

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152562	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER NEOMEDICA-MUNSTER	STREET ADDRESS, CITY, STATE, ZIP CODE 314 RIDGE RD MUNSTER, IN 46321
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V0000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: February 27, 28, and 29 and March 1, 2012</p> <p>Facility #: 011063</p> <p>Medicaid Vendor #: 10017090</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Neomedica Munster is out of compliance with the Condition for Coverage for End Stage Renal Disease facilities 42 CFR Part 494.90 Patient Plan of Care.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 6, 2012</p>	V0000		

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

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

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V0113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, the facility failed to ensure staff followed infection control practices in 1 of 2 observations with the potential to affect all 56 dialysis patients.</p> <p>Findings.</p> <p>February 27, 2012, at 4:20 PM, Employee A was observed initiating dialysis on patient # 3. Employee A sanitized her hands and put on gloves. She set up her work area on the chair side table. She took her trash to the trash can, used her gloved hands to open the trash can, threw the trash away and returned to her patient without changing her gloves or sanitizing her hands. The patient placed a pillow brought from home to prop up the arm, over the supplies on the chair side table. Employee A then used those supplies to cannulate the patient.</p>	V0113	<p>V113 By 3/16/12 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-090A Hand Hygiene Policy with emphasis on decontamination using alcohol based hand rub or by washing hands with antimicrobial soap and water after removing gloves and after contact with body fluids or excretions and FMS-CS-IC-II-155-080A Personal Protective Equipment Policy with emphasis on disposable gloves must be changed between each patient and/or station to prevent cross-contamination. In addition the Clinical Manager will review and reinforce FMS-CS-IC-II-155-070A Dialysis Precautions with emphasis placed on separation of clean and dirty supplies and ensuring if patients bring in pillows or blankets from home, that they must be kept separate from the clean supplies so as to prevent cross contamination.</p> <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>By 3/16/12, the Clinical Manager</p>	03/30/2012

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			<p>or designee will meet with patients who bring in pillows or blankets from home to reinforce that while they are welcome to bring these articles with them, they must be kept separate from clean supplies so as to prevent cross contamination.</p> <p>The Clinical Manager or designee will perform infection control audits daily for four weeks, then weekly including checking to see that staff and patients are adhering to the infection control practices regarding hand hygiene and personal protective equipment and dialysis precautions. Frequency of ongoing monitoring will be determined by the QAI Committee upon review of audit findings and resolution of the issue. The Clinical Manager will follow up on identified issues including disciplinary action as indicated.</p> <p>The Clinical Manager will report results of audits and actions taken during monthly QAI Committee 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.</p> <p>The Clinical Manager is</p>		

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			responsible to present all data to the Committee, the Director of Operations is responsible to ensure all data required has been presented and the QAI Committee monitors to ensure hand hygiene and proper use of PPE is performed according to policy to prevent cross contamination.		

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V0412	<p>494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.</p> <p>Based on clinical record review and interview, the facility failed to ensure the patient had been trained in emergency procedures in 4 of 6 records reviewed with the potential to affect all of the facility's 56 patients. (#2, 3, 4, and 6)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of dialysis 6/10/10, failed to evidence a completed training program for emergency procedures. 2. Clinical record 3, start of dialysis 3/11/07, failed to evidence a completed training program for emergency procedures. 3. Clinical record 4, start of dialysis 8/17/11, failed to evidence a completed training program for emergency procedures. 4. Clinical record 6, start of dialysis 11/19/11, failed to evidence a completed training program for emergency procedures. 	V0412	<p>V412</p> <p>By 3/16/12 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-132-070-000 Guidelines for Emergency Preparedness Policy with emphasis on ensuring all patients have been educated in the current emergency procedures and that the documentation is current on all patients.</p> <p>By 3/16/12 the Clinical Manager or designee will perform 100% chart audit to ensure all patients have the current emergency preparedness education. The Clinical Manager will follow up on identified issues and all identified missing emergency preparedness education and/or documentation of education by the IDT will be updated by 3/31/12.</p> <p>By 3/16/12 all patients identified as part of the survey on 3/1/12 as having incomplete education documentation regarding emergency preparedness medical records were audited and found to have current documentation regarding emergency preparedness. Although these records were not</p>	03/30/2012	

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	5. On March 1, 2012, at 10:30 AM, Employee E, Administrator, indicated agreement that the records did not contain a completed training program for emergency procedures.		<p>documented as part of the patient education tool and records were kept separately, the education is evidenced within the facility and the attendance was documented as part of the QAI tool. By 3/30/2012 the patient education tool will be updated with the appropriate documentation of past audits and will be kept current as this education is performed quarterly. Documentation will be available for review on the patient education tool.</p> <p>The Clinical Manager has developed a tickler system to track all new patients to ensure they receive education in all emergency procedures appropriately upon admission.</p> <p>The Clinical Manager or designee will monitor documentation of all patient's emergency education monthly times 3 months to ensure new patients are receiving education timely. In addition, the Clinical Manager will audit existing patients' quarterly education for the next three months. Any issue of noncompliance will be addressed immediately and corrective action taken as appropriate.</p> <p>The Clinical Manager will report results of audits and actions taken during monthly QAI Committee meetings. In the event of discrepancies or</p>		

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			<p>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.</p> <p>The Clinical Manager is responsible to provide all data to the Committee; the Director of Operations is responsible to ensure all required data has been presented and the QAI Committee monitors to ensure that all patients are educated on emergency preparedness.</p>		

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V0501	<p>494.80 PA-IDT MEMBERS/RESPONSIBILITIES The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the physician member of the interdisciplinary team completed the comprehensive assessment in 6 of 6 clinical records reviewed with the potential of affecting all 56 patients of the facility. (#1, 2, 3, 4, 5, and 6)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1, first dialysis date 12/1/10, included a registered nurse (RN) assessment dated 12/1/10 by employee F, a registered dietitian (RD) assessment dated 12/8/10 by employee G, and an unsigned and undated social worker (SW) assessment. The record failed to evidence a physician assessment. Clinical record 2, first dialysis date 6/9/10, included an annual RN assessment 	V0501	<p>V501 By 3/14/12 the Director of Operations will meet with the IDT to review and reinforce FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment (CIA) and Plan of Care (POC) with emphasis on ensuring the IDT, which consists of the patient or the patients designee, a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian, provides each patient with an individualized and comprehensive Assessment of his or her needs that is complete and current. In addition, the Director of Operations and Clinical Manager will meet with the responsible physicians to review requirements regarding assessments. Emphasis will be place on ensuring the physician will thoroughly review the assessment performed by the IDT, indicate they are in agreement with the assessment</p>	03/30/2012			

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	<p>dated 8/1/11 by employee F, the RD assessment dated 7/25/11 by employee G, and a SW dated 7/26/11 by employee H. The record failed to evidence a physician assessment.</p> <p>3. Clinical record 3, first dialysis date 3/11/07, included an annual RN assessment dated 1/27/12 by employee F, the RD assessment dated 2/22/12 by employee G, and the SW assessment dated 2/17/12 by employee H. The record failed to evidence a physician assessment.</p> <p>4. Clinical record 4, first dialysis date 8/17/11, included a RN assessment dated 8/17/11 by employee F, the RD assessment dated 8/18/11 by employee G, and an unsigned and undated SW assessment. The record failed to evidence a physician assessment.</p> <p>5. Clinical record 5, first dialysis date 6/24/11, included a RN assessment dated 7/14/11 by employee F, the RD assessment dated 7/14/11 by employee G, and an unsigned and undated SW assessment. The record failed to evidence a physician assessment.</p> <p>6. Clinical record 6, first dialysis date 11/19/11, included a RN assessment dated 12/13/11 by employee F, the RD assessment dated 11/22/11 by employee</p>		<p>by noting, signing and dating in the appropriate area within the CIA form or adding additional comments to the assessment as needed. In addition the physicians will update all co-morbid conditions. In addition by 3/14/12 the Clinical Manager will meet with the Social Worker to review the social work Assessment requirements emphasizing required documentation includes signing and dating the Assessments.</p> <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>By 3/16/12 the Clinical Manager or designee will perform 100% chart audit to ensure all patients have a current evaluation and Assessment by the IDT documented within their records. The Clinical Manager will follow up on identified issues and all identified CIAs missing evaluation and Assessment by the IDT will be updated by 3/30/12.</p> <p>The team updated the CIA/POC Tracking Tool on 3/12/12 to manage CIAs to ensure completion at the required frequencies and per stable/unstable status. Effective immediately, the Clinical Manager or designee will perform Medical record audits monthly verifying CIAs due that month are completed as required.</p>		

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	<p>G, and the SW assessment dated 12/8/11 by employee H. The record failed to evidence a physician assessment.</p> <p>7. A policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care", FMS-138-020-091 Effective Date 02-FEB-2011, states, "The Comprehensive Interdisciplinary Assessment and Plan of Care must be developed and implemented by an interdisciplinary team (IDT) consisting of at a minimum, the patient or patient's designee (if patient desires), a registered nurse, the patient's attending physician ... , qualified Master's social worker and qualified registered dietitian."</p> <p>8. March 1, 2012, at 10 AM, Employee E, Administrator, indicated the physician had not completed assessment and some social worker forms were not signed.</p>		<p>The Clinical Manager will report results of audits and actions taken during monthly QAI Committee 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.</p> <p>The Clinical Manager is responsible to provide all data to the Committee; the Director of Operations is responsible to ensure all required data has been presented and the QAI Committee monitors to ensure the physician and SW complete the medical evaluation and Assessment for the CIA.</p>				

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V0540	<p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on clinical record and policy review and interview, it was determined the facility failed to ensure the interdisciplinary team identified and addressed the patient's heparin allergy on the plan of care in 1 of 1 records reviewed of patients with heparin allergies with the potential to affect all patients with allergies (See V 541), failed to ensure the patient achieved the prescribed dose of dialysis by ensuring heparin was given as ordered to maintain the patency of the access site in 2 of 5 records reviewed of patients without a heparin allergy with the potential to affect all patients without a heparin allergy and alternate methods were used for one patient with a heparin allergies in 1 of 1 records reviewed of patients with heparin allergies with the potential to affect all patients with allergies (See V 544), and failed to ensure the patients and family members were educated in all aspects of the dialysis experience in 4 of 6 clinical records reviewed with the potential to affect all 56 patients of the facility (See V 562).</p> <p>The cumulative effect of these systemic problems resulted in the facility's inability to meet the requirements of this Condition for Coverage 494.90 Patient Plan of Care.</p>	V0540	<p>V540</p> <p>The Governing Body of this facility takes seriously the responsibility to ensure that every patient will have a current and complete Plan of Care (POC), completed by all members of the IDT per policy that addresses:</p> <ul style="list-style-type: none"> ·V541 Identification of allergies ·V544 Achievement prescribed dose of dialysis ·V562 Patient/Family Education & Training <p>On 3/14/12 the Governing Body reviewed the deficiency statement and developed the corrective plan as detailed within. Additionally, the Clinical Manager has formalized a Patient Plan of Care report for the monthly QAI meeting detailing compliance gaps, and corrective actions implemented to correct any identified deficiencies.</p> <p>The Governing Body will meet weekly to monitor the progress of the Plan of Correction until the Condition level deficiencies are lifted, then monthly for an additional three months to ensure that the corrective actions have resulted in resolution of the cited issues. Once this is determined, the Governing Body will return to quarterly or as needed meetings.</p> <p>Effective immediately:</p> <ul style="list-style-type: none"> · The Clinical Manager (CM) will analyze and trend all data and monitoring/audit results as related 	03/30/2012			

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			<p>to this Plan of Correction prior to presenting the monthly data to the QAI Committee.</p> <ul style="list-style-type: none"> · A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. · The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues · The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. · Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility. <p>Specific activities relating to the V-tags that are identified under this Condition are planned and described below under V541, V544, and V562.</p>		

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V0541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team identified and addressed the patient's heparin allergy on the plan of care in 1 of 1 records reviewed of patients with heparin allergies with the potential to affect all patients with allergies. (4)</p> <p>Findings.</p> <p>1. Clinical record 4, first dialysis date 8/17/11, included a registered nurse (RN) assessment dated 8/17/11 by employee F, the Registered Dietician assessment dated 8/18/11 by employee G, and an unsigned and undated social worker assessment. The record failed to evidence a physician assessment.</p>	V0541	<p>V541</p> <p>By 3/14/12 the Director of Operations will meet with the IDT to review and reinforce FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment (CIA) and Plan of Care (POC) with emphasis on ensuring that all patients' allergy status are identified, reviewed, updated and documented in the patients' CIA.</p> <p>A meeting was held with the Governing Body on 2/29/12 to immediately review the findings of the surveyor and direct the action plan. Documentation is noted within the GB Minutes.</p> <p>The Clinical Manager immediately notified the Nephrologist 2/29/12 regarding findings on patient #1 chart. Orders were received to hold heparin until a HIPA test can</p>	03/30/2012			

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	<p>A. A history and physical from Regency Hospital dated 7/11/2011 listed heparin as an allergy.</p> <p>B. The Comprehensive Interdisciplinary Assessment completed by the RN on 8/17/11 listed heparin as an allergy.</p> <p>C. The clinical record evidenced the patient received 3,000 units of heparin 1/31/12, 2/2/12, 2/4/12, 2/7/12, 2/11/12, 2/14/12, 2/18/12, 2/21/12, and 2/25/12.</p> <p>D. On February 20, 2012, at 4 PM, Employee E, Administrator, indicated the physician had ordered the heparin and no one had questioned it. She indicated the facility had not investigated why heparin was listed as an allergy nor tested to identify the severity of the allergy.</p> <p>2. A policy titled "Medication Preparation and Administration", FMS-132-080-104 Effective date 12-Jan-2011, states, "Procedure ... 5. Assure that the patient has no known allergies to the drug."</p>		<p>be performed. Original HIPA test was cancelled secondary to patient's transportation issues. Test has been rescheduled for 3/9/12. Once the test results are available the patient's physician will make a final determination regarding the patient's allergy to heparin and orders will reflect the patient's status. Until that time, the patient has orders to dialyze without heparin.</p> <p>On 2/29/12, 100% of the medical records audit was performed by Clinical Manager and Director of Operations and all patients with documented allergies were identified. Any patient with an identified allergy and an apparent discrepancy within their prescribed medications was reviewed with their attending physician and any orders obtained are documented within their medical record and CIA.</p> <p>A spreadsheet was developed and will be reviewed with the Registered Nurses by the Clinical Manager by 3/2/12. A copy will be kept at the medication prep area for quick reference. As new patients are admitted the spreadsheet will be updated to ensure all allergies are documented. The Clinical Manager will ensure this spreadsheet is updated and reviewed monthly and reported to QAI committee.</p>		

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			<p>The Director of Operations reviewed policy # FMS-CS-IC-I-120-040A Medication Preparation and Administration Policy with the Clinical Manager on 3/1/12 with emphasis placed on reviewing each patient's allergy status prior to the administration of any medication to ensure the patient does not have an allergy to the medication. The Director of Operations instructed the Clinical Manager to in-service all registered nurses on the policy and the meeting was completed on 3/2/12. Documentation is available within the facility.</p> <p>The Clinical Manager or designee will review the medication administration records from the electronic system daily times one week then weekly times four to ensure that no patient is being administered any medication for which they have a recorded allergy. Frequency of ongoing audits will be determined by the QAI Committee upon review of the data.</p> <p>The Clinical Manager is responsible to provide all data to the QAI Committee; the Director of Operations is responsible to ensure all required data has been presented and the QAI Committee will review the data and provide oversight to ensure all patient allergies have been identified and reviewed prior to</p>		

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			<p>the administration of any medications.</p> <p>The meeting agenda and attendance records are available for review at the facility.</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 and policy review and interview, the facility failed to ensure the patient achieved the prescribed dose of dialysis by ensuring heparin was given as ordered to maintain the patency of the access site in 2 of 5 records reviewed of patients without a heparin allergy with the potential to affect all patients without a heparin allergy (3 and 5) and alternate methods were used for one patient with a heparin allergies in 1 of 1 records reviewed of patients with heparin allergies with the potential to affect all patients with allergies. (4)</p> <p>Findings:</p> <p>1. Clinical record 3, first dialysis date 3/11/07, included physician orders dated 12/21/11 for a loading dose of heparin of 6000 units and 1000 units per hour for a run time of 8 hours to be discontinued at 7 hours for a total of 13000 units.</p> <p>A. The clinical record for 2/1/12 evidenced a run time of 5.48 hours and the patient received 9000 units, for 2/3/12</p>	V0544	<p>V544 By 3/16/12 the Clinical Manager will meet with nurses to review and reinforce FMS-CS-IC-II-150-033A "Physician Order Documentation" requiring staff to carry out treatment based on physician orders emphasizing Heparin, and FMS-CS-IC-II-150-019C Completing a Manual Hemodialysis Treatment Sheet-Proton and Chairside Facilities (Heparin administration entry). In addition the Clinical Manager will meet with nurses to review and reinforce their responsibility for reviewing treatment records each patient shift to verify orders are carried out as written and Heparin is administered as ordered.</p> <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>By 3/8/12 pt #3 as identified during the survey as having a discrepancy with heparin as ordered by the physicians, medical record was reviewed and orders changed to reflect pts new dialysis prescription. Pt#5 medical</p>	03/30/2012			

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	<p>evidenced a run time of 3.3 hours and the patient received 6500 units, for 2/6/12 evidenced a run time of 3.3 hours and the patient received 0 units, for 2/8/12 evidenced a run time of 5.01 hours and the patient received 9000 units, for 2/10/12 evidenced a run time of 4.57 hours and the patient received 9000 units, for 2/13/12 evidenced a run time of 4.5 hours and the patient received 9000 units, for 2/15/12 evidenced a run time of 4.4 hours and the patient received 9000 units, for 2/17/12 evidenced a run time of 4.25 hours and the patient received 9000 units, for 2/20/12 evidenced a run time of 4.25 hours and the patient received 9000 units, and for 2/22/12, 2/24/12 and 2/27/12 evidenced run time of 4.5 hours and the patient received 9000 units.</p> <p>B. A policy titled "Physician Order Documentation", FMS-238-030-040-2.2 effective Date 20-OCT-2008, states, "Nurse practice acts require nurses to carry out treatment care, medication administration ... based on physician orders."</p> <p>C. On March 1, 2011, at 11 AM, Employee E, Administrator, indicated this patient had been nocturnal and had changed to late shift and the orders had not been changed.</p>		<p>record was reviewed to ensure all orders are carried out by the RN.</p> <p>By 3/16/12 the Clinical Manager or designee will perform 100% chart audit to ensure all patient's physician orders are being followed. The Clinical Manager will follow up on identified issues and all identified discrepancies regarding physician orders through referral back to the individual patient's attending physician by 3/16/12.</p> <p>To ensure ongoing compliance to the facility policies, the nurse will verify patient Heparin administration is accurately recorded and document review on the Clinical Practice Supervision Tool. The nurses will review all treatment sheets daily to ensure heparin is being administered as ordered and that the correct dose is documented. Any non-compliance will be addressed immediately.</p> <p>The Clinical Manager will review weekly - the daily review of treatment sheets by the nurses. The Clinical Manager will immediately address observed noncompliance including corrective action and report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the</p>	

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	<p>2. Clinical record 4, first dialysis date 8/17/11, included a registered nurse (RN) assessment dated 8/17/11 by employee F, the Registered Dietician assessment dated 8/18/11 by employee G, and an unsigned and undated social worker assessment. The record failed to evidence a physician assessment.</p> <p>A. A history and physical from Regency Hospital dated 7/11/2011 listed heparin as an allergy.</p> <p>B. The Comprehensive Interdisciplinary Assessment completed by the RN on 8/17/11 listed heparin as an allergy.</p> <p>C. The clinical record evidenced the patient received 3,000 units of heparin 1/31/12, 2/2/12, 2/4/12, 2/7/12, 2/11/12, 2/14/12, 2/18/12, 2/21/12, and 2/25/12.</p> <p>D. On February 20, 2012, at 4 PM, Employee E, Administrator, indicated the physician had ordered the heparin and no one had questioned it. She indicated the facility had not investigated why heparin was listed as an allergy nor tested to identify the severity of the allergy.</p> <p>E. A policy titled "Medication Preparation and Administration", FMS-132-080-104 Effective date 12-Jan-2011,</p>		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 Heparin administration is accurately recorded.				

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	<p>states, "Procedure ... 5. Assure that the patient has no known allergies to the drug."</p> <p>3. Clinical record 5, first dialysis date 6/24/11, included physician orders dated 12/21/11 for heparin 3000 units loading dose.</p> <p>A. The clinical record failed to evidence heparin was given on 2/2/12.</p> <p>B. On March 1, 2012, at 11 AM, Employee E, Administrator, indicated there was no documentation of the heparin being given.</p>						

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V0562	<p>494.90(d) POC-PT/FAMILY EDUCATION & TRAINING The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.</p> <p>Based on clinical record review and interview, the facility failed to ensure the patients and family members were educated in all aspects of the dialysis experience in 4 of 6 clinical records reviewed with the potential to affect all 56 patients of the facility. (1, 2, 4, and 6)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1, first dialysis date 12/1/10, included a patient education record that failed to evidence "Welcome to Dialysis", "Dialysis management: Treatments & Medications", "Rehabilitation and Quality of Life", "Infection Control, Safety and Personal Care", "Nutrition Management", and "Treatment Options." Clinical record 2, first dialysis date 6/9/10, included a patient education record that failed to evidence "Medical Emergencies and Natural Disasters." 	V0562	<p>V562 By 3/14/12 the Clinical Manager will meet with all staff to review and reinforce FMS CS IC-138-020-061 "Patient Education Policy" with emphasis on ensuring the following topics i.e. education regarding welcome to dialysis, dialysis management, rehabilitation and quality of life, infection control, safety and personal care, nutrition management, treatments and medications, treatment options and caring for yourself have been addressed with all patients and documented on the patient education record.</p> <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>By 3/16/12 all patients identified as part of the survey on 3/1/12 as having incomplete education documentation regarding welcome to dialysis, dialysis management, rehabilitation and quality of life, infection control, safety and personal care, nutrition</p>	03/30/2012	

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	<p>3. Clinical record 4, first dialysis date 8/17/11, included a patient education record that failed to evidence "Dialysis management: Treatments & Medications", "Treatment Options", and "Caring for Yourself."</p> <p>4. Clinical record 6, first dialysis date 11/19/11, included a patient education record that failed to evidence "Welcome to Dialysis", Dialysis Management: Treatments & Medications", "Rehabilitation and Quality of Life", "Caring for Yourself", "Nutrition Management", "Emergency Education", "Treatment Options", and "Rights / Responsibilities, Grievance Procedure, Eating / Drinking Policy and Advanced Directives."</p> <p>5. On March 1, 2012, at 11 AM, Employee E, Administrator, indicated not all education had been completed.</p>		<p>management, treatments and medications, treatment options and caring for yourself have been addressed with all patients and documented on the patient education record. Patients #1, 2, 4 and 6 will be updated and completed as required.</p> <p>In addition by 3/16/12 the Clinical Manager or designee will perform 100% chart audit to ensure all patient's have a current education plan to include welcome to dialysis, dialysis management, rehabilitation and quality of life, infection control, safety and personal care, nutrition management, treatments and medications, treatment options and caring for yourself have been addressed with all patients and documented on the patient education record by the IDT. The Clinical Manager will follow up on identified issues and all identified missing education documentation by the IDT will be updated by 3/31/12.</p> <p>Effective immediately the Clinical Manager or designee will perform Medical record audits monthly times three then return to the audit schedule according to the QAI calendar verifying education records are completed as required.</p> <p>The Clinical Manager will report results of audits and actions taken during monthly QAI</p>		

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			<p>Committee 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.</p> <p>The Clinical Manager is responsible to provide all data to the Committee; the Director of Operations is responsible to ensure all required data has been presented and the QAI Committee monitors to ensure all patients' education plan is included in the POC.</p>		

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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>Based on clinical record and policy review and interview, the medical director failed to ensure all policies and procedures for patient care and safety were followed in 1 of 1 facilities that could potentially affect all 56 patients of the facility.</p> <p>Findings:</p> <p>1. The medical director failed to ensure staff followed the policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care", FMS-138-020-091 Effective Date 02-FEB-2011, that states, "The Comprehensive Interdisciplinary Assessment and Plan of Care must be developed and implemented by an interdisciplinary team (IDT) consisting of at a minimum, the patient or patient's designee (if patient desires), a registered nurse, the patient's attending physician ... , qualified Master's social worker and qualified registered dietitian." (See V 501)</p>	V0715	<p>V715 The Director of Operations will meet with the Medical Director by 3/14/12 to review the MD citation and review with him, his role in ensuring all policy and procedures relative to Comprehensive Interdisciplinary Assessment (CIA) and Plan of Care (POC), Medication Preparation and Administration and the process of identifying and responding to patient allergies and RN requirements to follow physician orders as noted within "Physician Order Documentation" are adhered to by all individuals who treat patients in the facility, including attending physicians and non-physician providers as defined with the Medical Staff Bylaws and Part 494 Conditions for Coverage for ESRD facilities. The citations related to the survey will be specifically reviewed along with the proposed corrective action plan.</p> <p>On 3/14/12, the Medical Director directed the Director of Operations to meet with the Clinical Manager to reinforce her</p>	03/30/2012	

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	<p>2. The medical director failed to ensure staff followed the policy titled "Medication Preparation and Administration", FMS-132-080-104 Effective date 12-Jan-2011, that states, "Procedure ... 5. Assure that the patient has no known allergies to the drug." (See V 541 and V 544)</p> <p>3. The medical director failed to ensure staff followed the policy titled "Physician Order Documentation", FMS-238-030-040-2.2 effective Date 20-OCT-2008, that states, "Nurse practice acts require nurses to carry out treatment care, medication administration ... based on physician orders." (See V 544)</p>		<p>role to ensure that all staff members follow policy and procedure, that monitoring occurs to ensure compliance and that noncompliance will be addressed immediately with corrective action as appropriate. Additionally the Medical Director directed staff re-education on the respective policies related to heparin administration and documentation.</p> <p>By 3/14/12 the Director of Operations will meet with the IDT to review and reinforce FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment (CIA) and Plan of Care" (POC) with emphasis placed on the Comprehensive Interdisciplinary Assessment and Plan of Care must be developed and implemented by an interdisciplinary team (IDT) consisting at a minimum, the patient or patient's designee (if patient desires), a registered nurse, the patient's attending physician, qualified Master's social worker and qualified registered dietitian.</p> <p>By 3/14/12 Clinical Manager will meet with all Team Leaders to review policy FMS-138-080-104 Medication Preparation and Administration with emphasis on assuring that any patient with a medication or other type allergy is identified, the allergies are recorded and that staff review all</p>		

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			<p>patients' allergies prior to the administration of any medications. Any staff administering any medications to a patient with a known allergy of that medication will immediately receive a corrective action and be subject to termination.</p> <p>By 3/14/11 Clinical Manager will meet with all Team Leaders to review policy FMS-CS-IC-II-150-033A Physician Order Documentation Policy and FMS-CS-IC-II-150-019C Medical record-Hemodialysis Sheet and CHAIRSIDE Clinical Charting System with emphasis on administering Heparin as ordered and accurate total dose documentation in the computer system. All staff members will be required to calculate heparin dosages as would be entered into the computer to ensure competency. Any staff with incorrect calculations will be retrained prior to being allowed to calculate and administer heparin dosage.</p> <p>The meeting agendas and attendance records are available for review at the facility.</p> <p>The Clinical Manager or designee will perform audits verifying that heparin is administered and documented according to physician order daily until the Conditions are lifted, then weekly.</p>		

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			<p>Frequency of ongoing monitoring will be determined by the QAI Committee upon review of audit findings and resolution of the issue. The Clinical Manager will follow up on identified issues including disciplinary action as indicated.</p> <p>The Clinical Manager will report results of audits and actions taken to the Medical Director during monthly QAI Committee meetings. The Medical Director as chairperson of the QAI committee will oversee the process. 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.</p> <p>The Clinical Manager is responsible to provide all data to the Committee; the Director of Operations is responsible to ensure all required data has been presented and the Medical Director/QAI Committee monitors to ensure Heparin infusions are documented as required.</p>		