

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V0000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: May 21, 22 and 23, 2012</p> <p>Facility #: 012064</p> <p>Medicaid Vendor #: 200942310</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Rush County Dialysis is out of compliance with the Condition for Coverage 494.40:Water and Dialysate Quality, 494.90 Patient Plan of Care, and 494.150 Responsibilities of the Medical Director.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 25, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0175	<p>494.40 CFC-WATER & DIALYSATE QUALITY</p> <p>Based on facility documents review and interview, it was determined the facility failed to ensure the product water used to prepare dialysate and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients (See V 178), failed to ensure the softener brine tank was at least half full in 1 of 1 water rooms reviewed (See V 190), failed to ensure the bacteria level shall be below action level for 2 of 5 months reviewed with the potential to affect all 11 patients (See V 213), failed to ensure the water treatment system was disinfected for the month of April and May 2012 with the potential to effect all 11 patients (See V 219), failed to ensure repeat cultures were done on a weekly basis until the bacterial count and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients (See V 255), and failed to ensure a corrective action plan for the product water used to prepare dialysate and concentrate was developed for 2 of 5 months reviewed with the potential to affect all 11 patients (See V 274).</p> <p>The cumulative effect of these systemic problems resulted in the facilities inability to provide safe water and dialysate as required by the Condition for Coverage</p>	V0175	<p>DaVita Rush County Dialysis takes the conditions of coverage very seriously, immediate steps were taken to ensure facility consistently provides safe quality product water, dialysate, and that the facility's Water & Dialysate testing is completed according to policies and procedures and all regulatory requirements. These actions are outlined in depth in the Plan of Correction (POC) for V178, V190, V213, V219, V255 and V274.</p> <p>The facility Governing Body (GB) met on 5/31/2012 to review the deficiencies received as a result of a survey concluded on 5/23/2012. Members of the GB including the Medical Director, Facility Administrator (FA), and Divisional Vice President (DVP) have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 1) Ensure product water used for dialysate and concentrate is below action level, 2) Ensure Softener Brine tank is at least half full, and above water level. 3) Ensuring facility water and dialysate cultures are drawn, evaluated, appropriate action</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	494.40:Water and Dialysate Quality.		taken in accordance with company policy & procedure 4) Ensure monthly disinfection of Water treatment system. 5) Ensuring facility water and dialysate cultures are repeated as needed until below action level. 6) Ensuring facility water and dialysate cultures are reviewed with Medical Director during monthly Quality Improvement Facility Management Meeting (QIFMM), action plans are developed and evaluated. GB will review QIFMM minutes to ensure minutes reflect POC, action plans are evaluated for effectiveness, and new plans developed as applicable. Once compliance is achieved, POC will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0178	<p>494.40(a) BACT OF H2O-MAXIMUM & ACTION LEVELS 4.1.2 Bacteriology of water: max & action levels Product water used to prepare dialysate or concentrates from powder at a dialysis facility, or to process dialyzers for reuse, shall contain a total viable microbial count lower than 200 CFU/mL and an endotoxin concentration lower than 2 EU/mL</p> <p>The action level for the total viable microbial count in the product water shall be 50 CFU/mL, and the action level for the endotoxin concentration shall be 1 EU/mL. If those action levels are observed in the product water, corrective measures shall promptly be taken to reduce the levels.</p> <p>Based on agency document and lab results review and interview, the facility failed to ensure the product water used to prepare dialysate and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients. (April and May)</p> <p>Findings:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p>	V0178	<p>Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting <10 CFU and < .10 LAL, QIFMM minutes reflect.</p> <p>The Area Biomedical Supervisor (ABS) will in-service Biomedical Technician (BMT) on <i>Policy & Procedure #2-05-01 Water Treatment System Disinfection, Policy & Procedure #2-06-01 Water Culture Policy, Policy & Procedure #2-04-03 Bicarbonate</i></p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not</p>		<p><i>Concentrate System Disinfection by 6/8/2012.</i> BMT instructed that the water distribution system must be chemically disinfected at a minimum of monthly, and when bacterial cultures and/or endotoxin results indicate need for disinfection. Distribution systems must be disinfected in an end-to-end process, during which disinfectant solution will be introduced to the following water inlet lines: 1) Dialysis Delivery System, 2) Dialyzer reprocessing equipment, 3) Dialyzer pre-cleaning machines, 4) Bicarb and acid missing systems, 5) Any unused outlets. ABS also reviewed chemical to be used, mixing procedure, dwell time (minimum 30 minute dwell), and rinse procedure. Documentation must be documented on appropriate log. BMT instructed that the Bicarbonate Concentrate Mixer will be chemically disinfected weekly per facility specific policy. ABS will review proper documentation on the Bicarbonate System Renalin Disinfect Log or Bicarbonate System Bleach Disinfect Log. BMT educated on required response to more than one site at or above action level or any site at or above unacceptable level: BMT must notify FA, Biomedical Services and Medical Director. FA will document notification of Medical Director on culture report. BMT must disinfect affected equipment at end of treatment</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. ABS must be notified of all actionable results. Attendance of in-service is evidenced by BMT signature on In-Service Form.</p> <p>ABS will conduct monthly audits of facility culture and endotoxin results x 3 months, then quarterly thereafter to ensure compliance with all required testing, and response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this Plan of Correction (POC)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V0190	<p>494.40(a) SOFTENERS-AUTO REGENERATE/TIMERS/SALT LVL 5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution.</p> <p>5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration.</p> <p>The face of the timers used to control the regeneration cycle should be visible to the user.</p> <p>6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated.</p> <p>The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and pistons and clog orifices in the softener control head.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on observation and interview, the facility failed to ensure the softener brine tank was at least half full in 1 of 1 water rooms reviewed with the potential to affect all the facility's patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On May 22, 2012, at 12:20 PM, the softener brine tank was observed one-third full with a foot of water above the salt pellets. 2. The biomedical technician, Employee B, indicated there was no excuse for this as there were multiple bags of salt in the next room. 	V0190	<p>BMT will in-service Patient Care Team on <i>Policy & Procedure # 2-07-02 Daily Water Treatment System Monitoring</i> by 6/8/2012. In-service will include: purpose of Water Softener, importance and function of timers and brine tank, and expectation that at the start of each operation day, TMs must verify timers and check salt level in the brine tank. If the level is not half full fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary contact the Biomed Team for direction and assistance. Attendance of in-service is evidenced by TM signature on In-Service Form.</p> <p>Charge Nurse will conduct daily audit daily x 30 days to ensure that the Brine tank is adequately filled and co-initial the Daily Water Log. Daily Water Treatment Log will be reviewed by FA monthly and reviewed with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC</p>	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0213	<p>494.40(a) DIST SYS-CULTURE/LAL/SITES/FREQ(NEW)/LOG 6.3.3 Water distribution systems: culture/LAL sample sites/frequency (new)/log Water distribution piping systems should be monitored for bacteria and endotoxin levels. Bacteria and endotoxins shall not exceed the levels specified in [AAMI] 4.1.2. [(i.e., bacteria <200 CFU/mL and endotoxin <2 EU/mL]</p> <p>Bacteria and endotoxin testing should be conducted at least monthly. For a newly-installed water distribution piping system, or when a change has been made to an existing system, it is recommended that weekly testing be conducted for 1 month to verify that bacteria or endotoxin levels are consistently within the allowed limits.</p> <p>Monitoring should be accomplished by taking samples from the first and last outlets of the water distribution loop and the outlets supplying reuse equipment and bicarbonate concentrate mixing tanks. If the results of this testing are unsatisfactory, additional testing (e.g., ultrafilter inlet and outlet, RO product water, and storage tank outlet) should be undertaken as a troubleshooting strategy to identify the source of contamination, after which appropriate corrective actions can be taken. Bacteria and endotoxin levels shall be measured as specified in ANSI/AAMI RD62:2001 (see 2.3).</p> <p>All bacteria and endotoxin results should be recorded on a log sheet to identify trends that may indicate the need for corrective action. Based on agency document and lab results review and interview, the facility failed to</p>	V0213	Water Treatment System Disinfection completed 5.23.2012.	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ensure the bacteria level was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients. (April and May)</p> <p>Findings:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p>		<p>Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting <10 CFU, < .10 LAL, QIFMM minutes reflect.</p> <p>ABS will in-service BMT on <i>Policy & Procedure #2-06-01 Water Culture Policy</i> by 6/8/2012. BMT instructed that all monthly cultures and endotoxins must be drawn by no later than the 10th calendar day of each month and all results must be reviewed with any necessary redraws, and actions per company policy and procedure. In-service will include but not be limited to: 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services and Medical Director, Disinfect affected equipment at end of treatment day in which results are</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) ABS must be notified of all actionable results. Attendance of in-service is evidenced by BMT signature on In-Service Form.</p> <p>ABS will conduct monthly audits of facility culture and endotoxin results x 3 months, then quarterly thereafter to ensure compliance with all required testing, and response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0219	<p>494.40(a) BACT CONTROL-DISINFECT 1X/MO/DWELL 7 Strategies for bacterial control 7.1 General: disinfect monthly/disinfection dwell Routine low-level disinfection of the pipes should be performed to control bacterial contamination of the distribution system. The frequency of disinfection will vary with the design of the system and the extent to which biofilm has already formed in existing systems, but disinfection must be performed at least monthly.</p> <p>A mechanism should be incorporated in the distribution system to ensure that disinfectant does not drain from pipes during the disinfection period.</p> <p>Based on facility documents review and interview, the agency failed to ensure the water treatment system was disinfected for the months of April and May 2012 with the potential to effect all 11 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director 	V0219	<p>Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting < 10 CFU, < .10 LAL, QIFMM minutes reflect.</p> <p>ABS will in-service BMT on <i>Policy & Procedure #2-05-01 Water Treatment System Disinfection, Policy & Procedure #2-04-03 Bicarbonate Concentrate System Disinfection</i> by 6/8/2012. BMT instructed that the water distribution system must be</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p>		<p>chemically disinfected at a minimum of monthly, and when bacterial cultures and/or endotoxin results indicate need for disinfection. Distribution systems must be disinfected in an end-to-end process, during which disinfectant solution will be introduced to the following water inlet lines: 1) Dialysis Delivery System, 2) Dialyzer reprocessing equipment, 3) Dialyzer pre-cleaning machines, 4) Bicarb and acid missing systems, 5) Any unused outlets. ABS also reviewed chemical to be used, mixing procedure, dwell time (minimum 30 minute dwell), and rinse procedure. Documentation must be documented on appropriate log. Attendance of in-service is evidenced by BMT signature on In-Service Form.</p> <p>BMT has been assigned to the clinic in the interim of new BMTs orientation to ensure continuity and accountability. ABS will conduct monthly audits of monthly Water Treatment System Disinfection x 3 months, then quarterly thereafter to ensure compliance with monthly disinfection. Results of audits will be reviewed with Medical Director during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.		FA & Medical Director are responsible for compliance with this POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0255	<p>494.40(a) MICROB MONITOR-REPEAT CULTURES 7.2 Microbial monitoring methods 7.2.1 General: repeat cultures Cultures should be repeated when bacterial counts exceed the allowable levels. If culture growth exceeds permissible standards, the water system and dialysis machines should be cultured weekly until acceptable results are obtained. Additional samples should be collected when there is a clinical indication of a pyrogenic reaction or septicemia, and following a specific request by the clinician or the infection control practitioner.</p> <p>If repeat cultures are performed after the system has been disinfected (e.g., with formaldehyde, hydrogen peroxide, chlorine, or peracetic acid), the system should be flushed completely before collecting samples. Drain and flush storage tanks and the distribution system until residual disinfectant is no longer detected before collecting samples.</p> <p>Based on agency document and lab results review and interview, the facility failed to ensure repeat cultures were done on a weekly basis until the bacterial count and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients. (April and May)</p> <p>Findings:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April</p>	V0255	<p>Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting < 10 CFU, < .10 LAL, QIFMM minutes reflect.</p> <p>ABS will in-service BMT on <i>Policy & Procedure #2-06-01 Water Culture Policy</i> by 6/8/2012. BMT</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out</p>		<p>instructed that all monthly cultures and endotoxins must be drawn by no later than the 10th calendar day of each month all results must be reviewed with any necessary redraws, and actions per company policy and procedure. In-service will include but not be limited to: 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services and Medical Director, Disinfect affected equipment at end of treatment day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) ABS must be notified of all actionable results. Attendance of in-service is evidenced by BMT signature on In-Service Form.</p> <p>ABS will conduct monthly audits of facility culture and endotoxin results x 3 months, then quarterly</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>thereafter to ensure compliance with all required testing, and response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0274	<p>494.40(c) H2O TEST-DEVIATIONS REQUIRE RESPONSE Water testing results including, but not limited to, chemical, microbial, and endotoxin levels which meet AAMI action levels or deviate from the AAMI standards must be addressed with a corrective action plan that ensures patient safety.</p> <p>Based on agency document and lab results review and interview, the facility failed to ensure a corrective action plan for the product water used to prepare dialysate and concentrate was developed for 2 of 5 months reviewed with the potential to affect all 11 patients of the facility. (April and May)</p> <p>Findings:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2</p>	V0274	<p>Facility Administrator will conduct mandatory in-service for all QIFMM members. In-service will include but not be limited to: review <i>Policy & Procedure #1-02-01: Continuous Quality Improvement Program, Policy & Procedure #2-06-01 Water Culture Policy</i> by 6/8/2012. 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services and Medical Director, Disinfect affected equipment at end of treatment day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) QIFMM</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done.</p>		<p>Team must review water culture and endotoxin testing results monthly, evaluate actions taken and trends during monthly QIFMM, 5) Underperformance will be reviewed to identify root cause, will have action plan identified that will result in performance improvement, and will track change in performance overtime to ensure improvements are sustained. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>Biomedical Technician will bring results of all monthly water and dialysate testing to QIFMM meetings for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance, minutes will reflect.</p> <p>FA & Medical Director are responsible for compliance with this POC</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0314	<p>494.50(b)(1) H2O SYS MEET AAMI BACTI/CHEM QUALITY 7.1 Water systems: meet AAMI bacti/chem quality monitoring The system providing water for reprocessing shall meet all of the requirements for pressure and flow rate for operating the reprocessing equipment under minimal and peak load conditions. Product water used for rinsing, cleaning, filling, and diluting the germicide shall be shown to comply with the chemical and microbiological quality requirements [specified in these regulations]. Water bacteriology monitoring shall be carried out where the dialyzer is connected to the reuse system or as close as possible to that point.</p> <p>11.4 Germicide 11.4.1.5 Water quality monitoring The water used to rinse and clean dialyzers and dilute the germicide should be tested for bacterial contamination and pyrogens according to the requirements [of these regulations] before a reprocessing program is undertaken. Once dialysis with the reprocessed hemodialyzers has begun, testing for bacterial contamination should be frequent (e.g., weekly). Less frequent testing, but not less than monthly, may be appropriate if there is a documented history of at least 3 months of results consistently below the required levels.</p> <p>Based on agency document and lab results review and interview, the facility failed to ensure the product water used for reuse was below action level for 2 of 5 months reviewed with the potential to affect all 9 patients on reuse. (April and May)</p>	V0314	Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p>		<p>bicarbonate system disinfected, Bicarb Return cultures redrawn resulting < 10CFU, <.10 LAL, QIFMM minutes reflect.</p> <p>ABS will in-service BMT on <i>Policy & Procedure #2-05-01 Water Treatment System Disinfection, Policy & Procedure #2-06-01 Water Culture Policy</i> by 6/8/2012. BMT instructed that the water distribution system must be chemically disinfected at a minimum of monthly, and when bacterial cultures and/or endotoxin results indicate need for disinfection. BMT instructed that all monthly cultures and endotoxins must be drawn by no later than the 10th calendar day of each month all results must be reviewed with any necessary redraws, and actions per company policy and procedure. In-service will include but not be limited to: 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>and Medical Director, Disinfect affected equipment at end of treatment day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) ABS must be notified of all actionable results. Attendance of in-service is evidenced by BMT signature on In-Service Form.</p> <p>ABS will conduct monthly facility audit x 3 months, then quarterly thereafter to ensure compliance with monthly disinfection, all required testing, and response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM, minutes will reflect. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0520	<p>494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team completed a comprehensive reassessment monthly for 2 of 2 unstable patients with the potential to effect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p>	V0520	<p>Immediate steps were taken to ensure that the facility's interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed previously noted unstable Patients (#1 and #2).</p> <p>Interdisciplinary Team (IDT) met on 5/25/2012 and developed comprehensive re-assessment followed by individualized plan of care for patient (# 1 and #2) to reflect resolution of identified unstable issues.</p> <p>FA in-serviced IDT on 5/25/2012 on <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis.</i></p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>In-service included: 1)IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA has developed a process for tracking all patients deemed unstable to ensure unstable patients are re-assessed monthly, and reviewed by the IDT team until the patient is deemed stable. All unstable plans of care will be maintained confidentially</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>on a clipboard to be reviewed each month. Social Worker will ensure Falcon triggers follow-up assessment/plan of care. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V0540	<p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on clinical record and policy review and interview, it was determined the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 541), failed to ensure the interdisciplinary team developed a written plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 542), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's dose of dialysis monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 543), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's dose of dialysis to have a Kt/V of at least 1.2 monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 544), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's albumin</p>	V0540	<p>DaVita Rush County Dialysis takes the conditions of coverage very seriously. Immediate steps were taken to ensure that the facility's interdisciplinary team develops and implements written and individualized comprehensive plan of care that address patient needs. These actions are outlined in depth in the POC for V541, V542, V543, V544, V545, V546, V547, V549, V550, V551, V552, V553, V554, and V555.</p> <p>Facility GB met on 5/31/2012 to review the deficiencies received as a result of a survey concluded on 5/23/2012. Members of the GB including the Medical Director, FA, and DVP have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 2) Ensure IDT completes IDT Re-assessment and Plans of Care for all unstable patients monthly until stable, stable comprehensive assessment and plan of care will reflect resolution of unstable issues. 2) Ensure IDT develops and implements written and individualized comprehensive plans of care that address patient's needs including but not limited to: volume status, dose of dialysis, albumin and body</p>	06/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	and body weight monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 545), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's mineral metabolism and prevented / treated renal bone disease monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 546), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's anemia management monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 547), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's erythropoieses-stimulating agent(s) monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 549), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's vascular access monitoring for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 550), facility failed to ensure the interdisciplinary team developed and implemented a written and individualized		weight, bone and mineral metabolism, anemia management, erythropoiesis stimulating agents, vascular access referrals/potential for AVF placement, vascular access monitoring to prevent stenosis, social service interventions, home dialysis plan, transplant status/referral, productivity activity. GB will review QIFMM minutes to ensure minutes reflect POC, action plans are evaluated for effectiveness, and new plans developed as applicable. Once compliance is achieved, POC will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive plan of care that addressed the patient's vascular access monitoring to prevent access failure monthly for 2 of 2 unstable patients with the potential to effect all 11 patients (See V 551), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's social work interventions monthly for 2 of 2 unstable patients with the potential to effect all 11 patients (See V 552), failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's need for home dialysis monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 553), facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's transplant referral monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 554), and failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's appropriate level of productive activity monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 555).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	The cumulative effect of these systemic problems resulted in the facility's inability to meet the requirements of this Condition for Coverage 494.90 Patient Plan of Care.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <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 policy review and interview the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly</p>	V0541	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (# 1 and #2) to reflect resolution of identified unstable issues.</p> <p>FA in-serviced IDT on 5/25/2012 on <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>. In-service included: 1)IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA has developed a process for tracking all patients deemed unstable to ensure unstable patients are re-assessed monthly, and reviewed by the IDT team until the patient is deemed stable. All unstable plans of care will be maintained confidentially on a clipboard to be reviewed each month. Social Worker will ensure Falcon triggers follow-up assessment/plan of care. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0542	<p>494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed a written plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. 2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. 3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon 	V0542	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (# 1 and #2) to reflect resolution of identified unstable issues.</p> <p>FA in-serviced IDT on 5/25/2012 on <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>. In-service included: 1)IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA has developed a process for tracking all patients deemed unstable to ensure unstable patients are re-assessed monthly, and reviewed by the IDT team until the patient is deemed stable. All unstable plans of care will be maintained confidentially on a clipboard to be reviewed each month. Social Worker will ensure Falcon triggers follow-up assessment/plan of care. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			FA & Medical Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0543	<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;</p> <p>Based on clinical record and policy review and interview the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's dose of dialysis monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary</p>	V0543	<p>IDT met on 5/25/2012 and developed comprehensive re-assessment followed by individualized plan of care for Patients (#1 and #2) to reflect dose of dialysis to manage patient's volume status and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for IDT by 5/25/2012. In-service included but was not be limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i> with attention to the IDT or individual IDT member that Plan of Care must address Dose of Dialysis, IDT must provide the necessary care and services to manage patient's volume status. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes,</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include dose of dialysis, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0544	<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.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's dose of dialysis to have a Kt/V of at least 1.2 monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record</p>	V0544	<p>IDT met on 5/25/2012 and developed comprehensive re-assessment followed by individualized plan of care for Patients (#1 and #2) to reflect dose of dialysis to manage patient's volume status and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for IDT by 5/25/2012. In-service included but was not be limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i> with attention to the IDT or individual IDT member that Plan of Care must address Dose of Dialysis, IDT must provide the necessary care and services to manage patient's volume status. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes,</p>	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include dose of dialysis, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0545	<p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's albumin and body weight monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. 2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record 	V0545	<p>IDT met on 5/25/2012 and developed comprehensive re-assessment followed by individualized plan of care for Patients (#1 and #2) to reflect dose of dialysis to manage patient's volume status and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for IDT by 5/25/2012. In-service included but was not be limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i> with attention to the IDT or individual IDT member that Plan of Care must address Dose of Dialysis, IDT must provide the necessary care and services to manage patient's volume status. IDT must follow-up and readjust plan of care must to address changes in dialysis prescription, blood pressure, and fluid management needs. Identified unstable patients must have monthly updated plan of care that</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>includes changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include dose of dialysis, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0546	<p>494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's mineral metabolism and prevented / treated renal bone disease monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive</p>	V0546	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to reflect evaluation of patient's mineral management, to prevent/treat renal bone disease status and resolution of identified unstable issues. FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must evaluate and address patients Mineral Metabolism to prevent and treat renal bone disease. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>re-assessment and plan of care that evaluate and address Mineral Metabolism to prevent and treat renal bone disease, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's anemia management monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient 	V0547	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to reflect evaluation of patient's anemia management needs, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must evaluate and address current anemia management needs of patient. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes, estimated timetables</p>	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address anemia management needs of patient, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0549	<p>494.90(a)(4) POC-MONITOR ESA RESPONSE The patient's response to erythropoiesis-stimulating agent(s), including blood pressure levels and utilization of iron stores, must be monitored on a routine basis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's erythropoieses-stimulating agent(s) monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a</p>	V0549	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to evaluate and address patient's erythropoieses-stimulating agent(ESA) response, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must evaluate and address current ESA response of patient including blood pressure levels and utilization of iron stores. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address ESA response of patient, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V0550	<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 clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's vascular access monitoring and potential for arteriovenous fistula placement monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p>	V0550	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to evaluate/address patient's vascular access monitoring and potential for arteriovenous fistula placement, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must address patients vascular access including vascular access monitoring, potential for arteriovenous fistula placement, goals, interventions, outcome of treatment, surveillance to detect symptoms</p>	06/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>of access problems and assist in preventing failure. Vascular Access Manager is responsible for updating IDT of patient's vascular access status and needs. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address patient's vascular access including vascular access monitoring and surveillance, potential for arteriovenous fistula placement, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			this POC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0551	<p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's vascular access monitoring to prevent access failure monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary 	V0551	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to address patient's vascular access monitoring to prevent access failure, and resolution of identified unstable issues. FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must address patients vascular access including vascular access monitoring, goals, interventions, outcome of treatment, surveillance to detect symptoms of access problems and assist in preventing failure. Vascular Access Manager is responsible for updating IDT of patient's vascular access status and needs. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>current individualized comprehensive re-assessment and plan of care that address patient's vascular access monitoring and surveillance to prevent access failure, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance. FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0552	<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 clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's social work interventions monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. Clinical record 2 included a POC 	V0552	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to reflect evaluation of patient's social work needs and interventions, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must develop and implement a written, individualized comprehensive plan of care that will include measurable and expected outcomes, interventions to achieve goal and timetables for</p>	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>achieving goals related to patient's psychosocial status. Social Worker must follow up and readjust plan of care as necessary, document patient specific interventions to achieve desired outcomes and to monitor the patients' psychosocial status and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include interventions to monitor patient's psychosocial status, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			FA & Medical Director are responsible for compliance with this POC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0553	<p>494.90(a)(7)(i) POC-HOME DIALYSIS PLAN OR WHY NOT The interdisciplinary team must identify a plan for the patient's home dialysis or explain why the patient is not a candidate for home dialysis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's need for home dialysis monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive</p>	V0553	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) that evaluate/address patient's needs for home dialysis, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must evaluate and address patient's needs for home dialysis. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address patient's needs for home dialysis, changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0554	<p>494.90(a)(7)(ii) POC-TRANSPLANT STATUS PLAN OR WHY NOT</p> <p>When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the-</p> <p>(A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with §494.80(a)(10).</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's transplant referral monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p>	V0554	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to reflect evaluation of patient's transplant status/referral, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must evaluate and address current transplant status and plans for referral. Plan of Care must include documentation of the: 1) Plan for transplantation,</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>if patient accepts transplantation referral, 2) Patient's decision, if patient is a transplantation referral candidate but declines transplantation referral, 3) Reasons for patient's non-referral as a transplantation candidate. Identified unstable patients must have monthly updated plan of care that includes changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address patients transplant status/referral changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			FA & Medical Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V0555	<p>494.90(a)(8) POC-REHAB STATUS ADDRESSED</p> <p>The interdisciplinary team must assist the patient in achieving and sustaining an appropriate level of productive activity, as desired by the patient, including the educational needs of pediatric patients (patients under the age of 18 years), and make rehabilitation and vocational rehabilitation referrals as appropriate.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's appropriate level of productive activity monthly for 2 of 2 unstable patients with the potential to affect all 11 patients. (#1 and 2)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the 	V0555	<p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (#1 and #2) to evaluate/address patient's appropriate level of productive activity as desired by patient, and resolution of identified unstable issues.</p> <p>FA held mandatory in-service for all members of IDT on 5/25/2012. In-service included but was not limited to: review of <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>, with attention to the IDT or individual IDT member that Plan of Care must reflect assisting patient to achieve and sustain an appropriate level of productive activity, as desired by the patient, and make rehabilitation and vocational rehabilitation referrals as appropriate. Identified unstable patients must have monthly updated plan of care that includes</p>	06/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p>		<p>changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. Verification of attendance at in-service will be evidence by TMs signature on In-Service Form.</p> <p>FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that address patient's appropriate level of productive activity as desired by patient changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes.QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0710	<p>Based on clinical record, agency document, and policy review and interview, it was determined the medical director failed to ensure the staff performed their duties with repeat cultures on a weekly basis till the bacterial count and concentrate was below action level for 2 of 5 months reviewed and the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients (See V 713) and failed to ensure the interdisciplinary team followed policies and procedures and developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients and failed to ensure the product water used to prepare dialysate and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients of the facility. (See V 715).</p> <p>The cumulative effect of these systemic problems resulted in the facility's inability to meet the requirements of this Condition for Coverage 494.150 Responsibilities of the Medical Director.</p>	V0710	<p>DaVita Rush County Dialysis takes the conditions of coverage very seriously, immediate steps were taken to ensure facilities TMs perform responsible duties and follow Policy & Procedure. These actions are outlined in depth in the POC for V713 and V715.</p> <p>GB meeting was held on 5/31/2012 to review the deficiencies received as a result of a survey concluded on 05/23/2012. Members of the GB including the Medical Director, FA, and DVP have agreed to meet weekly to monitor the facility's ongoing progress towards compliance including but not limited to: 1) Ensuring product water used to prepare dialysate & concentrate is below action level, TMs perform water treatment system disinfections and water cultures including repeat cultures per policy to ensure patient safety, 2) Ensure IDT develops and implements written individualized comprehensive plan of care that addresses patients needs monthly for the unstable patients until deemed stable. GB will review QIFMM minutes to ensure minutes reflect, action plans initiated, evaluated for effectiveness, new plans</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			developed as applicable. Once compliance is achieved, POC will be monitored during GB meetings at a minimum of quarterly. This POC will also be reviewed during QIFMM and the FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0713	<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 agency document, policy, and lab results review and interview, the medical director failed to ensure the staff performed their duties with repeat water cultures on a weekly basis until the bacterial count and concentrate was below action level for 2 of 5 months reviewed (April and May) and the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients with the potential to affect all 11 patients.</p> <p>Findings:</p> <p>Related to the plan of care:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p>	V0713	<p>Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting < 10 CFU, < .10 LAL, QIFMM minutes reflect. BMT assigned to the clinic in the interim of new BMTs orientation to ensure continuity and accountability.</p> <p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (# 1 and #2) to reflect resolution of identified unstable issues.</p> <p>ABS will conduct mandatory in-service for BMT and FA on <i>Policy & Procedure #2-06-01 Water Culture Policy</i> by 6/8/2012, emphasizing that all monthly cultures and endotoxins must be</p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p> <p>Related to the water culture:</p> <p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and</p>		<p>drawn by no later than the 10th calendar day of each month and all results must be reviewed with any necessary redraws, and actions per company policy and procedure. In-service will include but not be limited to: 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services and Medical Director, Disinfect affected equipment at end of treatment day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) ABS must be notified of all actionable results.</p> <p>FA in-serviced IDT on 5/25/2012 on <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis</i>. In-service included: 1)IDT is responsible for providing each patient with an individualized and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu, Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p>		<p>comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues.</p> <p>Attendance at in-services is evidenced by TMs signature on In-Service Form.</p> <p>ABS will conduct monthly audits of facility culture and endotoxin results x 3 months, then quarterly thereafter to ensure compliance with all required testing, and response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM. FA has developed a process for tracking all patients deemed unstable to ensure unstable patients are re-assessed monthly, and reviewed by the IDT team until the patient is deemed stable. All unstable plans of care will be maintained confidentially on a clipboard to be reviewed each month. Social Worker will ensure Falcon triggers follow-up assessment/plan of care. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are responsible for compliance with this POC.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&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, agency document, and policy review and interview, the medical director failed to ensure the interdisciplinary team followed policies and procedures and developed and implemented a written and individualized comprehensive plan of care that addressed the patient's needs monthly for 2 of 2 unstable patients and failed to ensure the product water used to prepare dialysate and concentrate was below action level for 2 of 5 months reviewed with the potential to affect all 11 patients of the facility. (April and May).</p> <p>Findings:</p> <p>Related to the plan of care:</p> <p>1. Clinical record 1 included a plan of care (POC) dated 9/23/11 that evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and</p>	V0715	<p>Water Treatment System Disinfection completed 5.23.2012. Bicarb Return resulted 5.24.12 at unacceptable level, Medical Director reviewed May culture results on 5/25/2012, water treatment system including bicarbonate system disinfected, Bicarb Return cultures redrawn resulting <10 CFU, < .10 LAL, QIFMM minutes reflect. BMT assigned to the clinic in the interim of new BMTs orientation to ensure continuity and accountability.</p> <p>IDT met on 5/25/2012 and developed comprehensive re-assessments followed by individualized plan of care for Patients (# 1 and #2) to reflect resolution of identified unstable issues.</p> <p>ABS will conduct mandatory in-service for BMT and FA on <i>Policy & Procedure #2-06-01</i></p>	06/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>2. Clinical record 2 included a POC dated 7/15/11 that evidenced the patient as being unstable due to being in the hospital for 30 days. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis.</p> <p>3. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis", dated September 2011, Policy : 1-01-14, states, "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients At least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations ... "</p> <p>4. On 5/23/12 at 11:40 AM, Clinical Manager, Employee A, indicated both these patients were unstable and neither had updated plans of care. Both should have been triggered in the software, but that didn't happen.</p> <p>Related to the water culture:</p>		<p><i>Water Culture Policy</i> by 6/8/2012, emphasizing that all monthly cultures and endotoxins must be drawn by no later than the 10th calendar day of each month and all results must be reviewed with any necessary redraws, and actions per company policy and procedure. In-service will include but not be limited to: 1) Interpreting culture results: Acceptable level below 50 cfu/ml , Action level 50-199cfu/ml, Unacceptable level 200cfu/ml or greater, 2) Required response to action level culture results: If single site at or above action level and all other results in acceptable range, site must be re-cultured within 7 days of original sample collection date, 3) Required response to more than one site at or above action level or any site at or above unacceptable level: Notify FA, Biomedical Services and Medical Director, Disinfect affected equipment at end of treatment day in which results are received/reported or as recommended by Medical Director, Re-culture of all affected sites within 7 days of original sample collection date. 4) ABS must be notified of all actionable results.</p> <p>FA in-serviced IDT on 5/25/2012 on <i>Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis.</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Agency document "Bicarb System Renalin Disinfect Log", revised September 2011, evidenced the tanks and loop were disinfected 1/10/12, 2/7/12, and 3/8/12. No disinfection occurred in April and "NO" was entered under "Tanks and Loop Disinfected?" for 5/16/12.</p> <p>2. Agency document "Monthly Water Quality Report" evidenced a collection date of 4/9/12 and a medical director signature date of 4/27/12. The report evidenced the test results for Reuse Out # 1 at 160 cfu, Reuse Out # 2 at 310 cfu, Pre-Bd Inlet # 1 80 cfu, Pre-Bd Inlet # 2 780 cfu, Reuse Disinfect out 550 cfu, and Dry Acid H2O 60 cfu.</p> <p>A. Redraws were done 4/13/12 with Reuse Out # 1 <10 cfu, Reuse Out # 2 < 10 cfu, Pre-Bd Inlet # 1 50 cfu, Pre-Bd inlet # 2 50 cfu, Reuse Disinfect Out 90 cfu, and Dry Acid H2O out 40 cfu.</p> <p>B. Redraw Reuse disinfect Out 4/5/12 < 10 cu.</p> <p>C. Agency documents indicated Water Culture Action Level was 50-199 cfu/ml and Unacceptable Level 200 cfu/ml or greater.</p> <p>D. A collection date of 5/14/12 evidenced Bicarb H2O out 450 cfu,</p>		<p>In-service included: 1)IDT is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs, 2) the comprehensive assessment will be used to develop the patient's treatment plan and expectations for care; 3) The plan of care will specify the services necessary to address patients needs as identified in the comprehensive assessment and changes in the patient's condition, 4) the plan of care will include measureable and expected outcomes and estimated timetables to achieve those outcomes identified, 4) review of unstable criteria, 5) patients deemed unstable will have comprehensive assessment followed by a Plan of Care completed monthly until deemed stable, 6) stable comprehensive assessment and plan of care will reflect resolution of unstable issues.</p> <p>Attendance at in-services is evidenced by TMs signature on In-Service Form.</p> <p>ABS will conduct monthly audits of facility culture and endotoxin results x 3 months, then quarterly thereafter to ensure compliance with all required testing, and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Bicarb Return 300 cfu, Dry Acid Out 920 cfu, Pre-Bd Inlet # 1 900 cfu, and Pre-Bd inlet # 2 1390 cfu.</p> <p>E. Redraws were Bicarb H2O out 5/18/2012 10 cfu, Dry Acid Out < 10, Pre-Bd inlet # 1 10 cfu, and Pre-bd inlet # 2 < 10. The Bicarb Return was not redrawn and retested and would still be considered at an unacceptable level.</p> <p>3. On May 22, 2012, at 4:10 PM, the Clinical Manager, Employee A, indicated there was no documentation in the system the disinfection for April had been done. She also indicated a large corporate reorganization had occurred and several biomedical technicians had been through the facility. The current assigned technician was still in orientation. The Medical Director was aware of the Action and Unacceptable level for April but there is no documentation that he is aware of the May Action and Unacceptable levels. She indicated the Bicarb Return had been tested during the survey and the results would be returned soon.</p>		<p>response. BMT will bring results of all monthly water and dialysate testing to QIFMM for review with Medical Director and team, QIFMM committee will review all results, responses and trends during monthly QIFMM. FA has developed a process for tracking all patients deemed unstable to ensure unstable patients are re-assessed monthly, and reviewed by the IDT team until the patient is deemed stable. All unstable plans of care will be maintained confidentially on a clipboard to be reviewed each month. Social Worker will ensure Falcon triggers follow-up assessment/plan of care. FA or designee will conduct a MR audit of 100% of unstable patients monthly to ensure unstable patients have current individualized comprehensive re-assessment and plan of care that include changes in condition, measureable outcomes, estimated timetables and resolution of any identified unstable issues. FA will review results of audits with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. QIFMM minutes and activities will be reviewed during GB meetings to monitor ongoing compliance.</p> <p>FA & Medical Director are</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RUSH COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 N CHERRY ST RUSHVILLE, IN 46173
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			responsible for compliance with this POC.	