

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152567		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/09/2012	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SEYMOUR				STREET ADDRESS, CITY, STATE, ZIP CODE 200 E THIRD ST SEYMOUR, IN 47274			
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Facility #: 002497</p> <p>Survey Dates: 8-7-12, 8-8-12, and 8-9-12</p> <p>Medicaid Vendor #: 200202800B</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 14, 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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V0122	<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 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, facility policy and procedure review, and staff interview, the facility failed to ensure dialysis equipment was adequately cleaned between patients in 4 (#s 1, 2, 3, and 4) of 4 observations creating the potential for the spread of disease causing organisms among staff and the facility's 37 current patients.</p> <p>The findings include:</p> <p>1. The facility's 01-04-12 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A states, "All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glisteningly wet . . . Externally disinfect the dialysis machine with 1:100 bleach solution after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are</p>	V0122	<p>On 8/28/12 the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution.</p> <p>On 8/22/12 the Clinical Manager met with all direct patient care staff to review policy # FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on cleaning all surfaces of the dialysis machine including the blood pump and prime bucket before setting up for the next patient and all surfaces of the dialysis chair including the back and footrest. All staff acknowledged understanding that all dialysis equipment must be cleaned between patients. Agenda and attendance sheet is available within the facility.</p> <p>Clinical Manager will ensure that infection control audits are completed utilizing the QAI Infection Control audit tool weekly</p>	08/28/2012			

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	<p>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.)"</p> <p>2. On 8-8-12 at 10:50 AM, employee J, a patient care technician (PCT), was observed to clean the dialysis machine at station number 5 while patient number 6 was sitting the dialysis chair but had just been disconnected. The PCT was observed to very quickly wipe the front of the machine missing portions and not leaving the surface "glisteningly wet." The PCT failed to clean the top, sides, or back of the machine or the drain bucket located on the side of the machine.</p> <p>3. On 8-8-12 10:55 AM, employee F, a PCT, was observed to clean the dialysis machine at station 1. (There was not a patient in the chair at the time.) The PCT was observed to wipe the front and the top of the machine missing portions. The PCT did not clean the blood pump thoroughly or the entire surface of the front of the machine. The PCT did not clean the sides or the drain bucket. At 11:10 AM, the PCT was observed to place supplies (tubing and dialyzer in packages) for the next patient (patient # 7) on top of the machine.</p>		<p>for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p>				

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	<p>4. On 8-8-12 at 11:02 AM, employee F, a PCT, was observed to clean the dialysis chair at station # 1. The PCT was not observed to clean all surfaces of the chair, the back of the chair, or the footrest.</p> <p>5. On 8-8-12 at 11:35 AM, employee J, a PCT was observed to clean the dialysis machine at station # 9. The PCT was observed to clean machine front and top, but was not observed to clean the sides or the drain bucket. The surface of the machine was not observed to be "glisteningly wet."</p> <p>6. On 8-9-12 at 11:20 AM, the acting administrator, employee L, indicated the PCTs had not cleaned the dialysis machines and chair according to facility policy.</p>						

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V0196	<p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>Based on observation, facility policy and procedure review, and staff interview, the facility failed to ensure all required personal protective equipment had been worn while performing the water test for chlorine in 1 of 1 water test observed creating the potential to affect all of the</p>	V0196	The Clinic Manager will hold an in-service for all employees that perform the Chlorine/ Chloramines testing on 8/30/12 to review the procedure of Chlorine/Chloramines	08/30/2012

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	<p>facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's 7-31-08 "Chlorine/Chloramine Testing of Water Using a Hach Colorimeter" procedure number FMS-CS-IC_I-140-006C states, "The following supplies are needed for this procedure: Appropriate PPE (personal protective equipment) . . . Step 1 Disinfect hands and do appropriate PPE to protect hands and ensure integrity of testing." On 8-7-12 at 1:19 PM, employee B, a patient care technician (PCT), was observed to perform the water test for chlorine. The PCT donned a cover gown and gloves but failed to don a face shield. The PCT indicated a face shield was not required to be worn. The acting administrator, employee L, indicated, on 8-7-12 at 3:52 PM, appropriate PPE would be a gown, gloves, and shield. 		<p>Testing of Water Using a Hach Colorimeter FMS-CS-IC-II-140-006. Emphasis was placed on step #1 which states "Disinfect Hands and don appropriate PPE (including face shield) to protect hands and ensure integrity of testing."</p> <p>The Clinical Manager will ensure that infection control audits are completed utilizing the QAI Infection Control audit tool weekly for 4 weeks then ongoing monitoring will occur per the QAcalendar.</p> <p>The Clinic Manager is responsible for reporting her findings of these audits to the QAI committee during the QAI monthly meetings</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p>		

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V0407	<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).</p> <p>Based on clinical record review and facility policy review and interview, the facility failed to ensure patients had been monitored at least every 30 minutes in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 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 necessary." Clinical record number 1 failed to evidence the patient had been monitored at least every 30 minutes during treatments. <ul style="list-style-type: none"> A. A post treatment flow sheet dated 7-13-12 evidenced a treatment check had been completed at 7:07 AM and not again until 8:03 AM, a period of 53 minutes between treatment checks. 	V0407	<p>The Clinical Manager/Education Coordinator will educate and review with all staff "Patient Monitoring During Patient Treatment" FMS-CS-IC-I-110-133A by 8/30/12 with emphasis on documentation of the treatment checks every 30 minutes.</p> <p>The Clinical Manager or designee will review treatment sheets daily for 2 weeks, weekly for 4 weeks, monthly times 2, then quarterly to ensure that all treatment checks are being done and documented. Any areas of non-compliance will be addressed immediately.</p> <p>The Clinic Manager is responsible for reporting her findings of these audits to the QAI committee during the QAI monthly meetings</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p>	08/30/2012			

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	<p>B. A post treatment flow sheet dated 7-20-12 evidenced a treatment check had been completed at 6:38 AM and not again until 7:34 AM, a period of 56 minutes between treatment checks.</p> <p>C. A post treatment flow sheet dated 8-1-12 evidenced a treatment check had been completed at 6:53 AM and not again until 8:04 AM, a period of 1 hour and 11 minutes between treatment checks.</p> <p>3. Clinical record number 2 failed to evidence the patient had been monitored at least every 30 minutes during the treatment.</p> <p>A. A post treatment flow sheet dated 7-24-12 evidenced a treatment check had been completed at 8:35 AM and not again until 9:37 AM, a period of 1 hour and 2 minutes between treatment checks.</p> <p>B. A post treatment flow sheet dated 7-31-12 evidenced a treatment check had been completed at 9:36 AM and not again until 10:31 AM, a period of 55 minutes between treatment checks.</p> <p>4. Clinical record number 3 failed to evidence the patient had been monitored at least every 30 minutes during the treatment.</p>		The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.		

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	<p>A post treatment flow sheet dated 7-30-12 evidenced a treatment check had been completed at 8:06 AM and not again until 8:46 AM, a period of 40 minutes between treatment checks.</p> <p>5. Clinical record number 4 failed to evidence the patient had been monitored at least every 30 minutes during the treatment.</p> <p>A. A post treatment flow sheet dated 7-18-12 evidenced a treatment check had been completed at 9:34 AM and not again until 10:35 AM, a period of 1 hour and 1 minute between treatment checks.</p> <p>B. A post treatment flow sheet dated 7-25-12 evidenced a treatment check had been completed at 10:33 AM and not again until 11:13 AM, a period of 40 minutes between treatment checks.</p> <p>C. A post treatment flow sheet dated 7-27-12 evidenced a treatment check had been completed at 10:33 AM and not again until 11:15 AM, a period of 43 minutes between treatment checks.</p> <p>D. A post treatment flow sheet dated 7-30-12 evidenced a treatment check had been completed at 9:36 AM and not again until 11:30 AM, a period of 1 hour and 54 minutes between treatment checks.</p>						

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	<p>E. A post treatment flow sheet dated 8-1-12 evidenced a treatment check had been completed at 10:05 AM and not again until 11:36 AM, a period of 1 hour and 31 minutes between treatment checks.</p> <p>6. Clinical record number 5 failed to evidence the patient had been monitored at least every 30 minutes during the treatment.</p> <p>A. A post treatment flow sheet dated 7-18-12 evidenced a treatment check had been completed at 11:09 AM and not again until 12:03 PM, a period of 54 minutes between treatment checks.</p> <p>B. A post treatment flow sheet dated 7-25-12 evidenced a treatment check had been completed at 8:08 AM and not again until 8:48 AM, a period of 40 minutes between treatment checks.</p> <p>C. A post treatment flow sheet dated 8-1-12 evidenced a treatment check had been completed at 10:35 AM and not again until 11:36 AM, a period of 1 hour and 1 minute between treatment checks.</p> <p>7. The acting facility administrator, employee L, was unable to provide any additional documentation and/or information when asked on 8-9-12 at</p>						

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V0413	<p>494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.</p> <p>Based on facility document review and interview, the facility failed to ensure oxygen tanks had been checked to ensure the presence of adequate oxygen in an emergency situation in 7 (January through July 2012) of 7 months reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's monthly emergency equipment and supplies checklist for January through July 2012 failed to evidence the amount of oxygen in the oxygen tanks had been checked in order to ensure adequate oxygen would be available in the event of an emergency. 2. The charge nurse, employee A, stated, on 8-9-12 at 8:08 AM, "I do check the levels in the tanks every month but there is not any place on our checklist to document it." 	V0413	<p>The Director of Operations will meet with the facility's staff on 8/30/12 to review their requirements detailed in Fresenius policy "Emergency Equipment/Supplies" to ensure that emergency supplies are maintained at the dialysis facility.</p> <p>The Clinical Manager will create a new checklist by 8/30/12 that contains a spot for the level of oxygen to be documented each month. The supplies and equipment will be checked monthly for expiration dates, quantities and the medications and supplies are covered and locked.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly to the QAI. The QAI Committee is</p>	08/30/2012	

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			responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.	

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V0511	<p>494.80(a)(8) PA-DIALYSIS ACCESS TYPE & MAINTENANCE The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(8) Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts and peritoneal catheters).</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure comprehensive assessments included an evaluation of the patient's access site in 3 (#s 3,4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 3 included a comprehensive assessment dated 3-27-12 that identified the patient had an arteriovenous fistula (AVF) in the right upper arm. The access evaluation portion of the assessment had been left blank. The assessment states, "pt c/o [complained of] pain with access. Seeing [name of physician] 3/15/12." Clinical record number 4 included a comprehensive assessment dated 4-24-12 that failed to identify the type of vascular access. 	V0511	<p>The Director of Operations met with the facility's Interdisciplinary Team on 8/28/12 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care completed and available within their medical record that meets all criteria including assessment/type of patient's access.</p> <p>The Clinical Manager completed 100% review of all patients' Comprehensive Assessments by 9/3/12 to ensure that all Assessments due are complete and current. Any patient's Assessment that does not include the assessment/type of patient's access including patient #3, 4 and 5 will be presented to the IDT for completion by 9/3/12.</p> <p>The Clinical Manager will utilize</p>	09/03/2012			

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	<p>3. Clinical record number 5 included a comprehensive assessment dated 4-24-12. The access evaluation portion of the assessment had been left blank.</p> <p>4. The acting facility administrator, employee L, was unable to provide any additional documentation and/or information when asked on 8-9-12 at 11:20 AM.</p> <p>5. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 policy states, "The comprehensive interdisciplinary assessment must include the following: . . . Evaluation of dialysis access types and maintenance."</p>		<p>the QAI tool for Assessment and Care-Plan tracking of all patients monthly to ensure that all patients Comprehensive Assessment is completed including the assessment/type of patient's access.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to include the number of Assessments due, completed and missed to the QAI. Any patient missing any component of the Assessment will be scheduled for completion the following month and corrective action will be taken as appropriate.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p>		

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V0541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included measurable goals and estimated timetables to achieve the desired goals in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number I included a plan of care dated 3-27-12. The plan of care failed to include a measurable blood pressure and fluid management goal. The plan of care states, "Blood Pressure & Fluid Management: . . . Estimated outcome: To maintain b/p [blood pressure] and EDW [estimated dry weight] where patient feels well."</p>	V0541	<p>On 8/28/12 the Director of Operations met with the members of the IDT to emphasize the requirements as defined within the Conditions of Coverage and Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" that all patients must have a Plan of Care that is specific to address the patient's needs and is based upon that patient's specific Comprehensive Assessment and that all disciplines must participate in the development.. The patient's Plan of Care must include specific measurable outcomes and timetables estimated to obtain each patient's outcomes. Emphasis was placed upon setting goals and timetables for blood pressure and fluid management.</p> <p>The Clinical Manager completed</p>	09/03/2012			

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	<p>2. Clinical record number 2 included a plan of care dated 6-26-12. The plan of care failed to include a measurable blood pressure and fluid management goal and failed to include an estimated timetable to achieve the desired outcomes. The plan states, "Blood Pressure & Fluid Management . . . Expected outcome: B/P and fluids to remain stable. Estimated timetable: Monitor at each treatment via electronic documenting system."</p> <p>3. Clinical record number 3 included a plan of care dated 3-27-12. The plan of care failed to include a measurable blood pressure and fluid management goal. The plan of care states, "Blood Pressure & Fluid Management: . . . Expected outcome: To continue to meet goal where pt. feels good."</p> <p>4. Clinical record number 4 included a plan of care dated 4-24-12. The plan of care failed to include a measurable blood pressure and fluid management goal. The plan of care states, "Blood Pressure & Fluid Management: . . . Expected outcome: B/P and fluid gain will remain stable."</p> <p>5. Clinical record number 5 included a plan of care dated 4-24-12. The plan of care failed to include a measurable blood</p>		<p>100% review of all patients' Plans of Care by 9/3/12, to ensure that all Plans of Care desired outcomes/goals and estimated timetables to achieve those outcomes/goals is addressed. Any patient's Plan of Care found to be out of compliance including patients # 1, 2, 3, 4 and 5 will be presented to the IDT for completion by 9/3/12.</p> <p>The Clinical Manager will review all Plans of Care monthly to ensure that desired outcomes/goals and estimated timetables have been included. Any POC's found out of compliance will be scheduled for completion within the next 30 days and corrective action will be taken as appropriate.</p> <p>The Clinical Manager are responsible to report a summary of findings monthly to the QAI. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>				

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	<p>pressure and fluid management goal. The plan of care states, "Blood Pressure & Fluid Management: . . . Expected outcome: B/P and fluid gain to remain stable."</p> <p>6. The acting facility administrator, employee L, was unable to provide any additional documentation and/or information when asked on 8-9-12 at 11:20 AM.</p> <p>7. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "The Plan of Care must include measurable and expected outcomes and an estimated timetable to achieve these outcomes."</p>				

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V0715	<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 the nurse had assessed patients post dialysis treatment in accordance with the facility's own policy in 3 (#s 2, 4, & 5) of 5 records reviewed creating the potential to affect all of the facility's 37 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's 1-28-04 "Evaluating the Patient Post-Dialysis" policy number 132-020-121 states, "Nurses assess the patient post treatment if warranted by the patient's condition." 2. Clinical record number 2 failed to evidence a nursing assessment had been completed post dialysis when edema and access problems had been identified at the beginning of the treatment. <p>A. A post treatment flow sheet dated 7-19-12 evidenced employee A, a registered nurse (RN), had completed an</p>	V0715	<p>The Director of Operations met with the Medical Director on 8/28/12 to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individual who treat patients in the facility emphasizing the requirement for the nurse to perform a post treatment assessment when warranted by the patient's condition. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below.</p> <p>The Director of Operations met with all nursing personnel on 8/30/12 to review the requirement that a post treatment assessment must be completed when issues were identified in the pre treatment assessment. This will be done through the completion of the Post Treatment Evaluation</p>	08/30/2012			

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	<p>assessment of the patient at the start of treatment, 7:40 AM. The assessment identifies the presence of "leg edema 3+ pitting." The assessment states, "Difficulty cannulating access. Pt c/o [complained of] pain with cannulation. Also note a thrill and bruit medial to graft. possibly from old fistula?"</p> <p>The post treatment flow sheet evidenced the patient left above the estimated dry weight (EDW) of 45 kilograms (kg) by 4.2 kg. The flow sheet failed to evidence the RN had assessed the leg edema and the status of the patient's access post treatment.</p> <p>B. A post treatment flow sheet dated 7-31-12 evidenced employee A, a RN, had completed an assessment of the patient at the beginning of the treatment at 7:34 AM. The assessment states, "2+ edema LLE [left lower extremity] and 1+ edema RLE [right lower extremity]."</p> <p>The flow sheet evidenced the patient had left above the EDW of 45 kg by 3.9 kg. The flow sheet failed to evidence the RN had assessed the leg edema at the end of the treatment.</p> <p>3. Clinical record number 4 identified the patient as a resident of a skilled nursing facility. The record failed to evidence a</p>		<p>on the Chair-side computer system.</p> <p>The facility's nursing staff will be in-serviced on the following policies, "Comprehensive Interdisciplinary Assessment", "Evaluating the Patient Pre-Dialysis" and "Evaluating the Patient Post-Dialysis" on 8/30/12 by education with a record of training reviewed by the QAI committee.</p> <p>The Clinical Manager or designee will audit 100% of all treatment sheets daily for 2 weeks, weekly for 4 weeks, monthly times 2, then quarterly to ensure that any issues identified pre treatment is addressed post treatment Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will be determined by the QAI Committee upon review of the audit results and resolution of the issue.</p> <p>The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the</p>				

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	<p>post dialysis nursing assessment had been completed when abnormal breath sounds and edema had been identified at the beginning of the treatment.</p> <p>A. A post treatment flow sheet dated 7-18-12 evidenced employee E, a RN, had completed an assessment at the beginning of the treatment at 7:29 AM. The assessment states, "decreased breath sounds or no breath sounds LLL [left lower lobe] LUL [left upper lobe] RLL [right lower lobe] RUL [right upper lobe]."</p> <p>The post treatment flow sheet failed to evidence the RN had completed an assessment of the patient's breath sounds at the end of the dialysis treatment.</p> <p>B. A post treatment flow sheet dated 7-23-12 evidenced employee D, a RN, had completed an assessment at the beginning of the treatment at 7:39 AM. The assessment states, "leg edema 1+ slight decreased breath sounds or no breath sounds LLL, LUL, RLL, RUL."</p> <p>The post treatment flow sheet failed to evidence the RN had assessed the patient's breath sounds and edema at the end of the dialysis treatment.</p> <p>4. Clinical record number 5 failed to</p>		<p>monthly QAI Committee Meeting.</p> <p>The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>				

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	<p>evidence a post dialysis nursing assessment had been completed when</p> <p>A. A post treatment flow sheet dated 7-18-12 evidenced employee A, a RN, had completed an assessment at the beginning of the treatment at 10:40 AM. The assessment states, "leg edema 2+ mild pitting."</p> <p>The post treatment flow sheet failed to evidence a nursing assessment of the patient's leg edema had been completed post dialysis.</p> <p>5. The acting facility administrator, employee L, was unable to provide any additional documentation and/or information when asked on 8-9-12 at 11:20 AM.</p>				