

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2014
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NAME OF PROVIDER OR SUPPLIER DAVISS COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 310 NE 14TH ST WASHINGTON, IN 47501
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V000000	This was a Federal ESRD [CORE] recertification survey. Survey Dates: 11-18-14, 11-19-14, and 11-20-14 Facility #: 002590 Medicaid Vendor #: 200521770A Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN November 24, 2014	V000000		
V000113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on facility policy review, observation, and interview, the facility failed to ensure staff had changed gloves and cleansed hands appropriately in 3 (#s 3, 4, and 5) of 9 infection control observations completed creating the potential to affect all of the facility's 46 current patients. (Employees H, I, and D) The findings include:	V000113	Facility Administrator (FA) will hold mandatory in-service for all clinical Teammates (TMs) by 12/11/2014. In-service will include but will not be limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, emphasizing 1) TMs must wear disposable gloves appropriately when caring for the patient or touching the patient's equipment at the dialysis station;	12/20/2014

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>1. Employee H, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 6 on 11-19-14 at 1:35 PM. The patient was observed to have an arteriovenous fistula (AVF) in the right lower arm. The PCT cleansed both the arteriole and venous needle insertion sites with an alcohol prep pad and a Betadine prep pad. The PCT was observed to remove her gloves and cleanse her hands. The PCT then drew up heparin into a syringe for the maintenance heparin dose to be administered throughout the treatment. The PCT was observed to retrieve laboratory sample tubes from a plastic bag and open packages of gauze. The PCT then donned clean gloves without cleansing her hands.</p> <p>A. The PCT placed the heparin filled syringe into the dialysis machine and adjusted the tubing. The PCT then touched the arteriole needle insertion site, and, without cleansing the site again after touching it, placed the needle into the site. The PCT then obtained a blood sample from the arteriole site. The PCT removed the glove from her right hand and donned a clean glove onto the right hand without cleansing her right hand. The PCT then inserted the venous site needle.</p>		<p>2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station; 3) Once cannulation site has been cleaned it must not be touched, otherwise area must be cleaned per policy prior to cannulation; 4) TMs must remove gloves and perform hand hygiene before entering clean supply storage; 5) TMs must conduct hand hygiene before and after documenting on keyboards; 6) TMs must perform hand hygiene every time gloves removed; 7) TMs must instruct and encourage patients every treatment to perform hand hygiene upon entering the treatment floor; and perform hand hygiene prior to leaving the unit after glove removal, and prior to touching any clean supply or area to assist in avoiding the risk of cross contamination. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct infection control audits daily x 1 week, weekly x4 weeks, then monthly. FA will review audit results with Medical Director during monthly Facility Health Meeting (FHM), continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes. FA is responsible for compliance with this plan of correction Completion</p>		

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	<p>B. After inserting the venous site needle, the PCT removed her gloves and cleansed her hands. She entered data into the system on the data entry keyboard at the station. The PCT then donned clean gloves without cleansing her hands. The PCT then connected the tubing to the patient and initiated the treatment.</p> <p>2. On 11-18-14 at 1:45 PM, observation noted patient number 7 holding gauze over the needle insertion sites after the needles had been removed from the access on the left arm. The patient was observed to be wearing a glove on the right hand while holding the sites. After the bleeding had stopped, and the PCT, employee I, had applied clean gauze and tape to the insertions sites, the patient was observed to remove the glove from the right hand. The patient then departed the facility without cleansing the hands. The PCT was not observed to remind the patient to cleanse the hands prior to leaving the facility.</p> <p>3. On 11-18-14 at 2:05 PM, observation noted patient number 5 holding gauze over the needle insertion sites after the needles had been removed from the access on the left arm. The patient was observed to be wearing a glove on the right hand while holding the sites. After</p>		Date: 12/20/2014				

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	<p>the bleeding had stopped, and the Facility Administrator (FA), employee D, a registered nurse, had applied clean gauze and tape to the sites, the patient was observed to remove the glove from the right hand. The patient departed the facility without cleansing the hands. The FA was not observed to remind the patient to cleanse the hands prior to leaving the facility.</p> <p>4. The above-stated observations were discussed with the FA on 11-20-14 at 1:20 PM. The FA indicated the employees had not provided care in accordance with facility infection control policies and procedures.</p> <p>5. The facility's September 2014 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area . . . Patients are encouraged to wash their hands and access extremity upon entering the treatment area prior to initiation of</p>			

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V000117	<p>dialysis and wash their hands after treatment before leaving the treatment area."</p> <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 facility policy review, observation, and interview, the facility failed to ensure the registered nurse (RN) delivered medications in a safe and aseptic manner in 1 (# 1) of 2 medication administration observations completed creating the potential to affect all of the facility's 46 current patients. (Employee</p>	V000117	FA to hold mandatory in-service for all clinical TMs on 12/11/2014 reviewing Policy & Procedure #1-06-01: Medication Policy emphasizing TMs must utilize aseptic technique when administering medications. TMs must distribute and administer medications to 1 patient at a time. Verification of	12/20/2014

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	<p>A)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee A, a RN, was observed to administer medications to patients numbered 7 and 8. The RN prepared 2 medications for patient number 7 and 4 for patient number 8 at the medication preparation area. The RN was then observed to take both patients' medications to stations numbered 1 and 2 and place them on the data entry cart between the stations. The RN administered the 2 medications to patient number 7, removed her gloves and cleansed her hands, and then administered the 4 medications to patient number 8. The above-stated observations were discussed with the Facility Administrator (FA) and the Clinical Services Specialist (CSS) on 11-20-14 at 1:20 PM. The FA indicated the employee had not provided care in accordance with facility policies and procedures. The CSS indicated the nurses were taught to take only one patient's medications to the station at a time. The facility's September 2013 "Medication Policy" number 1-06-01 states, "All teammates administering 		<p>attendance at in-service will be evidenced by TMs signature on in-service sheet</p> <p>FA or designee to audit medication preparation and administration every shift x 1 week, then daily x 2 weeks, then monthly x 2 months. Ongoing monitoring will be conducted by ICM or designee performing infection control audits monthly. FA will review audit results with Medical Director during monthly FHM, continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>		

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V000122	<p>medications must utilize aseptic technique." The facility's January 2014 "Preparation and Administration of Parenteral Medications (Non-EPO) With All Dialyzer Types" procedure number 1-06-01A states, "Distribute the medication to the patient station in an aseptic manner."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure dialysis stations had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed creating the potential to affect all of the facility's 46 current patients. (Employees A and I)</p> <p>The findings include:</p> <p>1. Employee I, a patient care technician</p>	V000122	<p>FA will hold mandatory in-service for all clinical TMs by 12/11/2014. In-service will include but will not be limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, emphasizing proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment. TMs must fully clean machine including top, sides, Hanson connectors, and bottom lip. TMs must completely recline and open chair foot rest to clean in the crevasses of chair, tables on chairs</p>	12/20/2014

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	<p>(PCT), was observed to clean dialysis station number 1 on 11-18-14 at 1:55 PM. The PCT was not observed to clean the Hansen connectors, the television controls, or the data entry station.</p> <p>2. Employee A, a registered nurse (RN), was observed to clean dialysis station number 5 on 11-18-14 at 2:14 PM. The RN was not observed to clean the television controls or the data entry station. The RN was observed to use the same cloth to clean the dialysis chair as was used to clean the dialysis machine.</p> <p>3. The above-stated observations were discussed with the Facility Administrator (FA) on 11-20-14 at 1:20 PM. The FA indicated the employees had not provided cleaned and disinfected the dialysis station in accordance with facility policy.</p> <p>4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheel chairs, outside of sharps</p>		<p>will be lowered and wiped with bleach solution between patients. All other equipment including TV/controls must be wiped with a bleach solution in between patients. Chair side snappy cart and keyboard/covers must be cleaned with appropriate bleach solution at a minimum end of each treatment day or if contaminated. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>ICM or designee will conduct infection control audits daily x 1 week, weekly x4 weeks, then monthly. FA will review audit results with Medical Director during monthly FHM, continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>		

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V000260	<p>containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment."</p> <p>494.40(a) PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS 9 Personnel: training program/periodic audits A training program that includes quality testing, the risks and hazards of improperly prepared concentrate, and bacterial issues is mandatory.</p> <p>Operators should be trained in the use of the equipment by the manufacturer or should be trained using materials provided by the manufacturer.</p> <p>The training should be specific to the functions performed (i.e., mixing, disinfection, maintenance, and repairs).</p> <p>Periodic audits of the operators' compliance with procedures should be performed.</p> <p>The user should establish an ongoing training program designed to maintain the operator's knowledge and skills. Based on personnel file and administrative record review and interview, the facility failed to ensure all staff members that prepared the</p>	V000260	Preceptor held mandatory in-service for TM H on 11/20/2014 reviewing Facility Specific Policy & Procedure Mar Cor MCB 210-50 Semi Automatic Bicarb System Mixing	12/20/2014

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	<p>bicarbonate and acid mixtures had been evaluated for compliance with facility procedures at least annually in 1 (file H) of 4 personnel files reviewed creating the potential to affect all of the facility's 46 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file H evidenced the individual had been hired on 6-24-02 as a patient care technician (PCT). The facility administrator (FA) indicated the PCT had transferred to this facility approximately 1-2 years ago from another facility within the corporation. The file failed to evidence the PCT had been evaluated for compliance with facility procedures when mixing bicarbonate solution for 2013 and had been evaluated for compliance with facility procedures in the proper mixing of acid solutions since 1-29-10. 2. The FA stated, on 11-20-14, "I cannot find any audits for [employee H]." The FA indicated the audits were to be completed at least annually. 3. The facility's "Bicarb Mix Log" evidenced employee H had prepared bicarbonate solution on 8-16-14, 8-27-14, 9-24-14, 9-30-14, 10-3-14, 10-8-14, 10-9-14, 10-18-14, 10-31-14, 11-5-14, 		<p>Procedure, and Facility Specific Policy & Procedure for Acid Preparation. TM educated on step by step policies and procedures for mixing, testing, rinsing, and disinfection. BMT or designee will complete re-validation of skills using skills checklist for preparing and mixing concentrate, documentation will be placed in TM training file. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA will initiate tracking system that will be reviewed monthly to ensure ongoing compliance with TMs annual competency training including competency skills checklist. FA will audit 100% of clinical TM personnel records quarterly to ensure training is up-to-date, and documentation is present in personnel record. Results of audits and TM education will be reviewed with the Medical Director during the monthly FHM with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>		

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V000356	<p>and 11-13-14.</p> <p>494.50(b)(1) RECORD ADV EVENTS/DIALYZER C/O LOG 13.2.3 Recording: adverse events dialyzer complaint log Any significant events such as the occurrence of symptoms listed in [AAMI] 13.2.1 and 13.2.2 should be recorded on an incident report form which would include the results of any evaluations conducted by the physician and others, and the event should be considered for reporting to the manufacturer(s) in accordance with the FDA's Medical Device User Reporting procedures. The resolution of actual or suspected problems caused by reprocessed dialyzers should be indicated. This form should be kept in the complaint investigation record file (see [AAMI] 4.5).</p> <p>4 Records 4.5 Complaint investigation record Records shall be kept of all complaints by patients and staff members about failures of preprocessed and reprocessed dialyzers or possible adverse reactions to any dialyzers; the results of a comprehensive investigation of these alleged problems; and, if appropriate, the corrective actions taken. The records shall be reviewed periodically for trends of adverse reactions. Compliance with the FDA's Medical Device User Reporting procedures shall be demonstrated.</p> <p>Based on reuse quality assurance document and facility policy review and interview, the facility failed to ensure complaint investigation records had been</p>	V000356	FA to hold mandatory in-service for reuse TMs on 12/11/2014 reviewing Policy & Procedure #6-01-13 Compliant Investigation Records emphasizing TMs must fill out a	12/20/2014

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	<p>completed for all required instances of reprocessed dialyzer failures in 1 (October 2014) of 1 month reviewed creating the potential to affect all of the facility's current patients that participate in the reuse program.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility administrator (FA) indicated, on 11-19-14 at 2:45 PM, she had found that the complaint investigation records had not been completed as required by facility policy and had implemented a performance improvement plan on 9-30-14. The FA indicated the plan included monthly monitoring of the complaint investigation log, re-education of the reuse technicians, and a visit by the corporate reuse preceptor. 2. The facility's September 2013 "Complaint Investigation Record" policy number 6-01-13 states, "A Complaint Investigation Record is completed for the following: . . . Pressure Failure, Visual Inspection." 3. The facility's "Daily Log of Failed Dialyzers" for 10-1-14 through 10-31-14 evidenced a dialyzer had been failed due to "pressure" on 10-7-14 and another dialyzer had been failed due to "visual 		<p>"Compliant Investigation Record" for all dialyzers failures for FA review. Complaint Investigation and Reuse Communication Log must be reviewed monthly during FHM. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet</p> <p>FA or designee will audit the complaint investigation record and reuse communication log weekly x 1 month, then monthly. Result of audits, Complaint Investigation Records and Reuse Communication Log will be reviewed monthly with Medical Director during FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p> <p>-</p>		

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V000407	<p>inspection" on 10-28-14. The facility's complaint investigation records failed to evidence an investigation record had been completed for these 2 failed dialyzers.</p> <p>4. The facility's September 2013 "Reuse Continuous Quality Improvement (CQI) Plan" policy number 6-01-02 states, "Monthly review of reuse records is performed to verify the records reflect the following: Complaint Investigation Records and Reuse Communication Logs are completed and reviewed as required."</p> <p>A. The facility's reuse CQI records failed to evidence a monthly review had been completed for October 2014.</p> <p>B. The FA stated, on 11-19-14 at 3:10 PM, "I must have missed the October one."</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation, facility policy review, and interview, the facility failed to ensure patients had been monitored at least every 30 minutes during the dialysis treatment in 2 (#s 1 and 4) of 5 records reviewed creating the potential to affect</p>	V000407	FA will hold mandatory in-service for all clinical TMs on 12/11/2014. In-service will include review of Policy & Procedure # 1-03-09 Intradialytic Treatment Monitoring, emphasizing treatment monitoring must be completed at a minimum of	12/20/2014

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	<p>all of the facility's 46 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a hemodialysis treatment flow sheet dated 11-8-14 that evidenced the patient had been checked at 9:30 AM and not again until 10:24 AM.</p> <p>The record included a hemodialysis treatment flow sheet dated 11-18-14 that evidenced the patient had been checked at 9:03 AM and not again until 10:06 AM.</p> <p>2. Clinical record number 4 included a hemodialysis treatment flow sheet dated 10-30-14 that evidenced the patient had been checked at 12:31 PM and not again until 1:19 PM.</p> <p>The record included a hemodialysis treatment flow sheet dated 11-8-14 that evidenced the patient had been checked at 12:30 PM and not again until 1:28 PM.</p> <p>3. The facility administrator indicated, on 11-20-14 at 1:20 PM, facility staff were to complete patient checks at least every 30 minutes and every 15 minutes if it was needed.</p> <p>4. The facility's March 2012</p>		<p>every 30 minutes, evaluation and documentation will include at a minimum patient's blood pressure, heart rate, blood and dialysate flows, arterial & venous pressures, fluid removal and/or replacement, vascular access status, line connections, patient status and subjective well being. Charge nurse is responsible for daily monitoring. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct daily audits on 25% of patient flow sheets x1 week, then weekly x4 weeks, then monthly on 10% of treatment sheets to ensure compliance. FA will review audit results with Medical Director during monthly FHM, continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>				

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V000410	<p>"Intradialytic Treatment Monitoring" policy number 1-03-09 states, "Treatment checks should be completed at least every thirty (30) minutes."</p> <p>494.60(d)(1) PE-PT CARE STAFF-CURRENT CPR CERT Staff training must be provided and evaluated at least annually and include the following: Ensuring that, at a minimum, patient care staff maintain current CPR certification</p> <p>Based on personnel file and facility policy review and interview, the facility failed to ensure staff had maintained current cardiopulmonary resuscitation (CPR) certification in 1 (file C) of 3 personnel files reviewed creating the potential to affect all of the facility's 46 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file C evidenced the individual had been hired on 11-4-13 as a registered nurse. The file failed to evidence documentation of current CPR certification. The file included an American Heart Association CPR certification card with an expiration date of 09/2014. 2. The facility administrator indicated, 	V000410	<p>Immediate CPR training/certification for TM C completed on 11/21/2014 and documentation placed in TM personnel file. Audit of 100% of TM personnel records completed to ensure CPR certification was current for all TMs, and documentation present in personnel file. FA will initiate tracking system that will be reviewed monthly to ensure ongoing compliance. FA or designee will conduct quarterly audits for 100% of TMs files to ensure compliance is maintained and documentation is present to support. FA will review audit results and TM education with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>	12/20/2014

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V000543	<p>on 11-20-14 at 2:00 PM, employee C did not have current CPR certification.</p> <p>3. The facility's September 2009 "Cardiopulmonary Resuscitation Certification (CPR) Classes" policy number 8-02-04 states, "All direct patient care teammates (i.e., nurses and patient care technicians) except patient care technician trainees must have current BLS [basic life support] CPR/AED [automated external defibrillator] certification."</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 provide the necessary care and services to manage the patient's volume status in 1 (# 2) of 5 records reviewed creating the potential to affect all of the facility's 46 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included</p>	V000543	<p>Interdisciplinary Team (IDT) will evaluate Patient #2 current health status and initiate individualized plan of care update to reflect evaluation of patient's current fluid volume status, dialysis treatment blood pressures and estimated dry weight.</p> <p>FA will hold mandatory in-service for Interdisciplinary Team on 12/11/2014 to review Policy & Procedure # 1-14-02 Patient Assessment and Plan of Care When</p>	12/20/2014

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	<p>physician orders dated 10-4-14 that evidenced the patient's estimated dry weight (the desired patient weight at the end of the dialysis treatment) was 91.5 kilograms (kg).</p> <p>A. A hemodialysis treatment flow sheet dated 10-28-14 evidenced the patient's weight at the end of the treatment was 94.8 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 10-30-14 evidenced the patient's weight at the end of the treatment was 95.4 kg.</p> <p>C. A hemodialysis treatment flow sheet dated 11-1-14 evidenced the patient's weight at the end of the treatment was 95.3 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 11-4-14 evidenced the patient's weight at the end of the treatment was 96.0 kg.</p> <p>E. A hemodialysis treatment flow sheet dated 11-6-14 evidenced the patient's weight at the end of the treatment was 94.6 kg.</p> <p>F. A hemodialysis treatment flow sheet dated 11-8-14 evidenced the patient's weight at the end of the</p>		<p>Utilizing Falcon Dialysis. In-service will emphasize that IDT must provide the necessary care and services to manage patient's fluid volume status. Patients' individualized plan of care must address dose of dialysis which addresses care and services to manage the patient's volume status; and achieve and sustain the prescribed dose of dialysis. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Examples given using surveyor observations for patients consistently not meeting estimated dry weight and IDT did not address. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct monthly Medical Records Audits for 10% of current patients monthly to ensure assessments and plans of care are in place, current, needs of patient including fluid volume and blood pressure management are evaluated/addressed, and documentation of action plans and response to interventions are present. FA will review audit results with Medical Director during monthly FHM with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>				

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V000550	<p>treatment was 92.7 kg.</p> <p>2. Clinical record number 2 evidenced the patient had been hospitalized from 11-9-14 to 11-11-14 due to "fluid overload."</p> <p>3. Clinical record number 2 failed to evidence any interventions or changes to the plan of care to address the patient's inability to reach the estimated dry weight during the treatments. The facility administrator was unable to provide any additional documentation and/or information when asked on 11-20-14 at 1:20 PM.</p> <p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status."</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</p>						

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	<p>consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure staff had verbally confirmed patients had washed their accesses upon entering the facility prior to the initiation of the dialysis treatment in 1 (# 2) of 2 access of fistula or graft observations completed creating the potential to affect all of the facility's 42 current patients with a fistula or graft.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's September 2014 "Arteriovenous Fistula (AVF) and arteriovenous graft (AVG) Vascular Access Care" policy number 1-04-01 states, "Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry." On 1-19-14 at 1:35 PM, employee H, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 6. Observation noted a fistula in the lower right arm. The PCT was not observed to ask the patient if the 	V000550	<p>FA will hold mandatory in-service on 12/11/2014 for all clinical TMs reviewing Policy & Procedure #1-04-01 Arteriovenous Fistula, and Arteriovenous Graft Vascular Access Care emphasizing patients must be encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>ICM or designee will conduct infection control audits daily x 1 week, weekly x4 weeks, then monthly. FA will review audit results with Medical Director during monthly FHM, continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>	12/20/2014

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V000626	<p>access had been washed upon arrival to the facility. When the surveyor asked the patient, the patient stated, "No, I did not wash my access."</p> <p>3. The above-stated observation was discussed with the Facility Administrator (FA) on 11-20-14 at 1:20 PM. The FA indicated the employee had not provided care in accordance with facility's policy.</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 performance improvement program for review by CMS.</p> <p>Based on quality assessment and performance improvement meeting minute review, facility policy review, and interview, the facility failed to ensure all</p>	V000626	FA will hold mandatory in-service for Facility Health Team on 12/4/2014 reviewing Policy & Procedure #1-14-06 Continuous Quality Improvement Program.	12/20/2014

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V000638	<p>members of the continuous quality improvement committee had participated in 3 (May, August, and September 2014) of 6 months reviewed creating the potential to affect all of the facility's 46 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QAPI meeting minutes dated 5-16-14, 8-22-14, and 9-19-14 failed to evidence participation by the biomedical technician. 2. The facility administrator stated, on 11-20-14 at 2:50 PM, "The biomed did not attend the meetings in May, August, or September 2014." 3. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: . . . Biomed Technician." <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that</p>		<p>Team will be notified that if they are unable to attend monthly FHM in person that they may attend telephonically, or they may report off to a committee member and designate another person from his/her discipline to attend in their absence, FA will send out notification to team informing them of scheduled meeting. FHM minutes must reflect signatures of participating members, discussion, actions and evaluation by team. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. CSS will attend review monthly FHM minutes x 3 months to ensure comprehensive QAPI program, and minutes reflective of actions taken. FHM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>	

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	<p>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 revised to address lack of improvement in the identified problem area in 6 (May, June, July, August, September, and October 2014) of 6 months reviewed creating the potential to affect all of the facility's 46 current patients.</p> <p>The findings include:</p> <p>1. The facility's QAPI documentation included "Target Weight Assessment" data for May through October 2014. The data tracked the percentage of hemodialysis treatments in which the post dialysis weight achieved was different from the prescribed target weight by 1 kilogram or more, above or below.</p> <p>A. The 5-16-14 data evidenced 14% of the hemodialysis treatments the post weight was different from the prescribed target weight.</p> <p>B. The 6-13-14 data evidenced an</p>	V000638	<p>FA will hold mandatory in-service for Facility Health Team on 12/4/2014 reviewing Policy & Procedure #1-14-06 Continuous Quality Improvement Program emphasizing importance of having an ongoing and comprehensive FHM process that includes tracking, trending, data analysis, action plan development and effective implementation dates related for facility indicators. Specific emphasis was placed on 1) Analyzing data collected, 2) Set measurable goals and continuously evaluate, track and trend indicators not meeting facility goals, 3) Identifying root causes for underperformance, 4) Developing action plans and timelines, 5) Reviewing current action plans in place, evaluating their effectiveness, and initiating new plans as needed to meet goals, 6) Tracking performance over time to ensure improvements are sustained, 7) Ensuring meeting minutes reflect discussion, actions and evaluation by team. CSS will attend review monthly FHM minutes x 3 months to ensure comprehensive QAPI program, and minutes reflective of actions taken. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FHM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect.</p>	12/20/2014			

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	<p>increase to 18% with the comment, "All nursing staff evaluating patients every treatment for Target Wt. changes. Decreasing patients DW [dry weight] when indicated. Evaluating b/p [blood pressure] when taken every 30 minutes to assure good treatments."</p> <p>C. The 7-18-14 data evidenced 13 % with no comment.</p> <p>D. The 8-22-14 data evidenced 11% with no comment.</p> <p>E. The 9-19-14 data evidenced an increase to 14% with no comment.</p> <p>F. The 10-24-14 data evidenced an increase to 16% with the comment, "We are at 86% on fluid mgt [management] goal >/+ 90%. [Employee A] is our fluid manager and she and staff continue to evaluate all patients every treatment for good DW."</p> <p>2. The QAPI documentation failed to evidence an investigation and analysis of root causes, the development of an improvement plan, the implementation of the plan, and tracking to ensure improvement is sustained.</p> <p>3. The facility administrator indicated, on 11-20-14 at 2:50 PM, the QAPI</p>		<p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>		

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V000715	<p>documentation did not evidence a performance improvement plan to address the fluid management issues.</p> <p>4. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>Based on clinical record and facility policy review and interview, the medical director failed to ensure all new patients had an evaluation by the registered nurse (RN) prior to the start of the first dialysis treatment in accordance with facility policy in 1 (# 4) of 2 records reviewed of patients on service for less than 90 days creating the potential to affect all new</p>	V000715	FA will hold mandatory in-service on 12/11/2014 for all Registered Nurses (RNs) reviewing Policy & Procedure #1-03-07 New Patient Pre-Treatment Evaluation emphasizing RN must perform initial pre-treatment evaluation of all new patients prior to initiation of first treatment at facility, pre-treatment evaluation will be documented on the New Patient Pre-Treatment Evaluation Form.	12/20/2014

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	<p>patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 4 evidenced the patient's first treatment at the facility was on 10-7-14 and that the treatment was initiated at 11:11 AM. The record failed to evidence an evaluation by the RN prior to the start of the first treatment on 10-7-14. 2. The Clinical Services Specialist stated, on 11-20-14 at 11:25 AM, "I am unable to find an initial evaluation by the RN." 3. The facility's September 2010 "New Patient Pre-Treatment Evaluation" policy number 1-03-07 states, "A registered nurse (RN) as required by federal regulation will perform an initial pre-treatment evaluation of all new patients prior to the initiation of their first treatment at the facility." 		<p>Verification of attendance will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct monthly Medical Records Audits for 100% of new patient admission to ensure RN evaluation is conducted and documented prior to first treatment. FA will review audit results with Medical Director during monthly FHM, continued frequency of audits determined by the team, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion Date: 12/20/2014</p>	