STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/07/2014
NAME OF PROVIDER OR SUPPLIER CORYDON DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1937B OLD SR 135 N CORYDON, IN 47112	

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V000000	This was a Federal ESRD recertification survey. Survey Dates: 11-5-14, 11-6-14, and 11-7-14 Facility #: 006653 Medicaid Vendor #: 200970240A Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN November 12, 2014	V000000		
V000116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. Based on observation, facility policy	V000116	V116 100% of clinical teammates will be	12/05/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	review, and interview, the facility failed to ensure non-disposable equipment had been cleaned and disinfected prior to use on other patients in 2 (#s 1 and 2) of 2 dialysis supply management and contamination prevention observations completed creating the potential to affect all of the facility's 27 current patients. The findings include: 1. On 11-7-14 at 9:20 AM, employee D, a patient care technician (PCT), was observed to use a Phoenix meter to check the conductivity of the machine at station 4. The PCT was not observed to clean and disinfect the machine and was observed to replace it on the countertop behind station 4. 2. On 11-7-14 at 9:40 AM, employee C, a PCT, was observed to use a thermometer to ascertain patient number 5's temperature. The PCT was observed to replace the thermometer on the counter behind the patient at station number 10. At 10:10 AM, the PCT was observed to retrieve the same thermometer and use it to measure patient number 6's temperature. At 10:15 AM, the PCT was observed to use the same thermometer on patient number 7. The PCT was not observed to clean and disinfect the thermometer between patients.		inserviced on Policy 1-05-01 “Infection Control for Dialysis Facilities”. Verification of attendance at in- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients…If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient…Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient. The Facility Administrator (FA) or designee will conduct infection control audits daily for two weeks and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility’s	

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	3. The employees' failure to clean and disinfect the Phoenix meter and thermometer was discussed with the facility administrator, employee A, on 11-7-14 at 11:00 AM. The administrator agreed the employees should have cleaned and disinfected the equipment between patients. 4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients . . . If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient . . . Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient."		monthly infection control audit. The FA will report findings in the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).	
V000122	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			

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	laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on facility policy review, interview, and observation, the facility failed to ensure dialysis stations had been appropriately cleansed and disinfected after use in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed creating the potential to affect all of the facility's 27 current patients. The findings include: 1. On 11-5-14 at 1:45 PM, employee D, a patient care technician (PCT), was observed to clean the dialysis chair and surrounding area at station number 4. The PCT failed to clean the data entry station and the counters surrounding the dialysis station. 2. On 11-5-14 at 4:05 PM, employee B, a registered nurse (RN), was observed to clean dialysis station number 8. The RN was observed to clean the machine and then use the same cloth to clean the dialysis chair. The RN was not observed to clean the data entry station and counters surrounding the dialysis station. 3. The observations were discussed with	V000122	V122 100% of clinical teammates will be inserviced on Policy 1-05-01 “Infection Control for Dialysis Facilities”. Verification of attendance at in-service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) 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, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment. The FA or designee will conduct infection control audits daily for two weeks and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility’s monthly infection control audit. The	12/05/2014

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	the facility administrator, employee A, on 11-7-14 at 11:00 AM. The administrator stated, "They are supposed to use different cloths to clean the machine and the chair." 4. The facility's September 2014 "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, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment."		FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.	
V000147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have			

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	tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].			
	Based on facility policy review, observation, and interview, the facility failed to ensure central venous catheter (CVC) care had been provided in accordance with facility policy in 2 (#s 1 and 2) of 2 CVC observations completed creating the potential to affect all of the facility's 2 current patients with CVCs. The findings include: 1. The facility's September 2014 "Central Venous Catheter (CVC) Procedure" number 1-04-02A provides guidance for the CVC dressing change, initiation, and discontinuation of the dialysis treatment with a CVC. A. The procedure outlines the CVC dressing change first. The procedure states, "Remove old dressing and discard. Observe site for signs and symptoms of	V000147	V147100% of clinical teammates will be inservicedon Policy 1-04-02A “CentralVenous Catheter (CVC) Procedure”.Verification of attendance at in- servicewill be evidenced by a signature sheet.Teammates will be instructed usingsurveyor observations as examples withemphasis on, but not limited to thefollowing: 1) Remove old dressing anddiscard. Observe site for signs andsymptoms of infection such as redness,drainage, swelling, or pain. If present,report to RN/MD. Observe CVC at exitsite for evidence of cuff migration,cracks, or leaks in the catheter limbs. Ifpresent, do not initiate dialysis. Reportto MD for further follow-up, and 2) ScrubCVC TEGO connectors of caps withLARGE alcohol prep pad, one (1) per limbfor 60 seconds. FA or designee will auditteam for proper	12/05/2014

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	infection such as redness, drainage, swelling or pain. If present, report to RN/MD . . . Observe CVC at exit site for evidence of cuff migration, cracks, or leaks in the catheter limbs. If present, do not initiate dialysis. Report to MD for further follow-up." B. On 11-5-14 at 2:00 PM, employee D, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 8. Observation noted a CVC was in use for the dialysis treatment. The PCT was not observed to change the CVC dressing prior to initiating the dialysis treatment. The PCT stated, "We change the dressing at the end of the treatment because of where the catheter is located. We have to pull the patient's pants down and we wait until no one else is here." C. The facility administrator, employee A, was unable to provide documentation the physician was aware of, and had ordered, the dressing not be changed until after the treatment when asked on 11-7-14 at 8:45 AM. 2. Employee D, a PCT, was observed to initiate the dialysis treatment on patient number 8 at 2:00 PM on 11/5/14. The employee was observed to clean the TEGO connectors of each catheter limb		CVC site careprocedures in accordance with policydaily x2 weeks and document via thequantitative Infection Control Auditform. Ongoing compliance will bemonitored with the facility's monthlyinfection control audit. The FA will reportfindings in the monthly FHM. The FA isresponsible for ongoing compliance withthis POC.	

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	for 4 seconds each. A. The facility's September 2014 "Central Venous Catheter (CVC) Procedure" number 1-04-02A states, "Scrub CVC TEGO connectors of caps with LARGE alcohol prep pad, one (1) per limb for 60 seconds." B. The observations were discussed with the facility administrator, employee A, on 11-7-14 at 11:00 AM. The administrator indicated the TEGO connectors were to be scrubbed at least for 60 seconds each.			
V000362	494.50(b)(1) QA AUDITS-PT CONSIDERATIONS ANNUALLY ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1) 14.3 Patient considerations: audit annually Personnel should audit at least annually compliance with the facility's policy to inform patients of the facility's reuse practices Based on administrative record and facility policy review and interview, the facility failed to ensure an annual audit to ensure compliance with the facility's patient notification of reuse practices policy had been completed in 1 (2014) of 1 year reviewed creating the potential to affect all of the facility's 12 current	V000362	V362 100% of clinical teammates will be inserviced on Policy 6-01-12 “Reuse Continuous Quality Improvement (CQI) Plan” and Policy 6-01-12A “Annual Continuous Quality Improvement (CQI) Form”. Verification of attendance at	12/05/2014

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	patients that participate in the reuse program. The findings include: 1. The facility's administrative records evidenced an audit of the facility's policy to inform patients of the facility's reuse practices had been completed on October 20, 2013. The records failed to evidence any further audits had been completed. 2. The facility administrator, employee A, stated, on 11-6-14 at 12:25 PM, "No, it was not done. I missed it." 3. The facility's September 2013 "Reuse Continuous Quality Improvement (CQI) Plan" policy states, "An annual review of reuse records is performed to verify the records reflect the following: . . . The medical record of each patient participating in the reuse program has a signed 'Reuse Information and Consent Form.'"		inservice will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) An annual review of reuse records is performed to verify the records reflect the following…The medical record of each patient participating in the reuse program has a signed “Reuse Information and Consent Form”. The annual reuse audit has been completed and will be discussed in the next regularly scheduled FHM. The Facility Administrator/designee is responsible for completion of the reuse quality improvement audits, including trend analysis, according to the Reuse Continuous Quality Improvement (CQI) Plan. Reuse audits will be monitored on a monthly basis by the FA. The FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance	

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			with this POC.	
V000363	494.50(b)(1) QA AUDITS-MANUALS/P&P ANNUAL & PRN 14.4 Equipment Manuals and Procedures: audit annually & prn Designated staff members should audit written procedures and manuals for relevance at least annually and whenever adverse findings could be attributed to equipment failure. Designated staff should also audit maintenance and repair policies at least annually. Based on administrative record and facility policy review and interview, the facility failed to ensure an annual audit to ensure reuse written procedures and manuals remained relevant had been completed in 1 (2014) of 1 year reviewed creating the potential to affect all of the facility's 12 current patients that participate in the reuse program. The findings include: 1. The facility's administrative records evidenced an audit of the facility's written procedures and manuals had been completed on October 20, 2013. The records failed to evidence any further audits had been completed. 2. The facility administrator, employee A, stated, on 11-6-14 at 12:25 PM, "No, it was not done. I missed it."	V000363	V363100% of clinical teammates will be inservicedon Policy 6-01-12 “ReuseContinuous Quality Improvement (CQI)Plan” and Policy 6-01-12A “AnnualContinuous Quality Improvement (CQI)Form”. Verification of attendance at inservicewill be evidenced by a signaturesheet. Teammates will be instructedusing surveyor observations as exampleswith emphasis on, but not limited to thefollowing: 1) An annual review of reuserecords is performed to verify the recordsreflect the following…Manufacturer’soperati ng manuals for automatedsystems are present and available foruse…The reuse training materials arecurrent and reflect the facility reusepractices…The Reuse Technician jobdescription reflects relevancy and thateach Reuse Technician has a signed jobdescription on file. The annual reuseaudit has been completed	12/05/2014

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	3. The facility's September 2013 "Reuse Continuous Quality Improvement (CQI) Plan" policy states, "An annual review of reuse records is performed to verify the records reflect the following: . . . Manufacturer's operating manuals for automated systems are present and available for use . . . The reuse training materials are current and reflect the facility reuse practices . . . The Reuse Technician job description reflects relevancy and that each Reuse Technician has a signed job description on file."		and will bediscussed in the next regularly scheduledFHM. The Facility Administrator/designeeis responsible for completion of thereuse quality improvement audits,including trend analysis, according to theReuse Continuous Quality Improvement(CQI) Plan. Reuse audits will bemonitored on a monthly basis by the FA.The FA will report findings in the monthlyFHM. The FA is responsible for ongoingcompliance with this POC.	
V000364	494.50(b)(1) QA AUDITS-PHYS PLANT/ENVIRON SAFE 1X/YR 14.5 Physical plant and environmental safety considerations: audit annually Designated staff members should audit the provisions of [AAMI] 8.1, [Reprocessing area and ventilation], at least annually. The provisions of [AAMI] 8.2, [Storage area], and [AAMI] 8.4, [Personnel protection] should be audited quarterly. Based on administrative record and facility policy review and interview, the facility failed to ensure an annual physical plant and environmental safety audit had been completed in 1 (2014) of 1 year reviewed creating the potential to affect all of the facility's 12 current patients that participate in the reuse program.	V000364	V364 100% of clinical teammates will be inserviced on Policy 6-01-12 “Reuse Continuous Quality Improvement (CQI) Plan” and Policy 6-01-12A “Annual Continuous Quality Improvement (CQI) Form”. Verification of attendance at inservice	12/05/2014

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	The findings include: 1. The facility's administrative records evidenced an audit of the facility's physical plant and environmental safety had been completed on October 20, 2013. The records failed to evidence any further audits had been completed. 2. The facility administrator, employee A, stated, on 11-6-14 at 12:25 PM, "No, it was not done. I missed it." 3. The facility's September 2013 "Reuse Continuous Quality Improvement (CQI) Plan" policy states, "An annual review of reuse records is performed to verify the records reflect the following: . . .Procedures for maintenance and calibration of reuse equipment are performed according to schedule . . . Reuse procedures are followed as written. Reuse supplies are used on a first in, first out basis. Confirm that an 'Incoming Reuse Supply Log' is maintained for reuse supplies. All reuse cleaning and disinfection solutions are USP grade, EPA or FDA certified."		will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) An annual review of reuse records is performed to verify the records reflect the following…Procedures for maintenance and calibration of reuse equipment are performed according to schedule…Reuse procedures are followed as written. Reuse supplies are used on a first in, first out basis. Confirm that an Incoming Reuse Supply Log is maintained for reuse supplies. All reuse cleaning and disinfection solutions are USP grade, EPA or FDA certified. The annual reuse audit has been completed and will be discussed in the next regularly scheduled FHM. The Facility Administrator/designee is responsible for completion of the reuse quality improvement audits, including trend analysis, according to the Reuse Continuous Quality Improvement (CQI) Plan. Reuse audits will be monitored on	

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			a monthly basis by the FA. The FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.	
V000407	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 facility policy review, observation, and interview, the facility failed to ensure all patients' accesses were visible at all times in 4 (#s 1, 2, 3, and 4) of 4 observations for visibility of accesses completed creating the potential to affect all of the facility's 27 current patients. The findings include: 1. The facility's March 2012 "Intradialytic Treatment Monitoring" policy number 1-03-09 states, "Each patient, including his/her face, vascular access site, and blood line connections, need to 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."	V000407	V407 100% of clinical teammates will be inserviced on Policy 1-03-09 “Intradialytic Treatment Monitoring”. Verification of attendance at in- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Each patient, including his/her face, vascular access site, and blood line connections, need to 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. FA	12/05/2014

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NAME OF PROVIDER OR SUPPLIER CORYDON DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1937B OLD SR 135 N CORYDON, IN 47112	

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	2. On 11-5-14 at 11:45 AM, observation noted the access was not visible for patient number 2. At 1:40 PM, observation noted the access was not visible. 3. On 11-7-14 at 8:15 AM, observation noted the accesses were not visible for patient number 9 at station number 4, for patient number 4 at station number 7, and for patient number 3 at station number 10. 4. On 11-7-14 at 11:25 AM, observation noted the access was not visible for patient number 2. 5. The observations were discussed with the facility administrator, employee A, on 11-7-14 at 11:00 AM. The administrator agreed all accesses should be visible at all times.		or designee has provided written education to all patients on the importance of having vascular access uncovered and in view during treatment. A copy of this patient education was also placed in each patient's medical record. Teammates were also instructed to reeducate any patient that has his/her vascular access covered and uncover the access. Teammate will also document in patient's medical record that education was given to patient. FA or designee will be conducting an observational daily audit for 2 weeks to ensure that patient's vascular accesses remain uncovered throughout treatment. Ongoing compliance will be monitored by monthly spot audits. The FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.	
V000544	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			

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	equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record review and interview, the facility failed to ensure it had maintained the prescribed dose of dialysis by failing to ensure blood flow rates had been maintained as ordered and continuous heparin had been administered as ordered in 3 (#s 1, 2, and 4) of 4 records reviewed creating the potential to affect all of the facility's 27 current patients. The findings include: 1. Clinical record number 1 included physician orders dated 10-27-14 that state "Duration: 210 [minutes]. Blood flow: 450 . . . Heparin Pork Infusion 400 Stop Time: 30. [total of 1200 units of continuous heparin]." A. A hemodialysis treatment flow sheet dated 10-27-14 evidenced a total of 1800 units of continuous heparin had been administered. B. A hemodialysis treatment flow sheet dated 10-29-14 evidenced the blood flow rate (BFR) had been maintained at 350 milliliters per minute (mL/min). C. A hemodialysis treatment flow sheet dated 10-31-14 failed to evidence	V000544	100% of clinical teammates will be inserviced on Policy 1-03-09 “Intradialytic Treatment Monitoring” and Policy 1-06-02 “Anticoagulation”. Verification of attendance at in- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Treatment checks should be completed at least every thirty (30) minutes. At a minimum, obtain and document the following… blood and dialysate flows, and 2) Heparin is administered per physician order. Order is to include order date and time, patient name, route, heparin loading dose, hourly infusion or bolus rate and stop/ discontinuation time, as applicable. The FA or designee will audit 50% of treatment flow sheets daily for one week then 50% of treatments sheets 2 X per week for 4 weeks. Ongoing compliance will be monitored with 10% of flow sheets being audited monthly. The FA will report	12/05/2014

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	the continuous heparin had been stopped 30 minutes prior to the end of the treatment. D. A hemodialysis treatment flow sheet dated 11-3-14 evidenced the BFR had been decreased to 400 mL/min 1.5 hours into the treatment. 2. Clinical record number 2 included physician orders dated 9-12-14 that state, "Duration: 240 [minutes] Blood Flow: 350 . . . Heparin Pork Infusion 300 Stop Time: 30 [total of 1050 units]." A. A hemodialysis treatment flow sheet dated 10-15-14 evidenced the continuous heparin infusion had been stopped at 3:02 PM and the treatment had been discontinued at 3:18 PM. B. Hemodialysis treatment flow sheets, dated 10-7-14, 10-20-14, 10-24-14, and 10-31-14, evidenced the BFR had been maintained at 300 mL/min. 3. Clinical record number 4 included physician orders dated 9-17-14 that state, "Duration 240 [4 hours]. Blood Flow: 450 . . . Heparin Pork Infusion 400 Stop Time 30 [a total of 1400 units of continuous heparin]."		findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.	

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	A. Hemodialysis treatment flow sheets, dated 10-13-14, 10-15-14, 10-20-14, 10-24-14, 10-27-14, and 10-31-14, failed to evidence the continuous heparin had been stopped 30 minutes prior to the end of the treatment. B. A hemodialysis treatment flow sheet dated 10-22-14 evidenced the BFR had been maintained at 400 mL/min. 4. The facility administrator, employee A, indicated, on 11-6-14 at 2:45 PM, the BFRs had not been maintained as ordered and the continuous heparin had not been stopped 30 minutes prior to the end of the treatment in records numbered 1, 2, and 4.			
V000550	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. Based on facility policy review, observation, and interview, the facility	V000550	100% of clinical teammates will be inservicedon Policy	12/05/2014

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	failed to ensure pre- and post access care had been provided in accordance with facility policy in 3 (#s 1, 3, & 5) of 5 arteriovenous fistula care observations completed creating the potential to affect all of the facility's 25 current patients with fistulas or grafts. The findings include: 1. The facility's September 2014 "Arteriovenous Fistula (AVF) and arteriovenous graft (AVG) Vascular Access Care" policy number 1-04-01 states, "Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry." A. On 11-7-14 at 9:25 AM, employee D, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 11 using an AVF. The PCT was not observed to ask the patient if the patient had washed the access upon arrival to the facility and prior to initiating the treatment. The patient stated, "I usually have Lidocaine cream on my arm and wash it off when I get here. I ran out and did not		1-04-01“Arteriovenous Fistula (AVF) andArteriovenous Graft (AVG) VascularAccess Care” and Policy 1-04-01B “PostDialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles”.Verification of attendance at in- servicewill be evidenced by a signature sheet.Teammates will be instructed usingsurveyor observations as examples withemphasis on, but not limited to thefollowing: 1) Patients are encouraged towash access extremity with soap andwater upon arrival for dialysis, if able. Ifpatient unable to wash access site,patient care teammate will clean accessextremity with skin cleansing agent andpat dry, and 2) Once bleeding hasstopped, discard gauze or band-aid usedto hold site. Inspect site for any traumaand for hemostasis. Apply band-aid typeor sterile dressing over cannulation site.The FA or designee will conduct infectioncontrol audits daily for two weeks toverify that pre and post access care iscompleted per policy and document viathe quantitative Infection Control Auditform. Ongoing compliance will bemonitored with the facility’s monthlyinfection control audit. The FA will reportfindings in the monthly FHM. The FA isresponsible for ongoing compliance withthis POC.	

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	use any today and didn't think to wash my arm." B. On 11-7-14 at 10:15 AM, employee C, a PCT, was observed to initiate the dialysis treatment on patient number 7 using an AVF. The PCT was not observed to ask the patient if the patient had washed the access upon arrival to the facility and prior to initiating the treatment. The patient stated, "I washed my access at home." 2. The facility's March 2014 "Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles" policy number 1-04-01B states, "Once bleeding has stopped, discard gauze or band-aid used to hold site. Inspect site for any trauma and for hemostasis. Apply band-aid type or sterile dressing over cannulation site." On 11-5-14 at 10:50 AM, employee C, a PCT, was observed to discontinue the dialysis treatment on patient number 10 using an AVF. The PCT was observed to pull the needles and the apply a folded 4 X 4 gauze. After the bleeding had stopped, the PCT was not observed to remove the used gauze from the sites and replace it with a clean dressing. A			

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	small amount of blood was noted on the gauze on the venous needle stick site when the patient was discharged. 3. The observations were discussed with the facility administrator, employee A, on 11-7-14 at 11:00 AM. The administrator indicated the PCTs had not followed facility policy.			