| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152564 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 08/27/2014 |
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| NAME OF PROVIDER OR SUPPLIER EAST CHICAGO DIALYSIS CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1207-19 E CHICAGO AVE EAST CHICAGO, IN 46312 | |

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| | This was a federal ERSD [CORE] recertification survey.<br><br>Survey dates: 8/22/14 - 8/27/14<br><br>Facility number: 002414<br><br>Medicaid number: 2000259750A<br><br>Surveyor: Ingrid Miller, PHNS, RN<br><br>Inpatient HD: 85<br><br>Quality Review: Joyce Elder, MSN, BSN, RN<br>September 8, 2014 | | | |
| V000111 | 494.30<br>IC-SANITARY ENVIRONMENT<br>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.<br>Based on observation, interview, and | V000111 | Immediately, on 08/22/14 the | 09/24/2014 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | review of policy, the facility failed to ensure a sanitary environment for its patients in 1 of 1 facilities reviewed with the potential to affect all 85 patients and 20 staff members.<br><br>Findings<br><br>1. On 8/22/14 at 11:30 AM, the acid storage room's floor was observed soiled with dust and powder. This was to the rear and sides of the acid storage tanks. There was also a dark discoloration on the front of the storage tanks close to the floor. There was a dead cricket on the floor in the walkway. The hoses of the tanks were dusty.<br><br>2. On 8/22/14 at 11:50 AM, Employee H, biomedical technician, indicated the acid storage room was not clean.<br><br>3. The agency policy titled "Housekeeping" with a date of March 20, 2013, stated, "All areas must be kept clean and organized, including but not limited to the treatment area, water /supply room and offices." | | external surfaces of the acid holding tanks and floor of storage room were cleaned and dust and powder were cleaned from all surfaces in this room. The dead cricket in the hallway was swept up and thrown in garbage.<br><br>On 09/08/14 the Director of Operations reviewed with the Clinical Manager and Area Technical Operation Manager, and by 09/24/14 the Clinical Manager will train all Technical, Registered Nurse (RN) and Patient Care Technician (PCT) staff on:<br><br>· #FMS-CS-IC-II-155-116A: Housekeeping with special attention to:<br>o General Housekeeping: All areas must be kept clean and organized, including but not limited to the treatment area, water/supply room and offices The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform environmental audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action | |

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| | | | plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure a sanitary environment for patients. | |
| V000115 | 494.30(a)(1)(i)<br>IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK<br>Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.<br>Based on observation, policy review, and interview, the facility failed to ensure personal protective equipment was utilized appropriately in 1 of 1 patient care observations of central venous catheter exit site care on day #2 of observations with Registered Nurse (I).<br><br>The findings include<br><br>1. On 8/25/14 at 2:45 PM, Employee I, Registered Nurse, was observed to bring more tape into station #5 to assist Employee M, licensed practical nurse, who was performing central venous exit site care to patient #3. Employee I did not don a face mask when she entered the station area to assist the caregiver. | V000115 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and by 09/24/14 the Clinical Manager will train all direct patient care staff on:<br>· #FMS-CS-IC-I-105-032C: Changing the Catheter Dressing Procedure with special attention to:<br>o Removal of Dressing and Inspection of site:<br>§ Important note: The patient and caregiver must mask for all procedures that require accessing the catheter<br>§ Apply mask to patient and caregiver to help prevent contamination by airborne nasal bacteria<br><br>. | 09/24/2014 |

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| | Employee I stood approximately 2 feet away from the patient.<br><br>2. On 8/25/14 at 4:05 PM, the medical director indicated staff should wear a mask during exit site care and if assisting the staff performing the exit site care.<br><br>3. The dialysis procedure titled "Changing the Catheter Dressing Procedure" with a date of January 6, 2014, stated, "Apply mask to patient and caregiver to help prevent contamination by airborne nasal bacteria."<br><br>4. The dialysis policy titled "Changing the Catheter dressing" with a date of January 6, 2014, stated, "Strict infection control practices and adherence to the catheter dressing change procedure is essential to prevent serious complications." | | #FMS-CS-IC-I-105-032A:Changing the Catheter Dressing Policy with special attention to:<br>o Background:<br>§ Strict infection control practices and adherence to the catheter dressing change procedure is essential to prevent serious complication.<br><br>The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform infection control audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personal protective equipment is utilized appropriately during central venous catheter exit site care. | |
| V000121 | 494.30(a)(4)(i)<br>IC-HANDLING INFECTIOUS WASTE<br>[The facility must demonstrate that it follows standard infection control precautions by implementing-]<br>(4) And maintaining procedures, in accordance with applicable State and local | | | |

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| | laws and accepted public health procedures, for the-<br>(i) Handling, storage and disposal of potentially infectious waste;<br><br>Based on observation, interview, and review of facility documents, the facility failed to ensure potentially infectious waste containers were stored properly in 1 of 1 observation of the biohazard room creating the potential to affect all of the facility's 85 patients.<br><br>Findings<br><br>1. On 8/26/14 at 10:40 AM, observation evidenced a small room to the rear of the dialysis clinic that stored both dirty and clean biohazard containers. This room was observed to contain 2 biohazard containers with lids off on the left side of the room with filled red biohazard bags of waste. There was one container with the lid on. The right side of the room contained unused containers.<br><br>2. On 8/26/14 at 10:40 AM, the biomedical technician indicated the biohazard containers were to have a lid on when the container was filled with biohazard waste.<br><br>3. The dialysis facility document titled "Medical Waste Management Plan" with a date of 1/1/10 and no signature stated, | V000121 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and by 09/24/14 the Clinical Manager will train all clinic staff on:<br>.<br>HSEAES&RM-EHS-14-400-CFR2 59 Medical Waste Management Plan with special attention to :<br>o Medical Waste Containers & Proper Disposal:<br>§ All medical and potentially infectious [Biohazard] waste storage bags shall be securely tied in containers and all containers shall be covered with a tight fitting lid before being moved to a storage area for transportation.<br>The meeting agenda and attendance records will be available for review at the facility.<br>The Clinical Manager and or designee will perform environmental and infection control audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical | 09/24/2014 |

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| | "All medical and potentially infectious [Biohazard] waste storage bags shall be securely tied in containers and all containers shall be covered with a tight - fitting lid before being moved to a storage area for transportation." | | Manager is responsible and the QAI Committee monitors to ensure potentially infectious waste containers are stored properly in the biohazard room. | |
| V000143 | 494.30(b)(2)<br>IC-ASEPTIC TECHNIQUES FOR IV MEDS<br>[The facility must-]<br>(2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and<br>Based on observation, interview, and review of policy, the facility failed to ensure medications were labeled with the date and time of opening and the initials of who had opened the medication for 1 of 1 facility with the potential to affect all the patients of the facility.<br><br>Findings<br><br>1. On 8/22/14 at 2:00 PM, a multi - dose vial of heparin was observed opened and not labeled with the time and date the medication had been opened.<br><br>2. On 8/22/14 at 2:20 PM, Employee K, Registered Nurse, indicated opened multi - dose vials were to be labeled with the date and time when opened and the | V000143 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and by 09/24/14 the Clinical Manager will train all clinic staff on:<br>· FMS-CS-IC-120-040-A: Medication Preparation and Administration with special attention to:<br>o Labeling vials: When preparing medications if the vial is not used immediately in its entirety, the nurse must place the date and time the vial was opened on the medication label along with the nurse initials.<br>o Label any open multi-dose vial that is not used immediately and store vial accordingly<br>The meeting agenda and attendance records will be available for review at the facility.<br>The Clinical Manager and or designee will perform infection | 09/24/2014 |

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| | initials of the staff who had opened the medication.<br><br>3. The agency policy titled "Medication preparation and administration" with a date of December 30, 2013, stated, "When preparing medications if the vial is not used immediately in its entirety, the nurse must place the date and time the vial was opened on the medication label along with the nurse initials ... label any open multi - dose vial that is not used immediately and store vial accordingly." | | control audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure medications are labeled with date and time of opening and the initials of who had opened the medication. | |
| V000401 | 494.60<br>PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT<br>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.<br><br>Based on observation, interview, and review of policy, the facility failed to ensure a sanitary environment for its patients in 1 of 1 facilities reviewed with the potential to affect all 85 patients and 20 staff members.<br><br>Findings<br><br>1. On 8/22/14 at 11:30 AM, the acid | V000401 | Immediately, on 08/22/14 the external surfaces of the acid holding tanks and floor of storage room were cleaned and dust and powder were cleaned from all surfaces in this room. The dead cricket in the hallway was swept up and thrown in garbage.<br>On 09/08/14 the Director of Operations reviewed with the Clinical Manager and Area Technical Operation Manager, and by 09/24/14 the Clinical Manager will train all Technical, | 09/24/2014 |

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| | storage room's floor was observed soiled with dust and powder. This was to the rear and sides of the acid storage tanks. There was also a dark discoloration to the front of the storage tanks close to the floor. There was a dead cricket on the floor in the walkway. The hoses of the tanks were dusty.<br><br>2. On 8/22/14 at 11:50 AM, Employee H, biomedical technician, indicated the acid storage room was not clean.<br><br>3. The agency policy titled "Housekeeping" with a date of March 20, 2013 stated, "All areas must be kept clean and organized, including but not limited to the treatment area, water /supply room and offices." | | Registered Nurse (RN) and Patient Care Technician (PCT) staff on:<br>· FMS-CS-IC-II-155-116A: Housekeeping: with special attention: to:<br>o General Housekeeping: All areas must be kept clean and organized, including but not limited to the treatment area, water/supply room and offices The meeting agenda and attendance records will be available for review at the facility. The Clinical Manager and or designee will perform environmental audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure a sanitary environment for patients. | |
| V000542 | 494.90(a)<br>POC-IDT DEVELOPS PLAN OF CARE<br>The interdisciplinary team must develop a plan of care for each patient.<br>Based on clinical record review, policy review, and interview, the facility failed to ensure an initial plan of care was | V000542 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and by 9/24/14 the Clinical Manager will train all | 09/24/2014 |

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| | developed by all members of the interdisciplinary team for 1 of 9 records (#4) reviewed with the potential to affect any new patients of the dialysis.<br><br>Findings<br><br>1. Clinical record #4 evidenced the patient's first date of dialysis was 9/24/13. The record failed to evidence the social worker had signed the initial plan of care that was dated by the medical director, clinic manager, and dietician on 10/2/13.<br><br>At 8/26/14 at 4:16 PM, the clinic manager indicated the social worker had failed to sign the initial plan of care.<br><br>2. The policy titled "Comprehensive Interdisciplinary assessment and Plan of Care" dated "The purpose of this policy is to provide guidance to clinicians in the requirements for the Comprehensive Interdisciplinary Assessment and the patient plan of care ... responsibility: interdisciplinary care team [RN, Attending physician and physician extenders as applicable, Social Worker, Registered Dietician] [Based on job description, licensure, certification, and state and federal regulations ... The comprehensive interdisciplinary assessment and plan of care must be | | Interdisciplinary team members (inclusive of the MSW) on:<br>· FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care with special attention to:<br>o General Policy for Patient and Assessment and Plan of Care: The Comprehensive Interdisciplinary Assessment (CIA) and Plan of Care (POC) must be developed and implemented by an interdisciplinary team(IDT) consisting of at a minimum the patient or patients designee (if patient desires) a registered nurse, the patients attending physician, and the physician extender where allowed by State regulations, qualified Masters Social Worker and qualified Registered Dietitian<br>o An initial CIA must be conducted on all new patients and a POC<br>o developed and implemented within the later of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session<br>The meeting agenda and attendance records will be available for review at the facility.<br>The Clinical Manager and or designee will perform medical record audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the | |

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| | developed and implemented by an interdisciplinary team consisting of at a minimum, the patient or patient's designee ... qualified Master's Social Worker." | | event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure an initial plan of care is developed by all team members of the interdisciplinary team. | |
| V000543 | 494.90(a)(1)<br>POC-MANAGE VOLUME STATUS<br>The plan of care must address, but not be limited to, the following:<br>(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;<br><br>Based on clinical record review, policy review, and interview, the facility failed to ensure the Registered Nurse (RN) completed an assessment within 1 hour of starting dialysis for 7 of 9 records reviewed (3, 4, 5, 6, 7, 8, 9) and patients' blood pressures were monitored every 30 minutes for 3 of 9 records reviewed (#4, 7, 9).<br><br>The findings include<br><br>1. Clinical record #3 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the | V000543 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and by 09/24/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:<br>· FMS-CS-IC-I-110-133A: Patient Monitoring During Patient Treatment<br>o Policy: Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary.<br>§ Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed.<br>§ Observe for changes in the patient's respirations, heart rate | 09/24/2014 |

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| | initiation of dialysis treatment.<br><br>A. The treatment sheet dated 7/7/14 evidenced the dialysis treatment started at 3:38 PM, but the RN failed to assess the patient until 6:42 PM.<br><br>B. The treatment sheet dated 8/1/14 evidenced the dialysis treatment started at 2:47 PM, but the RN failed to assess the patient until 5:49 PM.<br><br>2. Clinical record #4 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment and failed to evidence the patient's blood pressure had been checked at least every 30 minutes.<br><br>A. The treatment sheet dated 3/18/14 evidenced the dialysis treatment started at 2:43 PM, but the RN failed to assess the patient until 4:21 PM.<br><br>B. The treatment sheet dated 3/27/14 evidenced the dialysis treatment started at 2:48 PM, but the RN failed to assess the patient until 5:10 PM.<br><br>C. The treatment sheet dated 5/8/14 evidenced the blood pressure had been checked at 4:00 PM and not again until 4:47 PM. | | and blood pressure<br>§ Verify and react to unusual findings such as atypical blood pressure readings<br>§ Monitor for trends such as hypotension and bradycardia<br>§ Respond to changes in vital signs as indicated by patient's symptoms, nursing judgment or as ordered by the physician.<br>§ Check for any changes in mental status, level of consciousness.<br><br>· FMS-CS-IC-I-110-149A: Nursing Supervision and Delegation with emphasis on:<br>o Policy: Patient evaluation by the nurse must be completed during the patient's treatment, preferably within the first hour or as specified by stricter state regulations. The registered nurse must evaluate each patient to:<br>§ Review accuracy and completeness of treatment and patient data<br>§ Review patient and treatment prescription and equipment parameters to verify correct settings, and if prescription is met.<br><br>The meeting agenda and attendance records will be available at the facility for review. The Clinical Manager and or designee will perform treatment record audits per the QAI Workflow Calendar, address identified issues, and report findings and actions taken at | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | D. The treatment sheet dated 6/3/14 evidenced the dialysis treatment started at 2:45 PM, but the RN failed to assess the patient until 4:04 PM.<br><br>E. The treatment sheet dated 7/16/14 evidenced the dialysis treatment started at 1:52 PM, but the RN failed to assess the patient until 4:03 PM.<br><br>F. The treatment sheet dated 7/16/14 evidenced the dialysis treatment started at 1:52 PM, but the RN failed to assess the patient until 4:03 PM.<br><br>3. Clinical record #5 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment.<br><br>The treatment sheet dated 7/26/14 evidenced the dialysis treatment started at 11:02 AM, but the RN failed to assess the patient until 12:18 PM.<br><br>4. Clinical record #6 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment.<br><br>The treatment sheet dated 7/24/14 evidenced the dialysis treatment started at 5:40 AM, but the RN failed to assess the | | monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure RNs complete an assessment within one hour of starting dialysis and patients' blood pressures are monitored every 30 minutes. | |

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| | patient until 7:53 AM.<br><br>5. Clinical record #7 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment and failed to evidence the patient's blood pressure had been checked at least every 30 minutes.<br><br>A. The treatment sheet dated 8/7/14 evidenced the dialysis treatment started at 10:58 AM, but the RN failed to assess the patient until 12:17 PM.<br><br>B. The treatment sheet dated 8/16/14 evidenced the dialysis treatment started at 11:45 AM, but the RN failed to assess the patient until 1:26 PM. The blood pressure and other vitals were checked at 1:10 PM and then not again until 2 PM. Then the blood pressure was checked at 2:30 PM and not again until 3:17 PM.<br><br>6. Clinical record #8 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment.<br><br>A. The treatment sheet dated 5/20/14 evidenced the dialysis treatment started at 6:12 AM, but the RN failed to assess the patient. | | | |

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| | B. The treatment sheet dated 5/27/14 evidenced the dialysis treatment started at 7:01 AM, but the RN failed to assess the patient until 8:49 AM.<br><br>C. The treatment sheet dated 6/3/14 evidenced the dialysis treatment started at 6:20 AM, but the RN failed to assess the patient until 8:13 AM.<br><br>7. Clinical record #9 included treatment sheets that evidenced the RN failed to assess the patient within 1 hour of the initiation of dialysis treatment and failed to evidence the patient's blood pressure had been checked at least every 30 minutes.<br><br>The treatment sheet dated 8/15/14 evidenced the dialysis treatment started at 4:17 PM, but the RN failed to assess the patient until 8:20 PM. The blood pressure was assessed at 4:35 PM and then not again until 5:31 PM and then not again until 6:38 PM.<br><br>8. On 8/27/14 at 10:45 AM, the clinical manager indicated the RNs had not completed timely assessments and the blood pressures were not completed every half hour.<br><br>9. The facility's policy titled "Patient Monitoring During Patient Treatment," | | | |

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| | #FMS-CS-IC-I-110-133A, revised 7/4/12 stated, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary. ... Vital Signs/Mental Status. ... Observe for changes in the patient's respirations, heart rate and blood pressure."<br><br>10. The facility's policy titled "Nursing Supervision and Delegation," #FMS-CS-IC-I-110-149A, revised 9/25/13 states, "Patient evaluation by the nurse must be completed during the patient's treatment, preferably within the first hour or as specified by stricter state regulations." | | | |
| V000544 | 494.90(a)(1)<br>POC-ACHIEVE ADEQUATE CLEARANCE<br>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.<br><br>Based on clinical record review and interview, the facility failed to ensure the blood flow rate prescription was followed for 1 of 9 records (#5) reviewed with the potential to affect all patients of the facility.<br><br>Findings | V000544 | On 09/08/14 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained all Interdisciplinary team members on:<br>· FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care with special attention to:<br>o Components of the Patient Comprehensive Assessment | 09/24/2014 |

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| | 1. Clinical record #5 included hemodialysis orders that identified the blood flow rate (BFR) was to be 450 milliliters per minute. The flow sheet dated 8/5/14 evidenced BFRs of 144, 154, 165, 163, 245, 167, and 168 through the treatment with no explanation as to why the BFR was not followed.<br><br>2. On 8/26/14 at 5 PM, the clinic manager indicated the blood flow rates were to match the orders unless an explanation was given on the treatment flow sheet. | | § Dose of Dialysis<br>§ Evaluation of appropriateness of dialysis prescriptions (including at least a monthly Kt/V or equivalent measure of HD)<br>§ The adequacy of the patients dialysis prescription must be assessed on an ongoing basis<br><br>· FMS 138-030-040-2.2 Physician Order Documentation<br>o Requiring staff to provide treatment based on physician orders and if the physician order cannot be achieved staff must notify the nurse and document reasons unable to carry out orders as written.<br><br>· FMS 132-020-425 Monitoring During Patient Treatment<br>o Delivering blood flow rate as prescribed and, if BFR cannot be maintained, notifying the RN and/or physician as appropriate and making adjustments as ordered.<br>In addition the Clinical Manager will review and reinforce with RNs their responsibility for reviewing treatment records each patient shift to verify orders are carried out as written and documentation is present if ordered BFR is not achieved. The meeting agenda and attendance records will be available for review at the facility. The meeting agenda and attendance records are available at the facility for review.<br>The Clinical Manager and or designee will perform treatment | |

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| | | | record audits, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure blood flow rate prescription is followed of explained as required. | |