

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2016
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NAME OF PROVIDER OR SUPPLIER JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
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V 0000 Bldg. 00	<p>This was a Federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: 3-8-16, 3-9-16, 3-10-16, & 3-11-16</p> <p>Facility #: 005982</p> <p>Medicare Provider # 15-2523</p> <p>Medicaid Vendor #: 200521760A</p> <p>Census: 62 incenter 7 peritoneal dialysis 2 home hemodialysis 71 total patients</p> <p>QA: 3/24/16 jlh</p>	V 0000		
V 0113 Bldg. 00	<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, interview, and record review, the facility failed to ensure staff had provided care in accordance with facility infection control policies and procedures in 3 (#s 3, 7, and 8) of 12 infection control observations completed.</p>	V 0113	<p>FA will hold mandatory in-services for all clinical TMs by 3/31/2016. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs will receive specific instruction including but</p>	04/09/2016

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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	<p>The findings include:</p> <ol style="list-style-type: none"> Employee K, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 8 with a central venous catheter on 3-9-16 at 10:20 AM (observation number 3). The PCT reinfused the extracorporeal circuit and touched the machine front and the tubing. The PCT failed to change her gloves and cleanse her hands prior to disinfecting the central venous catheter connections and disconnecting the blood lines. Employee L, PCT, was observed to initiate the dialysis treatment on patient number 9 on 3-9-16 at 10:45 AM using an arteriovenous fistula (observation number 7). The PCT failed to cleanse her hands and change her gloves after evaluating the access and prior to applying antiseptic to the skin over the cannulation sites. Employee J, a PCT, was observed to initiate the dialysis treatment on patient number 2 on 3-9-16 at 10:45 AM using an arteriovenous fistula (observation number 8). The PCT failed to cleanse her hands and change her gloves after evaluating the access and prior to applying antiseptic to the skin over the 		<p>not limited to: 1) TMs must remove gloves and perform hand hygiene between each patient and station, even if the contact is casual. 2) TMs must remove gloves perform hand hygiene and don new gloves between dirty to clean tasks with same patient i.e. change gloves and cleanse hands prior to disinfecting the CVC connections and disconnecting the blood lines and cleanse hands and change gloves after evaluating the access prior to applying antiseptic to the skin over cannulation sites 3) TMs must remove gloves and perform hand hygiene before entering clean supply cart. 4) TMs must perform hand hygiene prior to gloving, each time gloves are removed, and prior to leaving the treatment floor. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct daily infection control audits x 2 weeks, then weekly x 2 months, then monthly thereafter. Facility Administrator (FA) will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly Facility Health Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC).</p>		

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V 0116 Bldg. 00	<p>cannulation sites.</p> <p>4. The facility administrator indicated, on 3-11-16 at 12:00 PM, employees K. J, and L had not provided care in accordance with the facility's infection control policies and procedures.</p> <p>5. The facility's September 2015 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area."</p> <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</p>				

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	<p>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 observation, interview, and record review, the facility failed to ensure staff had cleaned and disinfected equipment before being used on another patient in 3 (#s 3, 5, and 6) of 6 equipment use observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On 3-10-16 at 10:05 AM, employee M, a patient care technician (PCT), was observed to use a tympanic thermometer on patient number 10 prior to the initiation of the dialysis treatment (observation number 3). The PCT took the patient's temperature and placed the thermometer on the computer stand between stations 9 and 10. The PCT was not observed to clean the thermometer and return it to a clean area. 2. On 3-11-16 at 11:40 AM, employee G, a registered nurse (RN), was observed to obtain a tympanic thermometer from the computer stand between stations 9 and 10 (observation number 5). The RN used the thermometer to take patient number 11's temperature. The RN was not observed to clean the thermometer 	V 0116	<p>FA will hold mandatory in-services for all clinicalTMs by 3/31/2016. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs will receive specific instruction including but not limited to: 1) Teammates will thoroughly wipe down all non-disposable items and equipment with an appropriate disinfectant after every treatment and before returning it to a clean area. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct daily infection control audits x 2 weeks, then weekly x 2 months, then monthly thereafter. Facility Administrator (FA) will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly Facility Health Meetings(FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan ofCorrection (POC)</p>	04/09/2016	

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V 0122 Bldg. 00	<p>prior to using it and was not observed to clean the thermometer after using it.</p> <p>3. On 3-10-16 at 11:00 AM, employee J, a PCT, was observed to use a tympanic thermometer on patient number 2 prior to initiating the dialysis treatment (observation number 6). The PCT retrieved the thermometer from the computer stand between stations 5 and 6. The PCT was not observed to clean the thermometer prior to replacing it onto the computer stand after using it on patient number 2.</p> <p>4. The facility administrator indicated, on 3-11-16 at 12:00 PM, employees G, J, and M had not cleaned and disinfected equipment in accordance with the facility's policy.</p> <p>5. The facility's September 2015 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Items taken into 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."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by</p>						

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	<p>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 record review, the facility failed to ensure staff had cleaned and disinfected dialysis stations in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfecting of the dialysis station observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee N, a patient care technician (PCT), was observed to clean and disinfect the dialysis machine and chair at station number 12 on 3-8-16 at 2:50 PM (observation # 1). The PCT was observed to clean the top half of the machine and then empty the prime waste container. The PCT was not observed to clean the Hansen connectors, the TV, the data entry station, or the dialysate delivery tubing. 2. Employee K, a PCT, was observed to clean and disinfect the dialysis machine and chair at station number 15 on 3-11-16 at 10:50 AM (observation # 2). The PCT was not observed to empty or 	V 0122	<p>FA will hold mandatory in-services for all clinical TMs by 3/31/16 on <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs will receive specific instruction including but not limited to: 1) 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. Priming containers are to be emptied and flushed with water. The interior and exterior should be wiped down with 1:100 (one to one hundred) bleach solution and rinsed thoroughly with water before using on next patient</p>	04/09/2016

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	<p>clean the prime waste container when cleaning the dialysis machine. The PCT was observed to start to place new tubing on the dialysis machine but was stopped by the clinical services specialist. The PCT was not observed to clean the Hansen connectors, the data entry station, or the dialysate delivery tubing.</p> <p>3. The facility administrator indicated, on 3-11-16 at 12:00 PM, employees K and N had not cleaned and disinfected the dialysis station in accordance with the facility's infection control policies and procedures.</p> <p>4. The facility's September 2015 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Equipment including the dialysis delivery system, the interior and exterior of the prime container . . . television arms and control knobs . . . 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. Priming containers are to be empties and flushed with water. The interior and exterior should be wiped down with 1:100 (one to one hundred) bleach solution and rinsed thoroughly with water before using on</p>		<p>treatment. Teammates will give special attention to cleaning control panels on the dialysis delivery systems and other surfaces that are frequently touched and potentially contaminated with patients' blood.</p> <ul style="list-style-type: none"> • After each treatment the floor area around chair/bed and dialysis delivery system will be evaluated and cleaned if necessary. The dialysis delivery system will be disinfected after a confirmed blood leak. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. Infection Control Manager (ICM) or designee will conduct daily infection control audits x 2 weeks, then weekly x 2 months, then monthly thereafter. Facility Administrator (FA) will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly Facility Health Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC). 	

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V 0147 Bldg. 00	<p>next patient treatment."</p> <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]. Based on observation, interview, and record review, the facility failed to ensure central venous catheter (CVC) care had</p>	V 0147	FA will hold mandatory in-services for all clinical TMs by 3/31/2016. In-service will include but not be limited to: review of	04/09/2016

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V 0200 Bldg. 00	<p>been completed per the facility's own policy in 1 (#1) of 2 discontinuation of dialysis with a CVC observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee K, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 8 using a CVC on 3-9-16 at 10:20 AM. The PCT was not observed to place a clean field under the CVC ports prior to starting the discontinuation procedure. 2. The facility administrator indicated, on 3-11-16 at 12:00 PM, employees K. had not provided CVC care in accordance with the facility's own procedure. 3. The facility's March 2015 "Central Venous Catheter (CVC) Procedure" number 12-06-02A states, "Upon completion of dialysis . . . Place patient in comfortable supine position. Discard initiation barrier and place a new barrier under the catheter to prevent contamination." <p>494.40(a) RO-MONITOR/ALARM/PREVENT UNSAFE H2O USE 5.2.7 Reverse osmosis: alarm/prevent use of unsafe water</p>		<p><i>Policy & Procedure #1-04-02A: Central Venous Catheter (CVC) Care Procedure emphasizing 1) TMs must place clean barrier under catheter limbs to prevent contamination. Verification of attendance at in-service will be evidenced by TMs signature on Clinical In-service Form. ICMor designee will conduct Daily Infection Control Audit x 2 weeks, then weekly x4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC).</i></p>	

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	<p>Refer to RD62:2001, 4.3.7 Reverse osmosis: Reverse osmosis devices shall be equipped with on-line monitors that allow determination of rejection rates and product water conductivity. The product water conductivity monitor should activate audible and visual alarms when the product water conductivity exceeds the preset alarm limit. The audible alarm must be audible in the patient care area when reverse osmosis is the last chemical purification process in the water treatment system. Monitors that measure resistivity or TDS may be used in place of conductivity monitors.</p> <p>6.2.7 Reverse osmosis: Reverse osmosis systems should be monitored daily using continuous-reading monitors that measure product water conductivity (or total dissolved solids (TDS)).</p> <p>5.2.7 Reverse osmosis: Refer to RD62:2001, 4.3.7 Reverse osmosis: When a reverse osmosis system is the last chemical purification process in the water treatment system, it [should] include a means to prevent patient exposure to unsafe product water, such as diversion of the product water to drain, in the event of a product water conductivity or rejection alarm. Based on record review and interview, the facility failed to ensure the reverse osmosis (RO) start-up logs included acceptable limits for pure water conductivity in 2 (January 2016 and February 2016) of 2 months reviewed.</p> <p>The findings include:</p> <p>1. The facility's March 2014 "Daily</p>	V 0200	FA held a mandatory in-service with the biomedical technician (BMT) on 3/09/16. In-service reviewed Policy & Procedure#2-01-02 <i>Daily Water Treatment System Monitoring</i> emphasizing 1) All observations and test results will be within the limits specified on the <i>Daily Water Treatment Log</i> . If observations or test results are found outside the specified limits, follow the	04/09/2016			

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V 0544 Bldg. 00	<p>Water Treatment System Monitoring" policy number 2-04-02 states, "All observations and test results will be within the limits specified on the 'Daily Water Treatment Log.' If observations or test results are found outside the specified limits, follow the instructions given on the 'Daily Water Treatment System Log' for the parameter(s) in question. In addition to following the log form instructions, the teammate completing the log will notify the Facility Administrator/designee and Biomed teammate assigned to the facility of any observation or test result found outside the limit specified on the 'Daily Water Treatment Log'."</p> <p>2. The daily water treatment logs, dated January 2 through January 30, 2016 and February 1 through February 29, 2016 failed to include acceptable limits for the pure water conductivity reading. The log states, under the "Acceptable limits" column, "Record value."</p> <p>3. The biomedical technician indicated, on 3-9-16 at 1:30 PM, the RO logs did not include an acceptable limit for the pure water conductivity.</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of</p>		<p>instructions given on the <i>Daily Water Treatment Log</i> for the parameter(s) in question. In addition to following the log form instructions, the teammate completing the log will notify the Facility Administrator/designee and Biomed teammate assigned to the facility of any observation or test result found outside the limit specified on the <i>Daily Water Treatment Log</i>. Verification of attendance by the BMT at the in-service will be evidenced by TMs signature on Clinical In-service Form. After the in-service the BMT immediately corrected the daily water treatment log adding acceptable limits for the purewater conductivity reading. FA or designee will conduct Daily Audits of the water treatment log x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FacilityHealth Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC).</p>		

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	<p>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. Based on observation and interview, the facility failed to ensure the prescribed dialysate was in use in 1 (# 1) of 4 prescription observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 3-8-16 at 1:15 PM, observation noted a 2 K 2 Ca [potassium, calcium] dialysate being used to dialyze patient number 12. Physician orders for patient number 12, dated 8-14-15, evidenced a 3 K 2 Ca dialysate had been ordered. The facility administrator, indicated, on 3-11-16 at 12:15 PM, the 2 K 2 Ca dialysate was not as ordered and that an adverse event report had been completed. The facility administrator stated, "Most of our patients dialyze on a 2 K bath. The nurse is supposed to high-lite an order if it is different than our usual. This was missed." 	V 0544	<p>Surveyor observations were discussed in homeroom meetings during the week of the survey March 9-11, 2016. Teammates (TMs) were formally in serviced on <i>Policy & Procedure #1-03-08A</i> on 3/14& 15, 2016: <i>Treatment Initiation</i> emphasizing 1.) Verify patient prescription. Prescription components include and are not limited to:</p> <ul style="list-style-type: none"> · Patient identity · Dialyzer make and model · Reuse status · Treatment time · Target weight · UFR and Max UFR · UFR profiling · Blood flow rate · Dialysate flow rate · Correct dialysate composition (potassium, calcium, base sodium and bicarb) settings <ul style="list-style-type: none"> · Heparinization (intradialytic infusion) <p>Verification of attendance at the in-service is evidenced by TMs signature on the Clinical In-service Form. FA or designee will conduct Daily Treatment Audits for all shifts x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility</p>	04/09/2016

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NAME OF PROVIDER OR SUPPLIER JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
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V 0638 Bldg. 00	<p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE</p> <p>The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.</p> <p>Based on record review and interview, the facility failed to ensure an analysis of root causes and updates to the performance improvement plans had been implemented to address a continued failure to reach facility goals in 3 (December 2015 and January and February 2016) of 3 months reviewed.</p> <p>The findings include:</p> <p>1. The facility's quality assessment performance improvement (QAPI) meeting minutes dated 12-17-15, 1-21-16, and 2-18-16, evidenced the facility had failed to reach the corporation goal of at least 75% of patients having a phosphorous level of less than or equal to 5.5 milligrams per deciliter (mg/dL). The 12-17-15 meeting minutes identified 64% of the patients had reached the goal. The 1-21-16</p>	V 0638	<p>Health Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC).</p> <p>FA will hold a mandatory in-service with the Registered Dietitian (RD) by 3/31/16. In-service will include but not belimited to: review of <i>Policy & Procedure #1-14-06 Continuous Quality Improvement Program</i> emphasizing 1) Continuous monitoring of Mineral Metabolism and Renal Bone Disease will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained. If there is no improvement or it is not sustained the plan will be reevaluated and adjusted as indicated. 2) Each action plan will be evaluated as to priority with Patient Safety and Clinical Outcomes indicators</p>	04/09/2016

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	<p>meeting minutes identified 59% of the patients had reached the goal. The 2-18-16 meeting minutes identified 61% of the patients had reached the desired goal.</p> <p>A. The meeting minutes dated 12-17-15 identified the root causes as "Chronic dietary and binder non-adherence." The action implemented was "RD [registered dietician] to start reviewing any PO4 [phosphorous] outliers with MM [?] labs-RD to start handing out lab reports when counseling-AA to post lab day reminders."</p> <p>B. The meeting minutes dated 1-21-16 identified the root causes as "Chronic dietary and binder non-adherence." The action implemented was "RD [registered dietician] to start reviewing any PO4 [phosphorous] outliers with MM [?] labs-RD to start handing out lab reports when counseling-AA to post lab day reminders."</p> <p>C. The meeting minutes dated 2-18-16 identified the root causes as "Chronic dietary and binder non-adherence." The action implemented was "RD [registered dietician] to start reviewing any PO4 [phosphorous]</p>		<p>considered for the highestlevel of priority. Verification of attendance by the RD at the in-service will be evidenced by TMs signature on Clinical In-service Form. Continuous Quality Improvement (CQI) Committee and the Medical Director will review patients with underperforming Mineral Metabolism and Renal Bone Disease areas during monthly Facility Health Meetings (FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC).</p>	

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V 0715 Bldg. 00	<p>outliers with MM [?] labs-RD to start handing out lab reports when counseling-AA to post lab day reminders."</p> <p>2. The facility administrator indicated, on 3-11-16 at 2:25 PM, the meeting minutes did not evidence a root cause analysis had been completed or that the performance improvement plan had been updated.</p> <p>3. The facility's September 2013 "Continuous Quality Improvement Program" policy number 1-14-06 states, "Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for under performance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all</p>						

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	<p>individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on observation, interview, and record review, the medical director failed to ensure the facility's infection control policies and procedures had been implemented by failing to ensure all personnel donned personal protective equipment (PPE) upon entering the treatment floor area in 2 (#s 1 and 2) of 2 transport personnel observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 3-9-16 at 10:35 AM and on 3-11-16 at 10:40 AM, observation noted 2 medical transport personnel bringing patient number 9 into the treatment area on a cart. The transport personnel were observed to transfer the patient into the dialysis chair, push the chair and patient onto the scales and obtain a weight, and place the dialysis chair at the station. The medical transport personnel were not observed to don any PPE while on the treatment floor. No dialysis facility staff were observed to offer or provide an PPE to the medical transport personnel while they were on the treatment floor. The clinical services specialist (CSS) indicated, on 3-11-16 at 10:50 AM, the 	V 0715	<p>FA will hold mandatory in-services for all clinical TMs by 3/31/2016. In-service will include but not be limited to: review of <i>Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities</i>. TMs received specific instruction including but not limited to reminding all:</p> <ol style="list-style-type: none"> Physicians, allied health professionals, social workers and dietitians to wear PPE when in the treatment area. PPE is to be removed prior to leaving the treatment area. All allied health professionals have also been in-serviced on wearing PPE and the importance of complying with our policy. Verification of attendance at in-service will be evidenced by TMs signature on Clinical In-service Form. ICM or designee will conduct Daily Infection Control Audit x 2 weeks, then weekly x 4 weeks, then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meetings(FHM), FHM minutes will reflect review and any improvement plans needed as indicated by results. FA is responsible for compliance with this Plan of Correction (POC). 	04/09/2016

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	<p>medical transport personnel had not been provided with any PPE. The CSS indicated the facility's infection control policy does identify the medical transport personnel should don PPE while on the treatment floor.</p> <p>3. The facility's September 2015 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Physicians, allied health professionals, social workers and dieticians will wear PPE when in the treatment area."</p>						