

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152636	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/15/2015
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NAME OF PROVIDER OR SUPPLIER  NORTH VERNON DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2340 N STATE HWY 7 NORTH VERNON, IN 47265
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V 0000  Bldg. 00	This was a Federal ESRD [CORE] recertification survey.  Survey Dates: 7-13-15, 7-14-15, & 7-15-15  Facility #: 012010  Medicaid Vendor #; 200934060A  QR: JE 7/17/15	V 0000		
V 0113  Bldg. 00	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, interview, and facility policy review, the facility failed to ensure staff had provided services in accordance with the facility's hand hygiene policies in 3 (#s 1, 11, and 15) of 16 total hand hygiene observations completed. (Employees B and C)  The findings include:  1. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 8 on 7-13-15 at 12:50 PM using an	V 0113	<b>V113</b> Inservicingon Policy #1-05-01: Infection Control for Dialysis Facilities was completed by 7/27/15by the Facility Administrator (FA). Teammates were instructed in, but notlimited to, 1) to change gloves and perform hand hygiene between "dirty" and"clean" tasks and items, and 2) to perform hand hygiene prior to donninggloves. The FA or designee will conduct observational audits on random shifts3xweek for two weeks, then weekly x2, then monthly. Each teammate will beobserved at least 3 times. Results of audits will be reviewed with	08/27/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>arteriovenous graft (AVG) located in the right upper arm. The PCT cleansed her hands and donned clean gloves. The PCT then retrieved the trash can and placed it closer to the dialysis chair. The PCT cleansed the needle insertion sites with alcohol and betadine pads. The PCT failed to change her gloves and cleanse her hands after retrieving the trash can and prior to cleansing the needle insertion sites.</p> <p>2. Employee B, a registered nurse (RN), was observed to administer intravenous Epogen to patient number 9 on 7-15-15 at 9:15 AM. The RN prepared the medication for administration at the medication preparation area and took the medication to the patient at station number 5. The RN donned clean gloves without cleansing her hands and administered the medication.</p> <p>3. The facility administrator, employee A, indicated, on 7-15-15 at 12:20 PM, the employees had not followed the facility's infection control policy.</p> <p>4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after</p>		<p>theMedical Director during the monthly Facility Health Meeting (FHM-QAPI) withsupporting documentation included in the meeting minutes. The FA is responsiblefor compliance with this plan of correction (POC).</p>		

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V 0122  Bldg. 00	<p>contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area."</p> <p>5. Employee C, a patient care tech, was observed providing care to patient 6 on 7/13/2015 at 4:50 PM. The employee was observed to touch the biohazard bin and computer keyboard with gloved hands then handle a tympanic thermometer used for care with all of the clinic patients without first performing hand hygiene. The employee then put on clean gloves without first cleaning her hands and touched the patient's clean supplies for central venous catheter (CVC) access. The employee was observed to touch the computer keyboard and put on clean gloves without performing hand hygiene then touched the caps, connectors, and supply lines of patient # 6's CVC.</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</p>			

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	<p>laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure the dialysis stations had been cleaned and disinfected appropriately in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed. (Employees C and D)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee C, a patient care technician (PCT), was observed to clean the dialysis machine and surrounding area at station number 5 on 7-13-15 at 4:20 PM. The PCT was not observed to clean the Hansen connectors, the intravenous solution pole, the dialysate hoses, or the prime waste container. The PCT was not observed to clean the data entry station.</li> <li>2. Employee D, a PCT, was observed to clean the dialysis machine and surrounding area at station number 9 on 7-13-15 at 5:10 PM. The PCT was not observed to clean the inside of the blood pump compartment on the dialysis machine, the right side of the dialysis machine, or the dialysate hoses. The</li> </ol>	V 0122	<p><b>V122</b></p> <p>Inservicing on Policy #1-05-01: Infection Control for Dialysis Facilities was completed by 7/27/15 by the FA. Teammates were instructed in, but not limited to, 1) clean all surfaces in the dialysis station between patients including the connectors, IV pole, dialysate hoses, prime waste container, inside of blood pump cover, all sides of the machine, and to recline and open sides, if possible, of the dialysis chair to reach all surfaces and crevices. The FA or designee will conduct observational audits on random shifts 3x week for two weeks, then weekly x2, then monthly. Each teammate will be observed at least 3 times. Results of audits will be reviewed with the Medical Director during the monthly FHM-QAPI with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC.</p>	08/27/2015

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	<p>PCT was not observed to clean the outer sides of the dialysis chair or the data entry station.</p> <p>3. The facility administrator, employee A, indicated, on 7-15-15 at 12:20 PM, the employees had not followed the facility's infection control policy which addresses cleaning and disinfection of the dialysis machine and station.</p> <p>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 waste container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment . . . Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables . . . IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. Priming containers are to be empties and flushed with water. The interior and exterior should be wiped down with 1:100 bleach solution and rinsed</p>			

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V 0187 Bldg. 00	<p>thoroughly with water before using on next patient treatment."</p> <p>494.40(a) ENVIRONMENT-SCHEMATIC DIAGRAMS/LABELS 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction.</p> <p>Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow.</p> <p>If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure the water system schematic diagram was accurate and identified all components of the facility's water system.</p> <p>The findings include:</p> <p>1. On 7-14-15 at 8:30 AM, observation of the facility's water room identified 2 smaller carbon tanks between the larger primary and secondary carbon tanks. The</p>	V 0187	<p><b>V187</b> The two smaller carbon tanks are to beremoved and the water schematic will be updated to clearly identify directionalflow and all components of the system by 8/31/15. Accuracy of schematics willbe monitored during monthly biomedical audits. Results of audits will bereviewed with the Medical Director during the monthly FHM-QAPI with supportingdocumentation included in the meeting minutes. The FA is responsible forcompliance with this POC.</p>	08/31/2015

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	<p>biomedical technician, employee H, indicated the 2 smaller carbon tanks were installed to help preserve the larger tanks when the city water source had been hyperchlorinated at one time. The biomedical technician indicated the water flowed from the multimedia filter to the first small tank, then to the second small tank, then to the water softener, then to the larger primary carbon tank and on to the second larger carbon tank. The piping failed to evidence labeling to identify the direction of flow.</p> <p>2. The water system schematic diagram posted in the water room was not observed to include the 2 smaller carbon tanks.</p> <p>3. The biomedical technician, employee H, stated, on 7-14-15 at 8:40 AM, the schematic diagram did not include the 2 smaller carbon tanks.</p> <p>4. The facility's December 2008 "Water Treatment System Minimum Components" policy number 12-14-01 states, "All water systems will include and post a schematic diagram which identifies components, valves, sample ports and flow directions. Additionally, piping will be labeled to indicate the contents in the pipe and direction of flow."</p>			

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V 0200  Bldg. 00	<p>494.40(a) RO-MONITOR/ALARM/PREVENT UNSAFE H2O USE</p> <p>5.2.7 Reverse osmosis: alarm/prevent use of unsafe water Refer to RD62:2001, 4.3.7 Reverse osmosis: Reverse osmosis devices shall be equipped with on-line monitors that allow determination of rejection rates and product water conductivity. The product water conductivity monitor should activate audible and visual alarms when the product water conductivity exceeds the preset alarm limit. The audible alarm must be audible in the patient care area when reverse osmosis is the last chemical purification process in the water treatment system. Monitors that measure resistivity or TDS may be used in place of conductivity monitors.</p> <p>6.2.7 Reverse osmosis: Reverse osmosis systems should be monitored daily using continuous-reading monitors that measure product water conductivity (or total dissolved solids (TDS)).</p> <p>5.2.7 Reverse osmosis: Refer to RD62:2001, 4.3.7 Reverse osmosis: When a reverse osmosis system is the last chemical purification process in the water treatment system, it [should] include a means to prevent patient exposure to unsafe product water, such as diversion of the product water to drain, in the event of a product water conductivity or rejection alarm. Based on facility policy review, reverse osmosis (RO) start-up log review, and interview, the facility failed to ensure the RO start-up logs included acceptable</p>	V 0200	<p><b>V200</b> The Daily Water Treatment Log was updated 7/14/15 by the BioMed Technician with facility specific acceptable limits in all</p>	07/31/2015			

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	<p>limits for pure water conductivity in 7 (6-1-15 to 7-13-15) of 7 weeks reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The facility's March 2014 "Daily Water Treatment System Monitoring" policy number 2-04-02 states, "All observations and test results will be within the limits specified on the 'Daily Water Treatment Log.' If observations or test results are found outside the specified limits, follow the instructions given on the 'Daily Water Treatment System Log' for the parameter(s) in question. In addition to following the log form instructions, the teammate completing the log will notify the Facility Administrator/designee and Biomed teammate assigned to the facility of any observation or test result found outside the limit specified on the 'Daily Water Treatment Log'."</li> <li>The daily water treatment logs, dated 6-1-15, 6-3-15, 6-5-15, 6-8-15, 6-10-15, 6-12-15, 6-15-15, 6-17-15, 6-19-15, 6-22-15, 6-24-15, 6-26-15, 6-29-15, 7-6-15, 7-7-15, 7-8-15, 7-10-15, and 7-13-15 failed to include acceptable limits for the pure water conductivity reading. The log states, under the "Acceptable limits" column, "Record value."</li> </ol>		<p>columns. Teammates were instructed 7/31/15 to report out of limit findings to the BMT/Charge Nurse/FA for follow up. Presence of facility specific acceptable limits will be monitored during monthly biomedical audits. Results of audits will be reviewed with the Medical Director during the monthly FHM-QAPI with supporting documentation included in the meeting for compliance with this POC</p>				

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V 0401 Bldg. 00	<p>3. The biomedical technician, employee H, stated, on 7-14-15 at 9:00 AM, "There should be a value there."</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, interview, and facility policy review, the facility failed to ensure the central solution delivery system had been maintained in 3 (#s 2, 3, and 10) of 10 stations observed.</p> <p>The findings include:</p> <p>1. On 7-14-15 at 9:18 AM, observation noted 10 dialysis stations with chase cabinets lining the perimeter of the dialysis treatment floor. The cabinets housed the central solution delivery system and had countertops with doors that could be lifted to view the inside of the cabinets. The outside of the cabinets were inset with piping that delivered 2 types of acid concentrate, bicarbonate solution, and water.</p> <p>2. A large amount of a yellow crystalline</p>	V 0401	<p><b>V401</b> The BMT repaired the leaks and cleaned the crystallinesubstances from all ports 7/20/15. Ports will be monitored during monthlybiomedical audits and cleaned and adjusted as needed. Results of audits will bereviewed with the Medical Director during the monthly FHM-QAPI with supportingdocumentation included in the meeting minutes. The FA is responsible forcompliance with this POC</p>	07/20/2015

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V 0407 Bldg. 00	<p>substance was noted on the 2K (potassium) 2 Ca (calcium) port at station number 2.</p> <p>A. A moderate amount of a yellow crystalline substance was noted on the 3K 2.25 Ca port at station number 3.</p> <p>B. A moderate amount of a brown/yellow crystalline substance was noted on the 3K 2.25 Ca port at station number 10.</p> <p>3. The biomedical technician, employee K, indicated, on 7-14-15 at 9:20 AM, the crystalline substance observed was dried acid and that it was a result of small leaks in the system. The biomedical technician stated, "It can be fixed."</p> <p>4. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS</p>				

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	<p>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure accesses were visible at all times in 3 (#s 3, 10, and 11) of 20 observations completed for access visibility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 7-13-15 at 4:35 PM, observation noted patient number 10 was receiving treatment via a central venous catheter (CVC) at station number 1. The access site was covered with clothing and was not visible.</li> <li>On 7-13-15 at 4:40 PM, observation noted patient number 11 was receiving treatment via a CVC at station number 6. The access site was covered with clothing and was not visible.</li> <li>On 7-15-15 at 8:40 AM, observation noted patient number 3 was receiving treatment via a CVC at station number 9. The access site was covered with clothing and was not visible.</li> <li>The facility administrator, employee A, indicated, on 7-15-15 at 12:20 PM, the accesses should not be covered and</li> </ol>	V 0407	<p><b>V407</b></p> <p>Inservicing on Policy #1-03-09: Intradialytic Treatment Monitoring will be completed by 7/31/15 by the FA. Teammates are being instructed in, but not limited to, 1) visualize accesses during 30 minute checks, and 2) every time a patient's access is seen covered, request the patient uncover, visualize and document intervention. In addition, patient education will be completed by 8/5/15. Patient verbalization of understanding to be documented and a signed acknowledgement of education will be placed in the medical record with completion by 8/5/15. The FA or designee will conduct observational audits on random shifts 3x week for two weeks, then weekly x2, then monthly. Results of audits will be reviewed with the Medical Director during the monthly FHM-QAPI with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC.</p>	08/05/2015

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V 0541 Bldg. 00	<p>should be visible at all times.</p> <p>5. 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, needs 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."</p> <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. Based on observation, interview, and review of clinical record and facility policy, the facility failed to ensure hemodialysis treatment orders were complete in 1 (patient # 7) of 5 records</p>			V 0541	<p><b>V541</b> The physician reviewed and updated the dialysate order for Patient #7 on 7/13/15. Teammates were instructed to check patient's orders prior to</p>		07/31/2015

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	<p>reviewed for hemodialysis treatment orders.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation noted, on 7-13-15 at 1:00 PM, patient number 7 was receiving treatment at station number 9 and was being dialyzed with a 2K 2 Ca (2 potassium, 2 calcium) dialysate bath. The clinical record for patient number 7 included hemodialysis treatment orders dated 5-20-15 that failed to evidence the dialysate orders. The dialysate orders were blank.</li> <li>2. The facility administrator, employee A, stated, on 7-14-15 at 11:45 AM, "We made a mistake. The orders were not entered into the electronic record. Thankfully, everyone here is on a 2K bath."</li> <li>3. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs . . . The plan of care will address, but not be limited to, the following: Dose of dialysis which</li> </ol>		<p>every treatment and to report to the Charge Nurse if orders are needed. The FA or designee will audit the medical records for 100% of new admissions and 10% of current patients monthly to verify complete orders are in place. Results of audits will be reviewed with the Medical Director during the monthly FHM-QAPI with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC</p>		

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V 0543 Bldg. 00	<p>addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed does of dialysis."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p> <p>The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record and facility policy review and interview, the facility failed to ensure the necessary care and services had been provided to manage the patient's blood pressure during the dialysis treatment in 1 (# 3) of 4 records reviewed for fluid volume and blood pressure management.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 3 included physician orders dated 1-15-14 that identified Midodrine 5 milligrams (a medication for the treatment of low blood pressure) 2 tablets were to be taken by mouth by the patient 1 hour before dialysis.</li> <li>2. The record included hemodialysis treatment flow sheets that evidenced the patient's blood pressure had been very low during the treatment.</li> </ol>	V 0543	<p><b>V543</b></p> <p>Anon-billable order for Patient #3 was entered on 7/20/15 to check with patient priorto each patient to see if medication had been taken. Teammates were inservicedto check orders and follow through with documentation. 100% of currentpatient's medical records were audited to identify and correct for any otherpatient on pre-treatment medications. The FA or designee will audit the medicalrecords for 100% of patients required to take medication to verify documentationis in place. Results of audits will be reviewed with the Medical Directorduring the monthly FHM-QAPI with supporting documentation included in themeeeting minutes. The FA is responsible for compliance with this POC.</p>	07/20/2015

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	<p>A. A hemodialysis treatment flow sheet dated 6-19-15 evidenced the patient's blood pressure had ranged from 131/18 to 67/35 during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 6-22-15 evidenced the patient's blood pressure had ranged from 154/74 to 87/38 during the treatment.</p> <p>C. A hemodialysis treatment flow sheet dated 6-24-15 evidenced the patient's blood pressure had ranged from 167/76 to 93/25 during the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 6-26-15 evidenced the patient's blood pressure had ranged from 25/56 to 78/41 during the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 6-29-15 evidenced the patient's blood pressure had ranged from 143/62 to 81/25 during the treatment.</p> <p>F. A hemodialysis treatment flow sheet dated 7-1-15 evidenced the patient's blood pressure had ranged from 158/67 to 43/19 during the treatment.</p> <p>G. A hemodialysis treatment flow sheet dated 7-3-15 evidenced the patient's blood pressure had ranged from 168/63 to</p>			

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	<p>92/23 during the treatment.</p> <p>H. A hemodialysis treatment flow sheet dated 7-6-15 evidenced the patient's blood pressure had ranged from 159/65 to 86/32 during the treatment.</p> <p>I. A hemodialysis treatment flow sheet dated 7-8-15 evidenced the patient's blood pressure had ranged from 138/62 to 85/26 during the treatment.</p> <p>J. A hemodialysis treatment flow sheet dated 7-10-15 evidenced the patient's blood pressure had ranged from 165/67 to 81/33 during the treatment.</p> <p>3. The record failed to evidence the registered nurse had checked with the patient to ensure the Midodrine had been taken as ordered before each dialysis treatment.</p> <p>4. The facility administrator, employee A, stated, on 7-14-15 at 3:25 PM, "[The patient] takes the Midodrine before [the patient] comes in. It is not documented that the nurse has asked."</p> <p>5. The facility's March 2013 "Patient Assessment And Plan Of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the</p>			

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V 0544 Bldg. 00	<p>following: Dose of dialysis which addresses care and services to manage the patient's volume status."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record review and interview, the facility failed to ensure it had maintained the prescribed dose of dialysis by failing to ensure continuous heparin had been administered as ordered in 3 (#s 1, 3, and 4) of 3 records reviewed of patients with continuous heparin orders.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included physician orders dated 12-12-14 that identified a total of 1800 units of continuous heparin was to be administered during each dialysis treatment.</p> <p>A hemodialysis treatment flow sheet dated 6-22-15 failed to evidence any continuous heparin had been administered during the treatment.</p>	V 0544	<p><b>V544</b> Physicians reviewed and updated heparin orders for all patients 7/20/15. Teammates were instructed to check heparin orders prior to treatment initiation, report to the Charge Nurse if orders are not clear, and to document amount of heparin administered each treatment. The FA or designee will audit flowsheets for 10% of patients weekly x4, then monthly x3 to verify patients are receiving heparin per physician orders. Results of audits will be reviewed with the Medical Director during the monthly FHM-QAPI with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC.</p>	07/20/2015

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	<p>2. Clinical record number 3 included physician orders dated 5-27-15 that identified a total of 1800 units of continuous heparin was to be administered during each treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 6-19-15 evidenced a total of 2300 units of continuous heparin had been administered during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 6-22-15 failed to evidence any continuous heparin had been administered during the treatment.</p> <p>C. Hemodialysis treatment flow sheets, dated 6-29-15 and 7-8-15, evidenced a total of 1700 units of continuous heparin had been administered during the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 7-1-15 evidenced a total of 2100 units of continuous heparin had been administered during the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 7-6-15 evidenced a total of 1400 units of continuous heparin had been administered during the treatment.</p> <p>3. Clinical record number 4 included physician orders dated 5-11-15 that</p>			

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V 0550 Bldg. 00	<p>identified a total of 1600 units of continuous heparin was to be administered during each dialysis treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 6-19-15 evidenced a total of 1500 units of continuous heparin had been administered during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 7-8-15 failed to evidence any continuous heparin had been administered during the treatment.</p> <p>4. The facility administrator was unable to provide any additional documentation and/or information when asked on 7-14-15 at 3:45 PM.</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. Based on observation, interview, and</p>	V 0550	V550	08/31/2015

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	<p>review of facility policy, the facility failed to ensure accesses were evaluated prior to the initiation of treatment in 1 (# 1) of 2 access of arteriovenous fistula or graft for the initiation of dialysis observations and failed to ensure clean gauze had been applied to needle removal sites post dialysis in 1 (# 1) of 2 discontinuation of dialysis and post dialysis care observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 8 on 7-13-15 at 12:50 PM using an arteriovenous graft in the right upper arm. The PCT was observed to palpate the graft site but was not observed to listen to the sound of the graft with a stethoscope prior to inserting the needles and initiating the treatment.</li> <li>2. The facility's March 2015 "AV Fistula Or Graft Cannulation With Nipro Or Medisystems Safety Fistula Needles (SFN) And Administration of Heparin" procedure number 1-04-01E states, "Prior to auscultating a bruit with a stethoscope, clean the diaphragm of the stethoscope first with an alcohol prep pad. Perform inspection, auscultation and palpation on entire length of access. Determine</li> </ol>		<p>Inservicingon Policy #1-04-01E: AV Fistula orGraft Cannulation with Nipro or Medisystems Safety Fistula <b>V550</b> Needles (SFN) and Administration of Heparin and Policy #1-04-01B:Post DialysisVascular Access Care: Fistula/Graft Using Safety Fistula Needles will be completed by 8/5/15 by the FA. Teammates are beinginstructed in, but not limited to, 1) evaluate accesses prior to cannulation bypalpating and by auscultation, and 2) after bleeding has stopped posttreatment, to replace used gauze with clean gauze. The FA or designee willconduct observational audits on random shifts 3xweek for two weeks, then weeklyx2, then monthly. Each teammate will be observed at least 3 times. Results ofaudits will be reviewed with the Medical Director during the monthly FHM-QAPIwith supporting documentation included in the meeting minutes. The FA isresponsible for compliance with this POC.</p>				

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	<p>presence of bruit and thrill."</p> <p>3. Employee C, a PCT, was observed to discontinue the dialysis treatment on patient number 9 using an arteriovenous fistula in the left lower arm on 7-13-15 at 4:50 PM. The PCT removed the needles and placed gauze pads on the sites. The patient held pressure on the sites for approximately 10 minutes. After the bleeding had stopped completely, the patient applied more tape to the gauze over the removal sites. The PCT was not observed to check the gauze for the presence of continued bleeding or to replace the gauze with clean gauze prior to the patient leaving the facility.</p> <p>4. The facility's March 2015 "Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles" procedure 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 or sterile dressing over cannulation site."</p> <p>5. The facility administrator, employee A, indicated, on 7-15-15 at 12:20 PM, the employees had not followed the facility's policies and procedures.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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