

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152554	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2014
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE FLOYD COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 1919 STATE ST STE 150 NEW ALBANY, IN 47150
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V000000	This was a Federal ESRD recertification survey.  Survey Dates: 6-17-14, 7-8-14, 7-9-14, and 7-10-14  Facility #: 010519  Medicaid Vendor #: 200185020A  Surveyor: Vicki Harmon, RN, PHNS  Quality Review: Joyce Elder, MSN, BSN, RN  July 15, 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 observation, facility policy review, and interview, the facility failed to ensure employees provided care in accordance with the facility's own infection control policies and in accordance with the Centers for Disease Control (CDC) recommendations in 5 (#s 1, 4, 5, 6, and 7)) of 14 infection control observations completed creating the potential to affect all of the facility's 63	V000113	<b>The management staff, including the facility's CEO, met via teleconference on July 18, 2014, and reviewed the summary of deficiencies from the July 8-10, 2014, inspection. After a thorough review of all appropriate policies a POC was developed. The following outlines the plan of correction for each deficiency. The Director of Operations will be</b>	08/15/2014

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>current incenter patients.</p> <p>The findings include:</p> <p>1. Infection control observation number 1 was completed on 6-17-14 at 1:50 PM. Employee G, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 7. The RN was observed to touch the machine, tubing, and intravenous (IV) fluid bag to start the reinfusion of the extracorporeal circuit process. While waiting for the reinfusion to complete, the RN was observed to open clean packages of gauze and touch the clean gauze, without changing gloves and cleansing her hands.</p> <p>2. Infection control observation number 4 was completed on 7-9-14 at 11:50 AM. Employee P, a patient care technician (PCT), was observed to draw up heparin into a syringe for administration to the patient at the medication preparation area. The PCT was then observed to don clean gloves without cleansing her hands.</p> <p>The PCT proceeded to station number 10 to initiate the dialysis treatment on patient number 9. Observation noted a central venous catheter was to be used for the dialysis treatment. The PCT was observed to touch the dialysis machine and then cleanse the catheter hubs with</p>		<p><b>responsible for coordinating all disciplines to carry out necessary training. V113 494.30(a)(1) IC-Wear Gloves/Hand Hygiene On or before 8/15/14 the Clinical Manager will reeducate all direct patient care staff on the following policies with attention to the requirement to follow all infection control policies:</b></p> <ul style="list-style-type: none"> <li>·FMS-CS-IC-II-155-060A “Infection Control Overview” Policy</li> <li>·FMS-CS-IC-II-155-080A “Personal Protective Equipment” Policy</li> <li>·FMS-CS-IC-II-155-090A “Hand Hygiene” Policy</li> </ul> <p><b>Clinical Manager (or designee) will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required. The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility’s QAI process with root cause</b></p>		

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	<p>alcohol pads. The PCT was not observed to cleanse her hands or change her gloves prior to cleansing the catheter hubs.</p> <p>3. Infection control observation number 5 was completed on 7-9-14 at 11:00 AM. Employee G, a RN, was observed to prepare medications for administration to patient number 10. The RN prepared the medications and proceeded to station number 9. The RN placed the medication syringes on the chairside table. The RN then donned clean gloves without cleansing her hands and administered the medications.</p> <p>4. Infection control observation number 6 was completed on 7-9-14 at 11:30 AM. Employee N, a RN, was observed to prepare medications for administration to patient number 11. The RN prepared the medications and proceeded to the dialysis station. The RN donned clean gloves without cleansing her hands and administered the medications.</p> <p>5. Infection control observation number 7 was completed on 6-17-14 at 2:10 PM. Employee G, a RN, was observed to clean and disinfect dialysis station number 13. There was no patient present in the dialysis chair. The RN was observed to empty the prime bucket located on the side of the dialysis</p>		<p><b>analysis. Identified deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</b></p>	

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	<p>machine. The RN then proceeded to clean the dialysis machine without first donning clean gloves and cleansing her hands.</p> <p>6. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC-II-155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation . . . Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and storage of reused items conforming to CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion,</p>			

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	<p>mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, After contact with inanimate objects near the patient, When moving from a contaminated body site to a clean body site of the same patient."</p> <p>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloves hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>7. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate</p>			

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V000116	<p>objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>8. The above-stated observations were discussed with the clinic manager and the Director of Operations on 7-9-14 at 1:00 PM. The clinic manager and the Director agreed employees P and G had not provided care in accordance with facility procedure.</p> <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. Based on observation, interview, and review of facility policy, the facility failed to ensure staff had appropriately</p>	V000116	<b>V116 494.30(a)(1)(i) IC-IF TO Station=DISP/DEDICATE OR DISINFECT On or before 8/15/14 the Clinical Manager</b>	08/15/2014

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	<p>cleaned and disinfected medical equipment after use at a dialysis station in 1 (# 3) of 3 dialysis supply management observations completed creating the potential to affect all of the facility's 63 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On 7-9-14 at 12:05 PM, employee P, a patient care technician, (PCT), was observed to take a dialysate meter to station number 10 and use the meter to check the conductivity of the dialysate at the dialysis machine. The PCT was observed to replace the meter in a common area at the nurse's station without first cleaning and disinfecting the meter.</li> <li>The above-stated observations were discussed with the clinic manager and the Director of Operations on 7-9-14 at 1:00 PM. The clinic manager and the Director agreed employees P and G had not provided care in accordance with facility procedure.</li> <li>The facility's 3-20-13 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A policy states, "After use, all equipment and supplies must be considered as potentially blood contaminated, and should be separated,</li> </ol>		<p><b>will reeducate all direct patient care staff on the following policy: FMS-CS-IC-II-155-110A "Cleaning and Disinfection" Policy Education to emphasize: Non-disposable patient care supplies, such as conductivity meters, should be cleaned with a 1:100 bleach solution after use, prior to taking to a common area or another dialysis station. Clinical Manager or designee will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required. The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for</b></p>	

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V000147	<p>handled with caution and either disinfected or discarded."</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream</p>		<p><b>review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</b></p>	

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	<p>infections].</p> <p>Based on observation, facility procedure review, and interview, the facility failed to ensure termination of treatment with a central venous catheter (CVC) had been completed in accordance with facility procedure in 2 (patients # 6 and 8) of 2 discontinuation of treatment with a CVC observations completed creating the potential to affect all of the facility's 12 current patients with CVCs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's 1-6-14 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" procedure number FMS-CS-IC-I-105-028 C procedure states, "Follow the steps below to prepare for the termination of dialysis: . . . Ensure that a clean under pad is below the catheter limbs to protect the work area and the clothing."</li> <li>2. On 6-17-14 at 2:30 PM, employee P, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 6. Observation noted the patient had a CVC in place and that the CVC had been used to provide the dialysis treatment. The PCT was not observed to place a clean field under the CVC ports prior to</li> </ol>	V000147	<p><b>V147 494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CAT HETER CARE On or before 8/15/14the Clinical Manager will reeducate all direct patient care staff on the following policies with attention to the need to ensure the blue pad under the catheter limbs is clean prior to discontinuation of treatment: FMS-CS-IC-I-105-002C "Initiation of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" Procedure FMS-CS-IC-I-105-028 C "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" Procedure. Clinical Manager (or designee) will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required.The Clinical Manager will present the findings at the monthly QAI</b></p>	08/15/2014			

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V000260	<p>starting the discontinuation process. The PCT stated, "We use the same one."</p> <p>3. On 6-17-14 at 2:40 PM, employee G, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 8. Observation noted the patient had a CVC in place and that the CVC had been used to provide the dialysis treatment. The RN was not observed to place a clean field under the CVC ports prior to starting the discontinuation process.</p> <p>4. The above-stated observations were discussed with the clinic manager and the Director of Operations on 7-9-14 at 1:00 PM. The clinic manager and the Director agreed employees P and G had not provided care in accordance with facility procedure.</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</p>		<p><b>meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</b></p>	

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	<p>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.</p> <p>Based on personnel file review and interview, the facility failed to ensure periodic audits of staff practices for the preparation and mixing of bicarbonate solution had been completed in 1 (file D) of 3 staff files reviewed creating the potential to affect all of the facility's 63 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file D evidenced the individual had completed patient care technician (PCT) orientation on 10-31-11. The file failed to evidence the individual had been periodically evaluated for the performance of bicarbonate mixing and preparation procedures since her orientation.</li> <li>2. The clinic manager stated, on 7-10-14 at 10:10 AM, "Employee D is one of 3 employees that mix bicarb. I have watched her mix bicarb lots of times but</li> </ol>	V000260	<p><b>V260.949.40 (a)</b></p> <p><b>PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS</b></p> <p>The Clinical Manager or designee will complete a 100% employee file audit to identify any employees responsible for bicarb mixing that are lacking a recent audit. Any employees lacking documentation will be audited by the Chief Technician or designee to bring them into compliance. This audit will be completed on or before 8/15/14. Documentation of this audit will be placed in the employee file. Annually, all staff responsible for mixing bicarb will be audited to ensure proper mix procedure is followed. Documentation of the annual audit will be available in the employee personnel file for review. The Clinical Manager or designee will track via the Personnel Tracking tool from the QAI package. This tool will be summarized and presented</p>	08/15/2014

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V000543	<p>have not written it down."</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 ensure the patient's fluid volume had been managed appropriately in 1 (# 2) of 3 records reviewed for fluid management creating the potential to affect all of the facility's 63 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included hemodialysis treatment flow sheets that</p>	V000543	<p>by the Clinical Manager on a quarterly basis to the QAI committee. Any identified deficiencies/trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</p> <p><b>V543 494.90(a)(1) POC-MANAGE VOLUME STATUS On or before 8/15/14 the Director of Operations will re-educate all members of the Interdisciplinary Team on the following policy: FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care" Policy Education to emphasize: Assessment and documentation of patient's fluid status and intra-dialytic fluid gains. Development of</b></p>	08/15/2014	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>evidenced intradialytic (during dialysis) weight loss greater than 5% for 10 consecutive treatments, from 6-14-14 to 7-5-14 creating the potential for adverse cardiac events and decreased organ tissue perfusion.</p> <p>A. A hemodialysis treatment flow sheet dated 6-14-14 evidenced the pre-treatment weight was 96.80 kilograms (kg) and the post treatment weight was 87.30 kg, a 9.8% weight loss during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 6-17-14 evidenced the pre-treatment weight was 96.8 kg and the post treatment weight was 88.2, an 8.9% weight loss during the treatment.</p> <p>C. A hemodialysis treatment flow sheet dated 6-19-14 evidenced the pre-treatment weight was 94.6 kg and the post treatment weight was 86.7 kg, an 8.4% weight loss during the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 6-21-14 evidenced the pre-treatment weight was 93.8 kg and the post treatment weight was 88.3 kg, a 5.9% weight loss during treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 6-24-14 evidenced the</p>		<p><b>patient's Plan of Care to address interventions for meeting goal of IDWG &lt;5% Periodic re-assessment and adjustment of the Plan of Care when desired patient outcomes not achieved. To ensure no reoccurrence of this deficiency, the Clinical Manager will review each completed Comprehensive Interdisciplinary Assessment and Plan of Care prior to filing in the patient record. Clinical Manager will confirm with review that patient's volume status has been addressed by all IDT members. In the event this review finds deficiencies, the Clinical Manager will review the CIA/POC with the IDT team for further development. Additionally, the Clinical Manager will report the findings of the CIA/POC tracking tool to the QAI committee with a summary of any deficiencies found. QAI committee will review and determine further action as necessary to maintain compliance. The QAI minutes document this activity and are available for review at the facility. The Clinical Manager is responsible and the QAI committee monitors for compliance.</b></p>		

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	<p>pre-treatment weight was 93.7 and the post treatment weight was 87.10, a 7% weight loss during treatment.</p> <p>F. A flow sheet dated 6-26-14 evidenced the pre-treatment weight was 95.7 kg and the post treatment weight was 86.6 kg, a 9.5% weight loss during the treatment.</p> <p>G. A flow sheet dated 6-28-14 evidenced the pre-treatment weight was 94.5 kg and the post treatment weight was 85.4 kg, a 9.6% weight loss during the treatment.</p> <p>H. A flow sheet dated 7-1-14 evidenced the pre-treatment weight was 97.9 kg and the post treatment weight was 88.10 kg, a 10% weight loss during the treatment.</p> <p>I. A flow sheet dated 7-3-14 evidenced the pre-treatment weight was 93.6 kg and the post treatment weight was 87.9 kg, a 6% weight loss during the treatment.</p> <p>J. A flow sheet dated 7-5-14 evidenced the pre-treatment weight was 95.3 kg and the post treatment weight was 88.7 kg, a 6.9% weight loss during the treatment.</p>			

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V000629	<p>2. The medical director (and the patient's attending physician) were interviewed on 7-9-14 at 4:05 PM. The physician indicated he would expect to be notified of the continued removal of greater than 5% of the patient's weight during dialysis. The physician stated, "We could order extra treatments or change the dialysis prescription."</p> <p>3. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Provide necessary care and services to manage the patient's volume status."</p> <p>494.110(a)(2)(i) QAPI-INDICATOR-ADEQUACY OF DIALYSIS The program must include, but not be limited to, the following: (i) Adequacy of dialysis. Based on administrative record review and interview, the facility failed to ensure its quality assessment performance improvement (QAPI) addressed fluid volume management in 7 (December 2013 through June 2014) of 7 months reviewed creating the potential to affect all of the facility's 63 current patients.</p>	V000629	<p><b>V629.494.110(a)(2)(i) QAPI-INDICATOR-ADEQUACY OF DIALYSIS On or before 8/15/14 the Director of Operations will re-educate all members of the QAI committee on the following policy with attention to the requirement that the QAI committee review outcomes on the Quality Status</b></p>	08/15/2014

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's "Quality Assessment and Performance Improvement (QAI) Meeting Minutes", dated 12-18-13, 1-23-14, 2-20-14, 3-20-14, 4-17-14, 5-22-14, and 6-19-14, failed to evidence the facility had systematically and comprehensively monitored patient data related to intradialytic fluid removal and weight loss.</li> <li>2. The facility's percentage of patients with less than a 5% intradialytic weight loss during treatment was 86.6%. The Centers for Medicare and Medicaid Services threshold for this clinical outcome is 90%.</li> <li>3. The Director of Operations indicated, on 7-10-14 at 12:40 PM, the QAPI program does not include a review of the facility's percentage of patients with greater than 5% intradialytic weight loss.</li> </ol>		<p><b>Reports to optimize the percentage of patients meeting the targets:</b>  <b>FMS-CS-IC-I-101-001A Quality Assessment and Performance Improvement Program (QAPI) Policy Effective in the July 31, 2014 QAPI Meeting, the QAI committee will review and discuss the percentage of patient's with greater than a 5% intradialytic weight loss during treatment. Committee will assess for root causes and an action plan will be developed to address root causes for IDWGs greater than 5%. Going forward, monthly QAI meetings will monitor trends and action plans will be adjusted accordingly to meet goal of less than 10% of patients with IDWGs greater than 5%. QAI minutes and action plans will document this discussion and review. Director of Operations will monitor QAI minutes and Action Plans for compliance. Deficiencies will be discussed in monthly QAI meetings. The Director of Operations summarize and report any deficiencies to the facility's Governing Body. Director of Operations is responsible with oversight by the Governing Body.</b></p>	