

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013	
NAME OF PROVIDER OR SUPPLIER JASPER DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 721 W 13TH ST STE 105 JASPER, IN 47546			
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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Survey Dates: 2-4-13, 2-5-13, 2-6-13, and 2-7-13</p> <p>Facility #; 005982</p> <p>Medicaid Vendor #: 200521760A</p> <p>Surveyor: Vicki Harmon, RN, PHNS Team Leader Dawn Snider, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 11, 2013</p>			V0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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, interview, and facility policy review, the facility failed to ensure dialysis equipment had been thoroughly cleaned and disinfected in 3 (#s 1, 2, and 3) of 3 cleaning observations completed creating the potential to affect all of the facility's 51 current incenter patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee A, a registered nurse, was observed to clean the dialysis chair at station 6 on 2-5-13 at 10:20 AM. The nurse failed to clean the inside of the arms of the chair. The nurse was observed to use back and forth swiping motions to clean the chair, missing portions of the chair surface in the process. Employee I, a patient care technician (PCT), was observed to clean the dialysis chair and machine at station number 2 on 	V0122	<p>V 122Facility Administrator (FA) held mandatory in-service for all clinical Teammates (TMs) on 02/18/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities</i>. TMs were instructed on proper procedure for disinfection with bleach solution between patient treatments of machine, chair and surrounding equipment. 1) TMs must fully clean machine including top, sides, bottom lip; 2) TMs must completely recline and open chair foot rest to clean in the crevasses of chair; 3) All other equipment including but not limited to TVs, blood pressure cuffs, blue clamps, IV poles must be wiped with bleach solution between patients, 4) TMs must empty prime buckets and disinfect between each patient; 5) TMs must disinfect oxygen concentrators after each use, and before returning to clean area. Verification of attendance to in-service will be evidenced by</p>	03/06/2013			

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	<p>2-7-13 at 9:45 AM. The PCT failed to clean the outside of the right side the chair.</p> <p>While cleaning the dialysis machine, the PCT failed to clean the lower half of the pole used to hang intravenous fluids, failed to clean the inside of the blood pump, and failed to clean the prime container located on the side of the machine.</p> <p>3. Employee C, a registered nurse, was observed to clean an oxygen concentrator on 2-7-13 at 9:50 AM. The nurse failed to clean the front and sides of the machine.</p> <p>4. The above-stated observations were discussed with the facility administrator, employee E, on 2-7-13 at 2:30 PM. The administrator indicated the observations were not in compliance with facility policy.</p> <p>5. The facility's March 2012 "Infection Control for Dialysis Facilities" policy number 1-05-01 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 container, tourniquets, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every</p>		<p>TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct daily infection control audits x 2weeks, then weekly x 2 months, then monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM), minutes will reflect. FA is responsible for compliance with this Plan of Correction Completion date: 03/6/2013</p>				

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	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 patient 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."			

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V0318	<p>494.50(b)(1) REPROCESSING AREA & VENTILATION ANSI/AAMI RD47:2002/A1:2003 Requirements as Adopted by Reference 42 CFR 494.50 (b)(1) 8 Physical plant and environmental safety considerations 8.1 Reprocessing area and ventilation The reprocessing area should be designed to suit the operation carried out and maintain acceptable ambient concentrations of harmful substances (see Table 1). The area should be kept clean and sanitary. It may be part of the dialysis treatment area, as long as equipment used is properly designed and vented to meet the requirements for environmental safety (see [AAMI] 8.5).</p> <p>Table 1-OSHA environmental exposure limits (29 CFR 1910, 1 July 1998), except as indicated</p> <table border="1"> <thead> <tr> <th>Substance/material</th> <th>Limits (PEL)^a</th> </tr> </thead> <tbody> <tr> <td>Acetic acid</td> <td>10 ppm TWAb</td> </tr> <tr> <td>Chlorine dioxide (syn: chlorine oxide)</td> <td>0.1 ppm TWA</td> </tr> <tr> <td>Citric acid developed</td> <td>None</td> </tr> <tr> <td>Formaldehyde</td> <td>0.75 ppm TWA 2 ppm</td> </tr> <tr> <td>STELc(15 min) action level</td> <td>0.5 ppm</td> </tr> <tr> <td>Glutaraldehyde</td> <td>0.2 ppm ceiling NIOSH/OSHA</td> </tr> </tbody> </table>	Substance/material	Limits (PEL) ^a	Acetic acid	10 ppm TWAb	Chlorine dioxide (syn: chlorine oxide)	0.1 ppm TWA	Citric acid developed	None	Formaldehyde	0.75 ppm TWA 2 ppm	STELc(15 min) action level	0.5 ppm	Glutaraldehyde	0.2 ppm ceiling NIOSH/OSHA			
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	<p>Hydrogen peroxide 1 ppm TWA</p> <p>Peracetic acid None developed</p> <p>Phenol 5 ppm TWA</p> <p>ppm = parts per million a) PEL (permissible exposure limit) represents the limit of what employees can be exposed to; PELs can be TWAs or STELs. b) TWA (time-weighted average) represents the limit of what an employee can be exposed to in an eight-hour period. c) STEL (short-term exposure limit) represents the limit of what an employee can be exposed to in any 15-minute time period.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure the hydrogen peroxide and acetic acid air test was performed quarterly for 1 of 1 facility with the potential to affect all the facility's 55 current patients and staff.</p> <p>Findings include:</p> <p>1. The facility's March 2012 " AIR TESTING POLICY" policy number 2-09-02 states, "4. Vapor concentration testing performed quarterly during times of peak activities in areas listed below, as applicable. ... 5. The vapor concentration testing results are recorded on the Acetic Acid and Hydrogen Peroxide in Air Test</p>	V0318	<p>V318</p> <p>Reuse Technician performed vapor concentration testing on 02/08/2013 with results of <1 ppm, and documented on <i>Acetic Acid and Hydrogen Peroxide In Air Test Result Log</i>.</p> <p>FA conducted mandatory in-service for facility reuse technician on 2/18/2013. In-service included but was not limited to review of <i>Policy & Procedure #2-09-02 Air Testing Policy</i>, emphasizing vapor concentration testing must be performed quarterly to ensure air levels of hazardous substances used to reuse dialyzers, disinfect water systems and dialysis delivery systems are maintained at levels acceptable by current</p>	03/06/2013			

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	<p>Results Log."</p> <p>2. The facility's "HYDROGEN PEROXIDE and ACETIC ACID IN AIR TEST RESULTS LOG" evidenced the test was to be performed in January, but the log failed to evidence the air test had been completed.</p> <p>3. On 2-6-13 at 11:30 PM, the facility administrator, employee E, and the bio medical technician, employee M, indicated the air test had not been documented for January 2013.</p>		<p>OSHA Environmental exposure limits. Results must be recorded on the <i>Acetic Acid and Hydrogen Peroxide in Air Test Result Log</i>. Air quality testing logs will be reviewed during monthly QIFMM. Verification of attendance to in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will audit air testing logs quarterly. Results will be reviewed with Medical Director during QIFMM, minutes will reflect.</p> <p>FA is responsible for compliance with this Plan of Correction</p> <p>Completion date: 03/6/2013</p>		

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V0356	<p>494.50(b)(1) RECORD ADV EVENTS/DIALYZER C/O LOG 13.2.3 Recording: adverse events dialyzer complaint log Any significant events such as the occurrence of symptoms listed in [AAMI] 13.2.1 and 13.2.2 should be recorded on an incident report form which would include the results of any evaluations conducted by the physician and others, and the event should be considered for reporting to the manufacturer(s) in accordance with the FDA's Medical Device User Reporting procedures. The resolution of actual or suspected problems caused by reprocessed dialyzers should be indicated. This form should be kept in the complaint investigation record file (see [AAMI] 4.5).</p> <p>4 Records 4.5 Complaint investigation record Records shall be kept of all complaints by patients and staff members about failures of preprocessed and reprocessed dialyzers or possible adverse reactions to any dialyzers; the results of a comprehensive investigation of these alleged problems; and, if appropriate, the corrective actions taken. The records shall be reviewed periodically for trends of adverse reactions. Compliance with the FDA's Medical Device User Reporting procedures shall be demonstrated.</p> <p>Based on administrative record and facility policy review and interview, the facility failed to ensure failed dialyzers were investigated in accordance with facility policy in 2(August 2012 and</p>	V0356	V356 Lead Reuse Technician conducted mandatory in-service for facility reuse technician on 2/18/2013. In-service included but was not limited to: review of <i>Policy & Procedure # 6-01-13 Complaint Investigation Record Policy</i> , emphasizing Complaint	03/06/2013			

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	<p>December 2012) of 6 months reviewed creating the potential to affect all of the facility's 51 current patients that are in the reuse program.</p> <p>Findings include:</p> <p>1. The facility's September 2011 "COMPLAINT INVESTIGATION RECORD" policy number 6-01-13 states, "A Complaint Investigation Record is maintained that includes all patient and teammate complaints related to reuse dialyzers . . . A Complaint Investigation Record is completed for the following: Cracked headers, Header leak, Defective / broken blood port, Defective / broken dialysate port, Blood leak, Lost dialyzer, Mislabeled, Clearance abnormality, Visual inspection failure, Pressure test failure, Clotted dialyzer, Improper storage, Not reprocessable, Equipment failure, Ultrafiltration abnormality."</p> <p>2. The facility's "Daily Log of Failed Dialyzers" for 8-1-12 through 2-28-12 evidenced 2 dialyzers had been failed on 8-25-12 and 12-31-12 due to "visual inspection." The facility's administrative records failed to evidence a complaint investigation record had been completed for the 2 failed dialyzers.</p> <p>4. On 1-7-13 at 3:30 PM, the facility</p>		<p>Investigation Record must be completed for visual inspection failures. Complaint Investigation and Reuse Communication Log must be reviewed monthly during QIFMM. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will audit the complaint investigation record and reuse communication log weekly x 1 month, then monthly. Result of audits, Complaint Investigation Records and Reuse Communication Log will be reviewed monthly with Medical Director during QIFMM, minutes will reflect. FA is responsible for compliance with this Plan of Correction Completion date: 03/6/2013</p>				

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	administrator, employee E, was unable to provide any additional documentation and/or information.				

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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 and facility policy review and interview, the facility failed to ensure comprehensive reassessments included the administration of a standardized physical and mental functioning tool to measure the patient's psychosocial status in 2 (#s 1 and 2) of 6 records reviewed creating the potential to affect all of the facility's 55 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a comprehensive reassessment completed by the medical social worker, employee L, on 6-26-2012. The assessment failed to evidence the social worker had administered the KDQOL per facility policy as a part of the reassessment.</p> <p>The facility administrator, employee E, stated, on 2-5-13 at 1:30 PM, "The</p>	V0552	<p>V552 MSW will ensure KDQOL Assessment Surveys are completed on patients #1 and 2 by 2/21/2013. 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>FA will hold mandatory in-service with MSW on 02/14/2013 reviewing <i>Policy & Procedure #3-01-10 Quality of Life Assessment Survey</i>, emphasizing IDT must provide monitoring and social worker interventions that include counseling services and referrals for other social services to assist patient in achieving and sustaining appropriate</p>	03/06/2013			

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	<p>comprehensive reassessment does not include use of the KDQOL. The MSW says it was offered but the patient refused. The refusal is not documented."</p> <p>2. Clinical record number 2 evidenced a first date of dialysis at this facility as 11-12-09. The record failed to evidence the KDQOL had been offered to the patient since 2-8-11.</p> <p>3. The facility's September 2012 "Quality of Life Assessment Survey" policy number 3-01-10 states, "The Quality of Life (QOL) assessment survey is to be administered by the Social Worker within four (4) months of initiating treatment, on an as needed basis, and repeated at least annually thereafter . . . Prior to conducting the QOL assessment survey, the Social Worker will have the patient complete the 'KDQOL-36 Informed Consent and Permission to Survey' form. The form will be maintained in the patient's medical record."</p>		<p>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 must 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 tracking tool will be utilized to track all Quality of Life Assessments. FA or designee will review tracking tool monthly and discuss findings with Medical Director at QIFMM.</p> <p>FA or designee will conduct medical records audits on 100% of new admissions, and 10% of current patients to ensure patient's individualized plan of care includes the appropriate, measurable goals for patient's psychosocial status, and plan of care includes KDQOL. Results of audits will be reviewed with the Medical Director during the monthly QIFMM, with supporting documentation included in the meeting minutes.</p> <p>FA is responsible for compliance with this Plan of Correction.</p>		

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V0587	<p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure patient home records had been reviewed in 1 of (#6) 1 home dialysis records reviewed creating the potential to affect all the facility's 4 home dialysis patients.</p> <p>The findings include:</p> <p>1. The facility's March 2011 "DAILY HOME TREATMENT RECORD" policy number 5-01-29 states, "Home training teammate will review completed Daily Home Treatment Records to assist in evaluating the patient's progress and self-care decision making process. This review will be verified by the home training nurse documenting review in the medical record."</p> <p>2. Clinical record #6 evidenced the patient was a home peritoneal dialysis patient. The record included a "Daily Home continuous Cycler Peritoneal Dialysis</p>	V0587	<p>V587 FA to hold mandatory in-service for TMs on 02/18/2013 to review <i>Policy & Procedure #5-01-29 Daily Home Treatment Record</i>. TMs will be instructed that all Daily Home Treatment Records must be maintained as a part of the patient's medical record and reviewed for accuracy. Patients must bring completed records to each clinic visit and TMs must review, evaluate, initial the data recorded on the "Daily Home Treatment Record" and document findings in the medical record. In the absence of Home Records, the licensed nurse TM must review importance of home records, the patient's responsibility to provide them, and issue new record sheets. Educational attempts will be documented in the medical record. Plans of care for identified non-compliant patients will be established to address adherence issues. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will perform monthly audits utilizing the "Daily Home</p>	03/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013
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	<p>Record" for 1-12-13 through 1-17-13. The record failed to evidence daily temperature and effluent had been recorded.</p> <p>A. Also documented on the record was the notation "Lost Dwell" in the margin area.</p> <p>B. The home program registered nurse, employee A, had signed and dated the incomplete home record on 1-17-2013.</p> <p>C. On 2-6-13 at 4:00 PM, employee A indicated being unsure as to why the record was incomplete and the reason for notation "Lost Dwell."</p>		<p>Treatment Record Tracker." Results of audits will be reviewed with the Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this POC. Completion date: 03/6/2013</p>		