

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  DUNELAND DIALYSIS - KNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 1008 S EDGEWOOD DR KNOX, IN 46534		
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V0000	<p>This was an ESRD recertification survey.</p> <p>Dates: November 28, 29, and 30, 2012</p> <p>Facility # #11218</p> <p>Medicaid # 200853190</p> <p>Surveyor: Susan E. Sparks, RN, Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 5, 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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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. Based on observation, staff interview, and policy review, the facility failed to ensure the emergency AED Respond Cart had medication available and had oxygen available in case of a power outage in 1 of 1 emergency carts reviewed with the potential to affect all 23 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 11/29/2012 3:00 PM, observation identified the only oxygen available on the AED Respond Cart was by oxygen concentrators.</li> <li>On 11/29/2012 3:06 PM, the Clinical Manager, Employee A, indicated there were no oxygen tanks at the facility. The patient on oxygen comes in and they hook the patient to the concentrators and the tanks are sent home with the families or are placed in a different part of the facility. When asked about a power outage, she indicated there would not be oxygen if a patient had a medical emergency or if a tank had been sent home.</li> </ol>	V0413	<p>V4131.-2. Oxygen tanks will be procured and available withthe AED Response Cart for patient use in an emergencysituation by 12/30/12. Patients own portable oxygentanks will remain in the clinic for use in an emergencysituation (i.e. power outage).3.-5. All of the emergency medications are locatedin the Nurse's Medication Prep Area under lock andkey. The following statement has been added to thispolicy to clarify the location of the emergencymedications &amp; adopted by the Local GoverningBoard (LGB):All emergency drugs, as listed below, are keptlocked in the Nurses's Medication Prep Areacabinets as the AED Response Cart does not havea locking mechanism. AED Response Cart Checks Policy 4a.201 hashad item #2 b (Medications expiration dates)removed from the policy, as these medications arebeing checked weekly with all other medicationslocated in the Nurse's Medication Prep Area.Additionally, the following statement has beenadded to this</p>	12/30/2012			

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	<p>3. On 11/29/2012 at 3:00 PM, observation failed to evidence any medications on the cart.</p> <p>4. 11/29/2012 3:06 PM, the Clinical Manager indicated they did not use medications during a medical emergency. They only provide the AED and CPR until the ambulance would arrive and the ambulance personnel would provide medications from the ambulance.</p> <p>5. A policy effective 10/27/2008 titled "AED Response Cart Checks", Policy #: 4a.201, states, "2. Using the AED Response Cart checklist, check for the following: A. AED Response Cart is clean. b. Medications' expiration dates. c. Defibrillator function. d. Standard external supplies. e. Suction machine function.</p>		<p>policy &amp; adopted by the LGB: on item 2c- Defibrillator function (Checked daily per policy 4a.205). E3: Emergency Equipment policy addition of Oxygentanks and maintenance. Adopted by LGB. All nursing staff will be in-serviced regarding PolicyE3: Emergency Equipment; 4a.201: AED ResponseCart Checks by 12/30/12. Nurse Manager or designee will monitor presence of oxygen tanks (patient and clinic); medications and expiration dates weekly x 4 or until 100% compliance is established, monthly x 2, then per E3 policy. Any staff found not to be in compliance with DSIPolicy &amp; Procedure will receive progressive disciplinary action. Nurse Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>		

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V0541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure plans of care included measurable outcomes and timelines for goals not met in 2 of 5 records reviewed with the potential to affect all 23 patients. (1 &amp; 2)</p> <p>Findings:</p> <p>1. Clinical Record 1 included a 90 day plan of care dated 11/28/12 that failed to evidence measurable outcomes and timelines for goals not met in TSAT, I-PTH, HbSab, and Transplant Status.</p> <p>2. Clinical Record 2 included an annual plan of care dated 10/31/12 that failed to evidence measurable outcomes and timelines for goals not met in Cardio/pulmonary Health, I-PTH,</p>			V0541	<p>The current POC used from the Korus/Spectralaboratory system is being replaced with the POC from the DSI electronic medical record (EMR) PEARL. All Interdisciplinary Team members will be in-serviced by 12/30/12 regarding the PEARL IDT/POC process; Policy 1.210 Patient POC. This includes but not limited to measurable goals that are unit specific and required goal completion timelines to achieve form completion.</p> <p>The Nurse Manager or designee will monitor all POCs monthly x 6 or until 100% compliance is established, then per the PEARL Medical Records audit tool. Any staff found not to be in compliance with the Policy &amp; Procedure will receive progressive disciplinary action. Nurse Manager or designee will review all education, auditing, and</p>		12/30/2012

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	<p>Albumin, Dialysis Access, HbSab, and Transplant Status.</p> <p>3. On November 30, 2012, at 11:30 AM, the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on them.</p> <p>4. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "3. The interdisciplinary team will develop and implement a written individualized comprehensive plan of care. ... b. The plan will include measurable and expected outcomes and estimated timetables to achieve these outcomes."</p>		non-compliance in the monthly QAPI & Local Governing Board meeting.		

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V0544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record and policy review, the facility failed to ensure the dialysis prescription for the blood flow rate was achieved in 5 of 5 clinical records reviewed (1, 2, 3, 4 and 5) with the potential to affect all 23 patients.</p> <p>Findings:</p> <p>1. Clinical Record 1 included a 90 day plan of care dated 11/28/12 with an order for the blood flow rate (BFR) to be 350. Hemodialysis Flowsheets failed to evidence the prescription had been achieved on 10/31/2012, 11/02/2012, 11/05/2012, 11/07/2012, 11/09/2012, 11/14/2012, 11/23/2012, and 11/26/2012. The reason the prescription was not achieved was not addressed.</p> <p>2. Clinical Record 2 included an annual plan of care dated 10/31/12 with an order for the BFR to be 350. Hemodialysis Flowsheets failed to evidence the prescription had been achieved on 10/31/2012, 11/05/2012, 11/07/2012, 11/12/2012, 11/14/2012, 11/19/2012,</p>	V0544	<p>1.-6.: All direct care staff were inserviced by the NurseManager or on 12/10/12 regarding Policy1.210: Patient POC and the requirement to attainprescribed blood flow rates. If the blood flow rates arenot achievable, it must be documented on the PEARLflowsheet and an Adverse Event form completedto annotate this discrepancy. All Plans of Care forpatients not achieving the ordered blood flow rate willbe updated to reflect current measures to achieveordered blood flow rate. The Nurse Manager or designee will monitor allflowsheets daily x 2 weeks or until 100% complianceis established, weekly x 2, monthly x 2 then per thePEARL Medical Records Audit tool for prescribedblood flow rates to include appropriate documentationas described in the staff inservice and Plan of Careupdates. Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinary action. Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly</p>	12/30/2012			

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	<p>11/21/2012, and 11/28/2012. The reason the prescription was not achieved was not addressed.</p> <p>3. Clinical Record 3 included a plan of care dated 6/27/2012 with orders for the BFR to be 450. The Hemodialysis Flowsheets failed to evidence the prescription had been achieved on 11/02/2012, 11/05/2012, 11/07/2012, 11/09/2012, 11/12/2012, 11/14/2012, 11/16/2012, 11/19/2012, 11/21/2012, 11/23/2012, 11/26/2012 and 11/28/2012. The reason the prescription was not achieved was not addressed.</p> <p>4. Clinical Record 4 included a plan of care dated 6/27/2012 with orders for the BFR to be 400. The Hemodialysis Flowsheets failed to evidence the prescription had been achieved on 11/12/2012 and 11/23/2012. The reason the prescription was not achieved was not addressed.</p> <p>5. Clinical Record 5 included a plan of care dated 11/26/2012 with orders for the BFR to be 400. Hemodialysis Flowsheets failed to evidence the prescription had been achieved on 11/16/2012, 11/21/2012 and 11/26/2012. The reason the prescription was not achieved was not addressed.</p>		QAPI & Local Governing Board meeting.				

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	6. A policy dated 2/17/2012, "Patient Plan of Care", Policy #1.210, 3. The interdisciplinary team will develop and implement a written individualized comprehensive plan of care. ... 4. The plan of care will address, but not be limited to, the following: a. Dose of dialysis ..."				

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V0545	<p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. Based on clinical record and policy review and interview, the facility failed to ensure the plan of care addressed the patient's albumin level in 1 of 5 records reviewed with the potential to affect all 23 patients. ( 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical Record 2 included a plan of care dated 10/31/12 that failed to evidence the patient's abnormal albumin level was addressed.</li> <li>2. On November 30, 2012, at 11:30 AM, the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on them.</li> <li>3. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "4. The plan of care will address, but not be limited to, the following: ... b. Nutritional Status."</li> </ol>	V0545	<p>1.-3. All patient charts with an IDT/POC due in the last3 months will be audited by 12/30/12 for POCcompleteness and all areas addressed. All IDT memberswill be in-serviced regarding Policy 1.210: Patient Planof Care by 12/30/2012. Clinic Manager or designee will complete monthlychart audits x 3 or until 100% compliance has beenestablished for all patients with POC's due for thosemonths, then quarterly per the PEARL Medical Recordsaudit. Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinaryaction. Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting..</p>	12/30/2012	

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V0546	<p>494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the plan of care addressed the patient's PTH levels in 2 of 5 records reviewed with the potential to affect all 23 patients. (1 &amp; 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical Record 1 included a plan of care dated 11/28/12 that failed to address the patient's abnormal I-PTH level.</li> <li>2. Clinical Record 2 included a plan of care dated 10/31/12 that failed to address the patient's abnormal I-PTH level.</li> <li>3. On November 30, 2012, at 11:30 AM, the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on them.</li> <li>4. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "4. The plan of care will address, but not be limited to, the following: ... c. Mineral metabolism. "</li> </ol>	V0546	<p>1.-4. All patient charts with an IDT/POC due in the last3 months will be audited by 12/30/12 for POCcompleteness and all areas addressed. All IDT memberswill be in-serviced regarding Policy 1.210 Patient Planof Care by 12/30/2012.</p> <p>Nurse Manager or designee will complete monthlychart audits x 3 or until 100% compliance has beenestablished for all patients with POC's due for thosemonths, then quarterly per PEARL Medical Recordsaudit tool.</p> <p>Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinaryaction. Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	12/30/2012			

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V0547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs. Based on clinical record and policy review and interview, the facility failed to ensure plans of care addressed the patient's TSAT level in 1 of 5 records reviewed with the potential to affect all 23 patients. (1)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical Record 1 included a plan of care dated 11/28/12 that failed to address the patient's abnormal TSAT Status.</li> <li>2. On November 30, 2012, at 11:30 AM, the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on them.</li> <li>3. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "4. The plan of care will address, but not be limited to, the following: ... d. Anemia."</li> </ol>	V0547	<p>1.-3. All patient charts with an IDT/POC due in the last3 months will be audited by 12/30/12 for POCcompleteness and all areas addressed. All IDT memberswill be in-serviced regarding Policy 1.210 Patient Planof Care by 12/30/2012.</p> <p>Nurse Manager or designee will complete monthlychart audits x 3 or until 100% compliance has beenestablished for all patients with POC's due for thosmonths, then quarterly per the PEARL Medical Recordsaudit tool.</p> <p>Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinaryaction. Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>	12/30/2012	

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V0550	<p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on clinical record and policy review and interview the facility failed to ensure the plan of care address vascular access monitoring in 2 of 5 records reviewed with the potential to affect all 23 patients. (1 &amp; 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical Record 1 included a pan of care dated 11/28/12 that failed to address interventions to monitor the vascular access.</li> <li>2. Clinical Record 2 included a plan of care dated 10/31/12 that failed to address interventions to monitor the vascular access.</li> <li>3. On November 30, 2012, at 11:30 AM, the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on</li> </ol>	V0550	<p>1.-4. All patient charts with an IDT/POC due in the last3 months will be audited by 12/30/12 for POCcompleteness and access monitoring addressed. Accessmonitoring will be completed for patients with anAVF/AVG. All IDT members and clinical staff willbe in-serviced regarding Policy 1.210 Patient Plan ofCare by 12/30/2012. All direct patient care staff will bein-serviced regarding access monitoring by 12/30/12. Nurse Manager or designee will monitor, track &amp; trendaccess monitoring results for all patients with anAVF/AVG including but not limited to appropriateinterventions; referrals for trended abnormal results;POC updates to reflect current interventions. Monitoringwill be completed weekly x 6 or until compliance isestablished, then monthly. Any staff found not to be in compliance with Policy&amp; Procedure will receive</p>	12/30/2012	

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	<p>them.</p> <p>4. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "4. The plan of care will address, but not be limited to, the following: ... e. Vascular access."</p>		<p>progressive disciplinary action. Nurse Manager or designee will review all education, auditing, and non-compliance in the monthly QAPI &amp; Local Governing Board meeting.</p>		

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V0554	<p>494.90(a)(7)(ii) POC-TRANSPLANT STATUS PLAN OR WHY NOT</p> <p>When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the-</p> <p>(A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with §494.80(a) (10).</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the plans of care included documentation of the patient's transplant status in 2 of 5 records reviewed with the potential to affect all 23 patients. (1 &amp; 2)</p> <p>Findings:</p> <p>1. Clinical Record 1 included a plan of care dated 11/28/12 that failed to include documentation of the patient's transplant status.</p> <p>2. Clinical Record 2 included a plan of care dated 10/31/12 that failed to include documentation of the patient's transplant status.</p> <p>3. On November 30, 2012, at 11:30 AM,</p>	V0554	<p>1.-4. All patients charts will be audited &amp; PEARLmedical record &amp; IDT/POCs updated for currentTransplant status by 12/30/12. Interdisciplinary Teamwill be in-serviced regarding Policy 1.210: PatientPlan of Care by 12/30/12.</p> <p>Nurse Manager or designee will monitor all "TransplantEligible" patients charts for updates to PEARL medicalrecord &amp; IDT/POC monthly x 6 months or until 100%compliance is established, then quarterly per the PEARLMedical Records audit tool.</p> <p>Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinaryaction.</p> <p>Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board</p>	12/30/2012	

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	<p>the Clinical Manager, Employee A, indicated the Care Plans were new forms and the necessary information was not on them.</p> <p>4. A policy dated 2/17/2012 "Patient Plan of Care" Policy #1.210 states, "4. The plan of care will address, but not be limited to, the following: ... g. ... ii. Transplantation status"</p>		meeting.		

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V0626	<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 assurance document review and interview, the facility failed to ensure all members of the interdisciplinary team had participated in the facility's quality assessment and performance improvement program in 3 of 11 months reviewed with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <p>1. The facility's "Duneland Dialysis-Knox Inservice Sign-In Sheet Jan 2012 QAPI Minutes" dated 2/29/12 failed to evidence a Technical representative had participated in the quality assurance and performance improvement meeting.</p>	V0626	<p>1.-4. The missing signature for the BiomedicalTechnician on January's QAPI reported on 2/29/12and February's QAPI reported on 3/14/12 QAPI signin sheet was corrected to include the BiomedicalTechnician's signature. The BiomedicalTechnician did call in for those meetings but failed tosign the sign in sheet. The June 2012 QAPI reported on7/25/12 also included the technical documentationreviewed previously by the Medical Director andwas documented in the QAPI minutes but the biomedwas on vacation. The Director of Operations in-servicedall the Interdisciplinary Team members regarding Policy494.110 by 12/30/12. For all QAPI meetings the Biomedtechnician will be</p>	12/30/2012			

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	<p>2. The facility's "Duneland Dialysis-Knox Inservice Sign-In Sheet Jan 2012 QAPI Minutes" dated 3/14/12 failed to evidence a Technical representative had participated in the quality assurance and performance improvement meeting.</p> <p>3. The facility's "Duneland Dialysis-Knox Inservice Sign-In Sheet Jan 2012 QAPI Minutes" dated 7/25/12 failed to evidence a Technical representative had participated in the quality assurance and performance improvement meeting.</p> <p>4. On 11/29/12 at 4:00 PM, the Clinical Manager Employee A indicated the Technical person had not been at the QAPI meetings.</p>		<p>present or have another Biomedpresent or call in for the QAPI meeting documented bysignature of the minutes. It is the dual responsibilityof both the Nurse Manager and the absent participantto ensure all signatures have been documented whetherattendance is in person or via phone. Director of Operations or designee will monitormonthly x 6 or until 100% compliance is established.</p> <p>Any staff found not to be in compliance with Policy&amp; Procedure will receive progressive disciplinaryaction. Nurse Manager or designee will review all education,auditing, and non-compliance in the monthly QAPI &amp;Local Governing Board meeting.</p>		

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;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 personnel record and policy review and interview, the medical director failed to ensure the "Tuberculosis (TB) Control and Testing" Policy # 1.410 was followed in 1 of 4 personnel records reviewed with the potential to affect all the facility's staff and patients. (D)</p> <p>Findings:</p> <p>1. Personnel record D, date of hire 5/26/11, failed to evidence a annual TB test for 2012.</p> <p>2. On 11/29/12 at 10 AM, the Clinical Manager, Employee A, indicated the employee had a PPD skin test on 6/7/2011 with induration of 0 mm, but the arm was hot and painful. The employee was not evaluated by a physician and the employee refused a skin test during the annual evaluations for 2012.</p> <p>3. A policy titled "Tuberculosis (TB) Control and Testing, Policy" # 1.410, Effective 01/12/2012 states, "Policy:</p>	V0715	<p>1.-3. All Employees having allergic reactions to thetuberculin will be evaluated by a physician at thetime of the reaction who will then decide the correctcourse of action. All employees personnel health recordswill be reviewed by the Nurse Manager to ensure TBtesting is completed annually or for those employeeswith documented reactions to the tuberculin, a chestx-ray to document absence of active TB disease. Afterthe initial chest x-ray, an annual checklist will bedocumented to ensure new indicators of active TB arenot present. Director of Operations or designee will monitormonthly x 6 or until 100% compliance is established,then annually. Nurse Manager or designee will review all educationand in the monthly QAPI &amp; Local Governing Boardmeeting.</p>	12/30/2012			

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	General Notes: ... 4. ... Staff and patients will be tested annually using the one-step method."				