

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152569	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/27/2012
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NAME OF PROVIDER OR SUPPLIER  EAST EVANSVILLE DIALYSIS PD	STREET ADDRESS, CITY, STATE, ZIP CODE 1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714
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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Survey Dates: 1-24-12 to 1-27-12</p> <p>Facility #: 002562</p> <p>Medicaid Vendor #: 200071340A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">January 31, 2012</p>	V0000		

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

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

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V0124	<p><b>Routine Testing for Hepatitis B</b></p> <p>The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit.</p> <p>Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results.</p> <p>Based on administrative record review and interview, the facility failed to ensure all patients that had been determined to be susceptible to the hepatitis B virus had been tested monthly in 15 (#s 14 through 28) of 35 susceptible patient results reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The Centers for Disease Control recommends testing for the presence of the hepatitis B antigen monthly when a patient has been determined to be susceptible, with an antibody level of less than 10.</li> <li>The facility's "Audit: Hepatitis status and Compliance with CDC Recommendations for Hepatitis B Testing on ESRD Patients" evidenced the facility had not completed monthly hepatitis antigen testing on patients the facility had determined to be susceptible as follows:</li> </ol>	V0124	<p>V 0124 Facility Administrator (FA) conducted review of 100% of patient census to ensure all susceptible patients with Hepatitis B Antibody &lt;10 have current lab orders in place to have Hepatitis B Antigen drawn monthly (including patients # 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28) as of 2/2/2012. FA will hold mandatory in-service for all Registered Nurses on <i>Policy and Procedure # 1-05-02 Hepatitis Surveillance, Vaccination and Infection Control Measures</i> by 2/8/2012. Nurses will be instructed to review patients Hepatitis status monthly and ensure monthly Hepatitis B Surface Antigen (HBsAg) testing is completed on all patients who are susceptible or not immune to hepatitis B infection: Hepatitis B Surface Antibody (HBsAb) is &lt;10 mIU/mL, including non-responders to the vaccine. Attendance of in-service is evidenced by RN signatures on In-Service Form. FA or RN designee will audit all susceptible</p>	02/27/2012			

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	<p>A. The audit evidenced patient number 14 was determined to be susceptible on 1-6-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of February, March, and April 2011.</p> <p>B. The audit evidenced patient number 15 was determined to be susceptible on 1-6-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of February, March, and July 2011.</p> <p>C. The audit evidenced patient number 16 was determined to be susceptible on 2-23-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of March, April, and May 2011.</p> <p>D. The audit evidenced patient number 17 was determined to be susceptible on 1-5-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of February and March 2011.</p> <p>E. The audit evidenced patient number 18 was determined to be susceptible on 1-20-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of</p>		<p>patients (HBsAb is &lt;10 mIU/mL), for the Hepatitis B antigen monthly. Result of audit will be reported to Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM) with supporting documentation included in the meeting minutes. FA is responsible for compliance with this Plan of Correction (POC).</p>		

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	<p>February and August 2011.</p> <p>F. The audit evidenced patient number 19 was determined to be susceptible on 5-5-10. The audit failed to evidence the patient had been tested for hepatitis B antigens the month of September 2010.</p> <p>G. The audit evidenced patient number 20 was determined to be susceptible on 1-7-10. The audit failed to evidence the patient had been tested for hepatitis B antigens the month of June 2010.</p> <p>H. The audit evidenced patient number 21 was determined to be susceptible on 1-5-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the month of June 2011.</p> <p>I. The audit evidenced patient number 22 was determined to be susceptible on 1-5-11. The audit failed to evidence the patient had been tested for hepatitis B antigens the months of February and March 2011.</p> <p>J. The audit evidenced patient number 23 was determined to be susceptible on 4-12-10. The audit failed to evidence the patient had been tested for hepatitis B antigens the month of June 2010.</p>				

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	<p>K. The audit evidenced patient number 24 was determined to be susceptible on 5-5-11, 9-22-11, 10-6-11, and 12-7-11. The audit failed to evidence any hepatitis B antigen testing had been completed after 5-5-11.</p> <p>L. The audit evidenced patient number 25 was determined to be susceptible on 6-1-10, 10-12-10, 2-9-11, and 12-7-11. The audit failed to evidence any hepatitis B antigen testing had been completed after 6-1-10.</p> <p>M. The audit evidenced patient number 26 was determined to be susceptible on 1-6-10. The audit failed to evidence any hepatitis B antigen testing had been completed the months of February, March, April, May, June, July, and August 2010.</p> <p>N. The audit evidenced patient number 27 was determined to be susceptible on 1-6-10. The audit failed to evidence any hepatitis B antigen testing had been completed the months of February and March 2010.</p> <p>O. The audit evidenced patient number 28 was determined to be susceptible on 10-11-10. The audit failed to evidence any hepatitis B antigen testing</p>						

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	<p>had been completed the month of February 2011.</p> <p>3. The facility administrator, employee C, indicated, on 1-27-11 at 11:35 AM, the facility had not completed routine hepatitis B antigen testing on all susceptible patients as required.</p>			
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V0403	<p>The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations.</p> <p>Based on preventative maintenance documentation and facility policy review and interview, the facility failed to ensure its preventative maintenance program for dialysis equipment had been implemented creating the potential to affect all of the facility's 127 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's September 2011 "Preventative Maintenance Schedules for Equipment" policy number 2-01-09 states, "All miscellaneous equipment will receive preventive maintenance at least annually or per manufacturer's recommendations. Examples of miscellaneous equipment may include but are not limited to . . . oxygen concentrators."</li> <li>2. The facility's 2011 preventative maintenance documentation failed to evidence the facility's oxygen concentrators had been maintained as required by the manufacturer's instructions.</li> </ol>	V0403	<p>V 0403Biomedical Technician conducted required preventative maintenance (PM) of cleaning the Air Intake Gross Particle Filter on oxygen Concentrator per manufacturer recommendations on 1/27/2012. FA held mandatory in-service for BMT on 1/27/2012. In-service included review of <i>Policy and Procedure #2-01-09 Preventative Maintenance Schedules for Equipment</i>, preventative maintenance will be completed on miscellaneous equipment minimum of annually or per manufacturers recommendations, review of New Life Elite Oxygen Concentrator Service and Maintenance Log for between patient maintenance, Attendance of in-service is evidenced by TMS signature on In-Service Form. On 1/27/2012, BMT created a Preventative Maintenance checklist for documentation of the weekly cleaning of the Air Intake Gross particle Filter as recommended per manufacturer of the New Life Elite Oxygen Concentrator Manual. The Biomedical Technician will clean the Air Intake Gross Particle Filter of the oxygen concentrator weekly and document on the</p>	01/27/2012			

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	<p>A. The preventative maintenance documentation failed to evidence any scheduled preventative maintenance had been performed on the oxygen concentrator.</p> <p>B. The oxygen concentrator service manual states, "Cleaning the Air Intake Gross Particle Filter. Note: The [user] must clean this filter weekly, as described below."</p> <p>C. The biomedical technician, employee G, indicated, on 1-25-12 at 1:45 PM, the oxygen concentrator had not been maintained per the manufacturer's recommendations.</p>		<p>Oxygen Concentrator weekly cleaning log. The FA will monitor this weekly x 1 month, then monthly to ensure compliance with this POC. Result of audit will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this POC.</p>		

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V0541	<p>The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included estimated timetables to achieve identified goals in 12 (#s 1, 3, 4, 5, 6, 8, 9, 10, 11, 12, and 13) of 13 clinical records reviewed creating the potential to affect all of the facility's 127 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included a plan of care dated 1-26-12. The plan of care failed to include estimated timetables for the following goals: <ul style="list-style-type: none"> <li>A. Access - "G - Patient will maintain function of fistula, ongoing."</li> <li>B. Anemia - "G - Pt [patient] will maintain Hgb [hemoglobin] of 10-11."</li> <li>C. Adequacy - "G - Pt will maintain</li> </ul> </li> </ol>	V0541	<p>V 0541 Interdisciplinary Team (IDT) will initiate individualized plan of care updates by 2/27/2012 for Patients (#1, 3, 4, 5, 6, 8, 9, 10, 11, 12, and 13) to include estimated timetables in POC to achieve patient identified issues with access, anemia, adequacy, mineral bone disease, blood pressure, fluid management and nutrition. Documentation will be placed in QIFMM when action item is complete. FA will hold mandatory in-service for all members of IDT by 2/27/2012. In-service will include but not limited to: review of Policy &amp; Procedure #1-01-07 Patient Assessment and Plan of Care When Utilizing Duck, with attention to the IDT or individual IDT member must include estimated timetables for achieving goals. IDT will follow up and readjust plan of care as necessary and document as such in patients' medical record. Attendance of in-service is</p>	02/27/2012			

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	<p>adequate dialysis as evidenced by KT/V of 1.2 and a URR of 65 or &gt;."</p> <p>D. Mineral Bone Disease (MBD) - "Goal is for phosphorous to remain 3.0 to 5.5, calcium to remain 8.0 to 10.2 and PTH to remain 150-600."</p> <p>E. Blood Pressure and Fluid Management (BP &amp; Fld Mgmt) - "Goal is for fluid to remain 4 kg [kilograms] or less between tx [treatments]."</p> <p>2. Clinical record number 2 included a plan of care dated 1-26-12. The plan of care failed to include estimated timetables for the following goals:</p> <p>A. Access - "Access will remain free of infection."</p> <p>B. Adequacy - "G - Kt/V will continue to be WNL [within normal limits]."</p> <p>C. MBD - "Goal is for phosphorous to remain 3.0 to 5.5, calcium to remain 8.0 to 10.2 and PTH to remain 150-600."</p> <p>D. Nutrition - "Goal is for potassium to remain 3.5 -5.5 and A1C to remain less than 7.0."</p> <p>E. BP &amp; Fld Mgmt - "Goal is for fluid</p>		<p>evidenced by IDT signature on In-Service Form. FA or designee will conduct Medical Record Audits monthly for 100% new admissions and 10% of current patient census reviewing plans of care to ensure patient's individualized plan of care included measureable goals and timetables specific to patients needs. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this POC.</p>	

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	<p>gains to remain 4 kg or less between tx."</p> <p>3. Clinical record number 3 included a plan of care dated 1-26-12 that failed to include estimated timetables for the following goals:</p> <p>A. Primary Access - "G - Maintain patency and maximum blood flows of CVC [central venous catheter]. Patient will remain free from any S/S [signs and symptoms] of infections. Pt will maintain adequate KT/V and URR."</p> <p>B. Adequacy - "G-Pt [patient] will maintain adequate dialysis as evidenced by KT/V of 1.2 or &gt; and URR of 65% or &gt;."</p> <p>C. Nutrition - "Goal is for potassium to remain 3.5 -5.5."</p> <p>D. BP &amp; Fld Mgmt - "Goal is for fluid gains to remain 4 kg or less between tx."</p> <p>4. Clinical record number 4 included a plan of care dated 10-24-11 that failed to include estimated timetables for the following goals:</p> <p>A. Primary Access - "G-Pt will maintain patency, maximum BF'S [blood flows] of CVC, and infection free."</p>			
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	<p>B. Adequacy - "Pt will continue to achieve adequate dialysis as evidenced by KT/V of 1.2 or &gt;."</p> <p>C. Nutrition - "Goal is for potassium to remain 3.5 to 5.5."</p> <p>D. BP &amp; Fld Mgmt - "Goal is to maintain current normal fluid gains."</p> <p>5. Clinical record number 5 included a plan of care dated 11-14-11 that failed to include estimated timetables for the following goals:</p> <p>A. Primary Access - "G-pt cvc [central venous catheter] to remain free of infection."</p> <p>B. Anemia - "G: Hgb [hemoglobin] will continue to be 10-12 . . . Ferritin level will be between 100-500."</p> <p>C. Adequacy - "G-pt to maintain adequate dialysis of Kt/v of 1.2 or &gt;."</p> <p>D. MBD - "Goal is for phosphorous to remain 3.0-5.5, PTH to remain 150-600 and calcium to remain 8.0 to 10.2."</p> <p>E. Nutrition - "Goal is for potassium to remain 3.5 -5.5 and A1C to remain less than 7.0."</p>			

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	<p>F. BP &amp; Fld Mgmt - "Goal is for fluid gains to remain 4 kg or less between tx."</p> <p>6. Clinical record number 6 included a plan of care dated 11-8-11 that failed to include estimated timetables for the following goals:</p> <p style="padding-left: 40px;">A. Primary Access - "Exit site to remain infection free."</p> <p style="padding-left: 40px;">B. Anemia - "To maintain hgb at acceptable range."</p> <p>7. Clinical record number 8 included a plan of care dated 12-13-11 that failed to include estimated timetables for the following goals:</p> <p style="padding-left: 40px;">A. Anemia - "Goal: hgb will be maintain 10-12."</p> <p style="padding-left: 40px;">B. Adequacy - "Goal: maintain adequacy."</p> <p>8. Clinical record number 9 included a plan of care dated 9-23-11 that failed to include estimated timetables for the following goals:</p> <p style="padding-left: 40px;">A. Primary Access - "Goal: Maintain functional primary AVF [arteriovenous fistula] in upper lt [left] arm."</p>			
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	<p>B. MBD - "Goal is for phosphorus to remain 3.0-5.5, calcium to remain 8.0-10.2, and PTH [parathyroid hormone] to remain 150-600."</p> <p>C. Nutrition - "Goal is for potassium to remain 3.5-5.5."</p> <p>D. BP &amp; Fld Mgmt - "Goal is for fluids gains to remain 4 kg or less between tx."</p> <p>9. Clinical record number 10 included a plan of care dated 11-14-11 that failed to include estimated timetables for the following goals:</p> <p>A. Primary Access - "G-Right AVF will continue to function properly."</p> <p>B. Adequacy - "G=Pt will maintain Kt/V&gt;1.2."</p> <p>C. Nutrition - "Goal is for potassium to remain 3.5-5.5 and A1C to remain less than 7.0."</p> <p>D. BP &amp; Fld Mgmt - "Goal is for fluid gains to remain 4 kg or less."</p> <p>10. Clinical record number 11 included a plan of care dated 11-14-11 that failed to include estimated timetables to achieve the following goals:</p>						

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	<p>A. Access - "Pt fistula will remain patent with adequate BFR [blood flow rate] and KT/v &gt;1.2."</p> <p>B. Adequacy - "goal: maintain Kt/v .1.2."</p> <p>C. Nutrition - "Goal is for potassium to remain 3.5-5.5."</p> <p>D. BP &amp; Fld Mgmt - "Goal is for fluid gains to remain 4 kg or less."</p> <p>11. Clinical record number 12 included a plan of care dated 12-19-11 that failed to include estimated timetables for the following goals:</p> <p>A. Primary Access - "G-Maintain patency and maximum blood flows of avg [average]. Patient will remain free from any S/S infections. Pt will maintain adequate KT/V."</p> <p>B. Anemia - "G-Pt will maintain Hgb of 10-11, Tsats &gt;20%, and Ferritin levels between 150-1200."</p> <p>C. Adequacy - "G-Pt will maintain adequate dialysis as evidenced by KT/V of 1.2 and a URR of 75 or &gt;."</p> <p>D. Nutrition - "Goal is for potassium</p>			
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	<p>to remain 3.5-5.5."</p> <p>12. Clinical record number 13 included a plan of care dated 12-20-11 that failed to include estimated timetables for the following goals:</p> <p style="padding-left: 40px;">A. MBD- "Goal is for phosphorous to remain 3.0-5.5, calcium to remain 8.0-10.2, and PTH to remain 150-600."</p> <p style="padding-left: 40px;">B. Nutrition - "Goal is for potassium to remain 3.5-5.5."</p> <p>13. The facility administrator, employee C, was unable to provide any additional documentation and/or information when asked on 1-27-12 at 3:10 PM.</p> <p>14. The facility's December 2010 "Patient Assessment and Plan of Care When Utilizing Duck" policy number 1-01-07 states, "The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that . . . will include measurable goals and expected outcomes and estimated timetables to achieve these outcomes."</p>				

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V0552	<p>The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included specific interventions to monitor the patients' psychosocial status in 6 (#s 3, 5, 6, 9, 10, and 13) of 13 records reviewed creating the potential to affect all of the facility's 127 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 3 included a plan of care dated 11-26-11. The plan of care failed to include specific interventions to monitor the patient's psychosocial status. The plan of care stated, "No interventions indicated."</li> <li>2. Clinical record number 5 included a plan of care dated 11-14-11. The plan of care failed to include specific interventions to monitor the patient's psychosocial status.</li> <li>3. Clinical record number 6 included a plan of care dated 11-8-11. The plan of</li> </ol>	V0552	<p>V 0552 Social Worker will initiate individualized plan of care updates by 2/27/2012 in the 6 patient records (#s 3, 5, 6, 9, 10, and 13) to ensure plans of care include specific interventions to monitor the patients' psychosocial status. Documentation will be placed in QIFMM when action item is complete. FA will hold mandatory in-service for all members of IDT by 2/27/2012. In-service will include but not limited to: review of <i>Policy &amp; Procedure #1-01-07 Patient Assessment and Plan of Care When Utilizing Duck</i>, with attention to the IDT or individual IDT member must: 1) develop and implement a written, individualized comprehensive plan of care that will include measurable and expected outcomes, interventions to achieve goal and timetables for achieving goals related to patient's psychosocial status, 2) Social Worker will follow up and readjust plan of care as necessary, document interventions to monitor the patient's psychosocial status.</p>	02/27/2012			

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	<p>care failed to include specific interventions to monitor the patient's psychosocial status.</p> <p>4. Clinical record number 9 included a plan of care dated 9-23-11. The plan of care failed to include specific interventions to monitor the patient's psychosocial status.</p> <p>5. Clinical record number 10 included a plan of care dated 11-14-11. The plan of care failed to include specific interventions to monitor the patient's psychosocial status.</p> <p>6. Clinical record number 13 included a plan of care dated 12-20-11. The plan of care failed to include specific interventions to monitor the patient's psychosocial status.</p> <p>7. The medical social worker, employee B, indicated, on 1-25-12 at 3:45 PM, the plans of care did not include specific interventions to monitor the patient's psychosocial status.</p> <p>8. The facility's December 2010 "Patient Assessment and Plan of Care Utilizing Duck" policy number 1-01-07 states, "The plan of care will address, but not be limited to, the following: . . . Psychosocial status which addresses necessary</p>		<p>Attendance of in-service is evidenced by IDT signature on In-Service Form. FA or designee will conduct Medical Record Audits monthly for 100% new admissions and 10% of current patient census reviewing plans of care to ensure patient's individualized plan of care includes appropriate, measurable goals and interventions to monitor patient's psychosocial status. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this POC</p>				

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	monitoring and social work interventions."			

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V0626	<p>The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.</p> <p>Based on quality assurance and performance improvement (QAPI) documentation and facility policy review and interview, the facility failed to ensure all members of the facility's QAPI committee had attended monthly meetings in 3 (October, November, and December) of 12 months reviewed (2011).</p> <p>The findings include:</p> <p>1. The facility's March 2011 "Continuous Quality Improvement Program" policy number 1-02-01 states, "Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: . . . Biomed technician."</p>	V0626	<p>V 0626FA will hold mandatory in-service for Biomedical Technician by 2/27/2012 on <i>Policy &amp; Procedure #01-02-01 Continuous Quality Improvement Program</i> with attention to the Continuous Quality Improvement (CQI) Committee is comprised of at least the following individuals from the Interdisciplinary Team: Facility Medical Director, Facility Administrator (FA)/designee, Registered Nurse , Biomed Technician, Registered Dietitian, and Social Worker. Biomedical Technician must attend monthly QIFMM. If unable to attend monthly QIFMM in person TM may attend telephonically, or they may report off to a committee member and designate another person from his/her discipline to attend in their absence. Attendance of in-service will be evidenced by TMs signature on In-Service Form. FA will ensure</p>	02/27/2012	

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	<p>2. The facility's CQI committee meeting minutes, dated 10-26-11, 11-9-11, and 12-14-11, failed to evidence the biomedical technician, employee G, or any representative from the biomedical department, had attended the meetings.</p> <p>3. The facility administrator, employee C, stated, on 1-27-12 at 3:35 PM, "He was unable to attend the meetings."</p>		<p>that the members identified in Policy &amp; Procedure #01-02-01 Continuous Quality Improvement Program are informed monthly of the scheduled date and time of QIFMM. FA will ensure all members attend as required. Attendance at QIFMM will be evidenced by signatures of committee member on QIFMM meeting minutes. FA is responsible for compliance with this POC.</p>	

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V0715	<p>The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on clinical record and facility policy review and interview, the medical director failed to ensure initial assessments were completed by the registered nurse (RN) prior to the initiation of their first treatment in 2 (#s 2 and 5) of 11 records reviewed of patients admitted since the last recertification survey on 3-5-09 creating the potential to affect all new admissions to the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's September 2010 "New Patient Pre-Treatment Evaluation" policy number 1-03-07 policy states, "A registered nurse (RN) as required by federal regulation will perform an initial pre-treatment evaluation of all new patients prior to initiation of their first treatment at the facility."</li> <li>2. Clinical record number 2 evidenced the patient was admitted to the facility on 9-10-11. The record failed to evidence an initial assessment by the RN.</li> </ol>	V0715	<p>V 0715FA will hold mandatory in-service for all Registered Nurses and Administrative Assistance on <i>Policy &amp; Procedure #01-03-07 New Patient Pre-Treatment Evaluation</i>. Registered Nurse must perform initial pre-treatment evaluation of all new patients prior to initiation of first treatment at facility, pre-treatment evaluation will be documented on the New Patient Pre-Treatment Evaluation Form. Attendance of in-service will be evidenced by TMs signature on In-Service Form. FA or designee will conduct monthly Medical Record audit on 100% of new patient admissions to ensure the Initial RN Assessment is completed prior to first treatment and documentation placed in patient medical record. Results of audits will be reported to Medical Director during the monthly QIFMM with supporting documentation included in the meeting minutes. FA &amp; Medical Director are responsible for compliance with this POC</p>	02/27/2012			

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	<p>3. Clinical record number 5 evidenced the patient was admitted to the facility on 7-22-10. The record failed to evidence an initial assessment by the RN.</p> <p>4. The facility administrator, employee C, stated, on 1-25-12 at 3:50 AM, "There are no initial assessments by the RN for patients [numbered 2 and 5]."</p>			