

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152553	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE MORGAN COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 2084 HOSPITAL DRIVE MARTINSVILLE, IN 46151
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V000000	This was a Federal ESRD [CORE] recertification, relocation, and addition of stations survey. Survey Dates: 9-24-14, 9-25-14, and 9-26-14 Facility #: 010148 Medicaid Vendor #: 200181270A Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN October 1, 2014	V000000		
V000122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on facility policy review, interview, and observation, the facility failed to ensure the dialysis machine had been cleaned in accordance with facility	V000122	On 10/1/14 and 10/2/14, Clinical Manager reviewed the Cleaning and Disinfection Policy, FMS-CS-IC-II-155-110A with all staff with emphasis on using a	10/02/2014

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>policy in 1 (# 11) of 2 cleaning and disinfection of the dialysis station observations completed and by failing to ensure blood spills had been cleaned appropriately in 2 (#s 6 and 10) of 2 blood spills observed creating the potential to affect all of the facility's 35 current patients.</p> <p>The findings include:</p> <p>1. On 9-24-14 at 11:10 AM, employee D, a registered nurse (RN), was observed to clean the dialysis chair at station number 11. The RN cleaned the front portion of the chair and then dropped the bleach soaked cloth onto the floor. The RN picked up the cloth and continued to clean the dialysis chair.</p> <p>A. After cleansing the front of the chair the RN was observed to clean the sides of the dialysis chair. The RN dropped the cloth again while cleaning the side of the chair, picked it up, and continued cleaning the rest of the dialysis chair using the same cloth.</p> <p>B. The Clinic Manager indicated, on 9-25-14 at 5:30 PM, the RN should have obtained a clean cloth to finish cleaning the chair after dropping the first cloth on the floor.</p>		<p>new cloth wetted with 1:100 bleach solution for a second cleaning of the surface and that a new cloth is required anytime it is dropped on the floor.</p> <p>The Clinical Manager or designee will monitor compliance through completion of the Infection Control Dialysis Station Audit weekly for a period of four weeks. Cleaning blood spills will be included as part of the audit. If there are no blood spills, the Clinical Manager will query the staff regarding what to do in the event of a spill.</p> <p>The Clinical Manager is responsible to report a summary of findings to the QAI Committee. At the end of one month, the QAI Committee will determine if the facility can return to monitoring monthly through the routine infection control audits.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>		

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	<p>2. On 9-24-14 at 10:30 AM, employee C, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 6. After removing the needle from the venous site, the PCT dropped the extension tubing on the floor. Five blood splatters were observed. The PCT cleaned the blood from the floor using a bleach soaked cloth. The PCT was not observed to clean the blood spill a second time.</p> <p>3. On 9-25-14 at 11:40 AM, patient number 10 was observed standing on the scale after the dialysis treatment had been completed. Blood (less than 10 milliliters) was observed dripping from the patient's femoral access down the patient's leg and onto the scale platform on the floor. The clinic manager assisted the patient to stop the bleeding and proceeded to clean the blood from the scale using a 1:10 bleach solution. The clinic manager was not observed to clean the scale a second time.</p> <p>4. The clinic manager indicated, on 9-25-14 at 5:30 PM, she was unaware blood spills were to be cleaned a second time using a bleach solution according to facility policy.</p> <p>5. The facility's 3-20-13 "Cleaning and Disinfection" policy number</p>			

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V000143	<p>FMS-CS-IC-II-155-110A states, "Work Surface Cleaning and Disinfection with Visible Blood < 10 ml [less than 10 milliliters] and Other Potentially Infectious Material Using Bleach Solutions. Use 1:100 bleach dilution to clean surfaces with visible blood. After cleaning up all visible blood, use a new cloth with 1:100 bleach solution for a second cleaning of the surface."</p> <p>The facility's 1-4-12 "Work Surface Cleaning and Disinfection with Visible Blood < 10 mls and OPIM [?] using Bleach Solutions" procedure states, "Clean up all visible blood. Discard the used cloth and gloves in appropriate waste container. Perform hand hygiene and don new gloves. After cleaning up all visible blood, use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface."</p> <p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on facility policy review, observation, and interview, the facility failed to ensure the registered nurse (RN) had used aseptic technique and followed</p>	V000143	On or before 10/26/14, the Clinical Manager will meet with the nurses and review the Medication Administration Policy, FMS-CS-IC-I-120-040A, with	10/26/2014

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	<p>infection control policies and procedures while administering medications in 2 (Employees D and E) of 2 medication preparation and administration observations completed creating the potential to affect all of the facility's 35 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee D, a registered nurse (RN), was observed to administer Hectorol and Epogen to patient number 6 on 9-24-14 at 8:20 AM. The RN was observed to prepare the medications and don clean gloves without cleaning her hands. The RN was observed to touch the dialysis machine and integrated keyboard and then cleanse the injection port and administer the medications. The RN failed to change her gloves and cleanse her hands after touching the potentially contaminated dialysis machine and prior to accessing the port. Employee E, a RN, was observed to administered Hectorol to patient number 7 on 9-25-14 at 10:05 AM. The RN was observed to prepare the medication and don clean gloves without cleansing her hands. The RN was observed to touch the dialysis machine and integrated keyboard and then cleanse the injection port and administer the medications. The 		<p>emphasis on performing hand hygiene prior to administering medications after touching the dialysis machine and prior to accessing the medication port on the saline line.</p> <p>The Clinical Manager or designee will monitor compliance through completion of a random Infection Control Medication Supply Audits conducted daily for 1 week, 3 times per week for the following 3 weeks.</p> <p>The Clinical Manager is responsible to report a summary of the audit findings to the QAI Committee at which time the QAI Committee will determine if the facility can return to monitoring monthly through the routine infection control audits.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>	

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	<p>RN failed to change her gloves and cleanse her hands after touching the potentially contaminated dialysis machine and prior to accessing the port.</p> <p>3. The clinic manager indicated, on 9-25-14 at 5:30 PM, the RNs should have changed their gloves and cleansed their hands after touching the potentially contaminated dialysis machine and prior to accessing the ports.</p> <p>4. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC-II-155-060A states, "All infection control policies for patient care are consistent with recommendation of the Centers for Disease Control (CDC)."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p>			

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V000543	<p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be</p>			

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	<p>limited to, the following:</p> <p>(1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on clinical record and facility policy review and interview, the facility failed to provide the care and services to maintain the patient's estimated dry weight and blood pressure in 2 (#s 1 and 2) of 4 records reviewed creating the potential to affect all of the facility's 35 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a physician order dated 8-20-14 that evidenced the desired weight after the hemodialysis treatment (EDW) was 106.5 kilograms (kg).</p> <p>A. A hemodialysis treatment flow sheet dated 9-8-14 evidenced the patient's EDW post treatment was 108 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 9-17-14 evidenced the patient's EDW post treatment was 107.7.</p> <p>C. A hemodialysis treatment flow sheet dated 9-19-14 evidenced the patient's EDW post treatment was 107.9 kg.</p>	V000543	<p>On or before 10/26/14, the Clinical Manager (CM) will meet with the nurses and review the Comprehensive Interdisciplinary Assessment and Plan of Care Policy, FMS-CS-IC-I-110-125A with emphasis on individualizing the plan of care specific to volume status and blood pressure management. At this same meeting the CM will review Physician Order Documentation Policy, FMS-CS-IC-II-150-033A. The CM will reeducate the licensed staff that the Nurse Practice Act requires the nurse to carry out treatment care and medication administration based on the physician order.</p> <p>To ensure compliance, the Clinical Manager will conduct the standard Medical Record Audit for October using the Medical Record Audit Workbook Tool and utilizing "fluid management" as the selection criteria to ensure Hypertension, if present, as well as achievement of Dry Weight is addressed and included on Plan of Care as appropriate. In addition, the staff nurses will conduct a daily audit of treatment sheets for compliance with prescribed achievement of Estimated Dry Weight on one (1) shift per day for a period of four</p>	10/26/2014

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	<p>D. A hemodialysis treatment flow sheet dated 9-22-14 evidenced the patient's EDW post treatment was 108.5 kg.</p> <p>2. Clinical record number 2 included a physician order dated 6-16-14 that states, "Clonidine HCl 0.1 mg [milligram] ORAL During Dialysis PRN [as needed] for SBP [systolic blood pressure] > [greater than] 180 after one hour on dialysis."</p> <p>A. A hemodialysis treatment flow sheet dated 8-29-14 evidenced the treatment had been initiated at 10:20 AM. The flow sheet evidenced the blood pressure reading was 197/118 at 11:41 AM, 201/95 at 12:04 PM, 208/80 at 12:34 PM, 190/92 at 1:04 PM, and 211/100 at 1:38 PM. The flow sheet failed to evidence the Clonidine had been administered as ordered by the physician.</p> <p>B. A hemodialysis treatment flow sheet dated 9-1-14 evidenced the treatment had been initiated at 6:45 AM. The flow sheet evidenced the blood pressure reading was 186/92 at 10:02 AM, 192/105 at 10:39 AM, and 192/94 at 11:01, 11:33, and 11:50 AM when the treatment was discontinued. The flow sheet failed to evidence the Clonidine had been administered as ordered by the</p>		<p>(4) weeks.</p> <p>The Clinical Manager is responsible to report a summary of the audit findings to the QAI Committee at which time the QAI Committee will determine if the facility should continue completion of the Treatment Sheet Audits and Medical Record Audit Workbook Tool utilizing the fluid management criteria or return to the normal rotation of selection criteria for Medical Record Audits.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>	

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	<p>physician.</p> <p>C. A hemodialysis treatment flow sheet dated 9-5-14 evidenced the treatment had been initiated at 6:45 AM. The flow sheet evidenced the blood pressure reading was 202/109 at 10:02 AM, 201/82 at 10:32 AM, and 194/88 at 11:02 AM. The flow sheet failed to evidence the Clonidine had been administered as ordered by the physician.</p> <p>D. A hemodialysis treatment flow sheet dated 9-12-14 evidenced the treatment had been initiated at 6:40 AM. The flow sheet evidenced the blood pressure reading was 187/81 at 9:33 AM, 194/79 at 10:05 AM, and 192/72 at 11:04 AM. The flow sheet failed to evidence the Clonidine had been administered as ordered by the physician.</p> <p>E. A hemodialysis treatment flow sheet dated 9-15-14 evidenced the treatment had been initiated at 6:30 AM. The flow sheet evidenced the blood pressure reading was 202/85 at 7:34 AM, 192/84 at 8:04 AM, 197/85 at 8:32 AM, 191/109 at 9:05 AM, 197/112 at 9:32 AM, 223/113 at 10:03 AM, 196/108 at 10:32 AM, and 189.82 at 11:37 AM when the treatment was discontinued. The flow sheet failed to evidence the Clonidine had been administered as</p>				

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V000544	<p>ordered by the physician.</p> <p>3. The clinic manager stated, on 9-24-14 at 3:20 PM, "It's all fluid. [The patient's] blood pressure usually comes down at the end of the treatment. We would not want [the patient] to get too low."</p> <p>4. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Dose of Dialysis . . . Provide necessary care and services to manage the patient's volume status."</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 and facility policy review, observation, and interview, the facility failed to ensure the prescribed blood flow rate had been sustained in 2 (patients 5 and 9) of 4 patients observed creating the potential to</p>	V000544	On or before 10/26/14, the Clinical Manager (CM) will meet with all direct patient care staff and review the Comprehensive Interdisciplinary Assessment and Plan of Care Policy, FMS-CS-IC-I-110-125A, with	10/26/2014
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	<p>affect all of the facility's 35 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 9-24-14 at 8:40 AM, observation noted the blood flow rate (BFR) on the dialysis machine at station number 4, where patient number 5 was receiving treatment, was set at 400 milliliters per minute (mL/min). Clinical record number 5 included physician orders dated 9-24-14 that evidenced the physician had ordered the BFR at 350 mL/min. On 9-24-14 at 8:45 AM, observation noted the BFR on the dialysis machine at station number 6, where patient number 9 was receiving treatment, was set at 400 mL/min. Clinical record number 9 included physician orders dated 9-22-14 that evidenced the physician had ordered the BFR at 420 mL/min. The clinic manager was unable to provide any additional documentation and/or information when asked on 9-25-14 at 5:30 PM. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FSM-CS-IC-I-110-125A states, "The patient's individualized comprehensive 		<p>emphasis on following the prescribed physician order for Blood Flow Rate (BFR). At this same meeting the CM will review Physician Order Documentation Policy, FMS-CS-IC-II-150-033A. The CM will reeducate the licensed staff that the Nurse Practice Act requires the nurse to carry out treatment care and medication administration based on the physician order.</p> <p>To ensure ongoing compliance, the staff nurses will conduct a daily audit of treatment sheets for compliance with prescribed Blood Flow Rate (BFR) on one (1) shift per day for a period of four (4) weeks.</p> <p>The Clinical Manager is responsible to report a summary of findings to the QAI Committee. At the end of one month, the QAI Committee will determine if the facility should return to standard monthly Medical Record Auditing procedures.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>	

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V000550	<p>Plan of Care must include, but is not limited to the following: . . . Dose of Dialysis. Sustain the prescribed dose of dialysis."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure post access care had been provided in accordance with facility policy in 2 (#s 2 and 5) of 4 discontinuation of dialysis and post dialysis access care for arteriovenous fistula and graft observations completed creating the potential to affect all of the facility's patients with arteriovenous fistulas or grafts.</p> <p>The findings include:</p> <p>1. Employee A, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 5 on 9-24-14 at 11:50 AM. The PCT was</p>	V000550	<p>On or before 10/26/14, the Clinical Manager will meet with all direct patient care staff and review the Post Treatment Fistula Needle Removal Procedure, FMS-CS-IC-I-115-013C, with emphasis on "Once hemostasis has been achieved, remove the gauze used to achieve hemostasis and replace with Band-Aids, adhesive dressing or clean tape with gauze dressing". To ensure ongoing compliance, the Clinical Manager or designee will complete the Infection Control Audit – Access – Discontinuation of AV Fistula or Graft for Discontinuation of Dialysis weekly for a period of four (4) weeks to monitor replacement of blood soiled bandages/gauze and bandage/gauze on each needle</p>	10/26/2014

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	<p>observed to place a Band-Aid, a folded 2 X 2 gauze, and tape over the needle insertion site after the needle had been removed. When the bleeding stopped, the PCT was observed to apply more tape to the Band-Aid and gauze. The PCT failed to remove the soiled Band-Aid and gauze and replace it with a clean and dry dressing.</p> <p>2. Employee A, a PCT, was observed to discontinue the dialysis treatment on patient number 2 on 9-24-14 at 11:45 AM. The PCT was observed to place a Band-Aid, a folded 2 X 2 gauze, and tape over the needle insertion site after the needle had been removed. When the bleeding stopped, the PCT was observed to apply more tape to the Band-Aid and gauze. The PCT failed to remove the soiled Band-Aid and gauze and replace it with a clean and dry dressing.</p> <p>3. The clinic manager indicated, on 9-25-14 at 5:30 PM, a clean and dry dressing should have been placed on the sites after the bleeding had stopped.</p> <p>4. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "Once hemostasis has been achieved, remove the gauze used for hemostasis and replace the sites with Band-Aids or</p>		<p>site is clean and dry prior to discharge.</p> <p>The Clinical Manager is responsible to report a summary of findings to the QAI Committee. At the end of one month, the QAI Committee will determine if the facility should return to standard monthly Infection Control Auditing procedures.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>	

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V000638	<p>adhesive dressing or clean tape with gauze dressing."</p> <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE 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. Based on interview and review of quality assessment and performance improvement (QAPI) documents and facility policy, the facility failed to ensure it had investigated root causes and developed and implemented a performance improvement plan to address the facility's declining anemia statistics in 3 (June, July and August 2014) of 3 months reviewed creating the potential to affect all of the facility's anemic patients.</p> <p>The findings include:</p> <p>1. The facility's Quality Status Report for period ending August 31.2014 evidenced the percentage of patients with a 3 month average hemoglobin of 10.0 to 11.0 grams per deciliter {g/dL} had declined from May 2014 to August 2014. The document evidenced the percentage of patients that met the facility's goal in May 2014 was 77.1%, 74.3% in June 2014,</p>	V000638	<p>On or before 10/26/2014, the Director of Operations will provide an in-service to the QAI committee members and review the programs' requirement to monitor, measure, analyze, and tract quality indicators and improve care in the facility. This education will be inclusive of the need to monitor, track, and trend factors related to anemia management. The QAI committee will take the following actions:</p> <ul style="list-style-type: none"> · Will routinely monitor for trends in anemia symptoms · Will provide documentation of any recognized trends in causes or contributing factors in anemia management · In the event a trend or contributing factor is identified the facility will take immediate action to implement, document and monitor performance improvement action plans <p>To ensure compliance, the Governing Body will review the QAI program on a quarterly basis</p>	10/26/2014

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	<p>69.4% in July 2014, and 66.2% in August 2014.</p> <p>2. The facility's QAPI documentation for June, July, and August 2014 failed to evidence the facility had investigated the root causes for the decline and had developed and implemented an improvement plan to address the declining rates.</p> <p>3. The clinic manager indicated, on 9-26-14 at 10:00 AM, the facility had recognized the need for a performance improvement plan but had not written a plan in the QAPI documentation. The manager stated, "I have started tracking each patient's hemoglobin and adjust the EPO doses every 2 weeks on patients below goal."</p> <p>4. The facility's 4-4-12 "Quality Assessment and Performance Improvement Program (QAPI)" policy number FMS-CS-IC-I-101-001A states, "QAI Program activities for each facility or program include: . . . Review of aggregate patient data by modality to identify opportunities for improvement for clinical outcomes, and track progress by: Evaluating clinical indicators monthly using the Quality Status Reports (QSR) . . . Identify commonalities among patients who do not reach the minimum</p>		<p>to ensure:</p> <ul style="list-style-type: none"> · Tracking, trending and analyzing of collected anemia data · Any trends or contributing factors identified have performance improvement action plan in place <p>To ensure the QAI committee prioritizes improvement and as part of the developed plan of correction, the Governing Body will review QAI activities monthly until full resolution of the implemented corrective processes is verified and quarterly thereafter.</p>		

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V000715	<p>expected patient targets. Develop a plan to address those causes. Implement the plan. Monitor the effectiveness of the plan. Adjust portions of the plan that are not successful."</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 individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on clinical record and facility policy review and interview, the medical director failed to ensure patient care technicians (PCT) had reported decreased heart rates in accordance with facility policy 1 (#1) of 4 records reviewed creating the potential to affect all of the facility's 35 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included hemodialysis treatment flow sheets that evidenced the patient's heart rate was between 50 and 60 at times and less than 50 at times during the treatments.</p> <p>A. A hemodialysis treatment flow</p>	V000715	<p>The Director of Operations met with the Medical Director on 10/8/2014 to review the medical director citation and review with her, the Medical Director role in ensuring all policies and procedures relative to patient care are adhered to by all individuals who treat patients in the facility.</p> <p>On 10/8/2014, the Medical Director directed the Director of Operations to meet with the Clinical Manager to reinforce her role to ensure that all staff follow policy and procedure, that monitoring occurs to ensure compliance and that noncompliance will be addressed immediately with re-education and with corrective action as appropriate. Additionally, the</p>	10/26/2014

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	<p>sheet dated 9-1-14 evidenced the patient's heart rate was 51 - 56 throughout the treatment. The flow sheet failed to evidence the PCT, employee C, had reported the decreased heart rate to the registered nurse (RN).</p> <p>B. A hemodialysis treatment flow sheet dated 9-3-14 evidenced the patient's heart rate was 52 - 57 throughout the treatment. The flow sheet failed to evidence the PCT, employee C, had reported the decreased heart rate to the RN.</p> <p>C. A hemodialysis treatment flow sheet dated 9-8-14 evidenced the patient's heart rate was 49 - 56 throughout the treatment. The flow sheet failed to evidence the PCT, employee C, had reported the decreased heart rate to the RN.</p> <p>D. A hemodialysis treatment flow sheet dated 9-15-14 evidenced the patient's heart rate was 52 - 59 throughout the treatment. The flow sheet failed to evidence the PCT, employee B, had reported the decreased heart rate to the RN.</p> <p>E. A hemodialysis treatment flow sheet dated 9-17-14 evidenced the patient's heart rate was 45 - 57</p>		<p>Medical Director directed staff re-education on the respective policy related to deficiencies as noted within this Statement of Deficiencies.</p> <p>On or before 10/26/14, the Clinical Manager will meet with all direct patient care staff and review the "Determination of Heart Rate" policy number FMS-CS-IC-I-110-135A which states, "A heart rate between 50-60 or greater than 100 beats per minute must be reported to the registered nurse for further assessment."</p> <p>To ensure ongoing compliance, the staff nurses will conduct a daily audit of treatment sheets for compliance with Determination of Heart Rate Policy on one (1) shift per day for a period of four (4) weeks to ensure that there is documentation of the notifying the RN per policy.</p> <p>The Clinical Manager is responsible to report a summary of findings to the QAI Committee. At the end of one month, the QAI Committee, of which the Medical Director is a member, will determine if the facility should return to standard monthly Medical Record Auditing procedures.</p> <p>The QAI Committee is responsible to analyze the results and determine a root causes analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee.</p>	

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	<p>throughout the treatment. The flow sheet failed to evidence the PCT, employee C, had reported the decreased heart rate to the RN.</p> <p>2. The clinic manager indicated, on 9-24-14 at 1:50 PM, the record did not evidence the PCT had reported the decreased heart rate to the RN.</p> <p>3. The facility's 9-25-13 "Determination of Heart Rate" policy number FMS-CS-IC-I-110-135A states, "A heart rate between 50-60 or greater than 100 beats per minute must be reported to the registered nurse for further assessment."</p>		The Medical Director will review the data presented to the QAI Committee to ensure oversight of staff education, training and performance. The Medical Director will also review that the tracking systems initiated to ensure correction has taken place and resolution is occurring.		