

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152521	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/14/2015
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NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE- GARY	STREET ADDRESS, CITY, STATE, ZIP CODE 4802 BROADWAY GARY, IN 46408
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V 0000 Bldg. 00	<p>This visit was for an ESRD recertification survey.</p> <p>Survey dates: 9/08/15, 9/9/15, 9/10/15, 9/11/15, 9/14/15</p> <p>Facility #: 5980</p> <p>Medicare #: 152521</p> <p>Medicaid vendor #: 200315330</p> <p>189 Incenter Hemodialysis patients 13 Peritoneal Dialysis patients</p> <p>17 Records Reviewed (14 incenter hemodialysis and 3 peritoneal records reviewed) 12 records (1-12) were a comprehensive record review</p> <p>QR: KH, R.N.</p>	V 0000		
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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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V 0111 Bldg. 00	<p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a sanitary environment for its patients in 1 of 1 facilities reviewed.</p> <p>The findings include:</p> <p>1. On 9/8/15 at 9:10 AM, an oxygen concentrator at station #14 was observed to be dusty on the top and soiled on the sides. This concentrator was being used by patient #16.</p> <p>On 9/8/15 at 9:30 AM, Employee J, Registered Nurse, indicated the oxygen</p>	V 0111	<p>Teammates immediately cleaned oxygen concentrator, medication refrigerator, and bicarbonate from supply room floor. Facility Administrator (FA) held mandatory in-service for all clinical Teammates (TMs) by 9/15/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents.</p> <p>1) facility must remain clean, uncluttered, and organized; 2) oxygen concentrators must remain clean and TMs must disinfect after each patient use and prior to returning to clean area; 3) Spills must be immediately cleaned, and floor</p>	10/14/2015	

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	<p>concentrator was dusty and not kept clean.</p> <p>2. On 9/8/15 at 9:45 AM, bicarbonate was noted on the floor in the supply room in front of the bicarbonate storage area. This had not been cleaned up after it had been spilled.</p> <p>On 9/8/15 at 9:45 AM, Employee K, Registered Nurse, indicated the bicarbonate that had been spilled on the floor should have been cleaned up.</p> <p>3. On 9/8/15 at 10:05 AM, a medication refrigerator in a locker room area was opened by Employee J. This refrigerator was soiled inside and did contain medications.</p> <p>On 9/8/15 at 10:05 AM, Employee J indicated the refrigerator was soiled and needed to be cleaned.</p> <p>4. A policy titled "Infection Control for Dialysis Facilities" with a revision date of Sept. 2014 stated, "To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment Policy: The Centers for Disease Control [CDC] Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients [Dialysis</p>		<p>free of bicarbonate residue; 4) Refrigerators must remain clean, TMs assigned to inspect and clean refrigerators at a minimum of monthly. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meeting (FHM), minutes will reflect. FA is responsible for compliance with this correction.</p>		

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V 0113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Precautions] will be followed when caring for all patients ... facility hygiene ... items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean are or used on another patient ... Teammates will thoroughly wipe down all non - disposable items and equipment ... clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled."			

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Bldg. 00	<p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on record review, observation, and interview, the facility failed to ensure hand hygiene and glove changes had been performed in accordance with facility policy in 1 of 2 access of AV Fistula or Graft observations completed (Employee L with Patient # 8) and 2 of 2 discontinuation of AV fistula or graft observations completed (Employee M with patients #4 and #5.)</p> <p>The findings include:</p> <p>Regarding Access of AV Fistula or Graft for Initiation of Dialysis</p> <p>1. On 9/8/15 at 11:45 AM, Employee L, patient care technician, was observed to initiate dialysis with patient #8 who had an AV Graft on the lower arm. With gloved hands, Employee L palpated the patient's right arm area with the AV Graft and then inserted the cannulation needles and taped the needles in place.</p> <p>2. On 9/8/15 at 12 noon, Employee L indicated she had palpated the area and not changed her gloves.</p>	V 0113	<p>FA held mandatory in-service for all clinical TMs by 9/15/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing 1) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient and station; 2) Once cannulation site has been cleaned it must not be touched, otherwise area must be cleaned per policy prior to cannulation. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p>	10/14/2015			

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	<p>3. The procedure titled "AV Fistula or Graft Cannulation with JMS sysloc minisafety fistula needles and administration of Heparin" with a date of March 2015 stated, "Locate and palpate the needle cannulation site prior to skin preparation ... While maintaining aseptic technique, cleanse the site by applying a 70% alcohol prep using a circular rubbing motion, center out."</p> <p>Regarding Discontinuation of Dialysis and post dialysis access care for AV Fistula or Graft</p> <p>4. At station #2, on 9/9/15 at 2:40 PM, Employee M, patient care technician was observed to discontinue dialysis with patient #4 who had an AV fistula on the left upper arm. With her gloved hands, Employee M rolled the sharps container on rollers into the patient's station from a nearby common area. She removed her gloves and washed her hands. She discarded her gloves by lifting the lid of a nearby biohazard container with her degloved hand. This biohazard container had discarded blood lines in it. She washed her hands and donned clean gloves prior to removing the AV fistula needle. She placed the needle into the sharps container and touched the inside of the sharps container with her gloved</p>			

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	<p>hands and did not remove her gloves or washed her hands before touching the patient's arm.</p> <p>5. At station #4, on 9/9/15 at 2:50 PM, Employee M was observed to discontinue dialysis with patient #5 who had an AV fistula in the left arm. With her gloved hands, Employee M rolled the sharps container from outside the patient station into the patient station. She took her gloves off and then touched the lid of the biohazard container with her ungloved hands. This biohazard container was in a common area outside the patient station. The biohazard container contained discarded blood lines.</p> <p>6. The policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Hand hygiene is to performed ... after removal of gloves, after contamination with blood or other infectious material ... gloves should be worn when ... potential for exposure to blood, dialysate and other potentially infectious substances ... appropriate PPE [personal protective equipment] will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces."</p> <p>7. On 9/9/15 at 6 PM, Employee A,</p>			

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V 0122 Bldg. 00	<p>assistant facility administrator, indicated glove changes are needed after sharps and biohazard containers are contacted prior to patient contact.</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-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on record review, observation, and interview, the facility failed to ensure surfaces were not contaminated with blood for 1 of 2 treatment floor</p>	V 0122	<p>FA held mandatory in-service for all clinical TMs by 9/15/2015. In-service included but was not limited to review of Policy & Procedure # 1-05-01:</p>	10/14/2015

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V 0142 Bldg. 00	<p>observations on 9/8/15.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 9/8/15 at 9:15 AM, several small amounts of blood about the size of a nickel each were noted on a chux under the left arm of patient #1 at station # 11. This blood spill was observed for about 10 minutes and was not cleaned up during this time. On 9/8/15 at 9:25 AM, Employee J, the clinic manager, indicated the blood was there and should be cleaned up immediately. The agency policy titled "Specified Control Methods" with a date of March 2012 stated, "Blood effluent spills will be cleaned up immediately." 		<p>InfectionControl for Dialysis Facilities, Policy & Procedure #4-02-03 Specified Control Methods emphasizingBlood spills must be cleaned immediately with appropriate bleach solution. TMs instructedon proper use of for 1:10 vs. 1:100 bleach solutions for cleaning anddisinfection tasks emphasizing for visible blood or gross blood spills a 1:10bleach solution must be utilized. After blood is cleaned with 1:10 bleachsolution TMs must use new disposable towel soaked with the 1:10 solution andclean second time. Verification of attendance at in-service will be evidencedby TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control auditsdaily x 2 weeks, weekly x2 weeks, and then monthly. FA will review results of all audits with TMsduring home room meetings and with Medical Director during monthly FHM, minuteswill reflect.</p> <p>FA is responsible for compliance with this correction.</p>				
	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P						

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	<p>The facility must-</p> <p>(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit;</p> <p>Based on record review, observation and interview, the facility failed to ensure supplies for the patients' use were not expired for 1 of 1 facility.</p> <p>Findings</p> <p>1. On 9/8/15 at 10:20 AM, the medication cabinet on the incenter treatment floor was observed to contained an opened multi - dose of lidocaine. The bottle was labeled with a date of 7/2015 (the exact date the medication was opened was not known) and labeled with an illegible initials of who had opened this vial. Also written on the vial was "exp [expired] 8/21." The bottle had not been discarded and was expired.</p> <p>2. On 9/8/15 at 10:20 AM, Employee J, Registered Nurse and clinic manager, indicated the bottle was to have been discarded.</p> <p>3. The policy titled "Medication Policy" with a revision date of March 2015 stated, "Medications containing a preservative must be discarded 28 days after opening or accessed ... each vial is labeled with the initials of the person</p>	V 0142	<p>FA held mandatory in-service for all clinical TMs by 9/15/2015. In-service review of Policy & Procedure #1-06-01: Medication Policy emphasizing 1) Medications containing preservative must be discarded 28 days after opening or accessed; or as directed by manufacturer; 2) Each vial must be labeled with initials of person opening the vial and expiration date; 3) Medications must be ordered and replaced prior to expiration date. RN/Charge Nurse is responsible for daily monitoring. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will confirm compliance during monthly observational audit. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p>	10/14/2015

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V 0196 Bldg. 00	<p>opening the vial and the expiration date ... medications are ordered and replaced prior to expiration."</p> <p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system</p>			

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	<p>has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>Based on record review and interview, the facility failed to test for free chlorine every 4 hours for 1 of 1 water log reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility water / dialysate log 2-07-02 A was noted to have a chlorine test on 7/25/15 with a time of 11 AM and next chlorine test of 3:50 PM with the signatures of Employee N, Patient Care Technician, and Employee J, Registered Nurse. The test had not been completed within 4 hours. 2. On 9/11/15 at 11:15 AM, Employee A, the assistant facility administrator indicated the chlorine test is to be every 4 hours. 3. The policy titled "Water System Chlorine / Chloramine monitoring" with a revision date of March 2013 stated, "To help provide safe water for dialysis by ensuring that chlorine / chloramines testing is regularly done and that patients are dialyzed only with water having chlorine / chloramine levels within the limits specified by the Association for the 	V 0196	<p>Biomedical Technician (BMT) and FA held mandatory in-services for all clinical TMs responsible for water treatment monitoring by 9/21/2015. In-service included but was not limited to review of Policy & Procedure #2-04-02: Daily Water Treatment System Monitoring, Policy & Procedure #2-05-02 Daily Water System Total Chlorine Monitoring emphasizing TMs must perform Total Chlorine testing daily prior to first patient treatment and every 4 hours until activities that require use of dialysis quality water are complete. TMs must record results on Routine Total Chlorine Testing Log. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct Daily Routine Total Chlorine Testing Log audits x 2 weeks, then weekly x 2 weeks, and then BMT will audit monthly during biomed audit. Results of audits will be reviewed with the Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction.</p>	10/14/2015

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V 0401	<p>Advancement of the Medical Instrumentation."</p> <p>4. Water quality testing guidelines from AAMI standards, ANSI/AM RD52, Table 4 states: "For carbon absorption beds, monitor the product water levels of free chlorine and/or total chlorine between the beds prior to beginning each patient shift. Expected result is <0.1 mg/L [milligram / liter of total chlorine. ... Chlorine and chloramines or total chlorine must be tested prior to each shift or if there is no set shifts testing should be performed every 4 hours (RD52, 6.2.5)."</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE</p>			

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Bldg. 00	<p>ENVIRONMENT</p> <p>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.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a sanitary environment for its patients in 1 of 1 facilities reviewed.</p> <p>The findings include:</p> <p>1. On 9/8/15 at 9:10 AM, an oxygen concentrator at station #14 was observed to be dusty on the top and soiled on the sides. This concentrator was being used by patient #16.</p> <p>On 9/8/15 at 9:30 AM, Employee J, Registered Nurse, indicated the oxygen concentrator was dusty and not kept clean.</p> <p>2. On 9/8/15 at 9:45 AM, bicarbonate was noted on the floor in the supply room in front of the bicarbonate storage area. This had not been cleaned up after it had been spilled.</p> <p>On 9/8/15 at 9:45 AM, Employee K,</p>	V 0401	<p>Teammates immediately cleaned oxygen concentrator, medication refrigerator, and bicarbonate from supply room floor.</p> <p>FA held mandatory in-service for all clinical Teammates(TMs) by 9/15/2015. In-service included but was not limited to: Review of Policy & Procedure # 1-05-01: InfectionControl for Dialysis Facilities emphasizing facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents. 1) facility must remain clean, uncluttered, and organized; 2) oxygen concentrators must remain clean and TMs must disinfect after each patient use and prior to returning to clean area; 3) Spills must be immediately cleaned, and floor free of bicarbonate residue; 4) Refrigerators must remain clean, TMs assigned to inspect and clean refrigerators at a minimum of monthly. Verification of attendance at in-service will be evidenced by TMs signature on in-servicesheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home</p>	10/14/2015			

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	<p>Registered Nurse, indicated the bicarbonate that had been spilled on the floor should have been cleaned up.</p> <p>3. On 9/8/15 at 10:05 AM, a medication refrigerator in a locker room area was opened by Employee J. This refrigerator was soiled inside and did contain medications.</p> <p>On 9/8/15 at 10:05 AM, Employee J indicated the refrigerator was soiled and needed to be cleaned.</p> <p>4. A policy titled "Infection Control for Dialysis Facilities" with a revision date of Sept. 2014 stated, "To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment Policy: The Centers for Disease Control [CDC] Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients [Dialysis Precautions] will be followed when caring for all patients ... facility hygiene ... items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean are or used on another patient ... Teammates will thoroughly wipe down all non - disposable items and equipment ... clean areas should be clearly</p>		<p>room meetings and with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p>				

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V 0457 Bldg. 00	<p>designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled."</p> <p>494.70(a)(6) PR-CAN HAVE ADVANCE DIR,TOLD FAC AD P&P The patient has the right to-</p> <p>(6) Be informed about his or her right to execute advance directives, and the facility ' s policy regarding advance directives;</p> <p>Based on record review and interview, the agency failed to ensure patients were provided the current Indiana advance directives, including a description of applicable State law, in 12 of 12 records reviewed (#1- #12).</p> <p>Findings include:</p> <p>1. The current admission package given to the patients failed to include the effective May 2004 and revised July 1,</p>	V 0457	<p>State of Indiana Advanced Directive revised July 2013 and effective May 2004 added to facility admission packet; Social Worker will inform each patient of the State of Indiana Advanced Directive and patient signature will be obtained verifying they have been informed.</p> <p>FA held mandatory in-service for Social Workers on 9/16/2015. In-service included but was not limited to: review of Policy & Procedure #3-02-19: Advance Directives DNR Policy emphasizing 1) Patients must be informed of their right to have Advance Directives 2)</p>	10/14/2015

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	<p>2013, state of Indiana advanced directives in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. On 9/10/15 at 11:45 AM, Employee P, Master's of Social Work, indicated the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013) and this document had not been given to the patients who were on service.</p> <p>3. On 9/14/15 at 1:45 AM, Employee B, facility administrator, indicated the advance directives were not complete for the patients reviewed.</p> <p>4. Clinical record #1, SOC 11/23/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record #2, SOC 10/2/02, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had no advance directives consent in the clinical record.</p> <p>6. Clinical record #3, SOC 4/29/14,</p>		<p>Be issued Indiana Advanced Directives document forms which will be followed in addition to general policy. 3) Patient signature must be obtained verifying that they have received advance Directive forms. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or Administrative Assistant (AA) will conduct medical record audits for 100% of patient admissions and 10% of patient census monthly. FA will review results of all audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p>				

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	<p>failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on 8/17/15.</p> <p>7. Clinical record #4, SOC 9/25/08 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had no advance directives consent in the record.</p> <p>8. Clinical record #5, SOC 8/27/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on the SOC date of 8/27/12.</p> <p>9. Clinical record #6, SOC 7/13/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on the SOC date of 7/13/15.</p> <p>10. Clinical record #7, SOC 9/19/08 , failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient had no advance directive consent in the record.</p> <p>11. Clinical record #8, SOC 4/24/14, failed to contain an updated July 1, 2013,</p>			

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	<p>version of the 2004 Indiana Advanced Directives document.</p> <p>12. Clinical record #9, SOC 5/14/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on the SOC date of 5/14/15.</p> <p>13. Clinical record #10, SOC 7/26/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on 1/21/15.</p> <p>14. Clinical record #11, SOC 1/22/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date of 1/22/14.</p> <p>15. Clinical record #12, SOC 9/15/10, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the advance directives document was received on the SOC date of 9/15/10.</p> <p>16. The agency document titled "Advance Care Planning for Dialysis patients and their families" with no date</p>			

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	<p>stated, "Speak with your social worker about Davita's policy regarding advance directives and your advance care needs."</p> <p>17. The agency policy titled "Advance Directives DNR Policy" with a revision date of September 2012 stated, "To inform patients of their right to have Advance Directives and the DaVita policy regarding Advance Directives ... The state in which the facility is located my have specific requirements, which will be followed in addition to the general policy."</p>			

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V 0544 Bldg. 00	<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 record review and interview, the facility failed to ensure the blood flow rate on the prescription was followed for 2 of 10 incenter hemodialysis records (#1 and 7) reviewed.</p> <p>Findings include:</p> <p>1. Clinical record #1 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute.</p> <p style="padding-left: 40px;">A. The flow sheet dated 8/20/15 evidenced BFRs of 450 during the treatment with no explanation as to why the BFR was not followed.</p> <p style="padding-left: 40px;">B. On 9/11/15 at 4:40 PM, Employee A , the assistant facility administrator, indicated there was no documentation to evidence why the BFR was not followed.</p> <p>2. Clinical record #7 included hemodialysis orders that identified the BFR was to be 350 milliliters per minute.</p>	V 0544	<p>FA held mandatory in-service for all clinical Teammates(TMs) by 9/15/2015. In-service included review of Policy & Procedure#1-03-09 Intradialytic Treatment Monitoring, emphasizing TMs must verify patient dialysis prescription, and set all treatments as prescribed including blood flow rate. Nurses are responsible for ensuring patients receive prescribed dose of dialysis and physician orders are followed; TMs must monitor patient's blood flow rates at a minimum of every 30 minutes, report and document flow rates outside of ordered parameters to licensed nurse, licensed nurse must take appropriate action, contact physician if warranted, and follow physician orders. All findings, interventions and patient response will be documented in patient's medical record. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee to conduct daily audits on 25% of patient treatment flow sheets x 2 weeks, then weekly x 4 weeks, and then monthly on 10% of treatment sheets to ensure compliance. FA will review results of</p>	10/14/2015

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V 0545 Bldg. 00	<p>A. The flow sheet dated 8/17/15 evidenced BFRS of 400 during the treatment with no explanation as to why the BFR was not followed.</p> <p>B. On 9/14/15 at 1:50 PM, Employee A indicated the BFR was not followed.</p> <p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. Based on record review and interview, the facility failed to ensure it had provided the necessary nutritional counseling services to maintain patients' albumin levels at the desired level of 4.0 grams per deciliter (g/dL) in 1 (#3) of 12 records reviewed.</p> <p>The findings include:</p>	V 0545	<p>audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction.</p> <p>Interdisciplinary Team (IDT) will initiate plan of care update for patient #3 to reflect measurable goals and timetables in plan including nutritional counseling services specific to patient identified issues with nutrition related to albumin levels.</p> <p>FA held mandatory in-service for</p>	10/14/2015

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	<p>1. Clinical record #3 included laboratory results that evidenced a decreasing albumin level. The albumin was 3.5 g / dL on 6/3/15 and 3.9 g / dL on 7/13/15.</p> <p>A. The record included a plan of care note completed by the registered dietician on 8/3/15. "Follow up time frame: 60 days: Albumin 3.9 trending up from 3.5 [June] goal not met. Continues on Novosource at dialysis, tolerating. Pt states ... likes mackerel / fish. Protein reinforced by RD [registered dietician] labs provided to patient." There was no other RD note since May 18, 2015.</p> <p>B. On 9/14/15 at 11 AM, Employee Q, the registered dietician, indicated completing the note for June and July combined for 60 days instead of writing one note every month.</p> <p>2. The agency policy titled "Provision of Nutrition Services" with a date of September 2013 stated, "Review of individual laboratory nutrition report with each patient and caregiver at least monthly. Review of individual laboratory nutrition report with each patient and / or caregiver at least monthly. Review includes discussion of the following outcomes: albumin, calcium, phosphorus ... monitor</p>		<p>Renal Dieticians on 9/17/2015. In-service included review of Policy & Procedure # 1-14-04: Provision of Nutrition Services emphasizing: 1) Review of patient individual laboratory report at least monthly; 2) Review of individual laboratory nutrition report with each patient and / or caregiver at least monthly. 3) Review includes discussion of the following outcomes including but not limited to: albumin, calcium, phosphorus and monitoring nutritional status and laboratory values to assess adherence and response to prescribed nutrition therapy and nutrition related medications; 4) Renal Dietician must provide documentation of nutritional interventions and the patient's nutritional progress monthly or more frequently as needed; update the POC for nutrition related problems based on timeline goals. Verification of attendance will be evidenced by TMs signature on in-service sheet.</p> <p>FA will review outcomes with Renal Dieticians weekly at IDT meeting.</p> <p>FA or designee will conduct medical record audits for 100% of patient admissions and 10% of patient census monthly to ensure assessments, plans of care, and progress notes are in place, current, nutritional needs of patient are evaluated/addressed, and documentation of action plans and response to interventions are present. FA will review results of all audits Medical Director during monthly</p>				

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V 0550 Bldg. 00	<p>nutritional status and laboratory values to assess adherence and response to prescribed nutrition therapy and nutrition - related medications."</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 record review, observation, and interview, the facility failed to ensure hand hygiene and glove changes had been performed in accordance with facility policy in 1 of 2 access of AV Fistula or Graft observations completed (Employee L with Patient # 8) and 2 of 2 discontinuation of AV fistula or graft</p>	V 0550	<p>FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this correction.</p> <p>FA held mandatory in-service for all clinical TMs by 9/15/2015. In-service included but was not limited to: Review of Policy & Procedure #1-04-01D: AV Fistula or Graft Cannulation With JMS Sysloc MiniSafety Fistula Needles (SFN) and Administration of Heparin, Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing 1) locate and</p>	10/14/2015	

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	<p>observations completed (Employee M with patients #4 and #5.)</p> <p>The findings include:</p> <p>Regarding Access of AV Fistula or Graft for Initiation of Dialysis</p> <p>1. On 9/8/15 at 11:45 AM, Employee L, patient care technician, was observed to initiate dialysis with patient #8 who had an AV Graft on the lower arm. With gloved hands, Employee L palpated the patient's right arm area with the AV Graft and then inserted the cannulation needles and taped the needles in place.</p> <p>2. On 9/8/15 at 12 noon, Employee L indicated she had palpated the area and not changed her gloves.</p> <p>3. The procedure titled "AV Fistula or Graft Cannulation with JMS sysloc minisafety fistula needles and administration of Heparin" with a date of March 2015 stated, "Locate and palpate the needle cannulation site prior to skin preparation ... While maintaining aseptic technique, cleanse the site by applying a 70% alcohol prep using a circular rubbing motion, center out."</p> <p>Regarding Discontinuation of Dialysis and post dialysis access care for AV</p>		<p>palpate the needlecannulation site prior to skin preparation; 2) once cannulation site has been cleanedit must not be touched, otherwise area must be cleaned per policy prior tocannulation; 3) Glovesand appropriate PPE must be worn when potential exposure to blood, dialysateand potentially infectious substances; 4) TMs must remove gloves andperform hand hygiene between dirty and clean tasks with same patient andstation; glove change andhand hygiene must be performed when in contact with sharps and biohazardcontainers prior to contact with patient. Verification of attendance atin-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control auditsdaily x 2 weeks, weekly x2 weeks, and then monthly. FA will review results of all audits with TMsduring home room meetings and with Medical Director during monthly FHM, minuteswill reflect.</p> <p>FA is responsible for compliance with this correction.</p>				

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	<p>Fistula or Graft</p> <p>4. At station #2, on 9/9/15 at 2:40 PM, Employee M, patient care technician was observed to discontinue dialysis with patient #4 who had an AV fistula on the left upper arm. With her gloved hands, Employee M rolled the sharps container on rollers into the patient's station from a nearby common area. She removed her gloves and washed her hands. She discarded her gloves by lifting the lid of a nearby biohazard container with her degloved hand. This biohazard container had discarded blood lines in it. She washed her hands and donned clean gloves prior to removing the AV fistula needle. She placed the needle into the sharps container and touched the inside of the sharps container with her gloved hands and did not remove her gloves or washed her hands before touching the patient's arm.</p> <p>5. At station #4, on 9/9/15 at 2:50 PM, Employee M was observed to discontinue dialysis with patient #5 who had an AV fistula in the left arm. With her gloved hands, Employee M rolled the sharps container from outside the patient station into the patient station. She took her gloves off and then touched the lid of the biohazard container with her ungloved</p>			

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	<p>hands. This biohazard container was in a common area outside the patient station. The biohazard container contained discarded blood lines.</p> <p>6. The policy titled "Infection Control for Dialysis Facilities" with a date of September 2014 stated, "Hand hygiene is to performed ... after removal of gloves, after contamination with blood or other infectious material ... gloves should be worn when ... potential for exposure to blood, dialysate and other potentially infectious substances ... appropriate PPE [personal protective equipment] will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces."</p> <p>7. On 9/9/15 at 6 PM, Employee A, assistant facility administrator, indicated glove changes are needed after sharps and biohazard containers are contacted prior to patient contact.</p>			

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V 0552 Bldg. 00	<p>494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL 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 record review and interview, the facility failed to ensure a standardized mental and physical assessment tool to measure the patient's psychosocial status had been completed in 1 of 12 records reviewed (#7).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #7, start of care 9/19/08, failed to evidence the social worker had administered the KDQOL (Quality of Life assessment) since the patient's start of care. 2. On 9/14/15 at 10:30 AM, Employee P, Master's of Social Work, indicated the 	V 0552	<p>SW will complete KDQOL Assessment Survey for patient #7 by 10/14/2015 utilizing language line translation services. If patient refuses to complete, documentation will be placed in medical record time survey is offered to complete and patient's refusal. MSW will initiate individualized plan of care updates for patient. Interventions will include counseling services and referrals to assist patient in achieving and sustain psychosocial status, as measured by KDQOL.</p> <p>FA held mandatory in-service for Social Workers on 9/18/2015. In-service included but was not limited to: review of Policy & Procedure # 3-01-10: Quality of Life Assessment Survey emphasizing 1) The Quality of Life Assessment</p>	10/14/2015

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	<p>KDQOL was not administered due to the patient's inability to speak English.</p> <p>3. On 9/14/15 at 1:45 PM, the facility administrator indicated the KDQOL should always be offered to the patient and language services in this patient's language were available to the patient.</p> <p>4. The policy titled "Quality of Life Assessment Survey" with a date of March 2015 stated, "The Quality of Life assessment survey is to be administered by the Social Worker within 4 months of initiating treatment, on an as needed basis, and repeated at least annually thereafter."</p>		<p>Survey must be completed by the Social Worker within 4 months of initiating treatment, on an as needed basis, and repeated at least annually thereafter.; 2) Use of Language Line Translation Services for any Non-English speaking/reading patient; 3) IDT must provide monitoring and social worker interventions that include counseling services and referrals for other social services to assist patient in achieving and sustaining appropriate psychosocial status as measured by KDQOL, at regular intervals or more frequently as needed. Plan of Care must reflect if patient has consented to completion of KDQOL, attempts made for completion, and if applicable patient's refusal. Social Worker must follow up and readjust plan of care as necessary, document interventions to monitor the patient's psychosocial status. Verification of attendance at in-service will be evidenced by TM's signature on in-service sheet.</p> <p>FA or designee will conduct medical record audits for 100% of patient admissions and 10% of patient census monthly to ensure assessments, plans of care, progress notes are in place, current, psychosocial needs of patient are evaluated/addressed, and documentation of action plans and response to interventions are present. FA will review results of all audits Medical Director during monthly FHM, minutes will reflect.</p>		

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V 0587 Bldg. 00	<p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record.</p> <p>Based on record review and interview, the agency failed to ensure that 1 of 2 home dialysis records reviewed (#10) maintained patient flow sheets in the clinical record.</p> <p>The findings include:</p> <p>1. The agency policy titled "Daily Home Treatment Record" with an origination date of September 2006 and revision date of March 2011 stated, "1. Each peritoneal dialysis patient will be instructed to complete documentation of each treatment procedure on the Daily Home Treatment record or by means of an electronic data card ... All Daily Home treatment records will be maintained as a part of the patient's medical record. In absence of Home records, the nurse will review the importance of home records."</p> <p>2. Clinical record #10, with a start of</p>	V 0587	<p>FA is responsible for compliance with this correction.</p> <p>IDT to meet withhome patient #10 by 10/9/2015; Nephrologist along with other IDT members will re-educatepatient to the necessity of completing Daily Home treatment records to providea continuity of care, patient will be instructed to complete documentation ofeach treatment procedure on the Daily Home Treatment Record and provide to PDRN during clinic visits, documentation of meeting and re-education placed inpatient ' s medical record.</p> <p>FA to hold mandatoryin-service for home TMs by 10/14/2015 to review Policy & Procedure #5-01-29Daily Home Treatment Record. TMs will be instructed that all Daily HomeTreatment Records must be maintained as a part of the patient ' s medical recordand reviewed for accuracy. Patients must bring completed records to each clinicvisit and TMs must review, evaluate, initial the data recorded on the DailyHome Treatment Record and</p>	10/14/2015

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V 0713 Bldg. 00	<p>care date of 7/26/14 evidenced the patient was an active peritoneal dialysis patient were found in the patient's record since January 2015. There were no notations since March 13, 2015 about the absence of these flow sheets.</p> <p>3. On 9/9/15 at 10:10 AM, Employee E, Registered Nurse, indicated no flow sheets were found in patient #10's record since January 2015 and no care plan notation had been completed.</p> <p>494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance.</p> <p>Based on record review and interview, the medical director failed to ensure all personnel had adhered to facility policies and procedures relative to dialysis treatment prescription delivery in 2 of 5 hemodialysis treatments reviewed by</p>	V 0713	<p>document findings in the medical record. In the absence of Home Records, the licensed nurse TM must review importance of home records, the patient's responsibility to provide them, and issue new records sheets. Educational attempts will be documented in the medical record. Plans of care for identified non-compliant patients will be established to address adherence issues. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct flow sheet audits monthly on 10% of PD patient daily home treatment records to monitor compliance. FA will review results of audits with Medical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</p> <p>FA will hold mandatory in-service for all clinical TMs by 10/14/2015. In-service will include but not be limited to: review of Policy & Procedure # 1-03-02 Prescription Verification and Safety Checks, Policy & Procedure</p>	10/14/2015	

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	<p>observing the hemodialysis machines during treatments (#11 and #12).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility policy titled "Treatment Initiation Patient Assessment" with a revision date of March 2015 stated, "Patient prescription machine settings are verified by teammate prior to initiation of treatment and confirmed by a licensed nurse teammate within one hour of treatment initiation as part of the patient assessment. Prescription components include and are not limited to ... correct dialysate composition ... bicarb." 2. On 9/9/15 at 8:30 AM, Patient #11 was observed to be receiving hemodialysis at station # 28 with machine #8080457. The machine's bicarb setting was observed to be at 34 milliequivalent / liter (mEq / L) and not 38 mEq / L as ordered. 3. On 9/9/15 at 8:35 AM, Patient #12 was observed to be receiving hemodialysis at station #27 with machine 8080424. The machine's bicarb setting was observed to be at 34 mEq / L and not 38 mEq / L as ordered. 3. On 9/9/15 at 8:35 AM, Employee I, patient care technician, indicated the 		<p>#1-03-08Treatment Initiation and Patient Assessment, emphasizing 1) TMs must verifydialysis prescription, set all treatments as prescribed including but notlimited to orders related to machine bicarb level, and perform safety checksprior to each treatment initiation. Any identified variance in prescribedtreatment must immediately be addressed including notifying licensed nurse offindings. Licensed nurse must take appropriate action, assess patient,contacting physician if warranted and follow physician orders, all findings andinterventions and patient's response must be documented in patient's medicalrecord; 2) RN must complete pre-treatment assessment and document within 1(one) hour of treatment initiation time. Nurses are responsible for ensuringpatients are achieving prescribed dose of dialysis and physician orders arefollowed. Verification of attendance at in-service will be evidenced by TMssignature on in-service sheet.</p> <p>FA or designee to conduct daily audits on 25% of patienttreatment flow sheets x 2 weeks, then weekly x 4 weeks, and then monthly on 10%of treatment sheets to ensure compliance. FA will review results of audits withMedical Director during monthly FHM, minutes will reflect.</p> <p>FA is responsible for compliance with this plan ofcorrection.</p>	

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	bicarb machine settings were ordered at 38 mEq/L but were set in error at 34 mEq/L.				