

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152589	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2015
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NAME OF PROVIDER OR SUPPLIER  NEW ALBANY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2669 E CHARLESTON RD NEW ALBANY, IN 47150
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V000000	This was a Federal ESRD recertification survey.  Survey Dates: 1-22-15, 1-22-15, & 1-23-15  Facility #: 004226  Medicaid Vendor #: 200024860E  Surveyor: Vicki Harmon, RN, PHNS  Quality Review: Joyce Elder, MSN, BSN, RN January 27, 2015	V000000		
V000113	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.  Based on observation, interview, and review of facility policy, the facility failed to ensure staff had changed gloves and cleansed hands appropriately in 2 (#s 6 and 11) of 13 infection control observations completed creating the potential to affect all of the facility's 25 current patients.  The findings include:	V000113	V113The Facility Administrator (FA) in-service teammates on 02/02/15 on Policy#1-05-01 "Infection Control for DialysisFacilities" Policy #1-05-01A "Use of Alcohol-Based Hand Rubs", and Policy#1-05-01B "Hand Washing Procedure". Verification of attendance at in-service is evidenced by a signature sheet. Teammates were	02/23/2015

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>1. Employee B, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 6 using an arteriovenous fistula on 1-21-15 at 11:50 AM. The PCT was observed to cleanse the needle insertion site and remove her gloves and cleanse her hands. The PCT touched the computer keyboard to enter data, touched a calculator to determine the amount of fluid to remove during the treatment and then donned clean gloves without cleansing her hands.</p> <p>A. The PCT was observed to check the orders and set the machine accordingly, touching the machine front and tubing. The PCT removed her gloves and cleansed her hands. The PCT touched the computer keyboard and entered more data. The PCT then donned clean gloves without cleansing her hands.</p> <p>B. The PCT inserted the needles and administered the heparin bolus dose. The PCT removed her gloves and cleansed her hands. The PCT touched the computer keyboard and entered more data. The PCT was then observed to don clean gloves without cleansing her hands.</p> <p>2. Employee B, a PCT, was observed to clean and disinfect the dialysis station at station number 9 on 1-21-15 at 4:15 PM.</p>		<p>instructed usingsurveyor observations as examples withemphasis on, but not limited to thefollowing: 1) Hand hygiene is to beperformed upon entering the patienttreatment area, prior to gloving, removalof gloves, after contamination with bloodor other infectious material, after patientand dialysis delivery system contact,between patients even if the contact iscasual, before touching clean areas sucharea. The FA or Facility InfectionManager (FIM) will conductdocumented observational audits oneach shift daily x 1 week, then 3 x perweek x 2 weeks. Ongoing compliancewill be monitored with the facility'smonthly infection control audit. Resultsof audits will be reviewed with theMedical Director during the monthlyQAPI meeting, known as Facility HealthMeeting (FHM). The FA is responsiblefor ongoing compliance with this Plan ofCorrection (POC).</p>		

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V000122	<p>The PCT failed to change her gloves and cleanse her hands after emptying and disinfecting the prime waste container and prior to cleaning the dialysis machine.</p> <p>3. The facility administrator indicated, on 1-23-15 at 1:25 PM, employee B had not followed the facility's infection control policies and procedures.</p> <p>4. The facility's September 2014 "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, 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)(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-]</p>				

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	<p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure staff had appropriately cleaned and disinfected the dialysis station and surrounding area in 2 (#s 1 and 2) of 2 cleaning and disinfecting the dialysis station observations completed creating the potential to affect all of the facility's 25 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Employee C, a patient care technician (PCT), was observed to clean and disinfect the dialysis station at station number 6 on 1-21-15 at 2:30 PM. The PCT failed to obtain a fresh cloth prior to cleaning the dialysis chair and after cleaning the dialysis machine.</li> </ol> <p>The PCT failed to clean the front of the arms of the dialysis chair, including the area where patients place their hands. The PCT failed to clean the data entry station or the countertop behind the dialysis station.</p> <ol style="list-style-type: none"> <li>Employee C, a PCT, was observed to clean and disinfect the dialysis station at station number 9 on 1-21-15 at 4:15 PM. The PCT failed to clean the front of the</li> </ol>	V000122	<p>V122The FA in-serviced teammates on 02/02/15 on Policy #1-05-01 "InfectionControl for Dialysis Facilities". Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including the dialysis delivery systems, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patient and teammates... 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. All teammates were also instructed on the need to use a fresh bleach wipe for each area cleaned. FA or Facility Infection Manager (FIM) will conduct documented observational audits on each shift daily x1 week, then 3 x per week x 2 weeks. Ongoing compliance will be monitored with the facility's monthly</p>	02/23/2015

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V000260	<p>arms of the dialysis chair, including the area where patients place their hands. The PCT failed to clean the data entry station or the countertop behind the dialysis station.</p> <p>3. The facility administrator indicated, on 1-23-15 at 1:25 PM, employee C had not followed the facility's infection control policies and procedures.</p> <p>4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Equipment including the dialysis delivery systems, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patient and teammates . . . 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."</p> <p>494.40(a) PERSONNEL-TRAINING PROGRAM/PERIODIC AUDITS</p>		infectioncontrol audit. Results of audits will bereviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.		

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	<p>9 Personnel: training program/periodic audits A training program that includes quality testing, the risks and hazards of improperly prepared concentrate, and bacterial issues is mandatory.</p> <p>Operators should be trained in the use of the equipment by the manufacturer or should be trained using materials provided by the manufacturer.</p> <p>The training should be specific to the functions performed (i.e., mixing, disinfection, maintenance, and repairs).</p> <p>Periodic audits of the operators' compliance with procedures should be performed.</p> <p>The user should establish an ongoing training program designed to maintain the operator's knowledge and skills.</p> <p>Based on personnel file review and interview, the facility failed to ensure individuals that prepared bicarbonate mixtures and completed the water start-up and total chlorine check procedures had been evaluated at least annually for compliance with facility policies creating the potential to affect all of the facility's 25 current patients.</p> <p>The findings include:</p> <p>1. The facility administrator indicated, on 1-22-15 at 2:30 PM, employees B and C, both patient care technicians, were the individuals that performed the water</p>	V000260	V260The FA and Biomedical Technician (BMT) have reviewed the summary statement of deficiencies regarding periodic audits of teammate skills related to water start up, total chlorine testing, and bicarbonate mixing. Teammate training on the water system, water room components, bicarbonate and acid concentrate mixing are conducted upon hire and annually. Annual training includes completion of skills checklists administered by the Biomedical Technician, as well as computer-based training and testing. Skills checklists and learning transcripts are placed in teammate file upon completion of training annually. Personnel B will	02/23/2015

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V000401	<p>start-up, total chlorine checks, and bicarbonate mixing procedures on a daily basis.</p> <p>2. Personnel file B failed to evidence the individual had been evaluated for compliance with facility policies and procedures in the performance of water start-up, total chlorine checks, and bicarbonate mixing procedures since 7-25-13 for the water and 8-16-12 for the bicarbonate mixing.</p> <p>3. The facility administrator indicated, on 1-22-15 at 2:30 PM, personnel file B did not evidence the individual had been evaluated for compliance with facility policies and procedures for water start-up, total chlorine checks, and bicarbonate mixing procedures at least annually.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, interview, and review of facility policy, the facility failed to ensure the reuse room and central distribution system had been maintained creating the potential to affect</p>	V000401	<p>have a completed skillschecklist for water start up, total chlorinetesting, and bicarbonate mixing completed by 2/27/15. The FA or designee will conduct an employee file audit on 100% of teammate files immediately to verify that any teammate performing water monitoring or bicarbonate mixing has an updated annual skills checklist. Ongoing compliance will be monitored by quarterly teammate file audits. Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p> <p>V 0401 The FA in-service teammates on 02/02/15 on Policy #8-04-01 "Physical Environment". Verification of attendance at in-service is evidenced by a signature sheet. Teammates</p>	02/23/2015

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	<p>all of the facility's 25 current patients.</p> <p>The findings include:</p> <p>1. On 1-22-15 at 10:00 AM, observation noted a continuous water leak at the reverse ultrafiltration station in the reuse room. The reuse technician, employee B, stated, "I told [the biomedical technician, employee G] about the leak about 2 weeks ago."</p> <p>A. Employee G stated, on 1-22-15 at 8:50 AM, "I cover 4 clinics. I have enough time to get the disinfections done, draw the water samples, and machine maintenance, but sometimes the little things do not get done. I have to prioritize."</p> <p>B. The employee stated, on 1-22-15 at 10:20 AM, regarding the leak in the reuse room, "It is a leak that needs to be fixed."</p> <p>2. On 1-22-15 at 1:20 PM, the following observations were made of the central distribution piping inside the chase cabinets located around the perimeter of the treatment floor at each dialysis station.</p> <p>A. At station number 1, observation noted small white flakes of a material on</p>		<p>were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. The BMT will clean all chase cabinets of "white crystalline substance" by 2/7/15 and repair leak in Reuse room no later than 2/28/15. The FA or designee will conduct observational audits of the reuse room and central distribution system daily x 2 weeks, then weekly x 2 weeks to verify cleanliness. Ongoing compliance will be monitored by the monthly Biomedical Audit (BAudit). Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>				

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	<p>the floor approximately 2 inches by 4 inches.</p> <p>B. At station number 2, observation noted a large of amount of a white crystalline substance on the acid distribution tubing and on the floor.</p> <p>C. At station number 3, a brown dried residue was observed on the acid distribution tubing.</p> <p>D. At station number 4, a brown crystalline substance was noted on the acid distribution tubing. A white crystalline substance was observed on the floor inside the cabinet.</p> <p>E. At station numbers 5 and 6, a brown dried residue was observed on the acid distribution tubing.</p> <p>F. At station number 7, a large amount of a brown crystalline substance was observed on the acid distribution tubing.</p> <p>G. At station numbers 8 and 9, observation noted a small amount of white crystals on the floor inside the cabinet.</p> <p>H. At station number 11, a mound of a white crystalline substance,</p>			

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V000543	<p>approximately 4 inches by 6 inches, was observed on the floor inside the cabinet.</p> <p>I. At station number 12, a small amount of a white dried substance was observed on the acid distribution tubing.</p> <p>3. The Group Facility Administrator stated, on 1-22-15 at 1:30 PM, "Apparently there have been leaks. It does need to be cleaned."</p> <p>4. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record and facility policy review and interview, the facility failed to ensure it had managed the patient's volume status in 1 (# 1) of 4 records reviewed creating the potential to affect all of the facility's 25 current</p>	V000543	The FA in-serviced teammates on 2/2/15 on Policy# 1-03-09 "Intradialytic Treatment Monitoring" and Policy#1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis". Verification of	02/23/2015

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	<p>patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included physician orders dated 12-5-14 that identified the estimated dry weight (EDW), the desired weight at the end of the treatment, as 76 kilograms (kg).</p> <p>A. A hemodialysis treatment flow sheet dated 12-29-14 evidenced the weight at the end of the treatment was 77.9 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 1-14-15 evidenced the weight at the end of the treatment was 77.8 kg.</p> <p>C. A hemodialysis treatment flow sheet dated 1-21-15 evidenced the weight at the end of the treatment was 80.5 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 1-16-15 evidenced 3.9 kg had been removed in less than 4 hours during the treatment which is greater than 5 % of the patient's EDW.</p> <p>2. The facility administrator was unable to provide any additional documentation and/or information when asked on 1-23-15 at 11:00 AM.</p>		<p>attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs... The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status. A new patient EDW tracking has been added to daily schedule and will be updated by the PCTs and reviewed and signed by the Charge Nurse (CN) every day to determine if patients are obtaining their prescribed EDW. This report will be reviewed in the bi-weekly Interdisciplinary Team (IDT) Core team meetings to communicate need for patient specific assessment and plan of care updates. The FA or designee will conduct audits of 100% of posttreatment flowsheets daily for two weeks, then 50% weekly for four weeks to verify compliance. Ongoing compliance will be monitored with the facility's monthly medical record audit. Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for</p>	

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V000544	<p>3. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs . . . The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses 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 and interview, the facility failed to ensure the prescribed dose of dialysis had been sustained in 3 (#s 2, 3, and 4) of 4 records reviewed creating the potential to affect all of the facility's 25 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included physician orders dated 10-22-14 that identified a total of 800 units of</p>	V000544	<p>ongoing compliance with this POC.</p> <p>The FA will in-service teammates on Policy # 1-06-02 "Anticoagulation" and Policy # 1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis". Verification of attendance will be evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Heparin is administered per physician's order. Order is to include order date and time, patient name, route, heparin loading</p>	02/23/2015

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	<p>continuous heparin was to be administered during each treatment and the infusion was to be stopped 60 minutes prior to the end of the treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 12-29-14 evidenced the heparin infusion had been completed 39 minutes prior to the end of the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 12-31-14 evidenced the heparin infusion had been completed 37 minutes prior to the end of the treatment.</p> <p>C. A hemodialysis treatment flow sheet dated 1-5-15 evidenced the heparin infusion had been completed 38 minutes prior to the end of the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 1-16-15 evidenced the heparin infusion had been completed 35 minutes prior to the end of the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 1-19-15 evidenced the heparin infusion had been completed 23 minutes prior to the end of the treatment.</p> <p>2. Clinical record number 3 included physician orders dated 12-1-14 that identified a total of 1100 units of continuous heparin was to be</p>		<p>dose, hourly infusion or bolus dose and stop/discontinuation time, as applicable, and 2) The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs... The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status: and achieve and sustain the prescribed dose of dialysis. FA or designee to audit posttreatment 100% flowsheets daily for two weeks, and then 50% weekly for four weeks to verify compliance. Ongoing compliance will be monitored with the facility's monthly medical record audit. Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>				

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	<p>administered during each treatment and the infusion was to be stopped 60 minutes prior to the end of each treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 12-29-14 evidenced the heparin infusion had been completed 37 minutes prior to the end of the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 1-12-15 evidenced the heparin infusion had been completed 27 minutes prior to the end of the treatment.</p> <p>3. Clinical record 4 included physician orders dated 12-31-14 that evidenced a total of 1000 units of continuous heparin was to be administered during each treatment and the infusion was to be stopped 30 minutes prior to the end of the treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 12-31-14 evidenced the heparin infusion had been completed 7 minutes prior to the end of the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 1-2-15 evidenced the heparin infusion had been completed 13 minutes prior to the end of the treatment.</p> <p>C. A hemodialysis treatment flow</p>			

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	<p>sheet dated 1-5-15 evidenced the heparin infusion had been completed 11 minutes prior to the end of the treatment.</p> <p>D. A hemodialysis treatment flow sheet dated 1-7-15 evidenced the heparin infusion had been completed 9 minutes prior to the end of the treatment.</p> <p>E. A hemodialysis treatment flow sheet dated 1-9-15 evidenced the heparin infusion had been completed 14 minutes prior to the end of the treatment.</p> <p>F. A hemodialysis treatment flow sheet dated 1-12-15 evidenced the heparin infusion had been completed 20 minutes prior to the end of the treatment.</p> <p>G. A hemodialysis treatment flow sheet dated -16-15 evidenced the heparin infusion had been completed 10 minutes prior to the end of the treatment.</p> <p>H. A hemodialysis treatment flow sheet dated 1-19-15 evidenced the heparin infusion had been completed 9 minutes prior to the end of the treatment.</p> <p>4. The facility administrator was unable to provide any additional documentation and/or information when asked on 1-23-15 at 11:00 AM.</p>						

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V000550	<p>5. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs . . . The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status; and achieve and 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 observation, interview, and facility policy review, the facility failed to ensure pre- and post-access care had been provided in accordance with facility policy in 4 (#s 1, 2, 3, and 4) of 4 access of arteriovenous fistula for the initiation of dialysis and post access care</p>	V000550	The FA in-serviced teammates on 2/2/15on Policy #1-04-01 "Arteriovenous Fistula(AVF) and Arteriovenous Graft (AVG)Vascular Access Care" and Policy #1-04-01B "Post Dialysis Vascular AccessCare: Fistula/Graft using Safety Needles".Verification of	02/23/2015

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	<p>observations completed creating the potential to affect all of the facility's 23 current patients with arteriovenous fistulas or grafts.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee B, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 6 using an arteriovenous fistula (AVF). The PCT failed to wash the skin over the access with soap and water or antibacterial scrub and failed to ask the patient if the patient had done so prior to initiating the treatment.</li> <li>2. Employee A, a registered nurse (RN), was observed to initiate the dialysis treatment on patient number 7 using an AVF. The RN failed to wash the skin over the access with soap and water or antibacterial scrub and failed to ask the patient if the patient had done so prior to initiating the treatment.</li> <li>3. Employee B, a PCT, was observed to discontinue the dialysis treatment on patient number 8 on 1-21-15 at 12:15 PM. The PCT failed to replace the gauze over the needle insertion sites with clean gauze after the needles had been pulled and the sites had stopped bleeding. A small amount of blood was observed on</li> </ol>		<p>attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient is unable to wash access site, patient care teammate will clean extremity with skin cleansing agent and pat dry, and 2) Once bleeding has stopped, discard gauze or band-aid used to hold site. Inspect site for any trauma and for hemostasis. Apply bandaid type or sterile dressing over cannulation site. FA or Facility Infection Manager (FIM) will conduct documented observational audits on each shift daily x1 week, then 3 x per week x 2 weeks. Ongoing compliance will be monitored with the facility's monthly infection control audit. Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>		

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	<p>the gauze initially applied to the sites.</p> <p>4. Employee B, a PCT, was observed to discontinue the dialysis treatment on patient number 9 on 1-21-15 at 2:05 PM. The PCT failed to replace the gauze over the needle insertion sites with clean gauze after the needles had been pulled and the sites had stopped bleeding. A small amount of blood was observed on the gauze initially applied to the sites.</p> <p>5. The facility administrator indicated, on 1-23-15 at 1:25 PM, employees A and B had not followed the facility's own policies and procedures.</p> <p>6. The facility's September 2014 "Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care" policy number 1-04-01 states, "Patients are encouraged to wash access extremity with soap and water upon arrival for dialysis, if able. If patient unable to wash access site, patient care teammate will clean extremity with skin cleansing agent and pat dry."</p> <p>7. The facility's March 2014 "Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Needles" procedure number 1-04-01B states, "Once bleeding has stopped, discard gauze or band-aid used to hold site.</p>						

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V000634	<p>Inspect site for any trauma and for hemostasis. Apply band-aid type or sterile dressing over cannulation site."</p> <p>494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. Based on quality assessment and performance improvement (QAPI) documentation and facility policy review and interview, the facility failed to ensure its QAPI program identified medical errors and adverse events to be reviewed in 5 (August 2014 through December 2014) of 5 months reviewed creating the potential to affect all of the facility's 25 current patients.</p> <p>The findings include:</p> <p>1. The facility's QAPI meeting minutes, dated 8-18-14, 9-15-14, October 2014, November 2014, and 12-15-14 identified the committee discussed adverse events and occurrences at each meeting. The meeting minutes failed to identify the individual adverse events or occurrences discussed, failed to include an</p>	V000634	<p>The FA in-serviced IDT on Policy #1-14-06"Continuous Quality ImprovementProgram". Verification of attendance is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not limited to, the following: Patient safety including: review of sentinel events, review of trends of adverse occurrences including falls and blood loss, review of product, equipment, or medication notices or recalls... The FA will complete Adverse Occurrence Report (AOR) tracking form via a spreadsheet which will be reviewed monthly in the</p>	02/23/2015	

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	<p>investigation of the root cause of each adverse event, and failed to evidence identification of any trends.</p> <p>The facility's "Alleged Incidents/AOR Tracking" for 2014 identified the facility had 5 incidents of "blood loss other", 1 medication error, 4 clotted access incidents, 7 infiltration, unable to dialyze incidents, and 1 infiltration, able to dialyze incident for the year.</p> <p>2. The facility administrator stated, on 1-23-15 at 11:45 AM, "We discuss adverse events at the meetings. I do not document the types of adverse events we review."</p>		<p>FacilityHealth Meeting (FHM) to ensure reviewand discussion of all events isdocumented. AOR Tracking Form resultswill be reviewed monthly in the FHMwith the Medical Director and any trendswill be addressed as necessary. The FA isresponsible for ongoing compliance withthis POC.</p>				