

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152564	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2012
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NAME OF PROVIDER OR SUPPLIER  EAST CHICAGO DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1207-19 E CHICAGO AVE EAST CHICAGO, IN 46312
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 8/20/12 through 8/22/12</p> <p>Facility #: 002414</p> <p>Medicaid Vendor #: 200259750A</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor - team leader Ingrid Miller, RN, BSN, Public Health Nurse Surveyor - team member</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 73 Number of Peritoneal Dialysis Patients: 1</p> <p>Total: 74</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">August 28, 2012</p>	V0000		

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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V0111	<p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>Based on observation, interview, and review of policies, the facility failed to ensure the bleach solutions for clean use and dirty use were covered with opaque container lids for 2 of 5 observations with the potential to affect all of the facility's 74 patients.</p> <p>Findings</p> <p>1. The facility policy titled "Cleaning and disinfection" with a effective date of 1/4/12 stated, "Bleach solution will be stored in labeled covered opaque containers to prevent disintegration of the chemical (sodium hypochlorite) when exposed to sunlight and air."</p> <p>2. At 2 of 5 observations, the bleach containers lids were not in place.</p> <p>a. On 8/22/12 at 9:50 AM - 10:20 AM, on the left side of the dialysis treatment room, two containers of bleach solutions were observed to be placed on a work table with cellophane tape separating the right and left sides of this table. Both containers had the lids off the</p>	V0111	<p>By 09/21/12 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-110A Cleaning and Disinfection Policy with emphasis on proper storage of bleach solution in opaque covered containers to prevent disintegration of the chemical when exposed to sunlight and air. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee will perform Infection Control audits according to QAI calendar and immediately follow up if issues are identified. The Clinical Manager will report all findings including disciplinary action to Medical Director and QAI Committee during monthly QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure bleach solutions for clean use</p>	09/21/2012			

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	<p>top of the containers. One container on the left side of the table was labeled "clean bleach 1:100" and labeled with the date of 8/22/12 5:00 AM with the initials "VJ." The other similar container was observed on the right side of the table. This container was labeled "dirty bleach 1:100" and was labeled with the date of 8/22/12 and time of 5:00 AM with the initials "VJ."</p> <p>b. On 8/22/12 at 11:30 AM - 11:40 AM, the lid of the clean container of bleach solution mentioned above in #2 a. was observed to have the lid off the container.</p> <p>3. On 8/22/12 at 9:50 AM, Employee B, a patient care technician, indicated the left side of the table was the clean side and the right side of the table was the dirty side and the cellophane tape placed down the center divided these two sides.</p> <p>4. On 8/22/12 at 12:50 PM, Employee A, the administrator, indicated the lids were to be kept on the clean and dirty bleach containers.</p>		and dirty use are covered with opaque container lids as required.				

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V0117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation and interview, the facility failed to ensure the conductivity meter was kept on the clean side of the work table in 3 of 5 observations with the potential to affect all of the facility's 74 patients.</p> <p>The findings</p> <p>1. For 3 of 5 observations, the conductivity meter was found to be on the dirty side of a work table.</p>	V0117	By 09/21/12 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-070A Dialysis Precautions with emphasis on designated dirty areas for used equipment, phoenix meter use procedure including storage when not in use by dirty sink, and transporting specimens to the phoenix meter for dialysate testing. The meeting agenda and attendance records will be available for review at the facility.	09/21/2012	

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	<p>a. On 8/21/12 at 10:15 AM - 10:30 AM, two hydrometers or conductivity meters were observed resting on the right side (dirty side) of the work table in front of the window on the left side of the dialysis treatment room. A piece of cellophane tape divided this table into a right side and a left side.</p> <p>b. On 8/22/12 at 10:30 AM, Employee C, a patient care technician, indicated both meters had been cleaned and were on the dirty side of the work table.</p> <p>c. On 8/22/12 at 9:50 AM - 10:20 AM, one conductivity meter was observed to be on the dirty side of the work table.</p> <p>d. On 8/22/12 at 9:50 AM, Employee B, a patient care technician, indicated the left side of the table was the clean side and the right side of the table was the dirty side and the cellophane tape placed down the center divided these two sides.</p> <p>e. On 8/22/12 at 11:30 AM - 11:40 AM one conductivity meter was observed on the dirty side of the table.</p> <p>2. On 8/22/12 at 6 PM, Employee A indicated the conductivity meter should</p>		The Clinical Manager or designee will continue to perform Infection Control audits according to QAI calendar and immediately follow up if issues are identified. The Clinical Manager will report all findings including disciplinary action to Medical Director and QAI Committee during monthly QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure the conductivity meter is stored as required.		

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	be on the clean side of the work table.			

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V0239	<p>494.40(a) BICARB CONC DISTRIB-WKLY DISINFECT/DWELL/CONC 5.5.4 Bicarbonate concentrate distribution systems: weekly disinfection/dwell times/conc Bicarbonate concentrate delivery systems should be disinfected on a regular basis to ensure that the dialysate routinely achieves the level of bacteriological purity [required by these regulations].</p> <p>For piped distribution systems, the entire system, including patient station ports, should be purged of bicarbonate concentrate before disinfection. Each patient station port should be opened and flushed with disinfectant and then rinsed; otherwise, it would be a "dead leg" in the system.</p> <p>Appropriate dwell times and concentrations should be used as recommended by the manufacturer of the concentrate system. If this information is not available, bleach may be used at a dilution of 1:100 and proprietary disinfectants at the concentration recommended by the manufacturer for disinfecting piping systems.</p> <p>6.5 Concentrate distribution: The interval between disinfection should not exceed 1 week. If the manufacturer does not supply disinfection procedures, the user must develop and validate a disinfection protocol.</p> <p>Based on interview and review of facility logs and policy, the facility failed to ensure documentation evidenced weekly disinfection of the bicarbonate mixing system had been completed for 1 of 3 weeks of disinfection reviewed for the</p>	V0239	By 09/21/12 the Clinical Manager will meet with direct patient care staff to review and reinforce 153-030-017 Disinfection Standards for Equipment (Solution Delivery System Requirements if Bleach is used	09/21/2012			

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	<p>month of August 2012.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The bicarbonate logs for August titled "Solution Delivery System Log," subtitled "Bicarbonate Mixing System" evidenced the last time the mixer and solution delivery system (SDS) was disinfected was August 9, 2012.</li> <li>2. At 3:25 PM on August 21, 2012, employee D indicated the mixing system was disinfected by her during the monthly disinfection on August 12, 2012, and that the SDS was disinfected on a weekly basis, usually on Thursdays by a patient care technician and was last due on August 16, 2012. Employee D indicated she was unable to find documentation the the SDS was disinfected since August 9, 2012.</li> <li>3. Facility policy titled "Disinfection Standards For Equipment," subtitle, "Solution Delivery System Requirements if Bleach is used as the Disinfectant" dated 04-04-07 and provided by employee D on August 22, 2012, at 5:20 PM, stated, "The frequency of bleach disinfection ... at least once a week at the end of the treatment day."</li> </ol>		<p>as Disinfectant) Policy with emphasis on the frequency of bleach disinfection for SDS system will be at least once a week at the end of the treatment day and records of bleach disinfection operations will be maintained on the SDS-1 Log. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager and/or the Biomedical Technician will audit SDS-1 Log for completeness and accuracy following weekly bleach disinfection of the SDS system. Audit findings and actions taken will be reported to the Medical Director and QAI Committee during monthly QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure documentation evidencing weekly disinfection of the bicarbonate mixing system has been completed as required.</p>		

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V0517	<p>494.80(b)(2) PA-F/U REASSESSMENT-WITHIN 3 MO OF INITIAL A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. Based on clinical record and policy review and staff interview, the facility failed to ensure a follow up comprehensive assessment was conducted within 3 months of the initial assessment in 1 of 7 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 6 evidenced the patient's initial comprehensive assessment was conducted on January 30, 2012. The record evidenced the patient was hospitalized April 2 through the 8, 2012, and again on April 25, 2012, and discharged 4/26/12. The record evidenced the patient was not hospitalized and did not miss treatments between April 26 and May 24, 2012, and the follow up comprehensive assessment was not completed until May 24, 2012.</li> <li>2. At 3:30 PM on August 22, 2012, employee A indicated the assessment was not completed timely.</li> <li>3. The facility's policy titled</li> </ol>	V0517	<p>By 09/21/12 the Clinical Manager will meet with the interdisciplinary team to review and reinforce FMS-CS-IC-I-110-125A Comprehensive Patient Assessment (CIA) and Plan of Care (POC) Policy with emphasis on:</p> <ul style="list-style-type: none"> <li>·Assessment must be conducted on all new patients and a plan of care developed and implemented within the later of 30 calendar days or 13 outpatient Hemodialysis sessions beginning with the first outpatient dialysis session.</li> <li>·A follow up comprehensive interdisciplinary assessment must occur on all new patients within 3 months after the completion of the initial assessment to adjust the patient's Plan of Care as appropriate or if necessary. The Plan of Care must be updated and implemented with in 15 days of reassessment.</li> <li>·Frequency of patient assessment and plan of care as determined by findings and whether the patient is determined to be stable or unstable; at least annually for stable patients</li> </ul>	09/21/2012	

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	"Comprehensive Interdisciplinary Assessment and Care Plan," effective date July 4, 2012, stated, "Role of the Interdisciplinary Team ... Within 3 months of the completion of the initial comprehensive assessment, the interdisciplinary team working collaboratively will: Reassess the patient to evaluate the criteria listed above. Modify the patient's treatment plan as appropriate."		The meeting agenda and attendance records will be available for review at the facility.  The Clinical Manager or designee will perform Medical Record audits per the QAI Calendar including verifying that patient assessments are completed at the required frequency by all team members. The Clinical Manager will immediately address identified issues. Audit findings and actions taken will be reported to the Medical Director and QAI Committee during monthly QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure that the follow up comprehensive assessment is completed with 3 months after the completion of the initial assessment.		

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V0726	<p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. Based on interview and policy and clinical record review, the dialysis clinic failed to ensure the patient records were complete and accurate for 2 of 7 clinical records reviewed and with the potential to affect all 74 current patients that receive services from the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2 identified the patient was hospitalized with seizures from July 19 through July 26, 2012. The record evidenced a physician summary titled "In-Center Hemodialysis Progress Note" signed by the medical director, dated 7/20/12, that stated, "BP's [blood pressure is] OK, no fluid overload, HR reg [heart rate regular] No edema," The patient was in the hospital when assessed by employee E.</li> <li>Clinical record 6 evidenced the patient was a chronic no show for scheduled dialysis treatments and missed dialysis 3</li> </ol>	V0726	<p>By 09/21/12 the Clinical Manager and Director of Operations will meet with the Medical Director and review policy FMS-CS-IC-1-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care with emphasis on at a minimum, monthly medical progress notes (<b>which denote the site of the visit</b>) must be in every patients medical record that document that a physician or a non-physician practitioner has seen each patient. In addition the Medical Director was notified on 08/24/12 that the date on the IN CENTER HEMODIALYSIS PROGRESS NOTE must be consistent with patient encounter date. The Clinical Manager or designee will perform Medical Record audits per the QAI Calendar including verifying that monthly physician progress notes are completed at the required frequency and when the patient is present in the facility as required. The Clinical Manager will immediately address identified</p>	09/21/2012			

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	<p>times in July 2012 on July 5, 9, and 13. The record evidenced the patient did receive dialysis on 7/19/12. The clinical record evidenced a document titled "In-Center Hemodialysis Progress Note" signed by the medical director, dated 7/20/12, that stated, "No edema, clear lungs, AVG [arteriovenous graft] free of infection." The record failed to evidence the patient was in the facility for any type of treatment on July 20, 2012.</p> <p>3. On August 22, 2012, at 6 PM, employee E, the medical director, indicated that he frequently documents outside the center, off site, and the dates of the summaries is the date he wrote the summary. He confirmed the summary for patient 6 dated 7/20/12 did contain an assessment and was the assessment was for the last time he saw the patient, not necessarily the date of the document. He indicated his usual practice was to visit the clinic once to twice a day and to document when he actually assessed the patient on another form, and he did not always have access to the form. He acknowledged the actual date of assessment was not clear.</p> <p>4. The facility's policy titled "Comprehensive Interdisciplinary Assessment and Care Plan," effective date July 4, 2012, stated, "Frequency of Patient</p>		<p>issues. Audit findings and actions taken will be reported to the Medical Director, Director of Operations and QAI Committee during monthly QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager and Medical Director are responsible and the QAI Committee monitors to ensure that patient records are completed and accurate.</p>		

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	<p>Visits by the physician or physician extender. The dialysis facility must ensure that all in-center patients are seen by a medical practitioner, (i.e., physician,, advanced practice registered nurse, or physician's assistant) providing ESRD care at least monthly. ... At a minimum, monthly medical progress notes (which denote the site of the visit) must be in every patent's medical record that document that a physician or a non physician practitioner has seen each patient."</p>			