

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE - HAMMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 222 DOUGLAS ST HAMMOND, IN 46320
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V 0000 Bldg. 00	<p>This visit was for a Federal ESRD recertification survey.</p> <p>Survey dates: 9/16/15, 9/17/15, 9/21/15, 9/22/15, and 9/23/15</p> <p>Facility #: 5981</p> <p>Medicare #: 152522</p> <p>Medicaid vendor #: 200315330B</p> <p>Census: 119 Incenter Hemodialysis Patients 17 Peritoneal Dialysis Patients 5 Home Hemodialysis Patients</p>	V 0000		
V 0111 Bldg. 00	<p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p>	V 0111	V111	10/23/2015

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>Based on record review, observation, and interview, the facility failed to ensure the dialysis clinic had been kept clean in 2 of 2 observations on 9/16/15.</p> <p>The findings include:</p> <p>1. On 9/16/15 at 11 AM, observation on the treatment floor near the isolation room and station #10 and the clean sink, a sharps container was noted to have small splatters coating the lid of the sharp container. A biohazard container near the sharps container was noted to have the lid up and blood lines were noted in this container. Near station #24 and machine 27, a biohazard container had a red biohazard bag draped out of the container and laying on the floor of the treatment floor. The lid of the container was closed, but the container had blood lines hanging outside the container. The laboratory refrigerator was opened about an inch with specimen tubes inside. This refrigerator was soiled inside on the bottom shelf. Near the dirty sink and the isolation room on a counter top, there was a 2 K Naturalyte gallon with the lid off and no label on it to show when it had been opened and brought to the treatment floor.</p> <p>2. On 9/16/15 at 12:46 PM, the</p>		<p>Teammates immediately cleaned sharps containers; closed the lid on the biohazard container, properly disposed of the red biohazard bag that was draped out of the container and laying on the floor; placed the bloodlines into the container; checked the temp in the refrigerator, cleaned the bottom shelf, and closed the door; placed a completed date label on the 2K Naturalyte gallon.</p> <p>Facility Administrator (FA) held mandatory in-service for all clinical Teammates (TMs) by 9/23/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure #1-05-08: Bleach Policy and Policy & Procedure #4-02-03: Specified Control Methods emphasizing facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents. 1) Facility must remain clean, uncluttered, and organized; 2) Spills must be immediately cleaned with proper bleach solution; TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection tasks emphasizing for visible blood or gross blood spills a 1:10 bleach solution must be utilized. After blood is cleaned with 1:10 bleach solution TMs must use new disposable towel soaked with 1:10 bleach solution and clean a second time; 3) Refrigerators must</p>	

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	<p>observation noted above in finding #1 was discussed with Employee K, administrator. The administrator indicated the observations were not in compliance with facility policy.</p> <p>3. On 9/16/15 at 2:25 PM, Patient #12 was observed to stand and attempt to walk from the dialysis chair at station 30. Patient #12's left upper arm fistula site which was dressed in gauze started to bleed. Approximately, 50 cc of blood fell onto the floor of the clinic. Employee I, patient care technician, cleaned up the spill with cloths dipped into 1:100 bleach obtained out of a container of bleach water, marked 1:100 bleach, at the treatment area's sink. She wiped up the blood with this solution.</p> <p>On 9/16/15 at 2:50 PM, Employee I indicated the blood spill was cleaned up with 1:100 ratio bleach to water and not the 1:10 bleach ratio.</p> <p>4. The dialysis policy titled "Specified Control Methods" with a date of March 2012 stated, "Dialysis Precautions: the Centers for Disease Control Recommendations for Preventing Transmission of Infections among chronic hemodialysis patients ... must be following when caring for all patients ... 13. Blood / effluent spills will be cleaned</p>		<p>remain clean, TMs assigned to inspect and clean refrigerators at a minimum of monthly; 4) All concentrate containers must be labeled according to their concentrate type and formulation. TMs must verify concentrate containers are labeled to reflect concentrate type. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meeting (FHM), minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p> <p>Completion date: 10/23/2015</p>	

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	<p>up immediately ... the surface will be cleaned with disposable cloths soaked in a bleach / water solution to remove visible blood / effluent ... biohazard spill kit contents will include germicidal surface wipes [1:10 bleach water] for blood spills ... Counter tops will be maintained in a clean and sanitary condition ... inner and outer surfaces of trash cans will be disinfected at the end of every treatment day, or when visibly contaminated."</p> <p>5. The dialysis policy titled "Bleach Policy" with a date of March 2015 stated, "A 1:10 bleach solution is used to clean any environmental surfaces or non - disposable supplies which are visibly contaminated with blood or body fluids."</p> <p>6. The dialysis policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient ... cleaning and / or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood ... for visible blood or gross blood spills, a 1:10 bleach solution must be utilized."</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, staff interview, and record review, the facility failed to ensure surfaces were not contaminated with blood for 2 of 2 treatment floor observations on 9/16/15 and cleaned according to facility policy.</p> <p>The findings include:</p>	V 0122	<p>V122</p> <p>TMs immediately cleaned sharps containers; closed the lidon the biohazard container, properly disposed of the red biohazard bag that wasdraped out of the container and laying on the floor; placed the bloodlines intothe container.</p>	10/23/2015

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	<p>1. On 9/16/15 at 11 AM, observation on the treatment floor near the isolation room and station #10 and the clean sink, a sharps container was noted to have small splatters of blood coating the lid of the sharp container. A biohazard container near the sharps container was noted to have the lid up and blood lines were noted in this container. Near station #24 and machine 27, a biohazard container had a red biohazard bag draped out of the container and laying on the floor of the treatment floor. The lid of the container was closed, but the container had blood lines hanging outside the container.</p> <p>2. On 9/16/15 at 12:46 PM, the observation noted above in finding #1 was discussed with Employee K, administrator. The administrator indicated the observations were not in compliance with facility policy.</p> <p>3. On 9/16/15 at 2:25 PM, Patient #12 was observed to stand and attempt to walk from the dialysis chair at station 30. Patient #12's left upper arm fistula site which was dressed in gauze started to bleed. Approximately, 50 cc of blood fell onto the floor of the clinic. Employee I, patient care technician, cleaned up the spill with cloths dipped</p>		<p>FA held mandatory in-service for all clinical TMs by 9/23/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure #1-05-08: Bleach Policy and Procedure #4-02-03: Specified Control Methods emphasizing facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents. 1) Facility must remain clean, uncluttered, and organized; 2) Spills must be immediately cleaned with proper bleach solution; TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection tasks emphasizing for visible blood or gross blood spills a 1:10 bleach solution must be utilized. After blood is cleaned with 1:10 bleach solution TMs must use new disposable towel soaked with 1:10 bleach solution and clean a second time. Verification of attendance at in-service will be evidenced by TM signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance</p>	

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	<p>into 1:100 bleach obtained out of a container of bleach water marked 1:100 bleach at the treatment area's sink. She wiped up the blood with this solution.</p> <p>On 9/16/15 at 2:50 PM, Employee I indicated the blood spill was cleaned up with 1:100 ratio bleach to water and not the 1:10 bleach ratio.</p> <p>4. The dialysis policy titled "Specified Control Methods" with a date of March 2012 stated, "Dialysis Precautions: the Centers for Disease Control Recommendations for Preventing Transmission of Infections among chronic hemodialysis patients ... must be following when caring for all patients ... 13. Blood / effluent spills will be cleaned up immediately ... the surface will be cleaned with disposable cloths soaked in a bleach / water solution to remove visible blood / effluent ... biohazard spill kit contents will include germicidal surface wipes [1:10 bleach water] for blood spills ... inner and outer surfaces of trash cans will be disinfected at the end of every treatment day, or when visibly contaminated."</p> <p>5. The dialysis policy titled "Bleach Policy" with a date of March 2015 stated, "A 1:10 bleach solution is used to clean any environmental surfaces or non -</p>		<p>with this correction.</p> <p>Completion date: 10/23/2015</p>				

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V 0343 Bldg. 00	<p>disposable supplies which are visibly contaminated with blood or body fluids."</p> <p>6. The dialysis policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Cleaning and / or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood ... for visible blood or gross blood spills, a 1:10 bleach solution must be utilized."</p> <p>494.50(b)(1) DIALYZER INSPECT P REPROCESS-ALL ASPECTS 11.5 Inspection: after reprocessing: all aspects/aesthetics The hemodialyzer shall be examined after reprocessing to ensure that the external surface is clean, the dialyzer is not damaged, and the rinsing of blood has been satisfactorily completed. The dialyzer should also be aesthetically acceptable in</p>			

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	<p>appearance to patients and staff.</p> <p>11.5.1 The dialyzer jacket should be free of visible blood or other foreign material.</p> <p>11.5.2 There shall be no leaks or cracks in the dialyzer jacket or the blood or dialysate ports.</p> <p>11.5.3 No more than a few dark, clotted fibers should be evident on inspection of the exterior of the hollow fibers.</p> <p>11.5.4 The headers of hollow-fiber dialyzers should be free of all but small peripheral clots or other deposits.</p> <p>11.5.5 Blood and dialysate ports shall be capped without evidence of leakage.</p> <p>11.5.6 The label shall be properly filled out and legible.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the headers of 1 of 20 reprocessed dialyzers viewed were free of several blood clots (#20).</p> <p>The findings include</p> <p>1. The policy titled "Visual Inspection of Dialyzer " with a date of September 2013 stated, "After reprocessing each dialyzer, verify there a no more than a few dark clotted fibers ... the headers are free of all but a small amount of peripheral clots."</p>	V 0343	V343 Teammates immediately inspected and removed all dialyzers that did not meet policy specifications. FA held mandatory in-service for all TMs responsible for reuse by 9/23/2015. In-service included review of Policy & Procedure #6-01-11: Visual Inspection of Dialyzer, emphasizing after reprocessing each dialyzer, verify there are no more than a few dark clotted fibers, the headers are free of all but a small amount of peripheral clots. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct dialyzer audits daily x	10/23/2015

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V 0401 Bldg. 00	<p>2. On 9/21/15 at 12 noon, the reuse room evidenced a reprocessed dialyzer that had been cleaned and processed and was ready for the next hemodialysis treatment on the wall of the reuse room. The header of the dialyzer had a ring of peripheral blod clots all the way around the circumference of this dialyzer's header.</p> <p>3. On 9/21/15 at 1:15 PM, Employee A, clinical services specialist, indicated the dialyzer did not look aesthetically pleasing and needed to be processed again.</p> <p>4. A facility reuse document with no title and date of 9/21/15 evidenced patient #20's dialyzer had been reprocessed at 9/21/15 at 11:05 AM and passed inspection with Employee L, reuse technician.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on record review, observation, and interview, the facility failed to ensure the dialysis clinic had been kept clean in 2 of 2 observations on 9/16/15.</p>			V 0401	<p>2weeks, weekly x 2 weeks, and then monthly for compliance. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect. FA is responsible for compliance with this correction. Completion date: 10/23/2015</p> <p>V401 Teammates immediately cleaned sharps containers; closed the lid on the biohazard container, properly</p>		10/23/2015

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	<p>The findings include:</p> <p>1. On 9/16/15 at 11 AM, observation on the treatment floor near the isolation room and station #10 and the clean sink, a sharps container was noted to have small splatters coating the lid of the sharp container. A biohazard container near the sharps container was noted to have the lid up and blood lines were noted in this container. Near station #24 and machine 27, a biohazard container had a red biohazard bag draped out of the container and laying on the floor of the treatment floor. The lid of the container was closed, but the container had blood lines hanging outside the container. The laboratory refrigerator was opened about an inch with specimen tubes inside. This refrigerator was soiled inside on the bottom shelf. Near the dirty sink and the isolation room on a counter top, there was a 2 K Naturalyte gallon with the lid off and no label on it to show when it had been opened and brought to the treatment floor.</p> <p>2. A document titled "Davita Labs" failed to show the refrigerator log for the lab area had been documented each day treatment had occurred in the month of September 2015. There was a lack of</p>		<p>disposed of the red biohazard bag that was draped out of the container and laying on the floor; placed the bloodlines into the container; checked the temp in the refrigerator, cleaned the bottom shelf, and closed the door; placed a completed date label on the 2K Naturalyte gallon.</p> <p>FA held mandatory in-service for all clinical TMs by 9/23/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities, Policy & Procedure #1-05-08: Bleach Policy, Policy & Procedure #1-06-06: Medications Requiring Refrigeration and Policy & Procedure #4-02-03: Specified Control Methods emphasizing facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents. 1) Facility must remain clean, uncluttered, and organized; 2) Spills must be immediately cleaned with proper bleach solution; TMs educated on proper use for 1:10 vs. 1:100 bleach solutions for cleaning and disinfection task emphasizing for visible blood or gross blood spills a 1:10 bleach solution must be utilized. After blood is cleaned with 1:10 bleach solution TMs must use new disposable towel soaked with 1:10 bleach solution and clean a second time; 3) Proper procedure for checking and recording refrigerator temperatures refrigerator temperature logs must be maintained at proper</p>		

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	<p>documentation for the temperature reading of this refrigerator on 9/4/15, 9/8/15, 9/10/15, and 9/11/15. These were treatment days.</p> <p>3. On 9/16/15 at 12:46 PM, the observation noted above in finding #1 and #2 were discussed with Employee K, administrator. The administrator indicated the observations and lack of documentation with the refrigerator log were not in compliance with facility policy.</p> <p>4. On 9/16/15 at 2:25 PM, Patient #12 was observed to stand and attempt to walk from the dialysis chair at station 30. Patient #12's left upper arm fistula site which was dressed in gauze started to bleed. Approximately, 50 cc of blood fell onto the floor of the clinic. Employee I, patient care technician, cleaned up the spill with cloths dipped into 1:100 bleach obtained out of a container of bleach water, marked 1:100 bleach, at the treatment area's sink. She wiped up the blood with this solution.</p> <p>On 9/16/15 at 2:50 PM, Employee I indicated the blood spill was cleaned up with 1:100 ratio bleach to water and not the 1:10 bleach ratio.</p> <p>5. The dialysis policy titled "Specified</p>		<p>daily intervals. Refrigerators must remain clean, TMs assigned to inspect and clean refrigerators at a minimum of monthly; 4) All concentrate containers must be labeled according to their concentrate type and formulation. TMs must verify concentrate containers are labeled to reflect concentrate type. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p> <p>Completion date: 10/23/2015</p>		

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	<p>Control Methods" with a date of March 2012 stated, "Dialysis Precautions: the Centers for Disease Control Recommendations for Preventing Transmission of Infections among chronic hemodialysis patients ... must be following when caring for all patients ...</p> <p>13. Blood / effluent spills will be cleaned up immediately ... the surface will be cleaned with disposable cloths soaked in a bleach / water solution to remove visible blood / effluent ... biohazard spill kit contents will include germicidal surface wipes [1:10 bleach water] for blood spills ... Counter tops will be maintained in a clean and sanitary condition ... inner and outer surfaces of trash cans will be disinfected at the end of every treatment day, or when visibly contaminated."</p> <p>6. The dialysis policy titled "Bleach Policy" with a date of March 2015 stated, "A 1:10 bleach solution is used to clean any environmental surfaces or non - disposable supplies which are visibly contaminated with blood or body fluids."</p> <p>7. A policy titled "General Information" from the Laboratory Reference Manual stated, "Temperature Record: Recording your refrigerator and / or freezer temperatures on a daily basis helps to ensure proper preservation of your</p>			

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V 0407 Bldg. 00	<p>patient's specimens. To assist you in monitoring the temperature record, a daily temperature log is provided by Davita labs, to be used only on refrigerators that contain specimens."</p> <p>8. The dialysis policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient ... cleaning and / or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood ... for visible blood or gross blood spills, a 1:10 bleach solution must be utilized."</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation, record review, and interview, the facility failed to ensure the treatment area was staffed so that 6 of 6 patients receiving dialysis treatment in pods #1 and #2 (patients #6, #13, #14,</p>	V 0407	<p>V407</p> <p>FA will hold mandatory in-service fort all clinical TMs by10/23/2015. In-service will review of Policy & Procedure # 1-04-11 VascularAccess</p>	10/23/2015

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	<p>#15, #16, #17,) could be seen at all times for 1 of 1 facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 9/22/15 at 2:04 PM, Employee H, Patient Care Technician, was observed to leave pods #1 and #2 and exited into the lobby though the entry door for the treatment floor. She closed the door behind her and was not able to see the patients being dialyzed in pods #1 and #2 which included stations #25 - #32 which were placed in a semi circle near the entry door for the facility. The patients receiving treatment at this time included patient #14 at station #25, patient #13 at station #26, patient #6 at station 27, patient #15 at station #28, patient #17 at station #29, patient #16 at station #32. There was no other staff member viewing the patients at this time or in this treatment area. On 9/22/15 at 2:07 PM, Employee I, Patient Care Technician entered pods #1 and #2 and resumed care of the patients in this area. On 9/22/15 at 2:30 PM, Employee B, Home Department facility administrator, indicated the patients are to be observed at all times. 		<p>Monitoring and Surveillance, Policy & Procedure #8-02-01: TeammateQualifications, Licensure, and Adequate Staffing, Policy & Procedure#7-05-03 Intradialytic Treatment Monitoring emphasizing an adequate number ofqualified personnel whenever patients are undergoing dialysis so that the patient/ staff ratio is appropriate to the level of dialysis care given and meets theneeds of the patients. Vascular accesssites must remain visible at all times during patient treatment to ensure orminimize the risk of needle dislodgement during treatment. TMs must provide aneffective, safe and comfortable dialysis treatment to every patient inaccordance with his/her individual plan of care; each patient, includinghis/her face, vascular access site, and blood line connections, needs to beseen by a staff member throughout the dialysis treatment. Verification of attendance at in-service willbe evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct observational audits weekly x4 weeks, then monthly. FA will review results of audits with Medical Directorduring monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan ofcorrection</p> <p>Completion date: 10/23/2015</p>				

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V 0470 Bldg. 00	<p>4. The agency policy titled "Teammate Qualifications, Licensure, and Adequate Teammate Staffing" stated, "An adequate number of qualified personnel whenever patient are undergoing dialysis so that the patient / staff ratio is appropriate to the level of dialysis care given and meets the needs of patients."</p> <p>5. The agency policy titled "Intradialytic Treatment Monitoring" with a date of March 2012 stated, "To provide an effective, safe and comfortable dialysis treatment to every patient in accordance with his / her individual plan of care ... Each patient, including his / her face, vascular access site, and blood line connections, needs to be seen by a staff member throughout the dialysis treatment."</p> <p>494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can</p>			

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	<p>be easily seen and read by patients. Based on record review, observation, and interview, the facility failed to ensure a copy of the patient's rights was prominently displayed in 1 of 1 facility including the current State Agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients (#1 - #10).</p> <p>The findings include</p> <ol style="list-style-type: none"> On 9/17/15 at 3:45 PM, it was observed that the current State Agency mailing address and telephone complaint numbers were not posted anywhere in the facility where the State Agency contact information could be seen. On 9/17/15 at 3:45 PM, Employee C and D, both Master's of Social Work, indicated the State agency contact information was not posted in the clinic. A review of 11 records showed that patients #1 - #10 had received their rights and patient grievance procedure on the day of admission to the dialysis clinic. The document titled "Davita Patient Grievance Procedure" with no date showed the state agency with the ESRD network in Indianapolis and the State 			V 0470	<p>V470</p> <p>Teammates immediately posted the missing and/or correct patient rights, patient grievance, ESRD Renal Network and State Agency contact information including mailing address, and telephone complaint numbers in the main lobby where it is visible to all patients.</p> <p>FA held mandatory in-service for all clinical TMs on 9/23/2015. In-service included review of Policy & Procedure #3-01-07: Patient Rights and Responsibilities; #3-01-07A: Patient Rights, Responsibilities and Facility Rules; #3-01-06: Patient Grievance; and, #3-01-06A: Addressing Patient Grievances: DaVita Teammates, emphasizing DaVita patients are entitled to the following...to freely express grievances verbally or in writing to facility teammates, administration, the DaVita Corporate Compliance Department, the ESRD Network organization, and appropriate regulatory agencies without fear of reprisal or denial of services, discrimination, or retaliation. Information regarding the grievance process will be provided to the patient and the facility social worker will assist as needed. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p>		10/23/2015

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V 0543	<p>Department of Health and Human Services in Chicago, Illinois with its address and phone number. The State Agency Contact number was not posted.</p> <p>5. The policy titled "Patient Rights, Responsibilities, and Facility Rules" with a date of March 2010 stated, "As a DaVita Patient you are entitled to the following ... to freely express grievances verbally or in writing to facility teammates, administration, the DaVita Corporate Compliance Department, the ESRD Network organization, and appropriate regulatory agencies without fear of reprisal or denial of services, discrimination, or retaliation. Information regarding the grievance process will be provided to you and the facility social worker will assist you if needed."</p> <p>6. The policy titled "Patient Rights and Responsibilities" with a date of December 2008 stated, "The facility will prominently display a copy of the patient rights, including the current state agency."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS</p>		<p>FA or designee will ensure that contact information is visible at all times and accessible to patients. FA or designee will conduct medical records audits monthly x 3 then at a minimum of quarterly thereafter on all new admissions to ensure documentation is present to support external grievance mechanisms and processes are reviewed with patients. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 10/23/2015</p>	

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Bldg. 00	<p>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 interview and record review, the facility failed to ensure it had provided the necessary care and services to manage the patient's fluid volume status in 2 (#4, 5) of 7 incenter hemodialysis records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record #4 included treatment sheets that failed to evidence the patient's blood pressure had been checked at least every 30 minutes.</p> <p style="padding-left: 40px;">a. The treatment sheet dated 8/20/15 with dialysis initiation at 9:33 AM and terminated at 1:23 PM evidenced the blood pressure was assessed at 11:05 AM and then not again until 12:04 PM.</p> <p style="padding-left: 40px;">b. The treatment sheet dated 8/27/15 with dialysis initiation at 9:48 AM and terminated at 1:38 PM evidenced the blood pressure was assessed at 10:17 AM and then not again until 11:17 AM.</p>	V 0543	<p>V543</p> <p>FA held mandatory in-service for all clinical TMs on 9/23/2015. In-service included review of Policy & Procedure #1-03-09 Intradialytic Treatment Monitoring, emphasizing treatment monitoring must be completed at a minimum of every 30 minutes during, evaluation and documentation must include a minimum patient's blood pressure, heart rate, blood and dialysate flows, arterial & venous pressures, fluid removal and/or replacement, vascular access status, line connections, patient status and subjective wellbeing. TMs must report and document any significant changes or indicators outside of ordered parameters to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee to conduct daily audits on 25% of patient treatment flow sheets x 2 weeks, then weekly x 4 weeks, and then monthly on 10% of</p>	10/23/2015

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	<p>c. On 9/23/15 at 2:20 PM, Employee A, Registered Nurse and clinical services specialist, indicated the blood pressure was not checked in a timely manner.</p> <p>2. Clinical record #5 included treatment sheets that failed to evidence the patient's blood pressure had been checked at least every 30 minutes.</p> <p>a. The treatment sheet dated 8/20/15 with dialysis initiation at 10:19 AM and terminated at 2:09 PM evidenced the blood pressure was assessed at 11:15 AM and then not again until 12:18 PM.</p> <p>b. On 9/23/15 at 2:40 PM, Employee A indicated the blood pressure was not checked in a timely manner.</p> <p>3. The agency policy titled "Intradialytic Treatment Monitoring" with a date of March 2012 stated, "To provide an effective, safe and comfortable dialysis treatment to every patient in accordance with his / her individual plan of care ... treatment checks should be completed every 30 minutes."</p>		<p>treatment sheets to ensure compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 10/23/2015</p>		

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V 0544 Bldg. 00	<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, the facility failed to ensure the blood flow rate on the prescription was followed for 2 of 7 incenter hemodialysis records (#2, 5) reviewed.</p> <p>Findings include:</p> <p>1. Clinical record #2 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute.</p> <p>A. The flow sheet dated 9/2/15 evidenced BFRs of 300 during the treatment with no explanation as to why</p>	V 0544	<p>V544</p> <p>FA held mandatory in-service for all clinical TMs on9/23/2015. In-service included review of Policy & Procedure #1-03-09Intradialytic Treatment Monitoring, emphasizing TMs must verify patientdialysis prescription, and set all treatments as prescribed including bloodflow rate. Nurses are responsible for ensuring patients receive prescribed doseof dialysis and physician orders are followed. TMs must monitor patient's bloodflow rates at a minimum of every 30 minutes, report and document flow ratesoutside of ordered parameters to licensed nurse, licensed nurse must takeappropriate</p>	10/23/2015	

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	<p>the BFR was not followed.</p> <p>B. The flow sheet dated 9/4/15 evidenced BFRs of 300 and 350 during the treatment with no explanation as to why the BFR was not followed.</p> <p>C. On 9/23/15 at 3:10 PM, Employee A, Clinical Services Specialist and Registered Nurse, indicated the blood flow rates were not run as prescribed on 9/2/15 and 9/4/15.</p> <p>2. Clinical record #5 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute.</p> <p>A. The flow sheet dated 9/8/15 evidenced BFRs of 350 during the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 9/12/15 evidenced BFRs of 330 and 375 during the treatment with no explanation as to why the BFR was not followed.</p> <p>C. On 9/23/15 at 2:40 PM, Employee A indicated the blood flow rates were not followed.</p> <p>3. The agency policy titled "Intradialytic Treatment Monitoring" with a date of</p>		<p>action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee to conduct daily audits on 25% of patient treatment flow sheets x 2 weeks, then weekly x 4 weeks, and then monthly on 10% of treatment sheets to ensure compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>Completion date: 10/23/2015</p>		

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V 0726 Bldg. 00	<p>March 2012 stated, "To provide an effective, safe and comfortable dialysis treatment to every patient in accordance with his / her individual plan of care."</p> <p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.</p> <p>Based on observation, record review, and interview, the facility failed to maintain pertinent and up to date records regarding an adverse access event in 1 of 7 incenter hemodialysis records reviewed (#6).</p>	V 0726	<p>V726</p> <p>FA held mandatory in-service for all clinical TMs on9/23/2015. In-service included review of Policy & Procedure #1-04-04:Needle Infiltration-Hematoma 0907;</p>	10/23/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of patient #6's record failed to evidence patient #6's event on 9/8/15 after an infiltration of the left arm AV fistula site occurred followed the agency policy. Documentation was lacking for this adverse event and the physician was not notified of the incident. 2. A hemodialysis treatment sheet with a date of 9/8/15 evidenced treatment had been initiated at 11:02 AM. Documentation at 11:03 AM showed the a blood flow rate of 350 and dialysis flow rate of 600. The treatment sheet evidenced that medications and ancillaries were not administered due to an access event. There was no documentation about the infiltration event from either Employee E, Registered Nurse, and Employee F, Patient Care Technician who each had the caregiver roles for this patient during the access infiltration event. 3. A clinical record document titled "Access Event Report" with a date of 9/8/15 stated, "Access Evaluation for dysfunction." There was no documentation on this event report except the date and the patient's past history of a AV Fistula in the left upper 		<p>#12-06-06: Needle Infiltration-Hematoma0906; #7-04-05: Needle Infiltration-Hematoma 0606; and #7-04-05A: NeedleInfiltration-Hematoma Procedure 0606, emphasizing as part of the dialysis datacollection, the vascular access site must be inspected per policy...the licensednurse must be notified of infiltrations and/or hematomas...The licensed nurse must assess the vascular access for signs and symptoms and will determine ifthere is localized or generalized pain and swelling and identify the followinglocation, size, induration, color, patients subjective description ofpain. With a clean pen or marker,outline border of infiltrate / hematoma on patient's skin for determination ofincreasing size. Circumferentialmeasurement will be recorded in case of deep hematoma that is enlarging. For a venous or arterial needle infiltratethat is localized but increasing in size or for generalized swelling or pain,remove the needle and with a clean gloved hand and sterile gauze, apply directpressure to the insertion site. Applyclean, disposable cold pack to infiltration, cold pack should be used on top ofclean, moisture proof barrier and not applied directly on patient's skin. Remove cold pack and check site every 5minutes for changes. Elevate the accessextremity. Monitor vital signs andprovide supportive care...Patient</p>	

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	<p>arm placed on 7/28/14 and first used on 8/19/14 and a access evaluation for dysfunction event which resulted in an access evaluation with an angioplasty and fistulogram successfully angioplastied.</p> <p>4. A hemodialysis treatment sheet with a date of 9/10/15 evidenced treatment had been initiated at 10:51 AM and terminated at 2:16 PM. Employee G, Registered Nurse, stated, "Access AV fistula left upper arm patent ecchymosis and edematous."</p> <p>5. On 9/17/15 at 4 PM, Patient #6 was observed to have bruising on the left upper arm which was purple in color and surrounded the upper left arm around the fistula site.</p> <p>6. Via phone call, on 9/17/15 at 7 PM, Patient #6 indicated the infiltration event occurred one morning about 2 weeks ago. Patient #6 indicated not being able to complete treatment because of the infiltration. When the infiltration occurred, patient #6 indicated the left arm felt warm. Treatment was stopped. Both the nurse and technician looked at the infiltration that had occurred in the left arm. The technician was apologetic. Ice was applied. Patient indicated receiving instructions from the technician on how to care for the arm at home.</p>		<p>education for an infiltration may include thefollowing: cold packs are to be used for the first 24 hours post infiltration,cold packs should be on 15 minutes and off 15 minutes, while awake...notifyphysician of any changes...document findings and interventions in patient'smedical record. Verification ofattendance at in-service will be evidenced by TMs signature on in-servicesheet.</p> <p>FA will hold mandatory in-service with all clinical TMsby 10/23/2015 to review Policy & Procedure #13-01-02 Adverse OccurrenceReport Policy (Non Teammate Related) to emphasize what events qualify as anAdverse Occurrence Report (AOR), and proper documentation of an AOR.Verification of attendance at in-service will be evidenced by TMs signature onin-service sheet.</p> <p>FA or designee will investigate AORs, verify appropriatedocumentation, and conduct Medical Records Audits monthly on 10% of patientcensus. FA will review results of allaudits, trend AORs and report during monthly FHM to ensure patients safety;continuous monitoring will be reflected in FHM minutes.</p> <p>FA is responsible for compliance with this plan ofcorrection</p> <p>Completiondate: 10/23/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE - HAMMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 222 DOUGLAS ST HAMMOND, IN 46320
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	<p>7. On 9/22/15 at 3:05 PM, Employee B, Home Department Facility Administrator and Registered Nurse indicated there was no documentation about the adverse event described in finding #2. Employee B indicated there was no documentation the physician had been updated about this event. There was no description of the event or description of patient #6's arm or any other signs and symptoms of the event that occurred. The infiltration procedure was not followed.</p> <p>8. On 9/23/15 at 12 PM, Employee E, Registered Nurse, was not available for interview.</p> <p>9. On 9/23/15 at 12:05 PM, Employee F, patient care technician, indicated performing the initiation of dialysis into the AV fistula site into the patient's left arm. When the infiltration occurred which was shortly after the initiation, the patient complained that the arm felt hot and prickly. The dialysis was running slow. Employee F indicated instructing patient to alternate hot and cold compresses on the site at home. Employee F indicated the nurse, employee E had indicated that she would document on the event. Ice was applied and the nurse was aware and assessed the site.</p>			

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	<p>10. The agency policy titled "Needle Infiltration / Hematoma" with a date of March 2013 stated, "As part of the dialysis data collection, the vascular access site will be inspected per policy ... the licensed nurse will be notified of infiltrations and / or hematomas ... The licensed nurse will assess the vascular access for the above signs and symptoms and will determine if there is localized or generalized pain and swelling and identify the following location, size, induration, color, patient's subjective description of pain 5. With a clean pen or marker, outline border of infiltrate / hematoma on patient's skin for determination of increasing size. Circumferential measurement will be recorded in case of deep hematoma that is enlarging. 6. For a venous or arterial needle infiltrate that is localized but increasing in size or for generalized swelling or pain, remove the needle and with a clean gloved hand and sterile gauze, apply direct pressure to the insertion site. Apply clean, disposable cold pack to infiltration, cold pack should be used on top of clean, moisture proof barrier and not applied directly on patient's skin. Remove cold pack and check site every 5 minutes for changes. Elevate the access extremity. Monitor vital signs and provide supportive care ...</p>			

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	Patient education for an infiltration may include the following: cold packs are to be used for the first 24 hours post infiltration, cold packs should be on 15 minutes and off 15 minutes, while awake ... notify physician of any changes ... document findings and interventions in patient's medical record."			