

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
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NAME OF PROVIDER OR SUPPLIER  CHESTERTON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 711 PLAZA DR STE 6 CHESTERTON, IN 46304
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V000000	<p>This was a federal ESRD [CORE] recertification survey.</p> <p>Survey dates were 10/3/2014 and 10/6/2014.</p> <p>Facility number : 011899</p> <p>Medicaid number: 200911120</p> <p>Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor</p> <p>Census: 12 Incenter Hemodialysis Patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 10, 2014</p>	V000000		
V000254	<p>494.40(a) MICROB MONITOR-SAMPLE BEFORE DISINFECT</p> <p>7.2 Microbial monitoring methods 7.2.1 General: samples before disinfect Samples should always be collected before sanitization/disinfection of the water treatment system and dialysis machines.</p> <p>Based on interview and review of six months of microbiological testing of water and dialysate and facility policy, the facility failed to sample the water treatment system before its</p>	V000254	<p>V254</p> <p>On 10/7/2014 Assistant Facility Administrator (AFA) contacted Bio Med Technician (BMT) and made arrangements for BMT to start</p>	11/06/2014

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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V000366	<p>sanitation/disinfection for 1 of 1 facility creating the potential to affect the facility's 12 hemodialysis patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On October 3, 2014, at 2:15 PM, the biomed technician, employee F, states, "The disinfect is always on a Monday and then I draw the samples once a month, usually on a Thursday because I can't send samples out on a Friday. Yes, after the disinfect, but I know our policy is within 72 hours."</li> <li>Facility policy 2-06-01 titled "Water Culture Policy" which provides guidance to reflect that water used to prepare dialysate and dilute concentrates meets or exceeds current standards states, "Routine water cultures are collected monthly and within 72 hours PRIOR to scheduled system disinfection."</li> </ol> <p>494.50(b)(1) QA AUDITS-HEMODIALYZER LABELING QUARTERLY 14.7 Hemodialyzer labeling: audit quarterly Designated staff members should audit the provisions of [AAMI] section 10. Based on facility document review and</p>	V000366	<p>collecting cultures on Monday within 72 hours prior to system disinfection. BMT in serviced by AFA on 10/16/2014 reviewing Policy &amp; Procedure # 2-06-01 Water Culture Policy and the ISDH findings emphasizing cultures must be drawn each month within 72 hours prior to scheduled system disinfection. Attendance of in-service is evidenced by TM signature on facilities standard clinical in service form.</p> <p>AFA will complete monthly audits of facility water and dialysate testing ensuring compliance. BMT will bring results of all monthly water and dialysate testing to monthly Facility Health Meetings (FHM) meetings for review with Medical Director and team. Team will review all results, responses and trends, minutes will reflect.</p> <p>AFA is responsible for compliance with this plan of correction</p>	11/06/2014	

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	<p>interview, the facility failed to audit the hemodialyzer labeling quarterly for the 3rd quarter of 2014 for 1 of 1 facility.</p> <p>Findings:</p> <p>1. On October 3, 2014, at 2:30 PM, Reuse QA Oversight results were reviewed with employee B, the reuse technician. The "Quarterly Continuous Quality Improvement Review Form" which includes the hemodialyzer labeling, revealed the last audit was dated 6/23/2014.</p> <p>2. On October 3, 2014, at 2:45 PM, the reprocessing employee, employee B, states, "I am responsible for the labeling and I verify it (the dialyzer) has the appropriate stickers. The nurse manager does the audits."</p> <p>2. The RN manager, employee A, on October 3, 2014, at 4:00 PM, states, "I can do this right away, it'll just be late."</p>		<p>Quarterly CQI Reuse Audit completed by AFA on 10/3/2014.</p> <p>On 10/13/2014 AFA held mandatory in service with Patient Care Technicians and Reuse Technician. In service included, review of Policy &amp; Procedure # 6-01-12, Reuse Continuous Quality Improvement (CQI) Plan. AFA is responsible for completion of the reuse CQI audits, including trend analysis, according to the Reuse CQI plan. Ultimately, the Medical Director is responsible for assuring these audits are completed. Reuse audit schedule reviewed, and initiated, all adverse findings must be reported as part of the FHM. For reuse audits, there is a two tier system of review required: the review of the process by the teammate (TM) assigned, and oversight of the review by another TM qualified to do so. Quarterly reviews of reuse records must be performed to verify the records reflect the following: 1) Reuse room and storage area are clean, sanitary and adequately ventilated, 2) new and reuse dialyzers are stored in separate areas so as to minimize deterioration contamination or breakage, 3) New, used, and reprocessed dialyzers segregated to make clear the status of each group of dialyzers, 4) Reprocessed dialyzers in storage are protected from unauthorized access to prevent tampering and to protect confidentiality of the patients involved in the reuse program, 5)</p>	

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V000520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of		Observations of set up for dialysis, including visually inspecting the dialyzer, testing for presence of germicide, adherence to dialyzer priming procedures, testing for residual germicide, and verification of the patient's identity with the reprocessed dialyzers, 6) All hazardous substances used in the facility are stored appropriately, 7) appropriate chemicals in air testing performed as required, 8) examination of a minimum of 10 reuse labels to verify the labels include patient name, number of previous uses, date of last reuse, identify TM that reprocessed dialyzer, 9) Review previous CQI audits for trends that may indicated changes. Attendance of in-service is evidenced by TM signature on facilities standard clinical in service form. AFA will verify CQI audits are completed, monthly, quarterly, semiannually, and yearly, indefinitely. Results of CQI reuse audits will be reviewed in monthly FHM with Medical Director, minutes will reflect.  AFA is responsible for compliance with this plan of correction	

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	<p>care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on medical record and facility policy review, the facility failed to revise the plan of care monthly in 1 of 1 record reviewed of patients labeled as unstable (#1) creating the potential to affect the facility's 12 patients.</p> <p>Findings:</p> <p>1. Medical record #1 listed patient #1 as unstable due to frequent hospitalizations on the plan of care dated 5/16/14. The record failed to evidence the plan of care was updated monthly, in June, July, and August, 2014. The next updated plan of care in the record was dated 9/26/14.</p> <p>2. Facility policy 1-14-02 titled "Patient Assessment and Plan of Care when Utilizing Falcon Dialysis" states, "A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: ... At least monthly for</p>	V000520	<p>V520</p> <p>AFA held mandatory in service for members of Interdisciplinary Team (IDT) on 10/16/2014. In Service included review of Policy &amp; Procedure # 1-14-02 Patient Assessment and Plan of Care when Utilizing Falcon emphasizing 1) IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment must be used to develop the patient's treatment plan and expectations for care. 3) The plan of care must specify the services necessary to address patients' needs as identified in the comprehensive assessment and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable must have comprehensive assessment followed by a POC completed monthly until deemed stable, 6) stable comprehensive assessment and POC must reflect resolution of unstable issues. Attendance of in-service is evidenced</p>	11/06/2014

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	unstable patients."		<p>by TM signature on facilities standard clinical in service form</p> <p>Clinical Service Specialist trained AFA on process for printing work list from Falcon that shows plan of care due dates which will be reviewed weekly in core team meetings with IDT.</p> <p>Beginning 10/16/2014 AFA will review physician notes and assessments in Falcon at least monthly to ensure any/all concerns noted by are addressed by IDT in a timely manner in regards to addressing unstable patient effectively and according to criteria.</p> <p>AFA or designee will audit 100% of patient census current IDT Assessment and Plan of Care to ensure unstable patients have current individualized comprehensive assessment and plan of care that includes changes in condition, measurable outcomes, estimated timetables and resolution of any identified unstable issues.</p> <p>AFA or designee will conduct a medical record audit for 100% of patient admissions 100% of patients deemed unstable and 10% of current patients, monthly to ensure current individualized Comprehensive Assessment and plan of care are in place, up-to-date, and documented appropriately. AFA will review audit results monthly in FHM with Medical Director, continued</p>		

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			frequency of audits will be determined by team, minutes will reflect.  AFA is responsible for compliance with this plan of correction		