/15 evidenced BFRs of 300, 390, and 400 through the treatment with no explanation as to why the BFR was not followed.</p> <p>C. The flow sheet dated 3/30/15 evidenced BFRs of 255 and 355 and DFR of 500 and 600 through the treatment with no explanation as to why the BFR and DFR was not followed.</p> <p>3. Clinical record #5 included</p>		<p>minutes, report and document flow rates outside of ordered parameters to licensed nurse; licensed nurse must take appropriate action, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct daily audits on 10% of patient treatments sheets daily x 2 week, then weekly x 2 weeks, then monthly to verify compliance. FA will review results of all audits with TMs during home room meetings and 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: 5/14/2015</p>	

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	<p>hemodialysis orders that identified the BFR was to be 450 milliliters per minute.</p> <p>A. The flow sheet dated 4/7/15 evidenced BFRs of 200, 450, 500, and 600 through the treatment with no explanation as to why the BFR was not followed.</p> <p>4. On 4/14/15 at 3 PM, the medical director indicated the plan of care and physician's orders were to be followed when patient care was performed during hemodialysis.</p> <p>5. On 4/14/15 at 4:15 PM, the administrator indicated the physician orders were not followed.</p>			