

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2012
NAME OF PROVIDER OR SUPPLIER BALL DIALYSIS AT FOREST RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EMERSON AVE NEW CASTLE, IN 47362		
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V0000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: June 11, 12, and 13, 2012</p> <p>Facility #: 010644</p> <p>Medicaid Vendor #: 200262540</p> <p>Surveyors: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 18, 2012</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.

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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 and interview, the facility failed to ensure staff wore disposable gloves when touching the patient's equipment in 1 of 2 observations (employee C) with the potential to affect all 33 patients.</p> <p>Findings:</p> <p>1. On June 11, 2012, at 10:17 AM, Employee C was observed at Station # 18, Patient # 8. The employee had been at a different station and was coming to assess this patient. He did not sanitize his hands, had a glove on his right hand, and grasped the tubing and syringe attached to the tubing in his ungloved left hand. He eventually finished the process of putting on his left glove.</p> <p>2. On June 13, 2012, at 1:00 PM, the Clinical Manager, employee A, indicated this employee was having a problem with appropriate glove wear and she had been working with him but gloves were to be worn at all times.</p>	V0113	<p>CD inserviced all staff on RAI Infection Control Policy G-71, with emphasis on #7: identification of instances when gloves must be worn and #8: identification of instances when hands must be washed. Effective immediately, staff will wear gloves when during patient contact and disinfect hands wash hands after glove removal and between patient contact.</p> <p>The CD/designee will conduct infection control audit each shift for two weeks, followed by daily audits for two weeks to ensure that staff maintains compliance with this aspect of the infection control policy. CD/designee will conduct on-going random audits to ensure the policy is followed. The CD will rotate the audit assignment between all staff to ensure all staff are educated and compliant with infection control practice per RAI Infection Control policy.</p> <p>Audit results will be reviewed by CD and MD during monthly meetings and shared with patient care staff during monthly staff meetings . Findings will be reviewed with IDT each month</p>	06/20/2012	

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			during QAPI meetings.	

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V0122	<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 and interview, the facility failed to ensure the dialysis machine was appropriately cleaned in 2 of 2 observations with the potential to effect all 33 patients.</p> <p>Findings:</p> <p>1. On June 11, 2012, at 10:45 AM, Employee G was observed cleaning the dialysis machine at station # 3 while patient # 6 sat in the chair holding pressure on his access. The employee had already removed the tubing and dialyzer from patient # 6's treatment and disposed of it in the biohazard bin. She then used the bleach water to wash the top of and the front of the machine. She did not wash the sides, the bucket to the side, nor the bottom shelf area. She then took the dialysis tubing and dialyzer for the next patient and set the machine back up, which included attaching the open tubing to the unclean bucket on the side of the</p>	V0122	<p>CD inserviced all staff on RAI Infection Control Policy G-77, Cleaning & Disinfection of Equipment, Supplies & Treatment area with emphasis on #7 a) dialysis machine. Effective immediately, staff will clean all parts of the dialysis machine after each patient treatment as specified in policy. If a patient is still seated at the station the machine will be pulled away to avoid recontamination.</p> <p>The CD/designee will conduct infection control audit each shift for two weeks to ensure staff maintain compliance with the infection control policy, followed by weekly audits for 2 weeks. CD/designee will conduct on-going random monthly audits to ensure policy is continued to be followed. The CD/designee will rotate the audit assignment between all staff to ensure all staff are educated and compliant with RAI Infection Control Policy and Procedure practice</p>	06/20/2012			

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	<p>machine that would later be attached to the patient's catheter.</p> <p>2. On June 13, 2012, at 11:35 AM, Employee G was observed repeating the process described above at station # 3 with patient #10.</p> <p>3. On June 30, 2012, at 1:00 PM, the Clinical Manager, Employee A, indicated the expectation is that the top, sides, bucket, and bottom shelf will all be cleaned with bleach water before the set up begins for the next patient. All employees had been trained and educated on the correct way to clean a machine.</p>		<p>Audit results will be reviewed by CD and MD during monthly meetings and shared with patient care staff during staff meetings. Findings will be reviewed with IDT each month during QAPI meetings.</p>	

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V0222	<p>494.40(a) ACID BULK STORAGE TANKS-SAFETY CONTROLS 5.4 Concentrate preparation 5.4.3 Bulk storage tanks (acid concentrate): safety controls Procedures should be in place to control the transfer of the acid concentrate from the delivery container to the storage tank to prevent the inadvertent mixing of different concentrate formulations. If possible, the tank and associated plumbing should form an integral system to prevent contamination of the acid concentrate. The storage tanks and inlet and outlet connections, if remote from the tank, should be secure and labeled clearly.</p> <p>Based on document review and interview, the facility failed to document the procedure in place to control the acid concentrate to the central control tanks in 1 of 1 water rooms with the potential to effect all 33 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the procedure to control the acid concentrate to the central control tanks. 2. On June 12, 2012, at 1:30 PM, during the water room observation, documentation was requested for the centrally delivered acid concentrate into the 2K and 3K tanks. The biomedical technician, Employee K, indicated 	V0222	<p>During staff meeting, CD reviewed RAI Water & Technical Policy T-01 "Central Acid Concentrate Delivery", #6 & #8, along with showing staff a copy of the vendor's acid delivery packing slip. Effectively immediately, the staff member accepting the concentrate delivery will sign and date the vendor's acid delivery packing slip to signify review of concentrate delivered and delivery to correct tank(s); the staff will then place the packing slip in the CD's mailbox. When the next concentrate delivery is made, the CD/Biomed/CN will monitor the process to ensure that the policy is followed by the staff member accepting the delivery.</p> <p>The CD/designee will audit the packing slips on a bi-weekly basis for 2 months to ensure that the staff member receiving the acid</p>	07/10/2012			

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	paperwork was not available to verify the transfers had been completed correctly or what actually had been delivered. The dialysis employee signs the paperwork of the company delivering but does not maintain any documentation of their own.		delivery has signed and dated the packing slips. Ongoing audits will be completed on a random basis by the CD/designee. The packing slips will be filed with PO invoices following the audit. CD will review audit results with MD during monthly meetings and with staff during monthly staff meetings; audit findings will also be reviewed monthly during QAPI meetings.		

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V0403	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>Based on observation, manufacture recommendations review, and interview, the facility failed to change the diasafe filters on the dialysis machines in a timely manner in 3 of 21 machines observed with the potential to effect all 33 patients. (7, 15, 21)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On June 12, 2012 at 9:45 AM, observation of machines 7, 15, and 21 identified the Diasafe filters on the 2008K dialysis machine had not been changed since December 2011. 2. On June 12, 2012, at 1:40 PM, the biomedical technician, Employee K, indicated the dates on the Diasafe filters were December 2011. 3. The "2008K Hemodialysis Machine Operator's Manual" Copyright 2000-2005, Fresenius, USA, Inc. on page 167 states, "The Diasafe Plus filter is intended for the preparation of ultra-pure dialysate. If the 	V0403	<p>Biomed changed out-dated diasafe filters on machines. CD and Biomed reviewed 2008K Hemodialysis Machine Operator's Manual with emphasis that diasafe filter change is recommended at least every 90 days. Biomed will use a tracking tool to indicate when diasafe filter change is needed for each machine; Biomed will send tracking tool to CD/designee each month.</p> <p>CD/designee will check dates on diasafe filter on each machine weekly for 4 weeks, followed by monthly checks to ensure filters are within compliance of 90 day period.</p> <p>Audit results and tracking tool will be reviewed each month during CD/MD meeting and will be reviewed with IDT during monthly QAPI meetings.</p>	06/14/2012			

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	machine has a Diasafe Plus filter, it should be replaced at least every 90 days (3 months)."			

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V0408	<p>494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on observation and interview, the facility failed to maintain the emergency evacuation cart in 1 of 1 carts observed with the potential to effect all 33 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> On June 13, 2012, at 12 PM, the Emergency Evacuation cart was observed. The cart did not contain enough supplies to safely evacuate 21 patients simultaneously. Registered Nurse, Employee B, indicated there were not enough supplies in the cart to safely evacuate 21 patients simultaneously. On June 13, 2012, at 12:20 PM, the Clinical Manager, Employee A, indicated the staff had been instructed to rotate the supplies about to expire out and to resupply the evacuation cart. The cart had not been re-supplied as instructed. 	V0408	<p>Normal Saline bags have been placed on the Emergency Cart. CD inserviced all staff on RAI Risk Management Policy 705 Emergency Evacuation Box with the emphasis on #10 supplies to include: specifically bags of Normal Saline.</p> <p>The CD/designee will audit the Emergency Cart each month to ensure designated supplies are on the cart.</p> <p>CD will review findings each month with the MD; audit results will be presented to IDT during QAPI meetings.</p>	06/20/2012			

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V0501	<p>494.80 PA-IDT MEMBERS/RESPONSIBILITIES The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the physician performed a comprehensive assessment with each plan of care and the social worker assessment was prior to the plan of care in 3 of 3 records reviewed of patients (#3, 4, and 5) that were on dialysis longer then 90 days with the potential to effect all 33 patients.</p> <p>Findings:</p> <p>1. Clinical record # 3, shows an admit date of 8/5/11, with a 90 day assessment due in December 2011. The clinical record evidenced a registered nurse assessment 12/1/11, registered dietitian assessment 12/12/11, and a social worker assessment 12/9/11 with a plan of care dated 12/15/11. The clinical record failed to evidence a physician assessment.</p>	V0501	<p>CD will audit all patients' charts to ensure Physician History & Physical or copy of recent (within past 3 months) medical history and physical from hospitalization signed by nephrologist is in each medical record and included with the RAI CPA template form. Patients with missing Physician H & P will be identified; the CD will review list of patients with missing H & P with the patient's nephrologist and set time-frame for completion. Physician H&P form/copy of hospitalization H&P will be included with CPA before the treatment plan is developed and is considered physician portion of CPA. Either document may be used as the MD portion of the Comprehensive Patient Assessment.</p> <p>The CD will audit medical records of patients missing Physician H&P each week until all have been completed. CD will review audit results with Medical Director</p>	07/10/2012			

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	<p>2. Clinical record # 4, shows an admit date of 4/11/11, with a 90 day assessment due in July 2011. The clinical record evidenced a registered nurse assessment 7/11/11, a registered dietitian assessment 7/13/11, and a social worker assessment dated 8/11/11 with a plan of care dated 7/21/11. The clinical record failed to evidence a physician assessment.</p> <p>3. Clinical record # 5, shows an admit date of 10/7/11, with a 90 day assessment due in January 2012. The clinical record evidenced a registered nurse assessment 1/30/12, a registered dietitian assessment 1/30/12, and a social worker assessment dated 2/15/12 with a plan of care dated 2/2/12. The clinical record failed to evidence a physician assessment.</p> <p>4. A policy titled "Comprehensive Patient Assessments", Policy # G-59, Revised: 11/11, states, "1. The comprehensive patient assessment is completed by the facility's interdisciplinary team that consists of, at minimum: the patient or patient's designee, Registered nurse, Physician treating the patient for ESRD, Social worker, Dietitian."</p> <p>5. On June 13, 2012, at 10:20 AM, the Clinical Manager, Employee A, indicated physician assessments had not been done</p>		<p>during monthly CD/MD meeting.</p> <p>Center Director will review Policy G-59 with Nephrologists with emphasis on #9-11. The Nephrologist may utilize the printed H&P template or an H&P from a recent hospitalization; the document will be filed in the patient's medical record upon completion. CD will use tracking tool to identify completion of medical H&P with each CPA.</p> <p>The CD reviewed RAI Policy G-59 and RAI Policy G-62 with MSW with emphasis that the CPA must be completed prior to completion of the Treatment Plan. On a monthly basis prior to Treatment Plan meetings, the CD/designee will audit the patient's CPA to ensure that the MSW has completed documentation on the CPA.</p> <p>The CD will review audit results with the MSW on a monthly basis. Audit results will be reviewed during monthly QAPI meetings with the IDT. CD will discuss audit results with MD during monthly meetings.</p>				

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	for the re-assessments and the social worker dates were not in line with the plan of care.			

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V0520	<p>494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure a plan of care was completed monthly for one patient who met the guidelines as unstable in 1 of 2 (#1) unstable patient records reviewed with the potential to effect all 33 patients.</p> <p>Findings:</p> <p>1. Clinical record 1, evidenced start of dialysis 3/28/12 and a plan of care 5/18/12 outside the 30 day window. The patient was unstable as the patient had been hospitalized for 21 days.</p> <p>2. A policy titled "Comprehensive Patient Assessments", Policy # G-59, Revised: 11/11, states, "19. The</p>	V0520	<p>CD reviewed RAI Policy G-59 with member of the IDT with emphasis on #19 which describes considerations for determining unstable patient. The first week of each month, the team will meet to identify patients meeting unstable patient criteria. The CPA will be opened by the CD; the CD will email IDT members to inform them that CPA has been opened. Each member of the IDT will complete documentation within designated time-frame. If the patient due for CPA and TP review is hospitalized, the CD/charge nurse will make a detailed entry in the EMR as to why the CPA/TP is late, along with the plan for completion of the CPA/TP upon the patient's return to the out-patient clinic. The CD/designee will utilize tracking calendar to identify hospital</p>	06/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2012
NAME OF PROVIDER OR SUPPLIER BALL DIALYSIS AT FOREST RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EMERSON AVE NEW CASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>following criteria shall be used by the interdisciplinary team whenever a comprehensive patient assessment is done to determine is the patient is or has become unstable. ... Frequent or extended hospitalization as demonstrated by any one of the following: Hospitalization more often than 3 times in a one month period, or Any hospitalization within 3 months that lasts longer than 5 treatments (in-center Hemodialysis) or more than 10 days for home patients."</p> <p>5. On June 13, 2012 at 10:20 AM, the Clinical Manager, Employee A, indicated they had not been able to do a plan of care because the patient had 4 dialysis treatments and then went into the hospital for 21 days. She indicated the patient had not been declared unstable but under the guidelines should have been and would be reviewed at this months plan of care meetings.</p>		<p>discharges dates, unstable patient criteria along with due dates for completion of the CPA and TP.</p> <p>The CD/designee will utilize a tracking tool to identify patients meeting unstable patient criteria to ensure that IDT members complete the CPA in timely fashion. The CD will review audit results of CPA completion tracking with the IDT during monthly QAPI meetings. The CD will review the audit results with the MD each month.</p>		