STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153522	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RILEY HOSPITAL RENAL SERVICES	705 RILEY HOSPITAL DRIVE ROC STE 1240 INDIANAPOLIS, IN 46202

(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
V000000	This was a federal ESRD recertification survey Survey Dates: 6/10, 6/11, 6/12, and 6/13/2013 Facility #: 011294 Medicaid Vendor #: 200853800 Surveyor: Dawn Snider, RN, PHNS Census: In-center hemodialysis: 6 Home Peritoneal Dialysis: 23 Quality Review: Joyce Elder, MSN, BSN, RN June 18, 2013	V000000		

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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V000113	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. Based on observation and review of policy, the facility failed to ensure the dialysis treatment area was maintained to minimize the transmission of infectious agents for 1 of 6 (#2) patient care observations with the potential to transmit disease causing organisms to all the facility's patients and staff. The findings include: 1. On 6/10/13 at 12:15 PM, employee D, a registered nurse (RN), was observed to open a sterile dressing kit for a central line for patient # 1, station #1, machine # F306. The employee removed her sterile gloves touched the computer keyboard and machine without proper hand hygiene and donning gloves. 2. Facility policy "HAND HYGIENE" revision date November 2013 policy number IC 1.14 states, "B. Hand Hygiene is required with ANY direct patient contact or contact with the patient's immediate environment. ... 8. Perform	V000113	Corrective Action: 1. All staff have viewed IC video from hhs, completion is documented in staff education files. 2. Staff discussion in Unit Meeting on 6/19/13 to clarify IC requirements. Attendance is documented in meeting minutes.3. All staff will complete an IC practices audit on their peers. to be completed by 7/9/13.Audit Measures1. Monthly audits will be completed, documented and reported in Dialysis QAPI. Audits will be ongoing with a benchmark of 90% compliance in all areas (see attachment)2. Staff will monitor peers and point out technique breaches at the time of occurance to increase awareness and change behavior.Responsible: Cheryl Seaman, MSN, RN Administrator/Clinical Manaager	07/09/2013

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NAME OF PROVIDER OR SUPPLIER RILEY HOSPITAL RENAL SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DRIVE ROC STE 1240 INDIANAPOLIS, IN 46202	

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	hand hygiene after the removal of gloves." 3. Facility policy "INFECTION CONTROL POLICIES" effective date June 2013 policy number PDU 1.14 states, "d. Everyone handling blood or touching a hemodialysis machine or patient's equipment for any reason must wear gloves. Gloves should be changed frequently and hands washed or sanitized before putting on and after removing gloves." 4. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."			

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V000114	494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing. Based on observation, review of policy, and interview, the facility failed to ensure sinks were sinks were not used for both handwashing and contaminated supplies in 1 of 2 days of observation with the potential to transmit disease causing organisms to all the facility's patients and staff. The findings include: 1. On 6/10/13 at 12:50 PM, employee E, a registered nurse, emptied jugs of dialysate in a sink at the same time employee D, a registered nurse, was washing her hands. None of the sinks in the facility treatment area were observed labeled to indicate which sinks were dirty or clean. 2. Facility policy titled "INFECTION CONTROL GUIDELINES IN HEMODIALYSIS" with an effective date July 2001 policy number 1.20 states, "Clean: Area is designated only for clean and unused equipment or supplies and medications. Dirty: An area where there is a potential for contamination with blood or body fluids and areas where	V000114	Corrective Action:1. Sinks in the unit have been identified as "dirty/dump" sinks2. Soap to wash hands has been removed from these sinksAudit Measures:1. Audit monthly per IC audit as reported in V113 plan2. Staff will monitor peers and point out technique breaches at the time of the occurance to increase awareness and change behavior.Responsible: Cheryl Seaman, MSN, RN Administrator/Clinical Manager	06/24/2013

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	contaminated or 'used' supplies, equipment, blood supplies or biohazard containers are stored and handled." 3. On 6/11/13 at 11:00 AM, the administrator, employee G, indicated there were no labels on the sinks in the treatment area to identify which were dirty and which were clean.			

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V000403	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. Based on observation and staff interview, the facility failed to ensure all equipment was maintained and operated in accordance with accepted standards for 1 of 1 dialysis facility reviewed with the potential to affect all the facility's patients. The findings include: 1. On 6/10/2013 at 3:30 PM, during the quick look tour of the water room with the administrator, employee G, water was observed on the floor by the carbon tanks. 2. On 6/11/2013 at 2:00 PM, water remained on the floor of the water room by the carbon tanks. A large white bucket was overflowing with water and also leaking on to the floor. Employee XX, the service technician, indicated this was a long time leak, was a back up from the water softener, and there was no drain for the overflow water.	V000403	Source of water on the floor has been determined to be due to 1. Leaking carbon tank2. Allowing water to flow onto floor during testingCorrective Action:1. Carbon tank will be exchanged by Siemens/MarCor by 7/15/132. Water on the floor has been dried3. Testing valve will be moved to allow easier access and drainage into a bucket with a drain hose connection.Audit Measures:1. Staff will monitor for water on the floor daily. (see attachment)2. Water wil be reported to Manager who will assure issue is corrected and floor is dryResponsible: Cheryl Seaman, MSN, RN Administrator/Clinical Manager	07/16/2013

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V000506	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. Based on clinical record review and interview, the facility failed to ensure all patients had been screened for for tuberculosis for 3 of 5 (#1, #2 and # 3) clinical records reviewed with the potential to affect all the facility's patients. The findings include: 1. Clinical record #1, dialysis date of 4/8/12, failed to evidence screening for tuberculosis. 2. Clinical record #2, dialysis date of 3/31/11, failed to evidence screening for tuberculosis. 3. Clinical record #3, dialysis date of 2/28/11, failed to evidence screening for tuberculosis. 4. On 06/11/2013 at 3:56 PM, the medical director indicated the facility had not been performing TB screening on the patients initially when started on dialysis.	V000506	Corrective Action:1. All patients will be screened for TB. Method used will be appropriate for patient age & condition, to include TST, IGRA, or Chest X-ray (specific to R.O. TB)2. Medical Director has discussed the need to screen for TB in the 6/20/13 Governing Body meeting, and with the Medical Director of Infection Control for Riley Hospital. The Administrator/Clinical Manager took the TB screen issue to the Renal Network Pediatric Meeting (6/18/13) to learn how other Pediatric units are meeting this requirement.3. A TB screen policy will be in place by 7/26/134. Staff and Physician education related to the need for TB screening occured in the 6/27/13 Renal team meeting.5. All current patients will be screened by 8/28/13 to allow clinic patients to cycle thru their monthly appointments.Audit Measures:1. Records of existing patients have been audited to determine current TB testing status.2. Annual audits will be performed to assure compliance ongoing. Responsible: Cheryl	08/30/2013

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			Seaman, MSN, RN Administrator/Clinical Manager Jeffrey Leiser, MD, PhD` Medical Director	

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V000715	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 observation, interview, and review of policy, the medical director failed to ensure the facility had provided services in accordance with its own policies and procedures with the potential to affect all the agency's patients. The findings include: 1. The medical director failed to ensure the facility followed its policy titled "HAND HYGIENE" revision date November 2013 policy number IC 1.14 that states, "B. Hand Hygiene is required with ANY direct patient contact or contact with the patient's immediate environment. ... 8. Perform hand hygiene after the removal of gloves." (See V 113) 2. The medical director failed to ensure the facility followed its policy titled "INFECTION CONTROL POLICIES" effective date June 2013 policy number PDU 1.14 that states, "d. Everyone handling blood or touching a	V000715	Corrective Action:1. The Medical Director met with the Governing Body on 6/20/13, and the Medical Director of Infection Control at Riley Hospital, where these issues were discussed & a plan of corrections was determined to assure that citations & responses cited and detailed in V0113, V0114, V0403, V0506 appropriately address the root cause of each citation.2. Additionally, the Medical Director reviewed identified action plans, auditing tools and techniques which will monitor and measure adherence to policies and procedures and confirm that corrective actions are instituted to ensure resolution of the areas of deficiency.3. The Medical Director is responsible to review the results of the Plan of Correction and ensuing activities and reports as a member of the Governing Body and to provide oversight monthly ongoing thrugh the QAPI Committee.Audit Measures:1. The Medical Director acknowledges his role to ensure that any issues not resolving will be reviewed with a	06/28/2013

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	hemodialysis machine or patient's equipment for any reason must wear gloves. Gloves should be changed frequently and hands washed or sanitized before putting on and after removing gloves." (See V 113) 3. The medical director failed to ensure the facility followed its policy titled "INFECTION CONTROL GUIDELINES IN HEMODIALYSIS"with an effective date July 2001 policy number 1.20 that states, " Clean: Area is designated only for clean and unused equipment or supplies and medications. Dirty: An area where there is a potential for contamination with blood or body fluids and areas where contaminated or "used" supplies, equipment, blood supplies or biohazard containers are stored and handled." (See V 114)		new root cause analysis and Plan of Action until all issues as cited within the Statement of Deficiency have been resolved and resolution sustained.Responsible: Jeffrey Leiser, MD, PhD Medical Director	