

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152614		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2014	
NAME OF PROVIDER OR SUPPLIER DSI NORTH GRANVILLE DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N GRANVILLE AVE MUNCIE, IN 47303			
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V000000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: January 13, 14, 15, and 16, 2014</p> <p>Facility #: 002903</p> <p>Medicaid Vendor #: 20927580</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Patient Census 31</p> <p>Quality Review; Joyce Elder, MSN, BSN, RN January 21, 2014</p>			V000000			

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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V000196	<p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N,N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly. Based on observation, interview, and review of policy, the facility failed to ensure it followed its own policies in testing for chlorine in 1 of 1 water test observed with the potential to affect all 31 patients.</p>	V000196	Clinic Manager or designee will in-service all staff which includes Employee A & G regarding T300-18a: Testing to Total Chlorine Using Ultra Low Total Holding Tank by 2/15/14. In-service to include but is not limited to: 1-3.. The RN accurately verifies test results are	02/15/2014			

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	<p>Findings:</p> <p>1. On 1/15/14 at 12:55 PM, Employee G, a Patient Care Technician (PCT), was observed performing the water test for chlorine. When completed, the PCT took the test strip to the dialysis floor for a second verification by the registered nurse (RN), Employee A. On the way, the PCT removed her gloves and threw the strip away. She filled in the water book and gave it to the Employee A to sign. He began to sign the form. When asked if he had actually seen the strip, he indicated he had not. The tech went to the water room to perform the test again and get a new strip. When she returned with the new strip, the RN looked at it but did not compare it to the color samples in the front of the water book. He signed the water book and went on.</p> <p>2. On 1/15/14 at 1:10 PM, Employee I, Director of Operations, indicated this is not acceptable verification of chlorine results.</p> <p>3. A policy titled, "Testing for Total Chlorine Using RPC Ultra Low Total Chlorine Test Strips with a RO Holding Tank", dated 2/7/13, T300-18a, states, "b. ... A registered Nurse will verify the test results are within acceptable range and documented correctly on the Daily</p>		<p>within acceptable range & documents chlorine test results; 1st verifier performs test accurately and takes the strip & bottle to 2nd verifier. Clinic Manager or designee will monitor daily x2 weeks or until 100% compliance has been established, weekly x 2, monthly x 2 then quarterly per the QM Workbook audit. Any staff found not to be in compliance will be subject to progressive disciplinary action. Clinic Manager or designee will review education, auditing & disciplinary action in the monthly QAPI & LGB meetings.</p>				

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	Chlorine Log. ... 8. After the 20 second period compare the strip color to the K100-0118 color chart to determine the Total Chlorine level in the sample. The color black that closely resembles the color of the test strip will be the total chlorine level of the sample."			

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V000200	<p>494.40(a) RO-MONITOR/ALARM/PREVENT UNSAFE H2O USE 5.2.7 Reverse osmosis: alarm/prevent use of unsafe water 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 facility documentation review and interview, the facility failed to ensure their staff reported abnormal values in reviewing 1 of 1 water rooms with the potential to affect all 31 patients.</p>	V000200	Area Technical Manager (ATM) or designee will in-service the biomed technician and all clinical staff regarding DSI P&P T200-16: Monitoring the Reverse Osmosis Machine by 2/15/14. In-service will include but not limited to: 1.-3.	02/15/2014			

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	<p>Finding:</p> <ol style="list-style-type: none"> 1. Facility document "Water Room Treatment Log" evidenced the Recirculation Pump Pressure should be 50-70 psi (pounds per square inch). From 12/2/13 through 12/30/13 the pressure ranged from 72 to 80 psi. The log failed to evidence the biomed technician had been informed by the technicians the reading was high. 2. Facility document "Water Room Treatment Log" evidenced the RO percent rejection should be <90%. On 10/9/13 the log read 150% and on 10/11/13 the log read 200%. The log failed to evidence the biomed technician had been informed by the technicians the reading was high. 3. On 1/15/14 at 3:40 PM, the biomed technician, Employee F, indicated he had not been informed of the high readings and had not noticed them on his audits. The staff have been informed to call the biomed technician with any readings out of parameters on the sheets. He indicated he did not know why they documented the RO percent rejection that high as there would not be water at that rejection rate and they did not have a day they did not 		<p>Staff finding "out of range" readings for water room equipment will notify the biomed & document notification on log; accurate monitoring and documentation of the water system equipment readings; biomed will respond and document actions taken for "out of range" readings. ATM or designee will monitor water room logs daily x 2 weeks or until 100% compliance is established, weekly x 2, monthly x 2 then per the Quarterly Technical Safety Audit. Any staff found not to be in compliance will be subject to progressive disciplinary action. Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI & LGB meetings.</p>	

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V000541	<p>run.</p> <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS 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 review and interview, the facility failed to ensure the plan of care was current and included measurable goals and estimated timetables to achieve the desired goals in 1 (2) of 4 records reviewed creating the potential to affect the facility's 31 current patients.</p> <p>Findings:</p> <p>1. Clinical record 2, start of dialysis (SOD) 6/13/11, evidenced a plan of care date of 9/13/13 and timeline dates for albumin and diabetic control of 11/30/13. The clinical record failed to evidence an addendum and timeline for</p>	V000541	<p>Clinic Manager or designee will in-service the IDT team regarding 600-12: Plan of Care by 2/15/14. The in-service will include but not limited to: 1.-2. Emphasis on current & measurable goals and timelines to meet the goals for the patient and updated as needed on the POC. The plan of care for clinical record 2 will be updated with new timelines & addendums to the POC for the unmet goals of albumin & diabetic control. All patients that had a POC completed in the last 60 days will be audited for evidence of new timelines and addendums to the POC for unmet goals. Updates will be completed for the POCs found not in compliance by 2/15/14. Clinic Manager or designee will monitor all POCs monthly x 3 or until 100%</p>	02/15/2014			

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V000544	<p>the unmet goals of albumin and diabetic control after 11/30/13.</p> <p>2. On 1/14/14 at 3:30 PM, the Nurse Manager, Employee A, indicated new goals and a new timeline had not been set for the patient.</p> <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. Based on clinical record review, observation, and interview, the facility failed to ensure patients achieved the prescribed dose of dialysis by ensuring continuous heparin was administered as ordered 1 of 1 active records reviewed of patients receiving incenter dialysis with orders for continuous heparin bolus (3) and the correct dialyzer was used in 1 of 3 prescriptions checked during observation (8) with the potential to affect all 31 patients.</p> <p>Findings:</p> <p>1. Clinical record 3, start of dialysis (SOD) 2/27/13, included physician orders dated 11/11/13 that identified heparin orders 500 units every hour for 4</p>	V000544	<p>compliance is established, then quarterly per the Quality Management Workbook Medical Records Audit. Any staff found not to be in compliance will be subject to progressive disciplinary action. Clinic Manager or designee will review all education, audit results & disciplinary action in the monthly QAPI & LGB meetings.</p> <p>Clinic Manager or designee in-serviced all clinical staff regarding DSI P&P 300-82: Patient Verification; 500-44: Heparin by 2/15/14. In-service will include but not limited to: 1. A&B: accurate documentation of Heparin hourly maintenance dosing in PEARL (EMR); 2. A&B: staff setting up machine will verify physician orders prior to set up; 2nd verifier will confirm dialyzer; bath; nurse plan of care approval to be completed within 30 mins of initiation of treatment to confirm physician orders are being followed. The plan of care for clinical records 3 & 8 will be updated to address the prescribed dose of dialysis & goals will be updated as needed. Clinic Manager or designee will monitor all patient documentation each</p>	02/15/2014			

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	<p>hours for a continuous heparin bolus of 2000 units per treatment.</p> <p>A. The clinical record failed to evidence 2000 units of heparin were received for 12/16/13, 12/18/13, 12/30/13, and 1/10/14 when the patient received 1900 units; 12/23/13 when the patient received 900 units; 12/26/13 when the patient received 1100 units; 12/28/13 and 1/2/14 when the patient received 00 units; and 1/4/14 when the patient received 1000 units.</p> <p>B. On 1/14/14 at 3:25 PM, Nurse Manager, Employee A, indicated the heparin dosages were not as ordered.</p> <p>2. Clinical record 8, SOD 8/28/10, included physician orders dated 12/20/13 for a Optiflux 160 NRE.</p> <p>A. On 1/15/14 at 11 AM, the patient was observed being dialyzed on a Optiflux 180 NRE dialyzer.</p> <p>B. On 1/15/14 at 11:20 AM, Employee I, Director of Operations, verified the patient was being dialyzed with the incorrect dialyzer.</p>		<p>shift daily x 2 weeks or until 100% compliance has been established, weekly x 2, monthly x 2, then quarterly per the QM Workbook Medical Records audit. Any staff found not to be in compliance will be subject to progressive disciplinary action. Clinic Manager or designee will review all education, audit results & disciplinary action in the monthly QAPI & LGB meetings.</p>		

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V000545	<p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate.</p> <p>Based on clinical record review and interview, the facility failed to provide ordered protein supplements for 1 of 1 record reviewed of patients with ordered supplements, with the potential to affect all patients with ordered supplements. (#2)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 2, start of dialysis (SOD) 6/13/11, included physician orders dated 12/6/13 that identified a protein supplement was to be given at each treatment. Hemodialysis treatment flow sheets dated 12/18/13 through 1/13/14 failed to evidence a protein supplement had been given. On 1/14/14 at 3:20 PM, Nurse Manager, Employee A. indicated the protein supplement had not been given 	V000545	<p>Clinic Manager or designee will in-service allnurses regarding Nutritional Supplement Protocol;300-82: Patient Verification by 2/15/14. In-servicewill include but not limited to: following physicianorders; protein supplements entered into PEARLas medication orders; documenting medication administration in PEARL upon being given to patient. The plan of care for clinical record 2 will be updated to address the patient's nutritional status & goals will be updated as needed.Clinic Manager or designee will monitor allpatients medication administration daily x 2 weeksor until 100% compliance has been established,weekly x 2, monthly x 2, then quarterly per the QM Workbook Medication Adminisration audit. Any staff found not to be in compliance will besubject to progressive disciplinary action.Clinic Manager or designee will review</p>	02/15/2014

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V000765	<p>to the patient.</p> <p>494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services.</p> <p>The grievance process must include-</p> <p>(1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.</p> <p>Based on interview, the facility failed to implement a process for internal grievances in 1 of 1 facilities reviewed with the potential to affect all 31 patients.</p> <p>Findings:</p> <p>1. On 1/13/14 at 11:15 AM, Employee A, the Nurse Manager, indicated he has not been keeping track of complaints or of their resolutions. When someone states they don't like something, he tries to resolve it and move on.</p> <p>2. On 1/14/14 at 11:09 AM, the Renal Network returned the pre-survey call with the information that the facility had a complaint this year called into the</p>	V000765	<p>alleducation, audit results & disciplinary actions in the monthly QAPI & LGB meetings.</p> <p>Director of Operations or designee will in-service all staff including Clinic Manager regarding DSI P&P 200-07 Pt Rights/Responsibilities/Grievance ; Pt Grievance Log; Pt Grievance FollowUp Letter; Pt Grievance form by 2/15/14. In-service will include but not limited to: 1.-3. all patient complaints/grievances will be documented on the Pt Grievance Log at time of complaint by any staff receiving complaint; Documentation of resolution or escalating to the next level for resolution; the Grievance follow up letter will be given to the patient to complete and then given to the Clinic Manager for resolution or escalation to Senior Management if unresolved. Director of Operations or designee will</p>	02/15/2014			

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	<p>Network related to cramping.</p> <p>3. On 1/15/14 at 1:30 PM, the Social Worker, Employee D, indicated complaints are told to Employee A and he deals with them.</p>		<p>monitorPt Grievance Log daily x 2 weeks or until 100%compliance is established, weekly x 2, monthlyx 2, then quarterly per the QM Workbook audit.Any staff found not to be in compliance will be subject to progressive disciplinary action.Director of Operations or designee will revieweducation, audit results & disciplinary action in tthe monthly QAPI & LGB meetings.</p>		