

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2015
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NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368
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V 0000 Bldg. 00	This visit was for an ESRD recertification survey. Survey dates: October 20, 21, 22, and 23, 2015 Facility #: 002456 Medicare #: 152565 Medicaid vendor #: 200279440A 45 Incenter Hemodialysis Patients	V 0000		
V 0113 Bldg. 00	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 record review, observation, and interview, the facility failed to ensure hand hygiene and glove changes had been performed in accordance with facility policy and procedure in 1 of 2 observations completed with a discontinuation of dialysis for a AV Fistula on 10/20/15 (Employee F with Patient #11) and 1 of 2 observations completed on 10/21/15 (Employee E with	V 0113	On 11-20-15 the Director of Operations reviewed with the Clinical Manager and by 11-23-15 the Clinical Manager trained all Registered Nurse (RN) and Patient Care Technician (PCT) staff on: ·FMS-CS-IC-II-155-080A: Personal Protective Equipment Policy with special attention to: ·Gloves ·Hand hygiene must always be performed after glove removal	11/23/2015

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>Patient # 9).</p> <p>The findings include:</p> <p>1. On 10/20/15 at 1 PM, Employee F, Patient Care Technician (PCT) was observed to care for patient #1 at station #8 during discontinuation of dialysis for AV Fistula care. As Employee F carried and discarded the used blood lines to the biohazard waste container, she removed her gloves and did not wash hands. She proceeded to a common storage area in the middle of the treatment floor and picked up a package of cloth wipes to the clean area by the clean sink.</p> <p>On 10/21/15 at 2:10 PM, Employee A, alternate administrator, indicated after a staff member removes gloves, hands should be washed.</p> <p>2. On 10/21/15 at 6:30 AM, Employee E, patient care technician, was observed to care for patient #9 at station #10. After leaving the patient's station, Employee E was observed to remove his gloves and wash his hands with hand antiseptic. He was observed to rub the palms of his hands together but did not wash between his fingers or wash the top of his hands or wrists.</p> <p>On 10/21/15 at 9:15 AM, Employee</p>		<p>·FMS-CS-IC-II-155-090C: Hand Hygiene Procedurewith special attention to:</p> <p>·Procedure for Decontaminating Hands withAlcohol Based Hand Rubs</p> <p>·Ifgloves are worn, remove and discard in appropriate waste container. Exposes theskin for decontamination</p> <p>·Applyalcohol based hand rub to the palm of one hand using the amount recommended bythe product manufacturer. Adequate amountof product must be used for maximum effectiveness</p> <p>·Rubhands together covering all surfaces of the hands and fingers, untilhands are dry. Allowing alcohol to dry completely allows adequate contact timeto kill germs, allows alcohol to evaporate, and prevents risk of ignitingflames due to alcohol's flammable properties. Duration of the entire procedure:20-30 seconds</p> <p>The meeting agenda and attendance records are available forreview at the facility. The Clinical Manager and or designee will perform InfectionControl Audits for compliance according to the QAI Workflow Calendar, addressidentified issues, and report findings and actions taken at monthly QAImeetings. In the event of discrepancies or</p>		

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	<p>B, the clinic manager, indicated the employee should wash the entire hands when sanitizing hands with antiseptis gel.</p> <p>3. The policy titled "Personal Protective Equipment" with a date of March 20, 2013 stated, "Hand hygiene must always be performed after glove removal."</p> <p>4. The procedure titled "Hand Hygiene" with a date of January 4, 2012 stated, "If gloves are worn, remove and discard in appropriate waste container. Exposes the skin for decontamination. 2. Apply the alcohol based hand rub to the palm of one hand using the amount recommended by the product manufacturer. Adequate amount of product must be used for maximum effectiveness. 3. Rub hands together covering all surfaces of the hands and fingers until hands are dry."</p>		<p>problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure hand hygiene and glove changes are performed in accordance with policy and procedure.</p>		

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V 0122 Bldg. 00	<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, interview, and review of facility policy, the facility failed to ensure dialysis stations had been cleaned and disinfected in accordance with facility policy in 2 (#s 1, #11) of 2 cleaning and disinfection of the dialysis station observations completed. (Employee F).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee F, Patient Care Technician, was not observed to clean the sides of the dialysis machine #1 at station #2 after patient #11 completed dialysis on 10/20/15 at 1 PM. 2. Employee F was not observed to clean the sides of the dialysis machine #12 at station #8 after patient #1 completed dialysis on 10/20/15 at 1:15 PM. 3. On 10/21/15 at 9:15 AM, Employee 	V 0122	<p>On 11-20-15 the Director of Operations reviewed with the Clinical Manager and by 11-23-15 the Clinical Manager trained all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-II-155-110A: Cleaning and Disinfection Policy with special emphasis on: ·Cleaning the Dialysis Machine: ·Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are frequently touched and potentially contaminated (sides of machine) <p>The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform Infection Control Audits for compliance according to the QAI</p>	11/23/2015
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V 0543 Bldg. 00	<p>B, clinic manager, indicated the sides of the machines should be cleaned after the patient completed dialysis while the dialysis station and hemodialysis machine were cleaned.</p> <p>4. The facility's 1-28-15 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A states, "Cleaning the dialysis machine ... Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment."</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 record review and interview, the facility failed to ensure it had provided the necessary care and services to monitor the patient's blood pressures every 30 minutes for 1 of 7 incenter hemodialysis patients (#2).</p> <p>The findings include:</p> <p>1. Clinical record #2 included treatment sheets that failed to evidence the patient's</p>	V 0543	<p>Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to dialysis stations are cleaned and disinfected in accordance with facility policy.</p> <p>On 11-20-15 the Director of Operations reviewed with the Clinical Manager and by 11-23-15 the Clinical Manager trained all Registered Nurse (RN) and Patient Care Technician (PCT) staff on: ·FMS-CS-IC-I-110-133A : Patient Monitoring During Patient Treatment Policy: ·Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed</p>	11/23/2015

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V 0544 Bldg. 00	<p>blood pressure had been checked at least every 30 minutes.</p> <p>a. The treatment sheet dated 9/29/15 with dialysis initiation at 11:09 AM and terminated at 2:11 PM evidenced the blood pressure was assessed at 12:02 PM and then not again until 1:01 PM.</p> <p>b. On 10/21/15 at 10:10 AM, Employee A, the alternate administrator, indicated the blood pressure was not checked in a timely manner.</p> <p>2. The policy titled "Patient Monitoring During Patient Treatment" with a date of August 20, 2014 stated, "Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently as needed."</p> <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 record review and interview,</p>	V 0544	<p>The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform Medical Record Audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure that patients are monitored every 30 minutes and as indicated per policy.</p> <p>On 11-20-15 the Director of</p>	11/23/2015	

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	<p>the facility failed to ensure the blood flow rate on the prescription was followed for 1 of 7 incenter hemodialysis records (#5) reviewed.</p> <p>The findings include:</p> <p>1. Clinical record #5 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute.</p> <p style="padding-left: 40px;">A. The flow sheet dated 10/3/15 evidenced BFRs of 445, 448, 450, 453, and 456 during the treatment with no explanation as to why the BFR was not followed.</p> <p style="padding-left: 40px;">B. The flow sheet dated 10/13/15 evidenced BFRs of 450, 453, and 456 during the treatment with no explanation as to why the BFR was not followed.</p> <p style="padding-left: 40px;">C. On 10/22/15 at 8:35 AM, Employee B, the clinic manager, indicated the blood flow rate had always been set at 400.</p> <p>2. The policy titled "Patient Monitoring During Patient Treatment" with a date of August 20, 2014 stated, "Check machine settings and measurement and document at the initiation of dialysis and at safety check ... blood flow rate: check</p>		<p>Operations reviewed with the Clinical Manager and by 11-23-15 the Clinical Manager trained all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-I-110-133A: Patient Monitoring During Patient Treatment Policy: ·Blood flow rate: Check prescribed BFR is being achieved. Make adjustments as needed. Document explanation as to why if indicated. <p>The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform Medical Record Audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure that the BFR on the prescription is followed.</p>		

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V 0715 Bldg. 00	<p>prescribed blood flow is being achieved."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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; Based on clinical record and facility policy review and interview, the medical director failed to ensure all new patients had an evaluation by the registered nurse (RN) prior to the start of the first dialysis treatment in accordance with facility policy in 1 (# 6) of 1 records reviewed of patients on service for less than 90 days creating the potential to affect all new patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #6 evidenced the patient's first treatment at the facility was on 10-7-15 and that the treatment was initiated at 11:56 AM eastern standard time. The record failed to evidence an evaluation by the RN prior to the start of the first treatment on 10-7-14. 2. On 10/23/15 at 10:30 AM, Employee 	V 0715	<p>On 11-20-15 the Director of Operations reviewed with the Clinical Manager and by 11-23-15 the Clinical Manager trained all Registered Nurse (RN) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-II-150-030A: Medical Record Documentation Standards with emphasis on: ·Policy: All patients' medical records will be maintained in accordance with accepted professional standards and practices, and in compliance with state law. Entries: Every entry in the medical record must include a complete date (month, day and year) and have a time associated with it. The time should reflect the actual time the entry was made. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is 	11/23/2015

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	<p>A, alternate administrator, and Employee B, clinic manager, stated, "The initial nursing evaluation was not documented correctly."</p> <p>3. The policy titled "Medical Record Documentation Standards" with a date of January 4, 2012 stated, "All patients' medical records will be maintained in accordance with accepted professional standards and practices ... every entry in the medical record must include a complete date [month, day, and year] and have a time associated with it ... the time should reflect the actual time the entry was made."</p> <p>4. The policy titled "Comprehensive Interdisciplinary Assessments and Plan of Care" with a date of July 4, 2012 stated, "A registered nurse must evaluate New to dialysis before initiation of their first treatment to determine immediate needs. Chairside - the RN must at a minimum, complete the nursing evaluation cascade that includes a systems assessment."</p>		<p>pertinent to the situation. Entries should be made as soon as possible after an event or observation is made.</p> <ul style="list-style-type: none"> ·FMS-CS-IC-I-110-125A: Comprehensive Interdisciplinary Assessment and Plan of Care with special emphasis on: <ul style="list-style-type: none"> ·Prior to initiation of the Patients First Treatment for Patients <u>New</u> to Dialysis: <ul style="list-style-type: none"> ·Registered nurse must evaluate patients NEW to dialysis and BEFORE initiation of their first treatment to determine immediate needs. ·Chairside: The RN must at a minimum, complete the nursing evaluation cascade that includes a system assessment. The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform Medical Record Audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			Committee, inclusive of the Medical Director as Chairperson, monitors to ensure that all new patients have an evaluation by the RN (Registered Nurse) prior to the start of the first dialysis treatment in accordance with facility policy.		