

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

V 0000 Bldg. 00	This was a Federal ESRD [CORE] recertification survey. Survey Dates: 9-21-15, 9-22-15, & 9-23-15 Facility #: 006659 Medicare Provider # 15-2617 Medicaid Vendor #: 200886090A Census: 24 incenter 5 home peritoneal 1 home hemodialysis	V 0000		
V 0117 Bldg. 00	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.			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<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 record review, observation, and interview, the facility failed to ensure clean non-disposable equipment was stored in a designated clean area between uses in 1 (day 2) of 2 days of observations.</p> <p>The findings include:</p> <p>1. On day 2 of observations on the treatment floor, 9-23-15, observation noted 2 Phoenix meters (used to test the conductivity and pH of the dialysate at each station prior to patients dialyzing) on the countertop next to a sink designated as "dirty."</p> <p>At 10:20 AM, employee I, a patient care technician (PCT), was observed to obtain a Phoenix meter from the countertop at the sink labeled "dirty." The PCT used the meter at station number 10. The PCT cleaned the meter</p>	V 0117	<p>The Clinic Manager or designee will in-service all staff including employee I regarding DSI P&P #800-01: Dialysis Precautions & #300-63: Phoenix Meter Maintenance by 10/24/15. The in-service will include but not be limited to the following: The external surface of the phoenix meter will be cleaned with a disposable washcloth moistened with bleach solution (1:100) before taking to the patient station, after each use and prior to storing in upright holder; Phoenix meter tri-station & holder will be in a designated clean area.</p> <p>The Clinic Manager or designee will monitor phoenix meter use and infection control practices daily x 2 weeks or until 100% compliance is established, weekly x 2, monthly x 2 then bimonthly per the Quality Management (QM) Workbook audit schedule.</p>	10/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0122 Bldg. 00	<p>and returned it to the "dirty" area. The PCT was observed to repeat this practice again at 10:30 AM. Observation noted 3 empty intravenous fluid bags draped over the dirty sink to drain.</p> <p>2. The clinic manager stated, on 9-23-15 at 10:35 AM, "They are supposed to be on the countertop at the clean sink. I don't know who moved them."</p> <p>3. The area biomedical manager stated, on 9-23-15 at 12:15 PM, "I moved the meters yesterday to be in compliance with an internal audit."</p> <p>4. The facility's 5-1-15 "Dialysis Infection Control Precautions" policy/procedure number 800-01 states, "Clean areas should be designated for the preparation, handling, and storage of medications and disinfected used supplies and equipment."</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-]</p>				Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review education, disciplinary action and audit results in the monthly QAPI & LGB meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the dialysis station had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 9-21-15 at 3:25 PM, employee D, a patient care technician (PCT) was observed to clean the dialysis machine at station number 1 (observation # 1). The PCT was not observed to clean the front of the machine, the dialysate hoses, or the Hansen connectors. On 9-21-15 at 3:20 PM, employee I, a PCT, was observed to clean the dialysis machine and chair at station number 14. The PCT was observed to wipe the front of the machine and the computer keyboard. The PCT then emptied the prime waste bucket into the drain at the chase cabinet behind the machine. A moderate amount of fluid from the prime waste bucket spilled onto the floor in front of the drain. The PCT was observed to return the prime waste bucket back to the machine without cleaning it. 	V 0122	<p>The Clinic Manager or designee will in-service all staff including employee D & I regarding DSI P&P #300-14: Cleaning Machine & Surrounding Areas; #800-01: Dialysis Precautions; #800-24: Clean up of Blood Spill & Other Potentially Infectious Material (OPIM) and #800-28: Hand Hygiene by 10/24/15. The in-service will include but not be limited to the following: cleaning the external surfaces of the machine will include but not be limited to the front of the machine, dialysate hoses and Hansen connectors after each patient treatment; prime bucket liquid contents will be emptied in a designated "dirty" sink; if a spill occurs, it will be cleaned immediately with 1:100 bleach solution; the prime bucket will be disinfected with 1:100 bleach solution prior to returning to the clean machine; hand hygiene will be performed between glove changes after performing a dirty task and moving to a clean task; when cleaning the dialysis chair after the patient treatment, the insides of the chair sides will also be disinfected.</p> <p>The Clinic Manager or designee will monitor infection control practices and OPIM spills daily x 2 or until 100% compliance is established, weekly x 2, monthly x 2 then</p>	10/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The PCT then completed the cleaning of the machine. The PCT failed to change her gloves and cleanse her hands after emptying the prime waste bucket and prior to cleaning the dialysis machine.</p> <p>The PCT was observed to clean the dialysis chair at station number 14. The PCT was not observed to clean the insides of the sides of the chair.</p> <p>3. The clinic manager indicated, on 9-23-15 at 12:10 PM, employees D and I had not cleaned and disinfected the dialysis station in accordance with facility policy.</p> <p>4. The facility's 5-1-15 "Dialysis Infection Control Precautions" policy/procedure number 800-01 states, "Clean and disinfect the treatment station at the end of each dialysis treatment . . . Disinfect the front, top, and sides of the dialysis machine . . . Hansen connectors, dialysis hoses, prime bucket . . . Between patients during machine external disinfection, remove the prime bucket from the side of the machine and pour residual fluid into a designated 'dirty' sink. Disinfect the prime bucket internally and externally with a 1:100 bleach moistened wipe before returning the prime bucket to the machine."</p>		<p>bimonthly per the QM Workbook audit schedule.</p> <p>Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V 0147 Bldg. 00	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>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.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have 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.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>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 record review, observation, and interview, the facility failed to ensure the discontinuation of the dialysis treatment using a central venous catheter (CVC) had been completed in accordance with facility policy in 2 (#s 1 and 2) of 2</p>	V 0147	The Clinic Manager or designee will in-service all staff including employees F & I regarding DSI P&P #300-78: Initiation & Termination of the External Access Using TEGO Connector by 10/24/15. In-service	10/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 0543	<p>discontinuation of dialysis with a CVC observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee F, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 1 using a CVC on 9-21-15 at 2:15 PM. The PCT was not observed to place a clean pad under the CVC ports prior to starting the discontinuation procedure. Employee I, a PCT, was observed to discontinue the dialysis treatment on patient number 5 using a CVC on 9-23-15 at 9:15 AM. The PCT was not observed to place a clean pad under the CVC ports prior to starting the discontinuation procedure. The clinic manager indicated, on 9-23-15 at 12:10 PM, employees F and I had not followed facility procedure. The facility's 6-1-14 "Treatment Initiation & Termination: Utilizing a Catheter with End Caps" policy/procedure number 300-21 states, "Treatment Termination. Supplies: . . . Clean barrier . . . Place barrier under catheter ports." 			494.90(a)(1)		<p>will include but not be limited to the following: a clean barrier will be placed under the CVC ports prior to discontinuing the treatment.</p> <p>The Clinic Manager or designee will monitor all patients with a CVC including Patients #1 & #2 daily x 2 weeks or until 100% compliance has been established, weekly x 2, monthly x 2 then bimonthly per the QM Workbook audit schedule.</p> <p>Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 00	<p>POC-MANAGE VOLUME STATUS</p> <p>The plan of care must address, but not be limited to, the following:</p> <p>(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services to achieve the desired estimated dry weights in 2 (#s 2 and 4) of 5 total records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 evidenced the patient received incenter hemodialysis treatments 3 days per week. The record included physician orders dated 8-17-15 that identified the desired estimated dry weight (EDW, the patient's weight at the end of the treatment) was 128 kilograms (kg). The record included a physician's order dated 9-9-15 that increased the EDW to 129 kg.</p> <p>A. A hemodialysis treatment flow sheet dated 8-31-15 evidenced the patient's weight at the end of the treatment was 133 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 9-2-15 evidenced the patient's weight at the end of the treatment was 134.4 kg.</p>	V 0543	<p>The Clinic Manager or designee will in-service all staff including the Home Nurse by 10/24/15 on DSI Policy & Procedure #300-56: Post-assessment & data collection and # 600-12: Plan of Care. The in-service will include but not be limited to the following: A deviation of 1kg or more from the current treatment target weight should be reported to the charge Nurse; the plan of care must address the dose of dialysis which includes volume management and if the expected outcome is not achieved, the patient's plan of care must be adjusted to achieve the specified goals, to reflect the patient's current condition & there should be documentation in the medical record the reasons why the patient was unable to achieve the goals. Home nurse will also be in-serviced regarding DSI P&P HM450PC-01: Monthly Patient Clinic Visits; HM1500-01: Pre-Dialysis & Post Dialysis Info Review by 10/24/15. In-service will include but not be limited to the following: addressing all patients that are not able to achieve EDW, notifying Nephrologist and adjusting the EDW; educating the patient to</p>	10/24/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>C. A hemodialysis treatment flow sheet dated 9-4-14 evidenced the patient's weight at the end of the treatment was 132.7 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 9-7-15 evidenced the patient's weight at the end of the treatment was 132.9 kg.</p> <p>E. A hemodialysis treatment flow sheet dated 9-9-15 evidenced the patient's weight at the end of the treatment was 132.3 kg.</p> <p>F. A hemodialysis treatment flow sheet dated 9-11-15 evidenced the patient's weight at the end of the treatment was 132.8 kg.</p> <p>G. A hemodialysis treatment flow sheet dated 9-14-15 evidenced the patient's weight at the end of the treatment was 133.3 kg.</p> <p>H. A hemodialysis treatment flow sheet dated 9-16-15 evidenced the patient's weight at the end of the treatment was 132.5 kg.</p> <p>I. A hemodialysis treatment flow sheet dated 9-18-15 evidenced the patient's weight at the end of the</p>		<p>notify the home nurse of inability to achieve EDW. The clinical records for patient's #2 & #4 will be updated to address each patient's inability to attain the physician ordered EDW. The Clinic Manager or designee will audit a random 10% of in-center & a random 10% of home patient charts including clinical records #2 & #4 daily X 2 weeks or until 100% compliance is achieved and then weekly X 2, monthly X 2 and then bi-monthly as per the QM Workbook Patient Flowsheet Audit tool schedule. Any staff found not to be in compliance with these policies and procedures will receive progressive disciplinary action. The Clinic Manager or designee will review all education, audit results & any disciplinary action in the monthly QAPI & LGB meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>treatment was 132.8 kg.</p> <p>J. A hemodialysis treatment flow sheet dated 9-21-15 evidenced the patient's weight at the end of the treatment was 133.9 kg.</p> <p>2. Clinical record number 4 evidenced the patient performed home hemodialysis treatments 6 days per week. The record included physician orders dated 6-17-15 that identified the desired EDW as 104.5 kg.</p> <p>A. A home hemodialysis treatment record dated 9-2-15 evidenced the patient's weight at the end of the treatment was 106.3 kg.</p> <p>B. A home hemodialysis treatment record dated 9-7-15 evidenced the patient's weight at the end of the treatment was 106.3 kg.</p> <p>C. A home hemodialysis treatment record dated 9-12-15 evidenced the patient's weight at the end of the treatment was 105.2 kg.</p> <p>D. A home hemodialysis treatment record dated 9-14-15 evidenced the patient's weight at the end of the treatment was 109.5 kg.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0544 Bldg. 00	<p>E. A hemodialysis treatment record dated 9-15-15 evidenced the patient's weight at the end of the treatment was 107.7 kg.</p> <p>F. Home hemodialysis treatment records, dated 9-4-15, 9-5-15, and 9-11-15 failed to evidence a weight at the end of the treatment.</p> <p>3. The clinic manager was unable to provide any additional documentation and/or information when asked on 9-22-15 at 2:15 PM regarding the patient's inability attain the physician ordered EDW for patient number 2.</p> <p>4. The home program registered nurse (RN), employee B, indicated, on 9-22-15 at 10:50 AM, the patient number 4 not reaching the EDW as ordered by the physician had not been addressed. The RN stated, "The EDW probably needs to be adjusted. [The patient] did not have any signs or symptoms of fluid overload."</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>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 record review and interview, the facility failed to ensure it had maintained the prescribed dose of dialysis by failing to ensure heparin had been administered as ordered by the physician in 3 (#s 1, 2, and 5) of 3 incenter records reviewed of patients with continuous heparin administration orders in a sample of 5 total clinical records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included physician orders dated 9-30-13 that identified a bolus dose of 2000 units of heparin was to be administered at the beginning of each treatment. The record included physician orders dated 4-8-15 that identified a total of 1750 units of continuous heparin was to be administered during each treatment for a total of 3750 units of heparin before and during the hemodialysis treatment.</p> <p>A. Hemodialysis treatment flow sheets, dated 8-31-15, 9-4-15, and 9-21-15 evidenced a total of 3200 units of heparin had been administered.</p> <p>B. Hemodialysis treatment flow sheets dated 9-7-15, 9-9-15, and 9-14-15</p>	V 0544	<p>The Clinic Manager or designee will in-service all staff by 10/24/15 on DSI Policy & Procedure #500-44: Heparin; # 600-12: Plan of Care; #300-82: Patient Verification. The in-service will include but not be limited to the following: How to turn the heparin pump on & off; clearing the heparin pump between treatments; proper procedure for entering heparin orders in PEARL; procedure for loading a heparin syringe on a 2008K machine; proper process for documenting Heparin administration; following physician orders regarding medication orders; the plan of care must address dialysis adequacy which includes achieving & sustaining the prescribed dose of dialysis to meet an HD Kt/V of at least 1.2 and if the expected outcome is not achieved, the patient's plan of care must be adjusted to achieve the specified goals, to reflect the patient's current condition & there should be documentation in the medical record the reasons why the patient was unable to achieve the goals. The clinical records for patient's #1, #2 & #5 will be updated to address each patient's dialysis adequacy. The Clinic Manager or designee will audit a random 10% of patient charts including clinical records #1, #2 &</p>	10/24/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>evidenced a total of 355 units of heparin had been administered.</p> <p>C. A hemodialysis treatment flow sheet dated 9-11-15 evidenced a total of 3000 units of heparin had been administered.</p> <p>D. A hemodialysis treatment flow sheet dated 9-18-15 evidenced a total of 3200 units of heparin had been administered.</p> <p>2. Clinical record number 2 included physician orders dated 6-6-14 that evidenced a bolus dose of 5000 units of heparin was to be administered at the beginning of the treatment. Physician orders dated 3-20-15 evidenced 3000 units of continuous maintenance heparin was to be administered during the treatment for a total of 8000 units of heparin before and during the treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 9-4-15 evidenced a total of 3300 units of heparin had been administered during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 9-16-15 evidenced a total of 7900 units of heparin had been administered during the treatment.</p>		#5 daily X 2 weeks or until 100% compliance is achieved and then weekly X 2, monthly X 2 and then bi-monthly as per the QM Workbook Patient Flowsheet Audit tool schedule. Any staff found not to be in compliance with these policies and procedures will receive progressive disciplinary action. The Clinic Manager or designee will review all education, audit results & any disciplinary action in the monthly QAPI & LGB meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Clinical record number 5 included physician orders dated 7-1-15 that evidenced a bolus dose of 3000 units of heparin was to be administered at the beginning of the treatment. The orders evidenced a total of 3500 units of continuous heparin was to be administered during the treatment for a total of 6500 units of heparin before and during the treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 8-26-15 evidenced a total of 5900 units of heparin had been administered.</p> <p>B. A hemodialysis treatment flow sheet dated 8-31-15 evidenced a total of 6100 units of heparin had been administered.</p> <p>C. A hemodialysis treatment flow sheet dated 9-2-15 evidenced a total of 5400 units of heparin had been administered.</p> <p>D. A hemodialysis treatment flow sheet dated 9-7-15 evidenced a total of 6000 units of heparin had been administered.</p> <p>E. A hemodialysis treatment flow sheet dated 9-11-15 evidenced a total of 3000 units of heparin had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V 0550 Bldg. 00	<p>administered.</p> <p>4. The clinic manager indicated, on 9-22-15 at 3:00 PM, the records did not evidence the heparin had been administered as ordered. The manager stated, "It must be something with the machine."</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure appropriate post-needle removal care had been provided in 1 (#s 1 and 2) discontinuation of the dialysis treatment observations completed.</p> <p>The findings include:</p> <p>1. Employee D, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 6 on 9-21-15 at 2:30 PM (observation # 1). The PCT was observed to remove the venous needle, apply a Band-Aid and</p>	V 0550	<p>The Clinic Manager or designee will in-service all staff including employees D & I by 10/24/15 on DSI Policy & Procedure #300-15: Decannulation with Safety Needle Device. The in-service will include but not be limited to the following: After removing tape from the first needle to be removed, apply folded gauze pads to hub area and press lightly; the dressing used to achieve hemostasis must be changed & replaced with a clean dressing prior to the each patient leaving the unit. The Clinic Manager or designee will perform Infection Control-Staff Audits on a random 10% of staff</p>	10/24/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>folded gauze and tape. Pressure was held for approximately 10 minutes. After the bleeding had stopped, the PCT was observed to change the gauze and tape but left the Band-Aid in place. The PCT repeated the same procedure for the removal of the arterial needle. The PCT was not observed to place a clean, dry Band-Aid over the site prior to the patient leaving the treatment floor.</p> <p>2. Employee I, a PCT, was observed to discontinue the dialysis treatment on patient number 7 on 9-21-15 at 3:00 PM (observation # 2). The PCT was observed to remove the venous needle, apply a Band-Aid and folded gauze and tape. Pressure was held for approximately 10 minutes. After the bleeding had stopped, the PCT was observed to change the gauze and tape but left the Band-Aid in place. The PCT was observed to repeat the same procedure for the removal of the arterial needle. The PCT was not observed to place a clean, dry Band-Aid over the site prior to the patient leaving the treatment floor.</p> <p>3. The clinic manager indicated, on 9-23-15 at 12:10 PM, it was not facility policy to place a Band-Aid over the needle removal sites first. The manager indicated the Band-Aid should have been</p>		<p>including employees D & I daily X 2 weeks or until 100% compliance is noted and then weekly X 2 and then monthly as per the QM Workbook Infection Control-Staff Audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0715 Bldg. 00	<p>changed prior to the patient leaving the treatment floor.</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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; Based on record review and interview, the medical director failed to ensure the facility's policy and procedure regarding patient grievances had been implemented by failing to ensure patient complaints had been documented in accordance with facility policy in 1 of 1 patient complaint reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 4 evidenced the patient performed home hemodialysis treatments 6 days per week. During a telephone interview with the spouse of patient number 4, on 9-22-15 at 12:15 PM, the spouse stated, "I did try to call the facility one time and was not able to get ahold of anyone. It was right after [employee B] started. We had no other</p>	V 0715	The Director of Operations or designee will in-service the Clinic Manager, Home Nurse, Medical Director & all staff by 10/24/15 on DSI Policy & Procedure #200-07: Patient Rights, Responsibilities and Grievance Procedure. The in-service will include but not be limited to the following: The staff member to whom the patient's complaint is verbalized should report the grievance to the nurse in charge and record the complaint on the Patient Grievance Log; if a solution is not reached through discussion between the nurse in charge and patient, the nurse in charge will inform the Clinic Manager within 24 hours. A late entry will be noted on the grievance log related to patient #4 complaint. Documentation will include that the complaint was resolved. The Clinic Manager or designee will	10/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>numbers but the DSI and it was a day they were closed. [The patient's] blood pressure went real low. I needed some back-up. I was kinda put out, when the other nurse was there we could get ahold of her anytime. The top number was in the 80s. [The patient] was really drowsy, towards the end of the session. I got [the patient] off and watched [the patient] real close. It was 2-3 weeks later [the patient] got pneumonia and went into the hospital. We have always had a little bit of a problem with low blood pressures. I needed a little bit of support and didn't have it. I told them about it, our nurse now."</p> <p>2. The facility's complaint documentation for January 2015 through current failed to evidence documentation of the complaint.</p> <p>3. The home program nurse stated, on 9-22-15 at 12:20 PM, "I did not write it up. The patient told me about it. I gave them the numbers [for the on-call after hours nurse].</p> <p>4. The clinic manager stated, on 9-22-15 at 12:25 PM, "This is the first I am hearing about it. It is not documented in the complaint log."</p> <p>5. The facility's 6-1-14 "Patient Rights,</p>		<p>audit the grievance log weekly X 4 or until 100% compliance is achieved, monthly X 3, quarterly X 3 and then annually as per the QM Workbook Annual Quality Assessment Performance Improvement Audit Tool. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. The Clinic Manager or designee will review the grievance log, education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152617	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER DSI KOKOMO DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3760 S REED ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Responsibilities and Grievance Procedure" number 200-07 states, "The staff member to whom the patient's complaint is verbalized should report the grievance to the nurse in charge and record the complaint on the Patient Grievance Log."				