

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2013
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NAME OF PROVIDER OR SUPPLIER  NORTH EVANSVILLE DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1151 W BUENA VISTA RD EVANSVILLE, IN 47710
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V000000	<p>This was a federal ESRD complaint investigation.</p> <p>Complaint # IN00131238; Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies were cited.</p> <p>Survey Date: 7-17-13</p> <p>Facility #: 009368</p> <p>Medicaid Vendor #: 200071340A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>North Evansville Dialysis was found to be in compliance with 42 CFR 494.60(d)(1) (ii), 494.150(b), and 494.170(b)(2) as were related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 18, 2013</p>	V000000		

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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V000451	<p>494.70 PR-PTS INFORMED OF RIGHTS WHEN BEGIN TX The dialysis facility must inform patients (or their representatives) of their rights (including their privacy rights) and responsibilities when they begin their treatment and must protect and provide for the exercise of those rights. Based on clinical record and facility policy review and interview, the facility failed to ensure patients had been informed of their rights in accordance with the facility's own policy in 1 (# 5) of 5 records reviewed creating the potential to affect all of the facility's 81 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's December 2008 "Patient Rights and Responsibilities" policy number 3-01-07 states, "Upon admission of a patient, an appropriate teammate will: Give the patient (or legal guardian) a copy of the patient rights and responsibilities statements; . . . After review with the patient and/or legal guardian, obtain the patient's (legal guardian's) signature on the acknowledgement section of the "Rights and Responsibilities."</li> <li>2. Clinical record number 5 failed to evidence the patient and/or representative had been informed on the patient's rights and responsibilities. The record failed to</li> </ol>	V000451	<p>FA reviewed Policy &amp; Procedure #3-01-07A Patient Rights and Responsibilities and Facility Rules with patient #5 on 7/17/2013 patient signature obtained acknowledging review, and placed in patient medical record. Facility Administrator (FA) will hold a mandatory in-service by August 17, 2013 for all Teammates (TMs) reviewing Policy &amp; Procedure #3-01-07A Patient Rights and Responsibilities and Facility Rules, emphasizing upon admission of a new patient appropriate TM must review, and give patient a copy of rights and responsibilities form. After review the patient's signature must be obtained on the acknowledgement section and placed in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. The FA or designee will conduct weekly chart audits on 100% of new admissions x 4 weeks, then monthly to ensure Patient Rights and Responsibilities form is completed upon patients first day,</p>	08/17/2013			

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	<p>evidence a signature to acknowledge the receipt of the rights and responsibilities documents.</p> <p>3. The Group Facility Administrator, employee S, indicated the acknowledgement of receipt of the patient rights and responsibilities had not been signed. The employee stated, "[The patient] was not always coherent. [The patient's] family lived away from here."</p>		<p>and supporting documentation is included in patient's medical record. FA will review audit results with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this Plan of Correction.</p>		

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V000636	<p>494.110(a)(2)(viii) QAPI-INDICATOR-PT SATIS &amp; GRIEVANCES The program must include, but not be limited to, the following: (viii) Patient satisfaction and grievances. Based on quality assurance and performance improvement (QAPI) meeting minutes and facility policy review and interview, the facility failed to ensure patient complaints/grievances had been reviewed in 2 (April and May 2013) of 3 months reviewed creating the potential to affect all of the facility's 81 current patient.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's QAPI meeting minutes dated 4-30-13 evidenced a checkmark by the "yes" box for patient complaints/concerns. The meeting minutes failed to include a review of the complaints/concerns. The meeting minutes state, "Patient complaints will be addressed by SWFA."</li> <li>2. The facility's QAPI meeting minutes dated 5-29-13 evidenced a checkmark by the "yes" box for patient complaints/concerns. The meeting minutes failed to include a review of the complaints/concerns. The meeting minutes state, "Patient complaints will be addressed by SWFA."</li> </ol>	V000636	<p>FA will conduct mandatory in-service by August 17, 2013 for all QIFMM members to review Policy &amp; Procedure 1-14-06: Continuous Quality Improvement Program with emphasis that all patient complaints and grievances must be recorded on Grievance Log and reviewed in QIFMM. QIFMM Team must report, measure, analyze, track and trend Grievances, review to identify root causes, and have action plan developed/initiated that will result in performance improvement. Team must track change in performance over time to ensure improvements are sustained. Action plans must be re-evaluated for effectiveness with new interventions initiated as needed. QIFMM meeting minutes must reflect discussion, actions and evaluation by team. FA will be responsible for maintaining Grievance Log and bringing Log for review with Medical Director to monthly QIFMM. Supporting documentation will be included in the meeting minutes with evaluation of complaints, action plans, resolution, and follow up with the patients noted. FA is responsible for proper documentation reflecting review as indicated in QIFMM minutes.</p>	08/17/2013			

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	<p>3. The facility's March 2013 "Continuous Quality Improvement Program" policy number 12-16-06 states, "The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following: . . . Patient Satisfaction and Grievances."</p> <p>4. The facility administrator, employee J, indicated, on 7-17-13 at 1:15 PM, the facility's April and Mary 2013 QAPI meeting minutes did not include a review of patient complaints.</p>		<p>Verification of attendance at in-services will be evidenced by TMs signature on in-service sheet. The FA is responsible for compliance with this Plan of Correction.</p>				

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V000765	<p>494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services.</p> <p>The grievance process must include-</p> <p>(1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.</p> <p>Based on facility policy and administrative record review and interview, the facility failed to ensure its patient grievance policy had been implemented by failing to document the existence, investigation, and resolution of a patient complaint in 1 (patient # 2) of 1 patient interviewed that expressed a complaint had been lodged with the facility creating the potential to affect all of the facility's 81 current patient.</p> <p>The findings include:</p> <p>1. The facility's March 2013 "Addressing Patient Grievances: Davita Teammates" policy number 3-01-06A states, "Patient grievances may verbal or written . . . Complaints/Grievances should be documented on the facility "Patient Grievance Log. All details of patient</p>	V000765	<p>Masters Social Worker will hold discussion with patient #2 and verify that patient grievance is documented on Patient Grievance Log. Grievance will have complete documentation of grievance, actions taken to date to address the grievance, and when indicated resolution to the grievance.</p> <p>FA will conduct in-service for all TMs by August 17, 2013 reviewing Policy &amp; Procedure # 3-01-06A Addressing Patient Grievances: Davita Teammates. TMs will be instructed on the importance of patients knowing external grievance mechanisms and processes in order to follow-up with the patients who verbalize a grievance. Grievances must be reported to charge nurse or FA who will be responsible for documenting grievance in log book. Each grievance must have complete documentation of the</p>	08/17/2013			

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	<p>grievances and discussions will be documented."</p> <p>2. Patient number 2 (start of care 4-4-13) was interviewed on 7-18-13 at 9:25 AM. The patient indicated there was one particular staff member the patient did not want providing care to the patient. The patient stated, "I did not like her attitude. I have been through enough without putting up with that. I talked to [employee L] and she took care of it."</p> <p>3. The facility's patient complaint log for 2013 failed to evidence patient number 2's complaint had been documented.</p> <p>4. The facility administrator, employee J, indicated, on 7-17-13 at 10:30 AM, the complaint had not been documented.</p>		<p>grievance, actions taken to address the grievance and when the grievance has been resolved. Charge nurse or FA will log all grievances and follow up information on grievance log. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet FA or designee will hold weekly homeroom meetings x 4 weeks to discuss/remind team about logging grievances and to check for any patient complaints that need to be addressed. FA or designee will conduct weekly audits x 4 weeks to check for grievances in log book. FA will be responsible for maintaining Grievance Log and bringing Log for review with Medical Director to monthly QIFMM. Supporting documentation will be included in the meeting minutes with evaluation of complaints, action plans, resolution, and follow up with the patients noted. FA is responsible for proper documentation reflecting review as indicated in QIFMM minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. The FA is responsible for compliance with this Plan of Correction.</p>		