

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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
V0000	<p>This was a federal ESRD [CORE] recertification survey.</p> <p>Facility #: 005135</p> <p>Survey Dates: 2-26-13, 2-27-13, 2-28-13, and 3-1-13</p> <p>Medicaid Vendor #: 200813010</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>March 5, 2013</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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	
V0113	<p>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.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure staff provided care in accordance with the facility's own infection control policy and procedure in 4 (#s 5, 7, 8, and 14) of 18 infection control observations completed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed upon entering the facility, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area . . . Gloves should be changed when: When soiled with blood, dialysate or other body fluids, When going from a 'dirty' area or task to a 'clean' area or task, When moving from a contaminated body site to a clean body site of the same</p>	V0113	<p>Facility Administrator (FA) will hold mandatory in-services for all Clinical Teammates (TMs) by 3/20/2013. In-service will include but not be limited to: review of <i>Policy & Procedure 1-05-01 Infection Control for Dialysis Facilities</i>, emphasizing importance of preventing cross-contamination by ensuring the following: 1) TMs must wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station; 2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station; 3) TMs must perform hand hygiene every time gloves are removed; 4) Effective contact time for alcohol is 1 minute, when using alcohol as the cleaning agent for access site, the alcohol must remain wet for cannulation and 4 alcohol pads are used per cannulation site for cleaning. Once cannulation site has been cleaned it must not be touched, otherwise area must be cleaned per policy prior to cannulation; 5) TMs instructed that post treatment the gauze that is used to stop bleeding on access sites must be changed</p>	04/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>patient; and After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient's dialysis delivery system . . . Hand washing will be performed if hands are visibly contaminated with blood or body fluids . . . Patients are encouraged to wash their hands and access extremity upon entering the treatment area prior to the initiation of dialysis and wash their hands after treatment before leaving the treatment area."</p> <p>2. On 2-27-13 at 4:20 PM, central time, employee K, a patient care technician (PCT), was observed to initiate the dialysis treatment for patient number 6 using a central venous catheter (CVC). The PCT performed a test for the absence of the disinfectant used to clean the dialyzer by placing a drop of fluid from the tubing connected to the dialysis machine onto a test strip. The PCT then touched the front of the machine multiple times to set the appropriate parameters for the treatment. The PCT was then observed to connect the patient to the machine without first changing her gloves and cleansing her hands.</p> <p>3. On 2-26-13 at 11:30 AM, central time, employee F, a PCT, was observed to prepare to initiate the dialysis treatment</p>		<p>with new sterile gauze prior to taping and discharging the patient; 6) TMs must instruct and encourage patients every treatment to perform hand hygiene upon entering the treatment floor; importance of asking patients to wash their access prior to cannulation; and perform hand hygiene prior to leaving the unit after glove removal, and prior to touching any clean supply or area to assist in avoiding the risk of cross contamination. Verification of attendance at in-service will be evidenced by TMs signature on Clinical In-service Form.</p> <p>Infection Control Manager (ICM) or designee will conduct Daily Infection Control Audit x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p> <p>Completion date: 04/1/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591
--	---

(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>on patient number 13. The PCT was not observed to wash the patient's access site or ask the patient if the patient had washed the access site (fistula in the left upper arm) upon entering the treatment area.</p> <p>4. On 2-26-13 at 11:45 AM, central time, employee L, a PCT, was observed to prepare to initiate the dialysis treatment on patient number 10. The PCT was not observed to wash the patient's access site or ask the patient if the patient had washed the access site (fistula right upper arm) upon entering the treatment area.</p> <p>The PCT was observed to cleanse the needle insertion site with an alcohol pad and then a betadine pad. After cleansing the arterial site, the PCT then touched the site and inserted the needle without cleansing the site again after touching it. The PCT was observed to repeat the same process on the venous needle insertion site.</p> <p>5. On 2-26-13 at 11:30 AM, central time, observation noted patient number 14 was holding pressure on the access site after the needles had been removed. A large amount of blood was observed on the gauze over the site and the patient's arm and glove. Employee H, a PCT, was observed to place clean gauze over the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>insertion sites and secure the gauze with tape. The employee then attempted to cleanse the patient's arm with alcohol pads, leaving traces of blood on the patient's arm. The patient removed the gloves and gathered his/her belongings and walked to the door to the lobby. The PCT stated to the patient, "You need to use the alcohol gel to wash your hands." The patient complied with the PCT's request. Traces of blood were visible on the patient's arm when the patient left the treatment floor. The PCT failed to encourage the patient to use soap and water to cleanse the blood from the arm and hand.</p> <p>6. The facility administrator, employee T, and the medical director, employee V, indicated, on 3-1-13 at 2:15 PM, the above-stated observations were not in compliance with the facility's infection control policy and procedure.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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	
V0147	<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 infections].</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure staff were aware of and followed the facility's own policy regarding post treatment care of the central venous catheter (CVC) in 2 (#s 1</p>	V0147	FA will hold mandatory in-services for all clinical TMs by 3/20/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-04-02D: Post Dialysis Central Venous Catheter (CVC) Care and Locking</i>	04/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>and 2) of 2 observations of discontinuation of dialysis on patients with a CVC creating the potential to affect all of the facility's patients that currently have CVCs in use.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's September 2012 "Post Dialysis Central Venous Catheter (CVC) Care and Locking Solution Instillation" procedure number 1-04-02D states, "Scrub and soak CVC and blood lines connections according to manufacturer's recommendations . . . Place clean barrier under catheter limbs to prevent contamination." Employee F, a patient care technician (PCT), was observed to disconnect patient number 11 from the dialysis machine post treatment on 2-28-13 at 3:10 PM, central time. The PCT was not observed to place a clean field under the catheter prior to starting the disconnect procedure. <ul style="list-style-type: none"> A. The PCT was not observed to disinfect the CVC connector before disconnecting the blood lines. B. Employee F indicated, on 3-1-13 at 3:45 PM, central time, she was not aware a clean field should be placed under the catheter limbs and the CVC connector 		<p><i>Solution Instillation</i> emphasizing</p> <ol style="list-style-type: none"> TMs must scrub and soak CVC and blood line connections according to manufacturer's recommendations to reduce risk of infection; TMs must place clean barrier under catheter limbs to prevent contamination. Demonstration on how to properly clean CVC prior to disconnection was shown to each TM. Verification of attendance at in-service will be evidenced by TMs signature on Clinical In-service Form. <p>ICM or designee will conduct Daily Infection Control Audit x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p> <p>Completion date: 04/1/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>devices be disinfected prior to disconnecting the blood lines.</p> <p>3. Employee K, a PCT, was observed to disconnect patient number 6 from the dialysis machine post treatment on 2-28-13 at 3:50 PM, central time. The PCT was not observed to place a clean field under the catheter prior to starting the disconnect procedure.</p> <p>A. The PCT was not observed to disinfect the CVC connector before disconnecting the blood lines.</p> <p>B. Employee K indicated, on 3-1-13 at 3:45 PM, central time, she was not aware a clean field should be placed under the catheter limbs and the CVC connector devices be disinfected prior to disconnecting the blood lines.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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			
V0260	<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 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 administrative record review and interview, the facility failed to ensure practice audits had been conducted to ensure staff compliance with facility procedures in 11 (employees A, C, D, E, F, H, I, J, K, M, and N) of 11 employee records reviewed of employees that completed water testing and dialysate mixing creating the potential to affect all of the facility's 91 current patients.</p> <p>The findings include:</p> <p>1. The facility's undated administrative</p>	V0260	<p>All TMs responsible for water treatment system monitoring have completed annual water testing via Star Learning system. Validation of training evidenced by TM training transcript.</p> <p>Biomedical Technician (BMT) will hold a mandatory in-service with all clinical TMs responsible for water treatment monitoring on by 4/1/2013. In-service will include but not be limited to: reviewing <i>Policy & Procedure #2-03-01 Water Treatment Systems Minimum Component Requirements, Policy &</i></p>	04/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>records evidenced employees A, C, D, E, F, H, I, J, M, and N all performed total chlorine testing of the water and start up of the water system in the mornings. The records failed to evidence the employees had been evaluated for the competent performance of the tasks after their initial evaluation.</p> <p>2. The biomedical technician, employee S, stated, on 2-27-13 at 11:20 AM, central time, "We have re-training on the water system every year. I do not check off every individual every year, though."</p> <p>3. The facility administrator, employee T, stated, on 2-27-13 at 11:50 AM, central time, "We do not audit each employee for the performance of the assigned water responsibilities."</p>		<p><i>Procedure #2-07-02 Daily Water Treatment System Monitoring, Policy & Procedure # 2-07-04 Daily Water System Total Chlorine Monitoring.</i> In-service will include demonstrations and explanations regarding components of the water treatment system and functions of those components, water testing including proper chlorine testing. Re-validation of skills will be conducted on all clinical TMs responsible for water treatment monitoring using the Dialysis Quality Water Monitoring and Testing Skills Verification of attendance at in-service will be evidenced by TMs signature on Clinical In-service Form.</p> <p>FA will develop and initiate tracking system that will be reviewed monthly to ensure ongoing compliance with TMs annual competency training including competency skills checklist. FA or designee will conduct personnel file audit for 100% of new TMs monthly and 25% of current TMs quarterly to ensure training is up to date, and documentation is present in personnel record. Results of audits and TM education will be reviewed with the Medical Director during the monthly Quality Improvement Facility Management Meetings (QIFMM) with supporting documentation included in the meeting minutes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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	
			FA is responsible for compliance with this Plan of Correction Completion date: 04/01/2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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
V0543	<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 post dialysis assessment data had been collected to determine the patient's discharge status in 5 (#s 1, 2, 3, 4, & 9) of 9 records reviewed creating the potential to affect all of the facility's 91 current patients.</p> <p>The findings include:</p> <p>1. The facility's March 2011 "Post Treatment Patient Assessment" policy number 1-03-12 states, "The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings . . . Assessment data includes the following: weight, temperature, blood pressure, cardiac status, respiratory status, peripheral edema, vascular access, mental status, ambulatory status."</p> <p>2. Clinical record number 1 included post treatment flow sheets dated 2-6-13 and 2-15-13 that failed to evidence post treatment data had been collected for</p>			V0543	<p>FA will hold mandatory in-service for all Clinical TMs by 3/20/2013. In-service will include but not be limited to: review of <i>Policy & Procedure #1-03-10 Pre-Post Dialysis Treatment Data Collection, Policy & Procedure #1-03-12 Post Treatment Patient Assessment</i>, 1) patient care staff must obtain and document basic data on each patient post dialysis and compare to pre dialysis findings, findings that may preclude the discharge of the patient must be reported to licensed nurse; 2) If the patient's condition requires intervention, the licensed nurse assesses the patient and collects any additional data needed; 3) Assessment data includes: Weight, Temperature, Blood Pressure, Cardiac status, Respiratory Status, Peripheral Edema, Vascular Access, Mental Status, and Ambulatory Status; 4) licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders 5) All findings, interventions and patient response will be documented in patient's medical record. RN is responsible for daily monitoring. Verification of attendance at</p>		04/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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>cardiac and respiratory status, peripheral edema, vascular access, and mental and ambulatory status.</p> <p>3. Clinical record number 2 included a post treatment flow sheet dated 2-4-13 that failed to evidence post treatment data had been collected for cardiac and respiratory status, peripheral edema, vascular access, and mental and ambulatory status.</p> <p>4. Clinical record number 3 included a post treatment flow sheet dated 2-15-13 that failed to evidence post treatment data had been collected for cardiac and respiratory status, peripheral edema, vascular access, and mental and ambulatory status.</p> <p>5. Clinical record number 4 included a post treatment flow sheet dated 2-9-13 that failed to evidence post treatment data had been collected for cardiac and respiratory status, peripheral edema, vascular access, and mental and ambulatory status.</p> <p>6. Clinical record number 9 included post treatment flow sheets dated 2-4-13 and 2-11-13 that failed to evidence post treatment data had been collected for cardiac and respiratory status, peripheral edema, vascular access, and mental and</p>				<p>in-service will be evidenced by TMs signature on Clinical In-service Form.</p> <p>FA or designee will conduct daily audits for 25% of patient treatment flow sheets x 1 week, and then weekly x 4 weeks, then monthly on 10% of patient treatment flow sheets to ensure post assessments are completed. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p> <p>Completion date: 04/1/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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	
	ambulatory status. 7. The facility administrator, employee T, stated, on 3-1-13 at 2:35 PM, central time, "There is supposed to be post data collection by the registered nurse every treatment."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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
V0632	<p>494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management. Based on administrative record review and interview, the facility failed to ensure its quality assurance performance improvement (QAPI) program identified and addressed root causes for continued decreasing patient hemoglobin values in 4 (November and December 2012 and January and February 2013) of 4 months reviewed creating the potential to affect all of the facility's 91 current patients.</p> <p>The findings include:</p> <p>1. The facility's QAPI meeting minutes dated 11-21-12 states, "Goal not met during October. All patients Hgb levels are monitored by [employee D], RN [registered nurse], CNM during weekly, bi-weekly, and monthly lab draws. Epogen and Venofer dosages are adjusted per protocol and Nephrologist orders. Significant drops in Hgb are thoroughly investigated and followed up on by in-center RNs."</p> <p>The meeting minutes failed to evidence the identification of the root causes of the goal not being met and failed to include a plan to address the</p>			V0632	<p>CSS will conduct a mandatory in-service for all QIFMM members by 4/1/2013. In-service will include but not be limited to: <i>Review of Policy & Procedure 1-02-01: Continuous Quality Improvement Program</i> with emphasis that QIFMM Team must set measurable goals, timelines, conduct ongoing monitoring/evaluation, and initiate interventions for quality indicators including Anemia Management 2) Any identified underperformance including patients with hemoglobin levels not meeting goal will be reviewed to identify root causes and will have action plan identified that will result in performance improvement, and will track change in performance over time to ensure improvements are sustained 3) Action plans must be re-evaluated for effectiveness with new interventions initiated as needed, 4) QIFMM meeting minutes must reflect discussion, actions and evaluation by team. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form.</p> <p>CSS will attend or review meeting minutes for the next three months to ensure minutes are</p>		04/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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>unmet goal.</p> <p>2. The facility's QAPI meeting minutes dated 12-19-12 state, "Goal not met during November, however a slight improvement was noted. All patients Hgb levels are monitored by [employee D], RN, CNM during weekly, bi-weekly, and monthly lab draws. EPOGEN and Venofer dosages are adjusted per protocol and Nephrologist orders. Significant drops in Hgb are thoroughly investigated and followed up on by in-center RNs."</p> <p>The meeting minutes failed to evidence the identification of the root causes of the goal not being met and failed to include a plan to address the unmet goal.</p> <p>3. The facility's QAPI meeting minutes dated 1-23-13 identify the goal was still unmet in December. The meeting minutes failed to evidence the identification of the root causes of goal not being met and failed to include a plan to address the unmet goal.</p> <p>4. The facility's QAPI meeting minutes dated 2-20-13 state, "Goal not met during January with an increase of 2.1% more patients not meeting goal. All patients Hgb levels are monitored by [employee D], RN, CNM during weekly, bi-weekly,</p>				<p>comprehensive and reflective of actions taken. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect.</p> <p>Medical Director & FA are responsible for compliance with this POC.</p> <p>Completion date: 04/01/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591
--	---

(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>and monthly lab draws. Significant Hgb drops are thoroughly investigated for the root cause and reported to MD [medical doctor]. Epogen dosages are adjusted per Protocol and MD orders."</p> <p>The meeting minutes failed to evidence the identification of the root causes of the goal remaining unmet and failed to include a plan of address the continued unmet goal.</p> <p>5. The facility administrator, employee T, stated, on 3-1-13 at 3:50 PM, central time, "The QAPI meeting minutes do not reflect an identification of the root causes."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591			
(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			
V0634	<p>494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification.</p> <p>Based on administrative record review and interview, the facility failed to ensure its quality assurance performance improvement (QAPI) program included an investigation of increased numbers of patients leaving or missing treatments against medical advice (AMA) in 3 (December 2012 and January and February 2013) of 3 months reviewed creating the potential to affect all of the facility's 91 current patients.</p> <p>The findings include:</p> <p>1. The facility's adverse event report identified 28 of 50 adverse events that occurred from 12-19-12 to 2-25-13 were patients missing treatments or leaving early against medical advice.</p> <p>The adverse event report identified there were 6 instances of AMAs in December 2012, 7 instances of AMAs in January 2013, and 15 during the month of February 2013.</p> <p>2. The facility's QAPI meeting minutes dated 1-23-13 state, "AORs: See attached</p>	V0634	<p>CSS will conduct a mandatory in-service for all QIFMM members by 4/1/2013. In-service will include but not be limited to: <i>Review of Policy & Procedure 1-01-09 Against Medical Advice (AMA)/Early Termination Of Treatment and 13-01-02 Adverse Reporting Policy (AOR) Non Teammate Related: Continuous Quality Improvement Program</i> with emphasis that QIFMM Team must set measurable goals, timelines, conduct ongoing monitoring/evaluation, and initiate interventions for quality indicators including patient no shows for treatments, and patients signing off treatment early AMA 2) Any identified trends of patients signing off early or not showing up for treatment will be reviewed to identify root causes and will have action plan identified that will result in performance improvement, and will track change in performance over time to ensure improvements are sustained 3) Action plans must be re-evaluated for effectiveness with new interventions initiated as needed, 4) QIFMM meeting minutes must reflect discussion, actions and evaluation by team. Attendance of in-service is</p>	04/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013
NAME OF PROVIDER OR SUPPLIER VINCENNES DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLOW ST STE 101 VINCENNES, IN 47591		
(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>sheet for AORs reported during the month of December. No trends noted. Increase in the number of AMAs noted, however, no trend seen, and [medical director] aware." The meeting minutes failed to evidence the facility had recognized and addressed an increasing trend in the number of patients missing treatments and/or leaving treatments early.</p> <p>3. The facility administrator, employee T, stated, on 3-1-13 at 2:40 PM, central time, "We did not develop an action plan. We did not think it was a trend."</p>		<p>evidenced by TMs signature on the Clinical In-Service Form.</p> <p>CSS will attend or review meeting minutes for the next three months to ensure minutes are comprehensive and reflective of actions taken. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect.</p> <p>Medical Director & FA are responsible for compliance with this POC.</p> <p>Completion date: 04/01/2013</p>		