

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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V000000	<p>This was an ESRD Federal [CORE] recertification survey.</p> <p>Survey Dates: 8-20-14, 8-21-14, 8-22-14, and 8-26-14</p> <p>Facility #: 005150</p> <p>Medicaid Vendor #: 100248060</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>FMC Ohio Valley Dialysis was found to be out of compliance with Conditions for Coverage 42 CFR 494.80 Patient Assessment, 42 CFR 494.90 Patient Plan of Care, and 42 CFR 494.110 Quality Assessment and Performance Improvement.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 5, 2014</p>	V000000		
V000113	<p>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</p>	V000113	On 8/26/2014 and on 8/27/2014,	09/18/2014

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

TITLE

(X6) DATE

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

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	<p>facility policy review, the facility failed to ensure staff had changed gloves and cleansed hands in accordance with infection control policies and procedures in 4 (#s 3, 10, 13, and 14) of 14 hand hygiene observations completed creating the potential to affect all of the facility's 57 total patients. (Employees B, F, and H)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee B, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 8 on 8-26-14 at 11:30 AM. The RN was observed to reinfuse the extracorporeal circuit, cleanse her hands, and then enter information into the medical record using the data entry station. The RN then donned clean gloves without cleansing her hands. 2. Employee H, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 9 on 8-20-14 at 2:10 PM. The PCT was observed to reinfuse the extracorporeal circuit, cleanse her hands, and then enter information into the medical record using the data entry station. The PCT then donned clean gloves without cleansing her hands. 		<p>the Clinical Manager, conducted a mandatory staff meeting for all Direct Patient Care staff to reinforce both the expectation and responsibility of facility staff in adhering to facility the hand hygiene polices of this facility. To ensure that all staff understands the importance of proper hand hygiene, the Director of Operations contacted the educational department and arranged for the formal reeducation of all staff to be completed no later September 16, 2014. This reeducation was inclusive of the following facility policies and procedures:</p> <p><input type="checkbox"/> FMS-CS-IC-II-155-090C Hand Hygiene Procedure <input type="checkbox"/> FMS-CS-IC-II-155-080A Personal Protective Equipment Policy Documentation of the education, monitoring process, staff and patient assignments document the implemented corrective actions and are available at the facility for review Monitoring of the staff for compliance has occurred and will continue to occur by the Clinical Manager or assigned Nurse as follows: <input type="checkbox"/> Direct observation of the staff's adherence to infection control policies and procedures. <input type="checkbox"/> Immediate intervention, consisting of reeducation up to disciplinary action, to address and correct identified noncompliance with the appropriate staff member. The Clinical Manager documents staff compliance on</p>		

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	<p>3. Employee F, an RN, was observed to prepare medications for administration to patient number 10 on 8-26-14 at 8:35 AM The RN drew up Epogen, Hecetrol, and Venofer. After drawing up the Venofer, the RN changed her gloves without cleansing her hands and administered the medications to the patient.</p> <p>The RN was observed to prepare medications for administration to patient number 11 on 8-26-14 at 8:50 AM. The RN drew up Epogen, Hecetrol, and Venofer. After drawing up the Venofer, the RN changed her gloves without cleansing her hands and administered the medications to the patient.</p> <p>4. The above-stated observations were discussed with the clinic manager on 8-26-14 at 1:10 PM. The manager indicated the employees had not cleansed hands and changed gloves in accordance with facility policies and procedures.</p> <p>5. The facility's 3-20-13 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A states, "Hand hygiene must always be performed after glove removal."</p> <p>The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A</p>		<p>the developed plan of correction monitoring tool. This tool was implemented on September 10, 2014 and was completed during each patient shift with decreased frequency as determined by the Governing Body. Any identified staff non-compliance will have an immediate intervention by the Clinical Manager/Designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees personnel file if warranted. FMS-CS-IC-II-155-090 A Hand Hygiene Policy</p> <p>In the event that a staff member is found to continually not follow the facility procedures for infection control, the Clinical Manager will be notified and is responsible to address the findings with the identified staff member. The Clinical Manager's action will be structured to reinforce by further education following through as necessary with the application of progressive disciplinary action.</p> <p>The Clinical Manager will summarize the findings and report to the QAI Committee and to the Governing Body monthly who will determine further audit frequency by decreasing the frequency incrementally. Once compliance has been established the monitoring will revert to the QAI infection control audit tool</p> <p>The Clinical Manager is responsible and the QAI Committee and the Governing Body monitor for ongoing complianc</p>		

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V000119	<p>states, "Hands Will Be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water . . . Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications. Immediately after removing gloves."</p> <p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. Based on observation, interview, and facility policy review, the facility failed to ensure staff refrained from carrying items in their pockets in 4 (#s 12, 2, 3, and 4) of 4 observations completed creating the potential to affect all of the facility's 57 total patients. (Employees C and H)</p> <p>The findings include:</p> <p>1. Employee H, a patient care technician (PCT), was observed to initiate the</p>	V000119	<p>On 8/26/2014 and on 8/27/2014, the Clinical Manager, conducted a mandatory staff meeting for all Direct Patient Care staff to reinforce both the expectation and responsibility of facility staff in adhering to facility the infection control polices of this facility. To ensure that all staff understands the importance of compliance to infection control policies, the Director of Operations contacted the educational department and arranged for the formal reeducation of all staff to be completed no later September 16, 2014. This reeducation was inclusive of the following facility policies and procedures</p> <ul style="list-style-type: none"> <input type="checkbox"/> FMS-CS-IC-II-155-060A Infection Control Overview Policy <p>Documentation of the education, monitoring process, staff and patient assignments document the implemented corrective actions and are available at the facility for review Monitoring of the staff for compliance has occurred and will continue to occur by the Clinical Manager or assigned Nurse as follows:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Direct observation of the staff's adherence to infection control policies and procedures. <input type="checkbox"/> Immediate intervention, consisting of reeducation up to disciplinary action, to address and correct identified 	09/18/2014

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	<p>dialysis treatment on patient number 1 using a central venous catheter (CVC) on 8-20-14 at 11:15 AM. The PCT was observed to cleanse her hands and reach into her pocket to retrieve a surgical mask. The PCT was observed to don the mask and then don clean gloves without cleansing her hands.</p> <p>2. Employee H, a PCT, was observed to discontinue the dialysis treatment on patient number 12 on 8-20-14 at 10:30 AM. The PCT was observed to reach into her pocket and retrieve a pen. The PCT used the pen to document information on a piece of paper stuck to the dialysis machine. The PCT then replaced the pen into her pocket.</p> <p>At 10:45 AM, the PCT was observed to reach into her pocket and again retrieve the pen. The PCT documented the patient's weight on a piece of paper at the nurse's station and replaced the pen into her pocket.</p> <p>3. Employee C, the home therapy registered nurse (HTRN), was observed to complete an assessment on patient number 13 in the home therapy room. The HTRN was observed to take the patient's temperature, pulse, and blood pressure. The HTRN retrieved a pen from her pocket and documented the</p>		<p>noncompliance with the appropriate staff member. The Clinical Manager documents staff compliance on the developed plan of correction monitoring tool. This tool was implemented on September 10, 2014 and was completed during each patient shift with decreased frequency as determined by the Governing Body.</p> <p>Any identified staff non-compliance will have an immediate intervention by the Clinical Manager/Designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees personnel file if warranted.</p> <p>In the event that a staff member is found to continually not follow the facility procedures for infection control, the Clinical Manager will be notified and is responsible to address the findings with the identified staff member. The Clinical Manager's action will be structured to reinforce by further education following through as necessary with the application of progressive disciplinary action.</p> <p>The Clinical Manager will summarize the findings and report to the QAI Committee and to the Governing Body monthly who will determine further audit frequency by decreasing the frequency incrementally. Once compliance has been established the monitoring will revert to the QAI infection control audit tool. The Clinical Manager is responsible and the QAI Committee and the Governing Body monitor for ongoing compliance</p>				

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V000122	<p>findings. The RN replaced the pen into her pocket.</p> <p>4. Employee H, a PCT, was observed to prepare heparin for administration to patient number 14. The PCT reached into her pocket and retrieved keys to unlock the medicine cabinet. The PCT obtained the heparin, locked the cabinet, and replaced the keys into her pocket.</p> <p>5. The above-stated observations were discussed with the clinic manager on 8-26-14 at 1:10 PM. The manager indicated the practice of keeping items in pockets would be changed.</p> <p>6. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC-II-155-060A states, "All infection control policies will adhere to CMS [Centers for Medicare and Medicaid Services] and OSHA [Occupational Safety Health and Administration] rules and regulations."</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-</p> <p>(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 medical equipment and machines had been cleaned and disinfected after use in 8 (#s 1, 2, 3, 4, 5, 6, 7, and 8) of 8 cleaning and disinfecting observations completed creating the potential to affect all of the facility's 57 current patients. (Employees B, E, F, H, and J)</p> <p>The findings include:</p> <p>1. Employee H, a patient care technician (PCT), was observed to clean and disinfect the dialysis machine and surrounding area at station number 6 on 8-20-14 at 10:45 AM. The PCT was not observed to clean the Hansen connectors on the dialysis machine.</p> <p>The employee was observed to clean the data entry station after cleaning the dialysis machine using the same disinfectant-soaked cloth.</p> <p>2. Employee F, a registered nurse, was observed to cleanse and disinfect the dialysis machine and surrounding area at station number 4 on 8-20-14 at 2:35 PM.</p>	V000122	<p>On 8/26/2014 and on 8/27/2014, the Clinical Manager, conducted a mandatory staff meeting for all Direct Patient Care staff to reinforce both the expectation and responsibility of facility staff in adhering to facility the cleaning and disinfection polices of this facility. To ensure that all staff understands the importance to clean and disinfect contaminated surfaces, the Director of Operations contacted the educational department and arranged for the formal reeducation of all staff to be completed no later September 16, 2014. This reeducation was inclusive of the following facility policies and procedures:</p> <ul style="list-style-type: none"> ∩ FMS-CS IC-II-140-510C1MS-CS-IC-II-155-110A Cleaning and Disinfection Policy ∩ Checking Conductivity and pH of Final Dialysate with the pHoenix Meter Procedure ∩ Documentation of the education, monitoring process, staff and patient assignments document the implemented corrective actions and are available at the facility for review <p>Monitoring of the staff for compliance has occurred and will continue to occur by the Clinical Manager or assigned Nurse as follows:</p> <ul style="list-style-type: none"> ∩ Direct observation of the staff's adherence to infection control policies and procedures. ∩ Immediate intervention, consisting of reeducation up to disciplinary action, to address and correct identified noncompliance with the appropriate staff member. ∩ The Clinical Manager documents staff compliance on the developed plan of correction monitoring tool. This tool was implemented on September 10, 2014 and was completed during each patient shift with decreased frequency as determined by the Governing Body. <p>Any identified staff non-compliance will have an immediate intervention by the Clinical Manager/Designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees personnel file if warranted.</p> <p>FMS-CS-IC-II-155-110C1 Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions Procedure</p> <p>In the event that a staff member is found to continually not follow the facility procedures for infection control, the Clinical Manager will be notified and is responsible to address the findings with the identified staff member. The Clinical Manager's action will be structured to reinforce by further education following through as necessary with the application of progressive disciplinary action.</p> <p>The Clinical Manager will summarize the findings and report to the QAI Committee and to the Governing</p>	09/18/2014
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	<p>The RN was not observed to clean the television or data entry station.</p> <p>3. Employee J, a PCT, was observed to clean and disinfect the dialysis machine and surrounding area at station number 14 on 8-26-14 at 10:15 AM. The PCT failed to cleanse the blood pump or the Hansen connectors. The employee then used the same cloth to clean the dialysis chair and television. The employee failed to clean the outside of the left side of the chair.</p> <p>4. Employee H, a PCT, was observed to use the dialysate meter to check the conductivity of the dialysate at station number 14 on 8-26-14 at 9 AM. The PCT completed the test and returned the meter to a clean area without cleaning and disinfecting the meter.</p> <p>At 9:55 AM, the PCT was observed to use the same meter to test the dialysate at station number 11. The PCT again returned the meter to the clean area without cleansing and disinfecting the meter.</p> <p>5. Employee E, a PCT, was observed to use the dialysate meter to check the conductivity of the dialysate at station number 1 on 8-26-14 at 9:35 AM. The PCT completed the test at the station and</p>		<p>Body monthly who will determine further audit frequency by decreasing the frequency incrementally. Once compliance has been established the monitoring will revert to the QAI infection control audit tool The Clinical Manager is responsible and the QAI Committee and the Governing Body monitor for ongoing compliance</p>	

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	<p>returned the meter to a clean area without cleaning and disinfecting the meter.</p> <p>6. Employee J, a PCT, was observed to use the dialysate meter to check the conductivity of the dialysate at station number 9 on 8-26-14 at 11:25 AM. Patient number 15 was sitting in the dialysis chair. The PCT completed the test and placed the meter on the chairside arm and tested the pH of the dialysate. The PCT then returned the meter to a clean area without cleaning and disinfecting the meter.</p> <p>7. Employee J, a PCT, was observed to use a tympanic thermometer on patient number 7 on 8-26-14 at 10:25 AM. The PCT returned the thermometer to a clean area without first cleaning and disinfecting the thermometer.</p> <p>8. Employee B, a RN, was observed to use a tympanic thermometer on patient number 8 on 8-26-14 at 11:20 AM. The RN returned the thermometer to a clean area without first cleaning and disinfecting the thermometer.</p> <p>9. The above-stated observations were discussed with the clinic manager on 8-26-14 at 1:10 PM. The manager indicated the employees had not followed facility policy and procedure.</p>			

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V000147	<p>10. The facility's 3-20-13 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A policy states, "Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are frequently touched and potentially contaminated . . . Discard all fluid and clean and disinfect all containers associated with the prime waste (including buckets attached to the machines) . . . Non-disposable items such as blood pressure cuffs, IV poles, TVs, TV remotes, portable phones, etc., as well as clipboards or plastic hemostat clamps placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment."</p> <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</p>			

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	<p>catheter-related infections.</p> <p>B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance</p> <p>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</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on observation and interview, the facility failed to ensure central venous catheter (CVC) dressing changes had been performed in an aseptic manner in 1 (# 1) of 2 CVC dressing changes observed creating the potential to affect all of the facility's current patients with CVCs.</p> <p>The findings include:</p> <p>1. Employee F, a registered nurse (RN), was observed to change the CVC dressing on patient number 1 on 8-20-14 at 11:15 AM. The RN was observed to</p>	V000147	On 8/26/2014 and on 8/27/2014, the Clinical Manager, conducted a mandatory staff meeting for all Direct Patient Care staff to reinforce both the expectation and responsibility of facility staff in adhering to facility the central venous catheter care polices of this facility. To ensure that all staff understands the importance of proper catheter care, the Director of Operations contacted the educational department and arranged for the formal reeducation of all staff to be completed no later September 16, 2014 This reeducation was inclusive of the following facility policies and procedures:¿	09/18/2014

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	<p>apply an antibiotic ointment to the exit site using her gloved finger instead of a sterile applicator.</p> <p>2. The Medical Director indicated, on 8-21-14 at 2:10 PM, the RN should have used a sterile applicator to apply the antibiotic ointment to the CVC exit site.</p>		<p>FMS-CS-IC-I-105-032A Changing the Catheter Dressing Policy FMS-CS-IC-I-105-032C Changing the Catheter Dressing Procedure Documentation of the education, monitoring process, staff and patient assignments document the implemented corrective actions and are available at the facility for review Monitoring of the staff for compliance has occurred and will continue to occur by the Clinical Manager or assigned Nurse as follows: • Immediate intervention, consisting of reeducation up to disciplinary action, to address and correct identified noncompliance with the appropriate staff member. The Clinical Manager documents staff compliance on the developed plan of correction monitoring tool. This tool was implemented on September 10, 2014 and was completed during each patient shift with decreased frequency as determined by the Governing Body Any identified staff non-compliance will have an immediate intervention by the Clinical Manager/Designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees personnel file if warranted. In the event that a staff member is found to continually not follow the facility procedures for infection control, the Clinical Manager will be notified and is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2014
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V000500	494.80 CFC-PATIENT ASSESSMENT Based on clinical record and facility policy review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure a monthly update to the comprehensive assessment included an assessment of renal bone disease factors in 1 of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients (See V 508); by failing to ensure a monthly update to the comprehensive assessment included an assessment of nutritional factors in 1 of 1 unstable patient record reviewed	V000500	responsible to address the findings with the identified staff member. The Clinical Manager's action will be structured to reinforce by further education following through as necessary with the application of progressive disciplinary action. The Clinical Manager will summarize the findings and report to the QAI Committee and to the Governing Body monthly who will determine further audit frequency by decreasing the frequency incrementally. Once compliance has been established the monitoring will revert to the QAI infection control audit tool. The Clinical Manager is responsible and the QAI Committee and the Governing Body monitor for ongoing compliance The Director of Operations conducted a review into the continued failure of the interdisciplinary team's non-compliance to ensure: ; Patients are assessed for renal bone disease factors by the Interdisciplinary Team inclusive of the dietitian to addresses their nutritional needs. Please refer to V-508; ; Unstable patients are reassessed monthly to update their plan of care by the interdisciplinary team until stability is determined. Please refer to V-509; ; Completion of a new Comprehensive Interdisciplinary	09/18/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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V000508	<p>creating the potential to affect all of the facility's 57 current patients (See V 509); and by failing to ensure a comprehensive re-assessment had been completed by all members of the interdisciplinary team (IDT) in 1 of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients (See V 520).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.80 Patient Assessment.</p> <p>494.80(a)(5) PA-ASSESS RENAL BONE DISEASE The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(5) Evaluation of factors associated with renal bone disease. Based on clinical record and facility policy review and interview, the facility failed to ensure a monthly update to the comprehensive assessment included an assessment of renal bone disease factors in 1 (# 6) of 1 unstable patient record reviewed creating the potential to affect</p>	V000508	<p>Assessment when a patient stability status is deemed unstable in accordance with facility guidelines. Please refer to V-520.</p> <p>On September 9, 2014 the Clinical Manager and Director of Operations met with the qualified Registered Dietician to review the citations from the August 26, 2014 CMS survey and to review the responsibilities of the Dietician in the completion of the Patient Comprehensive Interdisciplinary Assessment</p> <p>To ensure that the Registered Dietician and the Interdisciplinary Team are knowledgeable on the Federal Requirements for the Comprehensive Interdisciplinary Assessment including a Nutritional evaluation of factors associated with Renal Bone Disease, on September 18, 2014, the Regional Quality</p>	09/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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	<p>all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 included a plan of care dated 6-12-14 that identified the patient as unstable. The record evidenced the registered nurse had completed a re-assessment on 7-2-14 and the medical social worker had completed a re-assessment on 7-7-14. The record failed to evidence the registered dietitian had completed a re-assessment that included renal bone disease factors. 2. The Registered Dietitian, employee M, stated, on 8-21-14 at 10:40 AM, "The documentation is not in the record. I guess I didn't document it." 3. The record included a "Nutrition Monthly Progress Note", signed and dated by the dietician, employee M, on 7-30-14. The note states, "Unable to talk with patient, was in hospital for several days in July." <p>The record included a "Clinical Notes Report" with an entry signed and dated by the registered nurse, employee C, that states, "Patient here as scheduled."</p> <ol style="list-style-type: none"> 4. The Medical Director indicated, on 8-21-14 at 2:10 PM, he was aware there 		<p>Manager will develop and present the following Plan of Education to the Interdisciplinary Team members.</p> <ul style="list-style-type: none"> ∩ Reeducation and reinforcement that the Dietician Comprehensive Patient Assessment must include evaluation of Factors Associated with Renal Bone Disease including: <ul style="list-style-type: none"> - Evaluation of the patients laboratory values for calcium, phosphorus, and PTH - (phosphate binders, vitamin D analogs, and calcimimetic agents) over the counter medications, Review of the patient's current CKD mineral and bone disorder medications - Dietary factors, and - ∩ Reeducation and reinforcement of each team member's responsibility to complete all required sections of the comprehensive assessments within the required time lines as outlined in the Federal Regulations: <ul style="list-style-type: none"> Medical conditions impacting this issue ∩ Reeducation and reinforcement on FMC Comprehensive Patient Assessment and Plan of Care policy # FMS-CS-IC-I-110-125A outlining the responsibilities of the qualified Dietician in the Comprehensive Patient Assessment <p>A copy of the educational agenda and attendance sheet is available for review at the facility. To ensure that reoccurrence of this deficiency will not occur, the Clinical Manager reviews each completed CIA and PoC prior to filing in the patient record. The Clinical Manager maintains a tickler file which identifies the due dates for patient CIA's and PoC's. In the event that noncompliance is identified, the Clinical Manager will communicate concerns directly to the Medical Director and Director of Operations. Additionally, the Clinical Manager will formalize a report for the monthly QAI meeting, detailing compliance gaps, and corrective actions implemented to correct any identified deficiencies. The committee reviews areas of non-compliance, interventions taken and evaluates to determine if further action is required. The QAI meeting minutes document this activity and are available for review at the facility. The Clinical Manager is responsible and the QAI committee monitor for compliance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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V000509	<p>was a problem with dietary services. The Medical Director stated, "[The lead dietitian] has been monitoring the situation."</p> <p>5. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The comprehensive interdisciplinary assessment must include the following: . . . Evaluation of factors associated with renal bone disease."</p> <p>494.80(a)(6) PA-RD-NUTRITIONAL STATUS The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(6) Evaluation of nutritional status by a dietitian Based on clinical record and facility policy review and interview, the facility failed to ensure a monthly update to the comprehensive assessment included an assessment of nutritional factors in 1 (# 6) of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a plan of care dated 6-12-14 that identified</p>	V000509	On September 9, 2014 the Clinical Manager and Director of Operations met with the qualified Registered Dietician to review the citations from the August 26, 2014 CMS survey and to review the responsibilities of the Dietician in the completion of the Patient Comprehensive Interdisciplinary Assessment. To ensure that the Registered Dietician and the Interdisciplinary Team are knowledgeable on the Federal Requirements with regard to the Patient Comprehensive Interdisciplinary	09/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2014	
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	<p>the patient as unstable. The record evidenced the registered nurse had completed a re-assessment on 7-2-14 and the medical social worker had completed a re-assessment on 7-7-14. The record failed to evidence the registered dietitian had completed a re-assessment that included an evaluation of nutritional factors.</p> <p>2. The Registered Dietitian, employee M, stated, on 8-21-14 at 10:40 AM, "The documentation is not in the record. I guess I didn't document it."</p> <p>3. The record included a "Nutrition Monthly Progress Note", signed and dated by the dietician, employee M, on 7-30-14. The note states, "Unable to talk with patient, was in hospital for several days in July."</p> <p>The record included a "Clinical Notes Report" with an entry signed and dated by the registered nurse, employee C, that states, "Patient here as scheduled."</p> <p>4. The Medical Director indicated, on 8-21-14 at 2:10 PM he was aware there was a problem with dietary services. The Medical Director stated, "[The lead dietitian] has been monitoring the situation."</p>		<p>Assessment and Evaluation of Nutritional Status, on September 18, 2014 the Regional Quality Manager will develop and present the following Plan of Education to the Interdisciplinary Team members:Reeducation and reinforcement that the Comprehensive Patient Assessment must include evaluation of nutritional parameters/status by a qualified Dietician including but not limited to:Nutritional status,Hydration status,Metabolic parameters -such as glycemic control (if diabetic) and cardiovascular health, Anthropometric data such as height, weight, weight history, weight changes, volume status, amputations, Appetite and Intake Ability to chew and swallow, Gastrointestinal issues, Use of prescribed and over the counter nutritional, dietary, or herbal supplements, Previous diets and/or nutritional education, Route of nutrition, Self management skills, Attitude to nutrition, health and well being and Motivation to make changes to meet nutrition and other health goals.Reeducation and reinforcement that other members of the Interdisciplinary Team may contribute to portions of the Nutritional Assessment Reeducation and reinforcement of each team member's responsibility to complete all required sections of the comprehensive assessments</p>				

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	5. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The comprehensive interdisciplinary assessment must include the following: . . . Evaluation of nutritional status by a qualified dietitian."		within the required time lines as outlined in the Federal Regulations:Reeducation and reinforcement on FMC Comprehensive Patient Assessment and Plan of Care policy # FMS-CS-IC-I-110-125A outlining the responsibilities of the qualified Dietician in the Comprehensive Patient Assessment. A copy of the educational agenda and attendance sheet is available for review at the facility.To ensure that reoccurrence of this deficiency will not occur, the Clinical Manager reviews each completed CIA and PoC prior to filing in the patient record. The Clinical Manager maintains a tickler file which identifies the due dates for patient CIA's and PoC's. In the event that noncompliance is identified, the Clinical Manager will communicate concerns directly to the Medical Director and Director of Operations.Additionally, the Clinical Manager will formalize a report for the monthly QAI meeting, detailing compliance gaps, and corrective actions implemented to correct any identified deficiencies. The committee reviews areas of non-compliance, interventions taken and evaluates to determine if further action is required. The QAI meeting minutes document this activity and are available for review at the facility.The Clinical Manager is responsible and the		

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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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V000520	<p>494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO</p> <p>In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure a comprehensive re-assessment had been completed by all members of the interdisciplinary team (IDT) in 1 (# 6) of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a plan of care dated 6-12-14 that identified the patient as unstable. The record evidenced the registered nurse had completed a re-assessment on 7-2-14 and</p>	V000520	<p>QAI committee monitor for compliance</p> <p>To ensure that each patient with a change of their stability status has a completed Comprehensive Assessment completed by all IDT members, and to prevent reoccurrence the following has been put into place: Clinical Manager review of patient hospitalizations and/or incident to ensure IDT notification of changes to patient status Clinical Manager will review each completed Comprehensive Interdisciplinary Assessment and Plan of Care for required documentation/signatures and timely completion by each respective team member prior to filing in the patient record. Revision of the Comprehensive Interdisciplinary Assessment/Plan of Care tracking system for all active patients to ensure that they are completed within the required time frame. No less than (30) days prior to the due date of each patient's Comprehensive Interdisciplinary Assessment or Plan of Care, the Clinical Manager/designee will prepare a list of those patient's due for initial, 90 day, annual, or unstable monthly assessment. Clinical Manager/designee will provide the list of those patient's due for assessment to the Interdisciplinary Team 30 days prior to due date Facility policies and procedures used as reference and the referenced educational staff meeting: FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy FMS-CS-IC-I-110-125D1 Comprehensive Interdisciplinary Assessment The Clinical Manager is responsible to alert the IDT members of those patients due for assessment/ plan</p>	09/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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	<p>the medical social worker had completed a re-assessment on 7-7-14. The record failed to evidence the registered dietitian had completed a re-assessment of the patient.</p> <p>2. The Registered Dietitian, employee M, stated, on 8-21-14 at 10:40 AM, "The documentation is not in the record. I guess I didn't document it."</p> <p>3. The record included a "Nutrition Monthly Progress Note", signed and dated by the dietician, employee M, on 7-30-14. The note states, "Unable to talk with patient, was in hospital for several days in July."</p> <p>The record included a "Clinical Notes Report" with an entry signed and dated by the registered nurse, employee C, that states, "Patient here as scheduled."</p> <p>4. The Medical Director indicated, on 8-21-14 at 2:10 PM he was aware there was a problem with dietary services. The Medical Director stated, "[The lead dietitian] has been monitoring the situation."</p> <p>5. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states,</p>		<p>of care development and presents a report at each monthly QAI meeting.</p> <p>The Clinical Manager will summarize the findings identified from the monitoring process and report daily to the Governing Body until resolution of the identified issues occurs.</p> <p>The Clinical Manager will report non-compliance of interdisciplinary team members to the Governing Body who will investigate the issue, implement corrective actions and follow through until acceptable resolution of the issue is determined</p> <p>The Clinical Manager is responsible and the Medical Director and Governing Body will monitor for ongoing compliance during the weekly Governing Body calls beginning September 23, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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V000540	<p>"Unstable patients must be reassessed by the IDT and a new comprehensive assessment and Plan of Care completed monthly until the patient is determined by the IDT to be stable . . . If the patient is declared unstable, the IDT should complete a new Comprehensive Interdisciplinary Interdisciplinary Assessment and Plan of Care in their entirety, monthly until the patient is determined by the IDT to be stable."</p> <p>494.90 CFC-PATIENT PLAN OF CARE Based on clinical record and facility policy review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure it had managed the patients' volume status by addressing those patients that had not attained their physician ordered estimated dry weights (desired weight after dialysis) in 2 of 6 records reviewed creating the potential to affect all of the facility's 57 current patients (See V 543); by failing to ensure it had provided the necessary nutritional counseling services to maintain patients' albumin levels at the desired level of 4.0 grams per deciliter (g/dL) in 3 of 6 records reviewed creating the potential to affect all of the facility's 57 current</p>	V000540	<p>The Clinical Manager and Director of Operations conducted a review into the continued failure of the interdisciplinary team's non-compliance to ensure: ; Assessment and revision to the patient plan of care to address identified issues related to patient volume status to achieve their physician prescribed target weight occurs when warranted. Please refer to V-543 ; Pre and post access care is provided in accordance with facility policy. Please refer to V-550 ; Unstable patients are reassessed monthly and revision occurs to their plan of care by the interdisciplinary team until stability is determined. Please refer to V-558 Assessment and development of a patient plan of care that addresses the patient's nutritional needs. Please refer to V 545</p>	09/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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V000543	<p>patients (See V 545); by failing to ensure pre- and post- treatment access care had been provided in accordance with facility policy in 4 of 4 arteriofistula or graft initiation and discontinuation observations completed creating the potential to affect all of the facility's patients with fistulas and grafts (See V 550); and by failing to ensure plans of care had been reviewed and updated monthly on unstable patients with participation by all members of the interdisciplinary team in 1 of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients (See V 558).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.90 Patient Plan of Care.</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS 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 it had managed the patients' volume status by addressing</p>	V000543	<p>On August 26 and 27, 2014 the Clinical Manager conducted a mandatory staff meeting to reinforce each employees obligation to conduct a pretreatment patient evaluation inclusive of the patient's ability to achieve physician orders as prescribed inclusive of the estimated dry weight and if in the event the order cannot be achieved or a parameter is not provided,</p>	09/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2014	
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	<p>those patients that had not attained their physician ordered estimated dry weights (desired weight after dialysis) in 2 (#s 1 and 2) of 6 records reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included physician orders dated 6-25-14 that evidenced a physician ordered estimated dry weight (EDW) of 89 kilograms (kg). The record failed to evidence the interdisciplinary team had addressed the failure to reach the EDW.</p> <p>A. A hemodialysis treatment flow sheet dated 7-28-14 evidenced the patient's weight at the end of the treatment was 91.8 kg.</p> <p>B. A flow sheet dated 7-30-14 evidenced the patient's weight at the end of the treatment was 91.5 kg.</p> <p>C. A flow sheet dated 8-1-14 evidenced the patient's weight at the end of the treatment was 92.4 kg.</p> <p>D. A flow sheet dated 8-4-14 evidenced the patient's weight at the end of the treatment was 92.8 kg.</p>		<p>referral to the assigned nurse who is responsible to notify the attending physician and if warranted obtain additional or revisions to the patient's orders. To ensure that all staff fully understands the policy, the Director of Operations contacted the Education Department and on September 16, 2014 each staff member will be reeducated on the below policies and procedures:</p> <ul style="list-style-type: none"> ¿ FMS-CS-IC-I-110-131A Patient Evaluation Pre Dialysis Treatment Policy ¿ FMS-CS-IC-I-110-131C Patient Evaluation Pre Dialysis Treatment Procedure ¿ FMS-CS-IC-I-110-132A Patient Evaluation Post Dialysis Treatment Policy ¿ FMS-CS-IC-I-110-132C Patient Evaluation Post Dialysis Treatment Procedure ¿ FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy <p>To prevent reoccurrence and to monitor compliance monitoring the following has been implemented:</p> <ul style="list-style-type: none"> ¿ RN Team Leader is responsible to will review each patient's treatment sheet to assure compliance with prescribed dialysis orders, and the appropriate notification in the event that orders are not implemented as prescribed. ¿ Staff members identified as failing to comply with the implemented process will receive immediate intervention by the nurse providing oversight and/or the Clinical Manager. <p>The Clinical Manager reports findings of audits and any non-compliance with reference to the process at the monthly QAI meeting.</p> <p>The QAI Committee will address any variance to the required process by identifying the root cause and developing and implementing a corrective action plan to resolution of the issue.</p> <p>The Clinical Manager will document all findings and actions in the QAI minutes. The QAI minutes will be available for review at the facility.</p> <p>The Clinical Manager is responsible and the QAI Committee will monitor for compliance</p>				

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	<p>E. A flow sheet dated 8-8-14 evidenced the patient's weight at the end of the treatment was 90.4 kg.</p> <p>F. A flow sheet dated 8-11-14 evidenced the patient's weight at the end of the treatment was 92 kg.</p> <p>G. A flow sheet dated 8-13-14 evidenced the patient's weight at the end of the treatment was 90.2 kg.</p> <p>H. The clinic manager stated, on 8-26-14 at 2:10 PM, "There is no order to change the dry weight in the record.</p> <p>2. Clinical record number 2 included physician orders dated 7-18-14 and 8-18-14 that evidenced a physician ordered EDW of 86 kg. The record failed to evidence the interdisciplinary team had addressed the failure to reach the EDW.</p> <p>A. A flow sheet dated 8-1-14 evidenced the patient's weight at the end of the treatment was 94.5 kg.</p> <p>B. A flow sheet dated 8-4-14 evidenced the patient's weight at the end of the treatment was 93.9 kg.</p> <p>C. A flow sheet dated 8-8-14 evidenced the patient's weight at the end of the treatment was 91.4 kg.</p>			

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V000545	<p>D. A flow sheet dated 8-18-14 evidenced the patient's weight at the end of the treatment was 89.4 kg.</p> <p>E. A flow sheet dated 8-15-14 evidenced the patient's weight at the end of the treatment was 90.4 kg.</p> <p>F. The clinic manager stated, on 8-26-14 at 2:15 PM, "There are no dry weight changes in the system."</p> <p>3. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Dose of Dialysis . . . Provide necessary care and services to manage the patient's volume status."</p> <p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly.</p>			

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	<p>Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. Based on clinical record and facility policy review and interview, the facility failed to ensure it had provided the necessary nutritional counseling services to maintain patients' albumin levels at the desired level of 4.0 grams per deciliter (g/dL) in 3 (#s 1, 5, and 6) of 6 records reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included laboratory results that evidenced a decreasing albumin level. The albumin was 3.7 g/dL on 6-4-14, 3.0 on 7-2-14, and 2.9 g/dL on 8-6-14. <p>A. The record included a comprehensive assessment completed by the registered dietician on 7-15-14 that states, "Currently needs to improve albumin level to 4.0 or greater. Recently, became NPO [nothing by mouth], about 3 weeks ago and started on tube feeding of Nepro 40 ml (milliliters)/24 hours with promod [?] 30 ml BID [two times per day] which provides approx. 94 gm [grams] protein per day to meet est. [estimated] protein needs."</p>	V000545	<p>On September 9, 2014, the Director of Operations met with the qualified Registered Dietician to review the citations from the August 26, 2014 CMS survey and to review the responsibilities of the Dietician in the completion of the Patient Comprehensive Interdisciplinary Plan of Care. This meeting included a review of the responsibilities of the dietitian as outline in the signed job description and expectations concerning nutritional care of the dialysis patient. In addition, the DO and Lead Dietitian will provide education on FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care (POC) Policy. A copy of the educational agenda and attendance sheet is available for review at the facility. To ensure that reoccurrence of this deficiency will not occur, the Clinical Manager reviews each completed CIA and PoC prior to filing in the patient record. The Clinical Manager maintains a tickler file which identifies the due dates for patient CIA's and PoC's. In the event that noncompliance is identified, the Clinical Manager will communicate concerns directly to the Medical Director and Director of Operations. Additionally, the Clinical Manager will formalize a</p>	09/18/2014
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	<p>B. A physician note dated 7-18-14 states, "Dietitian reviewing records with SNF [skilled nursing facility] staff."</p> <p>C. A nurse practitioner (NP) visit note dated 8-13-14 states, "Albumin remains low-on tube fdg [feeding] will chesck [sic] on protein supp [supplement] in tube fdg @ SNF. Send alert to Dietitian, alert comments: Please check with [name of SNF] if additional protein supp. available with tube fdg."</p> <p>D. An NP note dated 8-20-14 states, "Please check with [name of SNF] if additional protein supp. available with tube fdg."</p> <p>E. The record failed to evidence any further follow-up by the dietitian to address the patient's low albumin level.</p> <p>F. The dietitian, employee M, stated, on 8-20-14 at 4:30 PM, "I have not done my August monthly note."</p> <p>2. Clinical record number 5 included physician orders dated 3-10-14 that state, "Nutritional Supplement: Nepro Car Steady 8 oz PO [by mouth] 3X [times a] week."</p> <p>A. A hemodialysis treatment flow sheet dated 8-13-14 failed to evidence the</p>		report for the monthly QAI meeting, detailing compliance gaps, and corrective actions implemented to correct any identified deficiencies. The committee reviews areas of non-compliance, interventions taken and evaluates to determine if further action is required. The QAI meeting minutes document this activity and are available for review at the facility. The Clinical Manager is responsible and the QAI committee monitor for compliance				

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	<p>protein supplement had been administered as ordered.</p> <p>B. The record included laboratory results that evidenced the patient's albumin level was 3.3 g/dL on 8-6-14.</p> <p>3. Clinical record number 6 evidenced the patient had been determined to be unstable at the 6-12-14 plan of care update due to frequent hospitalizations, chronic nausea and vomiting, and pancreatitis. The record included laboratory results that identified the patient's albumin level was 2.9 g/dL on 6-3-14, 2.7 g/dL on 7-2-14, and 2.4 g/dL on 8-7-14.</p> <p>A. The record included dietitian monthly progress notes dated 4-30-14 and 5-15-14. The record failed to include any further dietary notes until 7-30-14. The note states, "Unable to talk with patient, was in hospital for several days."</p> <p>B. The record included a "Clinical Notes Report" that evidenced the patient was in the clinic 7-29-14 and 8-5-14 and was assessed by the home therapy registered nurse, employee C. The notes failed to evidence any dietary counseling had been provided to the patient during these visits.</p>			

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	<p>4. The Medical Director indicated, on 8-21-14 at 2:10 PM, he was aware there was a problem with dietary services. The Medical Director stated, "[The lead dietitian] has been monitoring the situation."</p> <p>5. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Nutritional Status. Provide the necessary care and counseling services to achieve and sustain an effective nutritional status."</p> <p>6. The facility's 7-4-12 "Nutrition Services" policy number FMS-CS-IC-I-111-001A states, "The Registered Dietitian (RD) is responsible for evaluation the nutrition status of and providing ongoing individualized counseling services to all patients admitted to an FMS Incenter and Home Therapies programs with the goal of assisting each patient in achieving and sustaining an effective nutritional status . . . The services of the facility dietitian shall be made available to all patients of this dialysis facility, both in-center and home patients (where a Home Program exists), on admission and on an ongoing</p>			

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V000550	<p>basis."</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, interview, and review of facility policy, the facility failed to ensure pre- and post- treatment access care had been provided in accordance with facility policy in 4 (#s 1,2 ,3 and 4) of 4 arteriovenous fistula or graft initiation and discontinuation observations completed creating the potential to affect all of the facility's patients with fistulas and grafts. (Employees E, H, and J)</p> <p>The findings include:</p> <p>1. Employee J, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 16 on 8-20-14 at 9:55 AM using an arteriovenous fistula (AVF). The PCT was observed to cleanse the arterial and venous needle insertion sites with an</p>	V000550	<p>On 8/26/2014 and on 8/27/2014, the Clinical Manager, conducted a mandatory staff meeting for all Direct Patient Care staff to reinforce both the expectation and responsibility of facility staff in adhering to facility the pre and post patient access care policies of this facility.To ensure that all staff understands the importance of compliance to comply with policies for the care of the patient access, the Director of Operations contacted the educational department and arranged for the formal reeducation of all staff to be completed no later September 18, 2014. This reeducation was inclusive of the following facility policies and procedures¿ FMS-CS-IC-I-105-001A Initiation of Treatment Using an Arteriovenous Graft or Fistula Policy¿ FMS-CS-IC-I-105-001C Initiation of Treatment Using an</p>	09/18/2014

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	<p>antiseptic. The PCT inserted the arterial needle touching the venous insertion site in the process. The PCT taped the arterial needle in place and then inserted the needle into the venous site without cleansing the venous insertion site again after touching it.</p> <p>2. Employee E, a PCT, was observed to initiate the dialysis treatment on patient number 17 on 8-21-14 at 11:45 AM using an AVF. The PCT applied the tourniquet to the patient's arm, palpated the fistula, and inserted the venous needle without first cleansing the site.</p> <p>3. Employee H, a PCT, was observed to discontinue the dialysis treatment on patient number 12 on 8-20-14 at 10:30 AM. The PCT applied gauze and tape and pressure was held until hemostasis (bleeding had stopped) was attained on both the venous and arterial stick sites. The PCT then applied more tape to the gauze without placing a clean piece of gauze on the insertion site.</p> <p>4. Employee H, a PCT, was observed to discontinue the dialysis treatment on patient number 9 on 8-20-14 at 2:10 PM. The PCT applied gauze and tape and the pressure was held until hemostasis (bleeding had stopped) was attained on both the venous and arterial stick sites.</p>		<p>Arteriovenous Graft or Fistula Procedure; FMS-CS-IC-I-105-029A Termination of Treatment Using a Graft or Fistula Policy; FMS-CS-IC-I-105-029C Termination of Treatment Using a Graft or Fistula ProcedureTo prevent reoccurrence and to monitor compliance monitoring the following has been implemented:RN Team Leader is responsible to will review each patient's treatment sheet to assure compliance with prescribed dialysis orders, and the appropriate notification in the event that orders are not implemented as prescribed.Staff members identified as failing to with the implemented process will receive immediate intervention by the nurse providing oversight and/or the Clinical Manager The Clinical Manager reports findings of audits and any non-compliance with reference to the process at the monthly QAI meeting.The QAI Committee will address any variance to the required process by identifying the root cause and developing and implementing a corrective action plan to resolution of the issue.The Clinical Manager will document all findings and actions in the QAI minutes. The QAI minutes will be available for review at the facility.The Clinical Manager is responsible and the QAI Committee will monitor for compliance</p>		

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V000558	<p>The PCT then applied more tape to the gauze without placing a clean piece of gauze on the insertion site.</p> <p>5. The above-stated observations were discussed with the clinic manager on 8-26-14 at 1:10 PM. The manager indicated the soiled gauze was not removed in order to prevent the sites from bleeding again.</p> <p>6. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "Once hemostasis has been achieved, remove the gauze used for hemostasis and replace the sites with Band-Aids or adhesive dressing or clean tape with gauze dressing."</p> <p>494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d). Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care had been reviewed and updated monthly on unstable patients with participation by all members of the interdisciplinary team</p>	V000558	<p>To address the issues of patient's records lacking a completed monthly or annual update of the plan of care being performed within 15 days of the completed patient assessments, the following actions have occurred:</p> <ul style="list-style-type: none"> ¿ Reeducation of the IDT inclusive of the home therapy nurse to facility policy ¿ Review of 100% of the patient records ¿ Scheduled care plan meetings to occur no later than 15 days after completion of the CIA. ¿ Appointed the Clinical Manager to review appropriate documentation and completion of all 	09/18/2014

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	<p>(IDT) in 1 (# 6) of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 6 included a plan of care dated 6-12-14 that identified the patient as unstable. <ul style="list-style-type: none"> A. The record included a monthly update to the plan of care dated 7-17-14 that addressed phosphorous and albumin not in goal signed by the Home Therapies Registered Nurse (HTRN), employee C. B. The record included an update to the plan of care dated 8-7-14 that addressed phosphorous and albumin not in goal signed by the HTRN. C. The record failed to evidence the entire plan of care had been reviewed and updated in July or August by all team members or that the physician had determined the patient was no longer unstable. D. The record included a "Clinical Notes Report" with an entry signed and dated by employee C on 7-29-14 that states, "Patient here as scheduled." A subsequent entry, signed and dated by 		<p>required sections of the CIA and POC by each respective team member prior to filing in the patient record.</p> <p>Implemented a revised tickler system to track the due dates of all CIA's/POC's for all active patients to ensure that they are completed within the required time frame.</p> <p>No less than (30) days prior to the due date of each patient's Comprehensive Interdisciplinary Assessment or Plan of Care, the Clinical Manager will prepare a list of those patient's due for initial, 90 day, annual, or unstable monthly assessment. The Clinical Manager will be responsible to prepare and maintain a written notification form monthly for the Interdisciplinary Team. The notification form will be presented to the IDT members at the monthly QAI meeting. The Clinical Manager is responsible and the QAI committee monitors for compliance</p>	

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V000581	<p>employee C on 8-5-14, states, "Patient arrived to unit as scheduled."</p> <p>2. The Home Therapies Registered Nurse (HTRN), employee C, stated, on 8-21-14 at 11:00 AM, "We were only able to complete the care plan in June because the patient was in the hospital several days in July and August.</p> <p>3. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy states, "Unstable patients must be reassessed by the IDT and a new comprehensive assessment and Plan of Care completed monthly until the patient is determined by the IDT to be stable . . . If the patient is declared unstable, the IDT should complete a new Comprehensive Interdisciplinary Assessment and Plan of Care in their entirety, monthly until the patient is determined by the IDT to be stable."</p> <p>494.100 H-IDT RESP FOR SERVICES=IN-CENTER PTS A dialysis facility that is certified to provide services to home patients must ensure through its interdisciplinary team, that home dialysis services are at least equivalent to those provided to in-facility patients and meet all applicable conditions of this part.</p>			

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	<p>Based on clinical record and facility policy review and interview, the facility failed to ensure dietary counseling services had been made available to all home patients in 1 (# 6) of 1 unstable patient record reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 included a plan of care dated 6-12-14 that identified the patient as unstable. The record evidenced the registered nurse had completed a re-assessment on 7-2-14 and the medical social worker had completed a re-assessment on 7-7-14. The record failed to evidence participation by the registered dietitian. 2. The Registered Dietitian, employee M, stated, on 8-21-14 at 10:40 AM, "The documentation is not in the record. I guess I didn't document it." 3. The record included a "Nutrition Monthly Progress Note", signed and dated by the dietician, employee M, on 7-30-14. The note states, "Unable to talk with patient, was in hospital for several days in July." <p>The record included a "Clinical Notes</p>	V000581	<p>On September 9, 2014 the Director of Operations met with the qualified Registered Dietician to review the citations from the August 26, 2014 CMS survey and to review the responsibilities of the Dietician in the completion of the Patient Plan of Care. To ensure that the Registered Dietician and the Interdisciplinary Team are knowledgeable on the Federal Requirements with regard to the Patient Plan of Care and that the home patients nutritional needs are address, on September 18, 2014 the Regional Quality Manager developed and will present the following Plan of Education to the Interdisciplinary Team members: Reeducation and reinforcement that the Comprehensive Patient Assessment and Plan of Care must include evaluation of nutritional parameters/status by a qualified Dietician including but not limited to: Nutritional status, Hydration status, Metabolic parameters -such as glycemic control (if diabetic) and cardiovascular health, Anthropometric data such as height, weight, weight history, weight changes, volume status, amputations. Appetite and Intake, Ability to chew and swallow, Gastrointestinal issues, Use of prescribed and over the counter nutritional, dietary, or herbal supplements, Previous diets and/or nutritional education, Route of nutrition, Self</p>	09/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2014
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	<p>Report" with an entry signed and dated by the registered nurse, employee C, that states, "Patient here as scheduled."</p> <p>4. The Medical Director indicated, on 8-21-14 at 2:10 PM, he was aware there was a problem with dietary services. The Medical Director stated, "[The lead dietitian] has been monitoring the situation."</p> <p>5. The Registered Dietitian indicated, on 8-20-14 at 1:20 PM, that she works 20 hours per week in the facility and does not provide services to patients at any other facility.</p> <p>The clinic manager indicated, on 8-21-14 at 11:20 AM, the dietitian did work 20 hours per week and was free to adjust her schedule to meet the needs of the patients. The manager stated, "We expect her to meet the needs of the patients."</p> <p>5. The facility's 7-4-12 "Nutrition Services" policy number FMS-CS-IC-I-111-001A states, "The Registered Dietitian (RD) is responsible for evaluation the nutrition status of and providing ongoing individualized counseling services to all patients admitted to an FMS Incenter and Home Therapies programs with goal of assisting</p>		<p>management skills, Attitude to nutrition, health and well being and Motivation to make changes to meet nutrition and other health goals.Reeducation and reinforcement that other members of the Interdisciplinary Team may contribute to portions of the Nutritional AssessmentReeducation and reinforcement of each team member's responsibility to complete all required sections of the comprehensive assessments and develop or revise the patient plan of care within the required time lines as outlined in the Federal Regulations:Reeducation and reinforcement on FMC Comprehensive Patient Assessment and Plan of Care policy # FMS-CS-IC-I-110-125A outlining the responsibilities of the qualified Dietician in the Comprehensive Patient Assessment.</p> <p>A copy of the educational agenda and attendance sheet is available for review at the facility.To ensure that reoccurrence of this deficiency will not occur, the Clinical Manager reviews each completed CIA and PoC prior to filing in the patient record. The Clinical Manager maintains a tickler file which identifies the due dates for patient CIA's and PoC's. In the event that noncompliance is identified, the Clinical Manager will communicate concerns directly to the Medical Director and Director of</p>		

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V000625	<p>each patient in achieving and sustaining an effective nutritional status . . . The services of the facility dietitian shall be made available to all patients of this dialysis facility, both in-center and home patients (where a Home Program exists), on admission and on an ongoing basis."</p> <p>494.110 CFC-QAPI</p> <p>Based on quality assessment and performance improvement (QAPI) documentation and facility policy review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure its QAPI program addressed water quality and preventative maintenance reviews in 1 of 5 months reviewed and failed to ensure the program addressed transplant referral rates in 2 of 5 months reviewed creating the potential to affect all of the facility's 57 current patients (See V 626); by failing to ensure performance improvement plans had been developed, implemented, and revised to address identified areas with a need for improvement in 5 of 5 months reviewed</p>	V000625	<p>Operations. Additionally, the Clinical Manager will formalize a report for the monthly QAI meeting, detailing compliance gaps, and corrective actions implemented to correct any identified deficiencies. The committee reviews areas of non-compliance, interventions taken and evaluates to determine if further action is required. The QAI meeting minutes document this activity and are available for review at the facility. The Clinical Manager is responsible and the QAI committee monitor for compliance</p> <p>As a result of the citations from the August 26, 2014, survey and as is the commitment of the Medical Director as the head of the Quality Assessment Improvement Program to ensure the that the program reflects the complexity of the dialysis Facility's organization, immediately following the exit interview the Director of Operations consulted with the Medical Director and as a result determined to:</p> <ul style="list-style-type: none"> ¿ Review the requirements of the facility's QAI program. Re-educate the facility Quality Assessment and Performance Improvement Team inclusive of all facility staff on the requirements to improve health outcomes and the prevention/reduction of medical errors. Please refer to V 626 ¿ Review the requirements of the facility's QAI program. Re-educate the facility Quality Assessment and Performance Improvement Team of the requirement to develop, implement and revise to address areas with a need for improvement. Please refer to V 638 ¿ Reinforce the need to prioritize performance improvement plans to address identified areas in need of improvement. Please refer to V 639 <p>To ensure ongoing compliance, the Medical Director mandated that a copy of the QAI meeting documentation be prepared for his review and approval within one week of the conducted meeting. The Medical Director will review the submitted documentation for inclusion and accuracy of discussions related to issues, action plan revision and any other pertinent information. The subsequent meeting will open with the Medical Director stating any necessary revisions or approval of the submitted meeting minutes.</p>	09/23/2014

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V000626	<p>creating the potential to affect all of the facility's 57 current patients (See V 638); and by failing to prioritize performance improvement plans to address identified areas with a need for improvement in 5 of 5 months reviewed creating the potential to affect all of the facility's 57 current patients (See V 639).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.110 Quality Assessment and Performance Improvement.</p> <p>494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and</p>		The Clinical Manager is responsible to ensure the documentation QAI meeting minutes and the Medical Director will monitor for compliance	

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	<p>performance improvement program for review by CMS.</p> <p>Based on quality assessment and performance improvement (QAPI) documentation and facility policy review and interview, the facility failed to ensure its QAPI program addressed water quality and preventative maintenance reviews in 1 (July 2014) of 5 months reviewed and failed to ensure the program addressed transplant referral rates in 2 (June and July 2014) of 5 months reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's July 7-17-14 QAPI meeting minutes failed to evidence the committee had reviewed the water quality and preventative maintenance data. 2. The facility's 6-19-14 and 7-17-14 meeting minutes failed to evidence the committee had reviewed the transplant referral rate data. 3. The clinic manager indicated, on 8-26-14 at 3:00 PM, meeting minutes did not reflect that water quality and preventative maintenance had been reviewed on 7-17-14. The manager stated, "I guess he didn't give it to me." 	V000626	<p>As a result of the citations from the August 26, 2014 survey and as is the commitment of the Medical Director as the head of the Quality Assessment Improvement Program to ensure the QAPI committee provided effective quality assessment and performance activities that identified, prioritized and corrected major problems, the Medical Director has implemented the following actions: On September 9, 2014 the Director of Operations met with facility staff inclusive of the members of the facility QAPI committee, to reeducate and reinforce to each committee member their responsibility to fully participate with all requirements of the facility QAPI program. To ensure that all staff understands the facility's QAI program, the Director of Operations contacted the Regional Quality Manager and arranged for the formal reeducation of all staff to be completed no later September 18, 2014. This reeducation was inclusive of the following facility policies and procedures: Quality Assessment and Performance Improvement Program (QAPI) Policy FMS-CS-IC-I-101-001A with emphasis on: oWater Quality and Preventive Maintenance oIn addition, the Regional Technical Operations Manager (RTOM) will</p>	09/23/2014

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	<p>The manager indicated further the 6-19-14 and 7-17-14 did not reflect a review of the facility's transplant referral data.</p> <p>4. The facility's 4-4-12 "Quality Assessment and Performance Improvement Program (QAPI)" policy number FMS-CS-IC-I-101-001A states, "Elements to be reviewed in the QAI meeting include: Patient Care Outcomes . . . Technical Operations, including water and dialysate quality and safety, and safe machine maintenance."</p>		<p>implement an electronic process for getting information to CM prior to QAI for all water quality and preventative maintenance documentation.assembled on 9/9/14 and agrees with plan.To establish and maintain compliance the Clinical Manager will post QAI action plans on the board outside of Clinical Manager office after each QAI meeting. The board will be updated monthly and a review of the monthly QAI activity will be discussed at the monthly staff meetings</p> <p>Transplant education and preference will be monitored by CM and briefed at monthly QAI. HT department will provide information to CM regarding home patients prior to QAI. Governing Body was assembled on 9/9/14 and agrees with plan.To establish and maintain compliance the Clinical Manager will post QAI action plans on the board outside of Clinical Manager office after each QAI meeting. The board will be updated monthly and a review of the monthly QAI activity will be discussed at the monthly staff meetings</p> <p>The facility Clinical Manager will present the action plan along with any revisions at each monthly QAI meeting revising the plan monthly until the facility goals are metTo ensure the QAI committee prioritizes improvement and as part of the developed plan of</p>	

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V000638	<p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. Based on quality assessment and performance improvement (QAPI) document and facility policy review and interview, the facility failed to ensure performance improvement plans had been developed, implemented, and revised to address identified areas with a need for improvement in 5 (February</p>	V000638	<p>correction, the Governing Body has determined to review QAI activities monthly until full resolution of the implemented corrective processes is verified and quarterly thereafter. To ensure that expected compliance is achieved as outlined in the developed plan of correction, the Governing Body determined that the Clinical Manager will formalize a report for the scheduled Governing Body meeting detailing compliance gaps, action taken to correct deficiencies. If sufficient progress to correct the identified deficiencies in not met, the Governing Body directs the revision of the action plan until resolution is achieved. The Clinical Manager is responsible and the QAI committee monitors for compliance.</p> <p>As a result of the citations from the August 26, 2014 survey and as is the commitment of the Medical Director as the head of the Quality Assessment Improvement Program to ensure the QAPI committee provided effective quality assessment and performance activities that identified, prioritized and corrected major problems, the Medical Director has implemented the following actions: On September 9, 2014 the Director of Operations met with facility staff inclusive of the members of the facility QAPI committee, to reeducate and reinforce to each committee member their responsibility to fully participate with all requirements of the facility QAPI program To ensure that all staff understands the facility's QAI program, the Director of Operations contacted the</p>	09/23/2014	

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	<p>through July 2014) of 5 months reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's QAPI cumulative results documentation (in the form of a graph with data for January 2014 through July 2014) evidenced 38.9% of the facility's patients had an albumin level greater than 4.0 grams per deciliter (g/dL) in May of 2014, 34.6% in June 2014, and 30.2% in July 2014. The documentation failed to evidence the facility had investigated root causes and had developed, implemented, and monitored a plan to address the declining percentage of patients with an albumin of greater than 4.0 g/dL. The QAPI cumulative results documentation (January 2014 through July 2014) evidenced 88.7% of the facility's patients had an adequacy value of greater than the desired 1.2 according to the Centers for Medicare and Medicaid Services Measures Assessment Tool. The documentation evidenced 88.5 % in June of 2014 and 81.1% in July 2014. <p>The documentation included a performance improvement plan dated 6-19-14 for adequacy that states, "Adequacy dropped to 88%. Action</p>		<p>Regional Quality Manager and arranged for the formal reeducation of all staff to be completed no later September 18, 2014. This reeducation was inclusive of the following facility policies and procedures</p> <p>∩</p> <p>Quality Assessment and Performance Improvement Program (QAPI) Policy FMS-CS-IC-1-101-001A with emphasis on:</p> <ul style="list-style-type: none"> o Monitoring and Tracking o Performance Improvement Plans o <p>As a result of this education, the QAI committee developed action plans to specifically address the following indicators:</p> <ul style="list-style-type: none"> ∩ Decreasing albumin percentages ∩ Decreasing adequacy percentages <p>To establish and maintain compliance the Clinical Manager will post QAI action plans on the board outside of the Clinical Manager office after each QAI meeting. The board will be updated monthly and a review of the monthly QAI activity will be discussed at the monthly staff meetings</p> <p>The facility Clinical Manager will present the action plan along with any revisions at each monthly QAI meeting revising the plan monthly until the facility goals are met</p> <p>To ensure the QAI committee prioritizes improvement and as part of the developed plan of correction, the Governing Body has determined to review QAI activities monthly until full resolution of the implemented corrective processes is verified and quarterly thereafter.</p> <p>To ensure that expected compliance is achieved as outlined in the developed plan of correction, the Governing Body determined that the Clinical Manager will formalize a report for the scheduled Governing Body meeting detailing compliance gaps, action taken to correct deficiencies. If sufficient progress to correct the identified deficiencies in not met, the Governing Body directs the revision of the action plan until resolution is achieved</p> <p>The Clinical Manager is responsible and the QAI committee monitors for compliance</p> <p>Root Cause Analysis</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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V000639	<p>plan/Goal: staff to be assigned on lab draw day to ensure that labs are drawn correctly, pt [patient] has a green light during treatment." The documentation failed to evidence any investigation of root causes and updates to the plan to address any identified causes.</p> <p>3. The clinic manager was unable to provide any additional documentation and/or information when asked on 8-26-14 at 3:00 PM.</p> <p>4. The facility's 4-4-12 "Quality Assessment and Performance Improvement (QAPI)" policy number FMS-CS-IC-I-101-001A states, "QAI Program activities for each facility or program include: . . . Review of aggregate patient data by modality to identify opportunities for improvement for clinical outcomes, and track progress by: Evaluating clinical indicators monthly Identify commonalities among patients who do not reach the minimum expected patient targets, Develop a plan to address those causes, Implement the plan, Monitor the effectiveness of the plan, Adjust portions of the plan that are not successful."</p> <p>494.110(c) QAPI-PRIORITIZING IMPROVEMENT ACTIVITIES</p>			

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	<p>The dialysis facility must set priorities for performance improvement, considering prevalence and severity of identified problems and giving priority to improvement activities that affect clinical outcomes or patient safety.</p> <p>Based on quality assessment and performance improvement (QAPI) document and facility policy review and interview, the facility failed to prioritize performance improvement plans to address identified areas with a need for improvement in 5 (February through July 2014) of 5 months reviewed creating the potential to affect all of the facility's 57 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's QAPI documentation evidenced the 38.9% of the facility's patients had an albumin level greater than 4.0 grams per deciliter (g/dL) in May of 2014, 34.6% in June 2014, and 30.2% in July 2014. The documentation failed to evidence the facility had investigated root causes and had developed, implemented, and monitored a plan to address the declining percentage of patients with an albumin of greater than 4.0 g/dL. The QAPI documentation evidenced 88.7% of the facility's patients had an adequacy value of greater than the desired 1.2 according to the Centers for 	V000639	<p>As a result of the citations from the August 26, 2014 survey and as is the commitment of the Medical Director as the head of the Quality Assessment Improvement Program to ensure the QAPI committee provided effective quality assessment and performance activities that identified, prioritized and corrected major problems, the Medical Director has implemented the following actions:</p> <p>On September 9, 2014 the Director of Operations met with facility staff inclusive of the members of the facility QAPI committee, to reeducate and reinforce to each committee member their responsibility to fully participate with all requirements f the facility QAPI program.</p> <p>To ensure that all staff understands the facility's QAI program, the Director of Operations contacted the Regional Quality Manager and arranged for the formal reeducation of all staff to be completed no later September 18, 2014. This reeducation was inclusive of the following facility policies and procedures</p> <ul style="list-style-type: none"> ¿ Quality Assessment and Performance Improvement Program (QAPI) Policy FMS-CS-IC-I-101-001A with emphasis on: <ul style="list-style-type: none"> o Monitoring and Tracking o Performance Improvement Plans o Root Cause Analysis <p>As a result of this education, the QAI committee developed action plans to specifically address the following indicators:</p> <ul style="list-style-type: none"> ¿ Decreasing albumin percentages ¿ Decreasing adequacy percentages <p>To establish and maintain compliance the Clinical Manager will post QAI action plans on the board outside of the Clinical Manager office after each QAI meeting. The board will be updated monthly and a review of the monthly QAI activity will be discussed at the monthly staff meetings</p> <p>The facility Clinical Manager will present the action plan along with any revisions at each monthly QAI meeting revising the plan monthly until the facility goals are met</p> <p>To ensure the QAI committee prioritizes improvement and as part of the developed plan of correction, the Governing Body has determined to review QAI activities monthly until full resolution of the implemented corrective processes is verified and quarterly thereafter.</p> <p>To ensure that expected compliance is achieved as outlined in the developed plan of correction, the Governing Body determined that the Clinical Manager will formalize a report for the scheduled Governing</p>	09/23/2014

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	<p>Medicare and Medicaid Services Measures Assessment Tool. The documentation evidenced 88.5 % in June of 2014 and 81.1% in July 2014.</p> <p>The documentation included a performance improvement plan dated 6-19-14 for adequacy that states, "adequacy dropped to 88%. Action plan/Goal: staff to be assigned on lab draw day to ensure that labs are drawn correctly, pt [patient] has a green light during treatment." The documentation failed to evidence any investigation of root causes and updates to the plan to address any identified causes.</p> <p>3. The clinic manager was unable to provide any additional documentation and/or information when asked on 8-26-14 at 3:00 PM.</p> <p>4. The facility's 4-4-12 "Quality Assessment and Performance Improvement (QAPI)" policy number FMS-CS-IC-I-101-001A states, "QAI Program activities for each facility or program include: . . . Review of aggregate patient data by modality to identify opportunities for improvement for clinical outcomes, and track progress by: Evaluating clinical indicators monthly Identify commonalities among patients who do not reach the</p>		<p>Body meeting detailing compliance gaps, action taken to correct deficiencies. If sufficient progress to correct the identified deficiencies in not met, the Governing Body directs the revision of the action plan until resolution is achieved The Clinical Manager is responsible and the QAI committee monitors for compliance</p>	

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V000715	<p>minimum expected patient targets, Develop a plan to address those causes, Implement the plan, Monitor the effectiveness of the plan, Adjust portions of the plan that are not successful."</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 clinical record and facility policy review and interview, the medical director failed to ensure patients had been monitored at least every 30 minutes in accordance with facility policy in 3 (#s 1, 3, and 5) of 5 incenter patient records reviewed creating the potential to affect all of the facility's 48 current incenter patients.</p> <p>The findings include:</p> <p>1. The facility's 7-4-12 "Patient Monitoring During Patient Treatment" policy number FMS-CS-IC-I-110-133A states, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as</p>	V000715	<p>The Medical Director of this facility takes seriously his responsibility to ensure that facility policy and procedures are adhered to by all facility staff. As such, the Medical Director participated in the development and implementation of the corrective actions through the actions of the Governing Body documented in the meeting minutes to ensure compliance to the following: FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy To prevent reoccurrence and to monitor compliance monitoring the following has been implemented: \checkmark RN Team Leader is responsible to will review each patient's treatment sheet to</p>	09/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/26/2014	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713			
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	<p>necessary."</p> <p>2. Clinical record number 1 included hemodialysis treatment sheets that evidenced the patient had not been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 7-23-14 evidenced the patient had been checked at 10:54 AM and not again until 11:58 AM, a period of 1 hour and 4 minutes between checks. The flow sheet evidenced the patient was not checked again until 1:08 PM, a period of 1 hour and 10 minutes between checks.</p> <p>B. A treatment flow sheet dated 7-28-14 evidenced the patient had been checked at 2:03 PM and not again until 3:14 PM, a period of 1 hour and 11 minutes between checks.</p> <p>C. A treatment flow sheet dated 8-11-14 evidenced the patient had been checked at 1:00 PM and not again until 1:42 PM, a period of 42 minutes between checks.</p> <p>D. A treatment flow sheet dated 8-13-14 evidenced the patient had been checked at 11:14 AM and not again until 12:33 PM, a period of 1 hour and 19 minutes.</p>		<p>assure compliance. Staff members identified as failing to comply with the implemented process will receive immediate intervention by the nurse providing oversight and/or the Clinical Manager. The Clinical Manager reports findings of audits and any non-compliance with reference to the process at the monthly QAI meeting. The QAI Committee will address any variance to the required process by identifying the root cause and developing and implementing a corrective action plan to resolution of the issue. The Clinical Manager will document all findings and actions in the QAI minutes. The QAI minutes will be available for review at the facility. The Clinical Manager is responsible and the QAI Committee will monitor for compliance</p>				

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	<p>E. A treatment flow sheet dated 8-15-14 evidenced the patient had been checked at 11:22 AM and not again until 12:35 PM, a period of 1 hour and 13 minutes.</p> <p>F. A treatment flow sheet dated 8-18-14 evidenced the patient had been checked at 12:02 PM and not again until 12:44 PM, a period of 42 minutes between treatment checks.</p> <p>3. Clinical record number 3 included hemodialysis treatment sheets that evidenced the patient had not been monitored at least every 30 minutes.</p> <p>A. A treatment flow sheet dated 8-2-14 evidenced the patient had been checked at 7:58 AM and not again until 8:44 AM, a period of 46 minutes between treatment checks.</p> <p>B. A treatment flow sheet dated 8-9-14 evidenced the patient had been checked at 11:52 AM and not again until 12:35 PM, a period of 43 minutes between treatment checks.</p> <p>4. Clinical record number 5 included hemodialysis treatment flow sheets that evidenced the patient had not been monitored at least every 30 minutes.</p>			

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	<p>A. A flow sheet dated 7-30-14 evidenced the patient had been checked at 9:32 AM. The flow sheet failed to evidence any further checks had been completed. The flow sheet evidenced the patient's treatment ended at 10:23 AM.</p> <p>B. A flow sheet dated 8-4-14 evidenced the patient had been checked at 7:27 AM and not again until 8:21 AM, a period of 54 minutes between treatment checks.</p> <p>5. The clinic manager stated, on 8-26-14 at 2:10 PM, "I thought we had up to 45 minutes between checks."</p>				