

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152603	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2012
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NAME OF PROVIDER OR SUPPLIER FRANKLIN DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 W JEFFERSON ST STE A FRANKLIN, IN 46131
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 12/5-12/6/2012, 12/10-12/11/2012</p> <p>Facility #: 011351</p> <p>Medicaid Vendor #: 200849390A</p> <p>Surveyors: Dawn Snider RN, BSN, PHNS-Team Leader Kelly Ennis RN, BSN, PHNS</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 30 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 3</p> <p>Total: 33</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 17, 2012</p>	V0000		
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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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V0116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure equipment was cleaned or disinfected before use on another patient or before returning it to a clean area for 2 of 2 days of observations creating the potential to spread infectious and communicable disease to all 30 in-center patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "Infection Control for Dialysis Facilities" policy number 1-05-01 with a revision date of March 2012 states, "Patient charts are not to be placed on top of the</p>	V0116	<p>V116 Facility Administrator (FA) held mandatory in-service on 12/14/2012 for all Clinical Teammates (TMs). In-service included but was not limited to: Review of Policy & Procedure #1-05-01: Infection control for Dialysis Facilities, TMs educated that items taken to dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Dirty supplies will not be placed in areas designated for clean items only. TMs instructed using surveyor observations as examples to the following: 1) TMs will keep treatment sheets in clean area only; if placing on top of dialysis machines, a barrier is</p>	01/11/2013	

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	<p>dialysis delivery systems, items taken in 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 ... Clean areas should be clearly designated for the preparation, handling, and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled ... The ChairSide Snappy cart, monitor and keyboard are considered clean areas."</p> <p>2. On 12/5/12 at 9:45 AM, station #2 and station #4 were observed with treatment sheets placed on top of dialysis machine with no barrier underneath.</p> <p>3. On 12/5/12 at 9:55 AM, a Phoenix meter was observed lying by the clean supplies at nursing station #1.</p> <p>4. On 12/5/12 at 10:00 AM, a Phoenix meter was observed lying by the clean supplies at nursing station #2.</p> <p>5. On 12/5/12 at 10:03 AM, a Phoenix meter was observed lying by the clean supplies at nursing station</p>		<p>to be placed underneath treatment sheets. 2) TMs must disinfect phoenix meters prior to patient use and ensure meters are stored in designated dirty area away from clean supplies; 3) patient supply bags must be disinfected after each patient treatment and prior to placing in designated clean areas. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet.</p> <p>Infection Control Manager (ICM) will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM) with minutes reflecting.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>				

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	<p>#3.</p> <p>6. On 12/5/12 at 10:17 AM, employee J, PCT, was at station #13 which was unoccupied. The PCT removed the previous patient's supply bag from the IV pole and placed it on the "clean" computer keyboard. The PCT then picked up the patient supply bag and placed it on a shelf with other patient supply bags in the "clean" area. No sanitation was completed prior.</p> <p>7. On 12/5/12 at 10:35 AM, the patient treatment sheet was observed placed on top of the dialysis machine at station #14 with no barrier underneath.</p> <p>8. On 12/5/12 at 10:55 AM, employee K, PCT, checked machine #14 with the Phoenix meter. When complete, the PCT placed the Phoenix meter on nursing station #3 by the clean supplies.</p> <p>9. On 12/5/12 at 11:00 AM, employee K, PCT, removed a treatment sheet from the top of machine #14 and placed on top of the "clean" computer keyboard.</p> <p>10. On 12/10/12 at 10:20 AM, a Phoenix meter was observed lying by</p>						

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	<p>the clean supplies at nursing station #1, #2, and #3.</p> <p>11. On 12/10/12 at 11:05 AM, employee D, PCT, obtained a Phoenix meter from nursing station #1 and placed it on the "clean" computer keyboard by station #5.</p> <p>12. On 12/10/12 at 5:00 PM, employee A, Facility Administrator, indicated the phoenix meter should be stored by the dirty supplies.</p>				

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V0117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure clean areas and equipment were clearly separated from contaminated areas for 2 of 2 days of observation creating the potential to spread infectious and communicable disease to all 30 in-center patients of the facility.</p> <p>The findings include:</p>			V0117	<p>V117 FA held mandatory in-service on 12/14/2012 for all Clinical TMs. In-service included but was not limited to: Review of Policy & Procedure #1-05-01: Infection control for Dialysis Facilities, TMs educated that items taken to dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Dirty supplies will</p>		01/11/2013

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	<p>1. Facility policy titled "Infection Control for Dialysis Facilities" policy number 1-05-01 with a revision date of March 2012 states, "Patient charts are not to be placed on top of the dialysis delivery systems, items taken in 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 ... Clean areas should be clearly designated for the preparation, handling, and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled ... The ChairSide Snappy cart, monitor and keyboard are considered clean areas."</p> <p>2. On 12/5/12 at 9:55 AM, a Phoenix meter was observed lying by the clean supplies at nursing station #1.</p> <p>3. On 12/5/12 at 10:00 AM, a Phoenix meter was observed lying by the clean supplies at nursing station #2.</p> <p>4. On 12/5/12 at 10:03 AM, a Phoenix meter was observed lying by the clean supplies at nursing station #3.</p>		<p>not placed in areas designated for clean items only. TMs instructed using surveyor observations as examples to the following: 1) TMs will keep treatment sheets in clean area only; if placing on top of dialysis machines, a barrier is to be placed underneath treatment sheets; 2) TMs must disinfect phoenix meters prior to patient use and ensure meters are stored in designated dirty area away from clean supplies; 3) patient supply bags must be disinfected after each patient treatment and prior to placing in designated clean area. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet.</p> <p>ICM will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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	<p>5. On 12/5/12 at 10:17 AM, employee J, PCT, was at station #13 which was unoccupied. The PCT removed the previous patient's supply bag from the IV pole and placed it on the "clean" computer keyboard. The PCT then picked up the patient supply bag and placed it on a shelf with other patient supply bags in the "clean" area. No sanitation was completed prior.</p> <p>6. On 12/5/12 at 10:35 AM, the patient treatment sheet was observed placed on top of the dialysis machine at station #14 with no barrier underneath.</p> <p>7. On 12/5/12 at 10:55 AM, employee K, PCT, checked machine #14 with the Phoenix meter. When complete, the PCT placed the Phoenix meter on nursing station #3 by the clean supplies.</p> <p>8. On 12/5/12 at 11:00 AM, employee K, PCT, removed a treatment sheet from the top of machine #14 and placed on top of the "clean" computer keyboard.</p> <p>9. On 12/10/12 at 10:20 AM, a Phoenix meter was observed lying by the clean supplies at nursing station</p>						

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	<p>#1, #2, and #3.</p> <p>10. On 12/10/12 at 11:05 AM, employee D, PCT, obtained a Phoenix meter from nursing station #1 and placed it on the "clean" computer keyboard by station #5.</p> <p>11. On 12/10/12 at 5:00 PM, employee A, Facility Administrator, indicated the phoenix meter should be stored by the dirty supplies.</p>				

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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 facility policy review and observation, the facility failed to ensure 3 of 5 Patient Care Technicians (PCT) (employee D, J, and K) observed cleaned and disinfected contaminated surfaces, medical devices, and equipment as required creating the potential to spread infectious and communicable disease to affect all 30 in-center patients of the facility.</p> <p>The findings include:</p> <p>1. Facility policy titled "Infection Control for Dialysis Facilities," policy number 1-05-01 with a revision date of March 2012 states, "Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime</p>	V0122	<p>V122 FA held mandatory in-service on 12/14/2012 for all Clinical TMs. In-service included but was not limited to: Review of Policy & Procedure #1-05-01: Infection control for Dialysis Facilities, TMs educated that all non-disposable items and equipment such as BP cuff, inside and outside of prime container, tourniquets, clamps, tables, TVs, control knobs, facility wheelchairs, IV poles, as well as all work surfaces must be wiped with proper bleach solution between patient treatments. Dirty supplies must not be stored in areas designated for clean items only. TMs must disinfect phoenix meters prior to patient use and ensure meters are stored in designated dirty area away from clean supplies; patient supply bags must be disinfected after each patient treatment and prior to placing in designated clean areas. Verification of attendance at in-service will be evidenced by TMs signature on In-service</p>	01/11/2013			

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	<p>container, tourniquets, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment ... Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment ... The outside surfaces of all equipment will be wiped with a bleach solution prior to removal from treatment area."</p> <p>1. On 12/5/12 at 10:15 AM, employee J, PCT, was cleaning machine #13. The PCT failed to clean the IV pole, blood pressure cuff, or television.</p> <p>2. On 12/5/12 at 10:17 AM, employee J, PCT, was at station #13 which was unoccupied. The PCT removed the previous patient's supply</p>		<p>sheet.</p> <p>ICM will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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	<p>bag from the IV pole and placed it on the "clean" computer keyboard. The PCT then picked up the patient supply bag and placed it on a shelf with other patient supply bags in the "clean" area. No sanitation was completed prior.</p> <p>3. On 12/5/12 at 10:30 AM, employee K, PCT, was cleaning machine #14. The PCT failed to clean the IV pole, blood pressure cuff, or television.</p> <p>4. On 12/5/12 at 10:55 AM, employee K, PCT, checked machine #14 with the Phoenix meter. When complete, the PCT placed the Phoenix meter on nursing station #3 by the clean supplies.</p> <p>5. On 12/5/12 at 11:00 AM, employee K, PCT, removed a treatment sheet from the top of machine #14 and placed on top of the "clean" computer keyboard, with no sanitation prior.</p> <p>6. On 12/10/12 at 11:05 AM, employee D, PCT, obtained a Phoenix meter from nursing station #1 and placed it on the "clean" computer keyboard by station #5.</p> <p>7. On 12/10/12 at 5:05 PM,</p>						

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	employee A, Facility Administrator, indicated the television and IV pole should be cleaned after each treatment.				

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V0147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on policy review, observation, and staff interview, the facility failed to ensure 1 of 2 Patient Care Technicians (PCT) (employee K) observed treating a patient with a</p>	V0147	<p>V147 FA held mandatory in-service for all clinical TMs on 12/14/2012. In-service included but was not limited to: review of Policy & Procedure # 1-04-02A Pre-dialysis Central Venous</p>	01/11/2013	

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	<p>central venous catheter (CVC) provided care in compliance with central venous catheter policy creating the potential to spread infectious and communicable disease which could affect all patients with a CVC.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Central Venous Catheter (CVC) Care," policy number 1-04-02 with a revision date of April 2009 states, "Dressings are changed every dialysis treatment on non-cuffed catheters, newly inserted catheters, cuffed catheter exit sites that are not well healed, exit sites with signs and symptoms of infection ... cuffed catheters with well-healed exit sites may not require a dressing but still require examination and cleaning of exit site each treatment." 2. Facility policy titled "Predialysis Central Venous Catheter (CVC) Care," policy number 1-04-02A with a revision date of September 2011 states, "Assess CVC at exit site for evidence of cuff migration, cracks or leaks in the catheter limbs. If present, do not initiate dialysis." 3. Facility policy titled "Central Venous Catheter (CVC) Cleaning and 		<p>Catheter (CVC) Care , Policy & Procedure # 1-04-02C: Central Venous Catheter (CVC) Cleaning and Dressing Change, emphasizing CVC dressings must be changed every dialysis treatment using proper technique. CVC site must be assessed prior to treatment initiation for evidence of cuff migration, cracks or leaks, infection or redness, drainage, swelling and presence of pain. If any abnormal signs are noted, TMs must not initiate dialysis, immediately report to RN and/ or MD. TMs instructed using surveyor's observations as examples: TMs educated during CVC care special attention must be taken to ensure clean supplies utilized for CVC care remain clean and barrier device must be utilized for clean supplies to prevent cross contamination. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet.</p> <p>Clinic Nurse Manager will conduct observational audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>				

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	<p>Dressing Change," policy number 1-04-02C with a revision date of March 2011 states, "Assess for infection by checking site for redness, drainage, swelling and the presence of pain. If signs of infection exist, report to MD."</p> <p>4. On 12/5/12 at 10:38 AM, employee K, PCT, was preparing to initiate treatment on patient #4 at station #14. Patient #4, who had a CVC, complained about a small rash that the patient felt was caused by the tape being used on the catheter dressing. The PCT then walked to nursing station #3 and obtained two new rolls of tape and gloves and placed them on top of the dialysis machine with no barrier underneath. The PCT applied gel and then applied the gloves that were placed on top of the dialysis machine and proceeded to initiate treatment. No catheter dressing change or inspection was completed prior to the initiation of treatment.</p> <p>5. On 12/5/12 at 11:07 AM, employee K, PCT, indicated catheter dressings can be changed at the beginning or end of treatment. She further indicated that dressing changes are completed every treatment.</p>			

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	6. On 12/10/12 at 5:10 PM, employee A, Facility Administrator, indicated dressing changes are to be completed at every treatment. Employee A indicated that if the dressing change is not completed at the beginning of treatment, the exit site should at least be examined prior to initiating treatment. Employee A indicated if a patient was complaining of irritation to the catheter site, it should have been examined prior to initiation of dialysis.				

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V0401	<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 observation, staff interview, and policy review, the facility failed to ensure all medications were not expired for 1 of 1 home dialysis training / treatment rooms reviewed with the potential to affect all patients on home dialysis.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/6/12 at 1:00 PM during the tour of the home dialysis training / treatment room, 77 individual prep pads of providine / iodine were observed expired on 1/2009 and 2 individual prep pads of providine/iodine had expired on 5/2009. On 12/6/12 at 1:05 PM, review of the refrigerator evidenced several black circular mold like areas located inside the refrigerator door and on the bottom shelf. The policy titled "MEDICATION POLICY" policy number 1-06-01 with a revision date of March 2011, states, "28. Disposal of expired medications, including all over the counter and nutritional product samples are removed 	V0401	<p>V401</p> <p>FA immediately discarded expired supplies identified during survey; identified refrigerator was deep cleaned removing stains.</p> <p>FA held a mandatory in-service with all clinical TMs on 12/14/2012 reviewing Policy & Procedure #1-06-01 Medication Policy, emphasizing importance of verifying all facility medications, solutions and supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs were educated that using expired items could have the potential to affect 100% of facility patient census. Designated TM will be assigned responsibility to clean facility refrigerators monthly to ensure they remain free of debris and stains. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet</p> <p>AA will check facility inventory monthly to verify all facility medications, solutions and supplies are checked for expiration in stock or available for use on treatment floor. Results of</p>	01/11/2013			

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	<p>from the treatment and inventory areas and disposed of per state/local regulations."</p> <p>4. The facility administrator, employee A, on 12/10/12 at 9:45 AM, indicated the providine / iodine prep pads were expired and also indicated the refrigerator was not currently in use. She acknowledged observation of the black substances that had been in the refrigerator.</p>		<p>audits will be reviewed with Medical Director during QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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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 review, document review, staff interview, and policy review, the facility failed to ensure the interdisciplinary team (IDT) conducted a comprehensive assessment at least monthly for a patient classified as unstable for 2 of 2 (#1 and 4) clinical records reviewed of unstable patients with the potential to affect all patient of the facility who have an unstable status.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 11/28/11, evidenced the following:</p> <p>A. A plan of care and assessment was completed on 7/18/12 and the patient was</p>	V0520	<p>V520 Interdisciplinary Team met on 12/19/2012 and developed comprehensive re-assessment followed by individualized Plan of Care for Patients (# 1 and #4) to reflect evaluation of patient's current health status, and resolution of any identified unstable issues.</p> <p>FA will hold mandatory in-service for IDT by 12/28/2012. In-service will include but not be limited to: review of Policy & Procedure #1-01-14 Patient Assessment and Plan of Care when Utilizing Falcon Dialysis, emphasizing 1) IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to</p>	01/11/2013			

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	<p>marked as unstable.</p> <p>B. The next plan of care and assessment was not completed until 9/17/12 and the patient was marked as unstable.</p> <p>C. The record failed to evidence any further plan of care or assessments have been completed.</p> <p>D. Review of a document titled "Hospitalization Log," evidenced patient #1 was hospitalized 8/2/12-8/10/12 and 10/1/12-10/4/12</p> <p>E. On 12/11/2012 at 2:35 PM, employee A, Facility Administrator, indicated the Medical Director (MD) was out of town in August so the IDT meeting was pushed back to September. Employee A further indicated the patient was actually stable but this did not get changed on the Plan of Care. Employee A indicated there is no proof that patient #1 was designated as stable.</p> <p>F. On 2/11/2012 at 2:43 PM, employee A, Facility Administrator, indicated the MD had no coverage while out of town. Employee A indicated they had an MD on call for emergencies but no coverage for regular rounding. Employee A indicated the MD joined a renal network in September and now there are other</p>		<p>develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet.</p> <p>FA or designee will audit 100% patient census current IDT Assessment and Plan of Care to ensure unstable patients have current individualized comprehensive assessment and plan of care that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues.</p> <p>FA or designee will conduct a Medical Record Audit for 100% of new admissions, 100% patients deemed unstable and 10% of current patients monthly to</p>		

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	<p>doctors to cover if the MD is out of town.</p> <p>2. Clinical record #4, start of care 2/2/2012, evidenced an IDT care plan dated 3/14/12 that was marked as unstable. The record failed to evidence any further plan of care or assessments had been completed.</p> <p>3. On 12/11/12 at 4:00 PM, employee A, facility administrator, indicated the patient should have been reassessed within one month if unstable.</p> <p>4. The facility policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" policy number 1-01-12 with a revision date of September 2012 states, " 7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations, marked deterioration in health status."</p>		<p>ensure current individualized Comprehensive Assessments and Plan of Care are in place, up-to-date, and documentation appropriate. FA will review audit results monthly with Medical Director during QIFMM and continued frequency of audits determined by the team. QIFMM Minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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V0544	<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.</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to ensure patients had achieved and sustained the prescribed dose of dialysis by failing to ensure heparin had been administered as ordered in 1 (#2) of 5 records reviewed and by failing to ensure ordered blood flow rate (BFR) and dialysate flow rate (DFR) had been maintained as ordered in 2 (# 3 and 4) of 5 records reviewed creating the potential to affect all of the facility's 30 current in-center patients.</p> <p>The findings include:</p> <p>1. Clinical record # 2 included hemodialysis orders that identified a Heparin 2000 units bolus was to be given at the start of dialysis. The hemodialysis treatment flow sheet dated 11/21/12 stated "Heparin Pork Bolus 2000 units IVP Not Given." There was no explanation documented for the reason the heparin was not given.</p>	V0544	<p>V544</p> <p>FA will conduct a mandatory in-service for all clinical TMs on 12/26/2012. In-service will include but not be limited to: reviewing Policy & Procedure 1-03-09: Intradialytic Treatment Monitoring, Policy & Procedure #1-06-01 Medication Policy, Policy & Procedure #1-04-5 Blood Flow Rate Problems, TMs must verify patient prescriptions and set all treatments as prescribed. 1) Heparin must be administered per physician orders or report and document reasons why medication not administered; 2) TMs must verify dialysis prescription, prescribed dose of dialysis, and perform safety checks prior to each treatment initiation, Nurses are responsible for ensuring patients are achieving prescribed dose of dialysis and physician orders are followed, 3) TMs must monitor patient's blood flow & dialysate flow rates at a minimum of every 30 minutes, report and document flow rates outside of ordered parameters to licensed nurse, licensed nurse must take</p>	01/11/2013	

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	<p>2. Clinical record #3 included hemodialysis orders that identified the BFR was to be 350 and the DFR was to be 600. The hemodialysis treatment flow sheet dated 11/19/12 evidenced a BFR of 300. The treatment flow sheet dated 11/21/12 evidenced a BFR of 400. The treatment flow sheet dated 11/26/12 evidenced a BFR of 200 and 300. The treatment flow sheet dated 11/28/12 evidenced a BFR of 200 and 400. The treatment flow sheet dated 12/3/12 evidenced a BFR of 300. There was no explanation documented for the variances in the BFR.</p> <p>3. Clinical record #4 included hemodialysis orders that identified the BFR was to be 300 and the DFR was to be 600. Hemodialysis treatment flow sheet dated 11/16/12 evidenced a BFR of 350. The treatment flow sheet dated 11/19/12 evidenced a BFR of 350. The treatment flow sheet dated 11/21/12 evidenced a BFR of 200, 350 and 250. The treatment flow sheet dated 11/26/12 evidenced a BFR of 325. The treatment flow sheet dated 11/30/12 evidenced a DFR of 800. There was no explanation as to the variances in the BFR and DFR.</p> <p>4. The policy titled "MEDICATION POLICY" policy number 1-06-01 with a revision date of March 2011 states, "9.</p>		<p>appropriate action. 4) Review of MD notification parameters for heparin documentation and patients not achieving blood & dialysate flow rates. Charge nurse is responsible for daily monitoring. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet.</p> <p>FA or designee will conduct daily audits on 25% of patient treatment sheets x 1 week, then weekly x 4 weeks, then monthly to ensure prescribed dose of dialysis including blood and dialysate flow rates, Heparin administration. Results of audits will be discussed with the Medical Director during monthly meetings at QIFMM meetings, continued frequency of audits determined by the team.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>				

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	<p>Medications are administered as prescribed and then documented in the patient's medical record."</p> <p>5. The policy titled "INTRADIALTIC TREATMENT AND MONITORING" policy number 1-03-09 with a revision date of March 2012 states, "9. The licensed nurse notifies the physician as needed of changes in patient status. 10. All findings, interventions and patient response will be documented in the patient's medical record."</p> <p>6. The policy titled "BLOOD FLOW PROBLEMS" policy number 1-04-05 with a revision date of March 2011 states, "5. The licensed nurse will assess the patient, their vascular access and extracorporeal circuit for the above and include the following: Assess, the effectiveness of above interventions, Determine need to reduce blood flow and extend treatment time ... 6. Document findings and interventions in the patient's medical record."</p> <p>7. On 12/11/12 at 3:30 PM, the facility administrator, employee A, was unable to provide any additional documentation and/or information when asked.</p>				

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V0547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO</p> <p>The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.</p> <p>Based on observations, staff interview, and policy review, the facility failed to ensure 1 of 3 Patient Care Technicians (PCT) (employee J) observed returning blood after the completion of dialysis treatment provided the necessary care and services to sustain the clinically appropriate hemoglobin / hematocrit level creating the potential for an increased risk anemia for all patients whose dialysis is discontinued by employee J.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 12/5/12 at 10:05 AM, employee J, PCT, was discontinuing treatment at station #13 with patient #6. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color. On 12/5/12 at 10:08 AM, the blood 	V0547	<p>V 547 FA will conduct a mandatory in-service for all clinical TMs on 12/28/2012. In-service will include but not be limited to: reviewing Policy & Procedure 1-03-12A: Termination of Dialysis. TMs educated on proper procedure for returning blood and TM expectation for flushing residual blood from extracorporeal circuits until pink tinged to assist in providing care and services to achieve and sustain clinically appropriate hemoglobin/hematocrit levels. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet. Clinic Nurse Manager will conduct observational audits daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting. FA is responsible for compliance with this Plan of Correction.</p>	01/11/2013	

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	<p>lines were still on machine #13 from the previous patient. The blood lines were bright red in color.</p> <p>3. On 12/5/12 at 10:26 AM, employee J was discontinuing treatment at station #11 with patient #7. The PCT returned the patient's blood. When complete, the blood lines were still bright red in color.</p> <p>4. On 12/10/12 at 5:15 PM, employee A, Facility Administrator, indicated the blood lines should be clear or light pink after returning the blood at the completion of dialysis.</p> <p>5. Facility policy titled "Termination of Dialysis," policy number 1-03-12A with a revision date of March 2012 states, "Turn blood pump on to 200-250 ml/min and infuse approximately 200-300 ml saline or until venous blood line is pink tinged."</p>						

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V0552	<p>494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.</p> <p>Based on clinical record review, policy review, and interview, the facility failed to ensure the the social worker completed the assessment required in 1 (#5) of 1 peritoneal dialysis (PD) records reviewed with the potential to affect all of the facility's PD patients.</p> <p>The findings include:</p> <p>1. Clinical record #5, a PD patient with a date of admission 7/30/10, failed to evidence the social worker had completed the "Kidney Disease Quality of Life 36 (KDQOL-36) Scores Report."</p> <p>A. On 2/28/12, the patient signed the consent form to administer the KDQOL-36.</p> <p>B. On 7/26/12, the social worker, employee G, documented on the</p>	V0552	<p>V552</p> <p>Master Social Worker (MSW) completed KDQOL for PD patient #5.</p> <p>MSW will ensure KDQOL Assessment Surveys are completed on all patients with each 90 day re-assessment and annually. If patient refuses to complete, documentation will be placed in medical record each time survey is offered to complete and patient's refusal. MSW will initiate individualized plan of care updates for patients. Interventions will include counseling services and referrals to assist patient in achieving and sustain psychosocial status, as measured by KDQOL.</p> <p>MSW will be in-serviced on Policy & Procedure # 1-02-03A Social Worker Intervention and Documentation, emphasizing IDT must provide monitoring and</p>	01/11/2013			

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	<p>assessment report, "Will offer KDQOL at next clinic visit."</p> <p>2. The facility policy titled "SOCIAL WORK INTERVENTION AND DOCUMENTATION REQUIREMENTS" Procedure: 1-02-03A revised September 2012 states, "4. Social workers will document patient records consistent with the parameters set forth in the following table: Social Work Assessment or Reassessment, Complete a Quality of Life assessment on all patients using the assessment tool selected by DaVita."</p> <p>3. On 12/11/12 at 4:15 PM, the facility administrator for home hemodialysis and peritoneal dialysis indicated there was no further documentation available.</p>		<p>social worker interventions that include counseling services and referrals for other social services to assist patient in achieving and sustaining appropriate psychosocial status as measured by KDQOL, at regular intervals or more frequently as needed. Plan of Care must reflect if patient has consented to completion of KDQOL, attempts made for completion, and if applicable patients refusal. Social Worker will follow up and readjust plan of care as necessary, document interventions to monitor the patient's psychosocial status. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>Social worker will track all Quality of Life Assessments through DaVita Helping Hands tracking tool. Social Worker will complete and FA/MSW will review tracking tool monthly and discuss findings with Medical Director at QIFMM.</p> <p>FA or designee conduct medical records audits on 100% of new admission, and 10% of current patients to ensure patient's individualized plan of care includes appropriate, measurable goals for patient's psychosocial status, and POC includes KDQOL. Results of audits will be reviewed with the Medical Director during the monthly QIFMM, with supporting</p>		

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			documentation included in the meeting minutes. FA is responsible for compliance with this Plan of Correction.	

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>6. The medical director failed to ensure the facility followed its policy titled "Infection Control for Dialysis Facilities" policy number 1-05-01 with a revision date of March 2012. (See V 116, V 117, V 122)</p> <p>7. The medical director failed to ensure the facility followed its policy titled "Central Venous Catheter (CVC) Care" policy number 1-04-02 with a revision date of April 2009. (See V 147)</p> <p>8. The medical director failed to ensure the facility followed its policy titled "Predialysis Central Venous Catheter (CVC) Care" policy number 1-04-02A with a revision date of September 2011. See V 147)</p> <p>9. The medical director failed to ensure the facility followed its policy titled "Central Venous Catheter (CVC) Cleaning and Dressing Change"</p>	V0715	<p>V715 Governing Body Meeting was held on 12/19/2012, upon receiving Statement of Deficiencies from survey ending on 12/11/2012 with Medical Director and FA. Statement of Deficiencies reviewed regarding deficiencies relating to Infection Control, CVC Care, Adherence to Dialysis Prescription, Medication Policy, Intradialytic Treatment Monitoring, Termination of Dialysis, Physical Environment, Patient Assessment, Patient Plan of Care, Social Worker Intervention, and Medical Records. Medical Director acknowledges that he is responsible to ensure facility TMs are trained and follow policy & procedure, and deficiencies identified need corrected timely with the support of facility team. Plans of Correction have been developed and initiated to correct identified deficiencies and sustain compliance. Medical Director will review progress of patient and TM education, results of audits, and adherence to this plan of correction during monthly QIFMM. FA will report progress,</p>	01/11/2013	

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	<p>policy number 1-04-02C with a revision date of March 2011. (See V 147)</p> <p>10. The medical director failed to ensure the facility followed its policy titled "Termination of Dialysis" policy number 1-03-12A with a revision date of March 2012. (See V 547)</p> <p>Based on policy and procedure review, the medical director failed to ensure the facility had provided services in accordance with its own policies and procedures with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The medical director failed to ensure the facility followed its policy titled "MEDICATION POLICY" policy number 1-06-01 with a revision date of March 2011 that states, "28. Disposal of expired medications, including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations." (See V 403 and 544)</p>		<p>as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes. Action plans will be evaluated for effectiveness, new plans developed as applicable to achieve 100% compliance with TM adherence to policy and procedure. QIFMM minutes will reflect. FA & Medical Director are responsible for compliance with this Plan of Correction</p>		

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	<p>2. The medical director failed to ensure the facility followed its policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" policy number 1-01-12 with a revision date of September 2012 that states, " 7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations, marked deterioration in health status." (See V 520)</p> <p>3. The medical director failed to ensure the facility followed its policy titled "INTRADIALYTIC TREATMENT AND MONITORING" policy number 1-03-09 with a revision date of March 2012 that states, "9. The licensed nurse notifies the physician as needed of changes in patient states. 10. All findings, interventions and patient response will be documented in the patient's medical record." (See V 544)</p> <p>4. The medical director failed to ensure the facility followed its policy titled "BLOOD FLOW PROBLEMS" policy number 1-04-05 with a revision date of March 2011 that states, "5. The licensed nurse will assess the patient, their vascular access and extracorporeal circuit</p>				

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	<p>for the above and include the following: Assess, the effectiveness of above interventions, Determine need to reduce blood flow and extend treatment time ... 6. Document findings and interventions in the patient's medical record." (See V 544)</p> <p>5. The medical director failed to ensure the facility followed its policy titled "SOCIAL WORK INTERVENTION AND DOCUMENTATION REQUIREMENTS " Procedure: 1-02-03A revised September 2012 that states, "4. Social workers will document patient records consistent with the parameters set forth in the following table: Social Work Assessment or Reassessment, Complete a Quality of Life assessment on all patients using the assessment tool selected by DaVita." (See V 552)</p>				