

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/11/2016
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NAME OF PROVIDER OR SUPPLIER DSI NORTHWEST INDIANAPOLIS RENAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6488 CORPORATE WAY INDIANAPOLIS, IN 46278
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V 0000 Bldg. 00	<p>This was an ESRD complaint investigation survey.</p> <p>Complaint #: IN00197201; Substantiated, deficiencies related to the complaint are cited.</p> <p>Survey Dates: 5-9-16, 5-10-16, & 5-11-16</p> <p>Facility #: 006144</p> <p>Medicare Provider # 15-2524</p> <p>Medicaid Vendor #: 201073800</p> <p>Census: 66 incenter patients</p>	V 0000	<p>The Local Governing Body of USRC Northwest Indianapolis Renal Center takes seriously its responsibility to ensure the health and safety of its patients and staff, and to ensure that patients receive dialysis and support services in a safe and sanitary environment. As such, the Governing Body met on 5/24/2013 to review the findings of the Statement of Deficiencies and further participate in the development, evaluation, and implementation of the following Plan of Correction that resulted from the 5/11/2016 complaint investigation survey. The Local Governing Body will hold all staff accountable for following all policies and procedures. The Clinic Manager will monitor all activities on an ongoing basis, through monthly QAPI process.</p>	
V 0113 Bldg. 00	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff had provided care in accordance with the facility's own infection control and hand hygiene policies and procedures in 3 (#s 1, 2, and 3) of 6 infection control</p>	V 0113	<p>All in-center staff including Employees I, M, and S, will bein-serviced on 6/2/2016 on Policy # C-IC-0060: Hand Hygiene as well as Policy#C-TP-0010: Termination of DialysisTreatment. A copy of</p>	06/09/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee I, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 1 on 5-9-16 at 2:10 PM using an arteriovenous fistula (AVF) (observation # 1). The patient was observed to hold pressure over the needle insertion sites with folded gauze and wearing a glove after the PCT had removed the needles. After the bleeding had stopped, the patient was observed to remove the glove, walk to the scale, and leave the facility. The patient was not observed to cleanse the hands after the gloves had been removed. The PCT was not observed to remind or encourage the patient to cleanse the hands after glove removal. Employee M, a PCT, was observed to discontinue the dialysis treatment on patient number 4 on 5-10-16 at 11:00 AM (observation number 2). The patient was observed to hold pressure over the needle insertion sites with folded gauze and wearing a glove after the PCT had removed the needles. After the bleeding had stopped, the patient was observed to remove the glove, pack belongings into a bag, and leave the facility. The patient was not observed to cleanse the hands 		<p>policies #C-IC-00600 and #C-TP-0010 will be given to all staff nurses and patient care technicians. The in-service will include but not be limited to the following: "Hand hygiene which should be performed after removal of old gloves and prior to donning clean gloves". As well, Termination of Dialysis Treatment which notes: "Patients must wear a glove to hold their sites and sanitize hands immediately upon glove removal." All patients will be re-educated by 6/9/16 regarding holding sites with a gloved hand and performing hand hygiene after glove removal. The Clinic Manager or designee will monitor all staff daily x 2 weeks, or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM) Workbook Infection Control audit schedule. Any staff found not to be in compliance with Policy will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and Governing Body meetings.</p>		

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	<p>after the gloves had been removed. The PCT was not observed to remind or encourage the patient to cleanse the hands after glove removal.</p> <p>3. Employee S, a PCT, was observed to initiate the dialysis treatment on patient number 10, using an AVG, on 5-10-16 at 10:30 AM. The PCT was observed to evaluate the access by locating and palpating the cannulation sites. The PCT was observed to change her gloves but failed to cleanse her hands after removing the old gloves and prior to donning new gloves before cleansing the needle insertion sites.</p> <p>4. The above-stated findings were discussed with the facility administrator on 5-11-16 at 10:15 AM. The facility administrator indicated employees I, M, and S had not provided care in accordance with the facility's infection control and hand hygiene policies and procedures.</p> <p>5. The facility's 9-2011 "Hand Hygiene" policy number C-IC-0060 states, "Hand hygiene should be performed: . . . Before any invasive procedure such as vascular access cannulation or administration of parenteral medications, immediately after gloves are removed . . . Before entering and on exiting the patient treatment</p>			

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V 0122 Bldg. 00	<p>areas."</p> <p>6. The facility's 07-2014 "Termination of Dialysis Treatment" policy number C-TP-0010 states, "Patients must wear a glove to hold their sites and sanitize their hands immediately upon glove removal."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the dialysis station had been cleaned and disinfected in accordance with facility policy in 1 (#1) of 2 cleaning and disinfection of the dialysis station observations completed.</p> <p>The findings include:</p> <p>1. Employee I, a patient care technician (PCT). was observed to clean and disinfect the dialysis machine and chair at station number 3 on 5-9-16 at 2:10 PM (observation # 1). The PCT failed to</p>	V 0122	All in-center staff including Employee I, will be in-serviced on 6/2/2016 on Policy #C-IC-0080: Disinfection and Cleaning of DialysisMachine/Equipment. Copies of the policy will be given to all staff & the in-service will include but not limited to the following: "After each patient treatment, clean environmental surfaces at the dialysis station, including the chair or bed which includes the outside of the sides of the chair & front of the arms of the chair, integrated keyboards, countertops, and external surfaces of the dialysis machine to include tops, sides, back of	06/09/2016

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	<p>empty the prime waste container prior to cleaning the dialysis machine.</p> <p>A. The PCT was not observed to clean the dialysate hoses from the machine to the chase cabinet.</p> <p>B. The PCT was not observed to clean the data entry station.</p> <p>C. The PCT was not observed to clean the outside of the sides of the dialysis chair. The PCT was not observed to clean the fronts of the arms of the chair where patients place their hands.</p> <p>D. The PCT was not observed to clean the blood pressure cuff or the television remote control.</p> <p>2. The above-stated findings were discussed with the facility administrator on 5-11-16 at 10:15 AM. The facility administrator indicated employee I had not cleaned and disinfected the dialysis station in accordance with facility policy.</p> <p>3. The facility's 09-2015 "Disinfection and Cleaning of Dialysis Machine/Equipment" policy number C-IC-0080 states, "After each patient treatment, clean environmental surfaces at the dialysis station, including the chair</p>		<p>machine and containers associated with the prime waste which includes emptying the prime waste container prior to cleaning the machine." Clean Hansen connectors and dialysis hoses from the machine to the chase cabinet. "Clean chair side computer keyboards and external surfaces of computer stations." Also to be addressed "Between uses of medical equipment (e.g., tourniquets, scissors, hemostats, clamps, stethoscopes, blood pressure cuffs & TV remotes), clean and apply a hospital disinfectant". The Clinic Manager or designee will monitor all staff daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM) Workbook Infection Control audit schedule. Any staff found not to be in compliance with Policy & Procedure will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GB meetings.</p>	

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V 0401 Bldg. 00	<p>or bed, integrated keyboards, countertops, and external surfaces of the dialysis machine to include tops, sides, back of the machine and the containers associated with the prime waste . . . Clean chair side computer keyboard and external surfaces of computer stations . . . Between uses of medical equipment (. . . blood pressure cuffs) clean and apply a hospital disinfectant."</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, interview, and record review, the facility failed to ensure patient restrooms had been maintained in 1 (#2) of 2 patient restrooms observed.</p> <p>The findings include:</p> <p>1. On 5-9-16 at 2:30 PM, observation noted 2 restrooms in the lobby waiting area for patient use. Observation noted, in the 2nd restroom, water dripping from the sink faucet. Observation also noted the toilet paper holder was missing the rod on which the toilet paper is placed and the toilet paper was sitting on a hand rail on the wall.</p>	V 0401	All staff including Employee O, will be in-serviced on 6/2/2016 on Policy #100-25: Physical Environment Dialysis Treatment Area. Copies of the policy will be given to all staff & the in-service will include but not limited to the following: "Maintain physical structure is in good repair and kept free of potential hazards created by damaged or defective parts of building. Maintain the integrity of all surfaces, (e.g., countertops, floors, walls, sinks) & keep these areas intact, clean and free from damage. Staff will notify clinic manager & biomedical technician of any areas noted to be damaged or in need of repair". Toilet paper roll holder (spindle) was replaced on	06/09/2016

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V 0405 Bldg. 00	<p>2. The biomedical technician, employee O, indicated, on 5-10-16 at 2:35 PM, "I didn't know anything about it [the dripping water faucet or the missing toilet paper holder]. I will order a new one and see if the washer needs replaced."</p> <p>3. The facility's "Physical Environment Dialysis Treatment Area" policy/procedure number 100-25 states, "The facility must: . . . Maintain physical structure is in good repair and kept free of potential hazards created by damaged or defective parts of the building. Maintain the integrity of all surfaces, (e.g., countertops, floors, walls, sinks) & keep these areas intact, clean and free of damage. Staff will notify clinic manager & biomedical technician of any areas noted to be damaged or in need of repair."</p> <p>494.60(c)(2) PE-COMFORTABLE TEMPERATURE The dialysis facility must: (i) Maintain a comfortable temperature within the facility; and (ii) Make reasonable accommodations for the patients who are not comfortable at this temperature. Based on observation, record review, and interview, the facility failed to maintain a comfortable temperature on the treatment floor creating the potential to affect all of the facility's 66 current incenter patients.</p>	V 0405	<p>5-10-16 per biomedical technician and new toilet paper roll holder (spindle) was ordered on 5-10-16 at 6:33 PM. Faucet washer was replaced on 5-10-16 per biomedical technician as well. No evidence of dripping water noted. The Clinic Manager or designee will monitor all restrooms and faucets daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per Biomed Status Report. Any issues noted will be addressed per Clinic Manager or Biomedical technician. Any staff found not to be in compliance with Policy will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GBmeetings.</p> <p>All staff will be in-serviced on 6/2/2016 on Policy #100-25: Physical Environment Dialysis Treatment Area. Copies of the policy will be given to all staff & the in-service will include but not limited to the following: "The</p>	06/09/2016

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	<p>The findings include:</p> <ol style="list-style-type: none"> On 5-9-16 at 2:00 PM, observation noted patient number 7 was receiving a dialysis treatment at station number 15. The patient was wrapped in 2 blankets, wore a knit cap, and requested a coat be placed over the patient's legs. The patient's access was not visible. On 5-9-16 at 2:00 PM, observation noted patient number 8 was receiving a dialysis treatment at station number 16. The patient was wrapped in a blanket with only the patient's head being visible. The patient's access was not visible. A thermostat, located on the wall at the nurse's station, was observed with a clear, plastic, locked box covering it. The thermostat read 72 degrees. A thermometer showed the ambient room temperature was 69.6 degrees. On 5-10-16 at 8:45 AM, patient number 4 stated, "It is always freezing in here." The patient was observed to be wrapped in 2 blankets. <p>The thermostat was again noted to be set on 72 degrees. The ambient room temperature was 71.2 degrees.</p> <ol style="list-style-type: none"> On 5-11-16 at 8:45 AM, the following 		<p>facility must: Maintain a comfortable temperature within the facility. Make reasonable accommodations for the patients who are not comfortable at this temperature without compromising infection control precautions and ensuring access site and line connections remain uncovered to allow staff to visually monitor these areas if patients use coverings or blankets". Thermometer set at 72 degrees per agreement of Clinic Manager and patient on 3-24-16, thermostat lock box purchased 3-25-16 at 9:53 am. Staff instructed not to manipulate room temperature on 3-25-16 and keys were given only to Clinical Manager and Biomedical Technician. Havel HVAC technician on site on 5-11-16, reported "I went to the roof and inspected units to make sure there were no electrical issues. And I found none. Tested return air and had a 71.0F. Checked supply air and had 52.0F, which is normal (you should have 18 to 20 degree drop across coil). Checked space with thermometer and tested thermostat and had reading of 72.0F. Walked thru space and was measuring 71.0F to 72.0F. I believe patients are feeling the cold air from vents when cooling comes on. There is no way to deflect that air. So I talked with manager and decided to turn thermostat to 73.0F and keep fan in the on position that</p>	

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	<p>observations were made:</p> <p>A. The patient at station number 9 stated, "I'm freezing." The patient was wearing a hooded sweatshirt and was covered with a blanket.</p> <p>B. The patients at stations numbered 4 and 1 were covered with blankets. Their accesses were not visible.</p> <p>C. The patient at station number 14 was observed to be covered with 3 blankets. The access was not visible</p> <p>5. On 5-11-16 at 8:50 AM, the ambient room temperature was 69.4 degrees. The facility administrator stated, "This room is so large. I have had the HVAC [heating and air conditioning] people out here. I will call again. I am not sure why the thermostat is set on 72 degrees and it still is only 69.4 degrees. It was 69.7 degrees in here this morning."</p> <p>6. The facility's 11-1-15 "Physical Environment Dialysis Treatment Area" policy/procedure number 100-25 states, "The facility must: . . . Maintain a comfortable temperature within the facility. Make reasonable accommodations for the patients who are not comfortable at this temperature without compromising infection control</p>		<p>way it is constantly moving air and should help regulate space temp better for patients. I also verified that when Stat is 73.0F it brings temp to 72.0 and A/C doesn't kick back on until space tempis reading 74.0" HVAC technician and clinical manager spoke with auditor and showed temperature readings throughout treatment floor. Auditor agreed to plan.</p> <p>Governing Body met on 5-24-16 and governed in Northwest Facility Specific "TX Room Temperature Log". RN to check room temperature daily to ensure room temperature remains within the range of 72-74 degrees. Checking of room temperature daily was added to RN daily duties. The Clinic Manager or Charge RN will monitor treatment room temperatures daily to ensure that temperatures are remaining between 72 and 74 degrees as above. Facility Specific Log will be used to document any adjustments which need to be made to accomplish temperature of 72to 74 degrees Fahrenheit. Readings to be evaluated by clinic manager or designee daily X2 weeks to evaluate trends,weekly x 2 and then monthly as per Biomed Status Report. Any issues noted will be addressed per clinic manager or biomedical technician and HVAC technician will be called if variations in temperature trends become an issue. Any</p>		

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V 0407 Bldg. 00	<p>precautions and ensuring access site and line connections remain uncovered to allow staff to visually monitor these areas if patients use coverings or blankets."</p> <p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation, interview, and record review, the facility failed to ensure patients' accesses were visible at all times in 2 (5-9-16 & 5-11-16) of 2 days access visibility observations were completed.</p> <p>The findings include:</p> <p>1 On 5-9-16 at 1:50 PM, observation noted patient number 7 was wrapped in a blanket while receiving the dialysis treatment at station number 15. The access was not visible.</p> <p>A. Patient number 8 was observed at station number 16. The patient had a blanket completely covering the patient except for the patient's head. The access was not visible.</p> <p>2. On 5-11-16 at 8:45 AM, the accesses</p>	V 0407	<p>staff found not to be in compliance with Policy will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GB meetings</p> <p>All in-center staff will be in-serviced on 6/2/2016 on Policy #300-11:Cannlation with Safety Needle Device. Copies of the policy will be given to all staff & the in-service will include but not limited to the following: "Ensure Access is visible at all times. Access must be visible during the entire treatment. If patient refuses, the nurse in charge must be notified. Document patient refusal and nurse in charge notification in flow sheet. During every 30 minute monitoring the access must be visibly checked and documented. This documentation must occur for every dialysis treatment the patient refuses to leave access uncovered". All patients will be re-educated by 6/9/16 regarding leaving their access visible and risks of staff not being able to visualize access during the treatment. The Clinic Manager</p>	06/09/2016

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V 0466 Bldg. 00	<p>were not visible for the patients at stations numbered 1, 3, 4, 6, 8, 9, 11, and 14. The patients were all covered in blankets.</p> <p>3. The above-stated observations were discussed with the facility administrator on 5-11-16 at 10:15 AM. The administrator indicated the patients' accesses should be visible.</p> <p>4. The facility's 5-1-15 "Cannulation with Safety Needle Device" policy number 300-11 states, "Ensure Access is visible at all times. Access must be visible during the entire treatment. If the patient refuses, the nurse in charge must be notified. Document patient refusal and nurse in charge notifications in the flow sheet. During every 30 minutes monitoring the access must be visibly checked and documented. This documentation must occur for every dialysis treatment the patient refuses to leave access uncovered."</p> <p>494.70(a)(15) PR-INFORMED OF EXTERNAL GRIEVANCE PROCESSES The patient has the right to-</p> <p>(15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State</p>		<p>or designee will monitor all staff daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM) Workbook Infection Control and Flow sheet audit schedule. Any staff found not to be in compliance with Policy & will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GB meetings.</p>	

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	<p>survey agency;</p> <p>Based on record review, observation, and interview, the facility failed to ensure patients had been informed of the State telephone number to file a complaint or grievance creating the potential to impact all of the facility's 66 current incenter patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 5-11-16 at 11:50 AM, observation noted a notice posted on a bulletin board in the lobby of the facility informing patients of telephone numbers to contact facility management, corporate management, the ESRD Network, and the Indiana State Department of Health (ISDH). The 2 telephone numbers for the ISDH were 800-228-6334 and 317-233-1325. A call was placed to the 800 number. This number is no longer in service. The 317 number is that of the general switchboard for the ISDH. The facility failed to ensure patients had been informed of the complaint hotline number used to receive complaints or grievances for ESRD patients. The facility administrator indicated, on 5-11-16 at 11:55 AM, she was unaware the 2 numbers for the ISDH were not accurate. 	V 0466	<p>All staff will be in-serviced on 6/2/2016 on Policy #200-07: Patient Rights, Responsibilities and Grievance Procedure and Policy C-Forms-0530: Patient Rights: Grievance. Copies of these policies will be given to all staff & the in-service will include but not limited to the following: "All patients have the right to have their grievances handled promptly and courteously. The patient may choose to by-pass the facility specific process at any point and initiate a grievance directly to the Network or State Department of Health." Clinic Manager updated Policies with all ESRD network and State Department of Health information (Directly on policy) on 5-11-16. State Board of Health Direct Hotline number was also corrected to read 1-800-246-8909. Policy was then posted in patient waiting room, treatment area, and employee lounge. All patients will be educated by 6/9/16 regarding the policy and postings with the correct information. The Clinic Manager or designee will monitor Policy information remains in place and up to date daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM) Workbook audit schedule. The Clinic Manager or designee will</p>	06/09/2016

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V 0550 Bldg. 00	<p>3. The facility's 6-1-14 "Patient Rights, Responsibilities and Grievance Procedure" policy number 200-07 states, "All patients have the right to have their grievances handled promptly and courteously . . . The patient may choose to by-pass the facility specific process at any point, and initiate a grievance directly to the Network of State Department of Health . . . The address and phone number of the Department of Health Services, Health Clinic Division is: [This portion of the policy is blank. There was no address or phone number listed in the policy] . . . The Patient Rights and Responsibilities, Clinic Code of Conduct, Patient Grievance Procedure shall be posted in the patient waiting room, the treatment area, and the employee lounge."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement. Based on observation, record review, and interview, the facility failed to ensure post vascular access care had been</p>	V 0550	<p>review education, audit results and disciplinary action in the monthly QAPI and GB meetings.</p> <p>All in-center staff including Employees I & M will be in-serviced on 6/2/2016 on Policy</p>	06/09/2016			

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	<p>provided in accordance with facility policy in 2 (#s 1 and 2) of 2 discontinuation of the dialysis treatment observations completed and failed to ensure pre-treatment access care had been completed in accordance with facility policy in 1 (#2) of 2 initiation of the dialysis treatment observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee I, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 1, using an arteriovenous fistula (AVF), on 5-9-16 at 2:10 PM (discontinuation observation # 1). The PCT removed the needles and the patient applied pressure to the needle removal sites with gauze and a gloved hand. After the bleeding had stopped the PCT applied more tape to the gauze and tape already present. The PCT failed to apply a clean gauze or band-aid to the needle removal site prior to the patient leaving the facility. 2. Employee M, a PCT, was observed to discontinue the dialysis treatment on patient number 4, using an arteriovenous fistula (AVF), on 5-10-16 at 11:00 AM (discontinuation observation # 2). The PCT removed the needles and the patient applied pressure to the needle removal 		<p>#300-11: Decannulation with Safety Needle Device and Policy # C-IT-0010: Initiation of Dialysis Treatment. Copies of Policy#300-11 and Policy #CT-IT-0010 will be given to all staff & the in-service will include but not be limited to the following: "Once homeostasis is achieved apply anew/clean/fresh band aid/gauze over cannulation site". As well, "Patient access has been pre-cleansed according to procedure and type of access (i.e. washed access arm, Life site skin prep scrub, etc.)" Emphasis will also be placed on removal of numbing cream by washing with soap and water prior to prepping site. A patient should be asked to wash access & staff should assist patient if needed in washing their access with soap and water when numbing cream has to be removed by staff member to decrease bacteria on skin and help reduce possibility of infection. The Clinic Manager or designee will monitor all staff daily x 2 weeks or until compliance has been established per the Governing Body(GB)recommendations, weekly x 2 and then monthly as per the Quality Management (QM)Workbook Infection Control audit schedule. Any staff found not to be in compliance with these Policies will be subject to progressive disciplinaryaction. The Clinic Manager or designee will review education, audit results</p>	

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	<p>sites with gauze and a gloved hand. After the bleeding had stopped the PCT applied a Tegaderm dressing over the gauze and tape already in place. The PCT failed to apply a clean gauze or band-aid to the needle removal site prior to the patient leaving the facility.</p> <p>3. Employee M, a PCT, was observed to initiate the dialysis treatment on patient number 11 on 5-10-16 at 10:50 AM (initiation observation number 2). Observation noted 2 pieces of gauze and tape over sites on the patient's AVF. The PCT indicated the patient's adult child had placed a numbing cream on the patient's access and covered the sites with the gauze and tape. The PCT was not observed to wash the access with soap and water prior to applying antiseptic and preparing the sites for the needle insertion.</p> <p>4. The above-stated findings were discussed with the facility administrator on 5-11-16 at 10:15 AM. The facility administrator indicated employees I, M, and S had not provided care in accordance with the facility's infection control and hand hygiene policies and procedures.</p> <p>5. The facility's 11-1-15 "Decannulation with Safety Needle Device"</p>		and disciplinary action in the monthly QAPI and GB meetings.	

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V 0715 Bldg. 00	<p>policy/procedure number 300-15 states, "Once hemostasis is achieved apply a new/clean/fresh band aid/gauze over cannulation site."</p> <p>6. The facility's 09-2015 "Initiation of Dialysis Treatment" policy number C-TI-0010 states, "Patient access has been pre-cleansed according to procedure and type of access (i.e. washed access arm, Lifesite skin prep scrub, etc.)"</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on record review, interview, and observation, the medical director failed to ensure pre- and post-treatment vital signs had been obtained in 3 (#s 1, 2, & 6) of 6 records reviewed, failed to ensure patients had been checked at least every 30 minutes during the dialysis treatment in 5 (#s 1, 3, 4, 5, & 6) of 6 records reviewed in accordance with the facility's own policies, and failed to ensure the facility's grievance procedure had been implemented in 1 (March 2016) of 4</p>	V 0715	<p>On 5-24-16 Medical Director reviewed and re-signed his Medical Director Job Description which notes: "Medical Director's duties and responsibilities shall include all of the duties and a physician directors set forth in the Medicare Conditions of Coverage for End Stage Renal Disease Facilities, 42 C.F.R. Section 494 et seq. (and any successor regulations)". Medical Director will also review policy C-AD-0010: Medical Director by 6/2/16. Review will include but not limited</p>	06/09/2016

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	<p>months reviewed.</p> <p>The findings include:</p> <p>Regarding pre- and post-treatment vital signs:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included physician orders dated 1-30-16 that state, "Vital Signs: Pre and post dialysis - TPR [temperature, pulse, respirations] and BP [blood pressure] (standing and sitting.)" A hemodialysis treatment flow sheet, dated 4-29-16, failed to evidence a post treatment standing blood pressure and pulse had been obtained at the end of the treatment. 2. Clinical record number 2 included physician orders dated 1-29-16 that state, ""Vital Signs: Pre and post dialysis - TPR [temperature, pulse, respirations] and BP [blood pressure] (standing and sitting.)" <p>A. A hemodialysis treatment flow sheet dated 4-15-16 failed to evidence a standing blood pressure and pulse had been obtained at the end of the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 5-2-16 failed to evidence the patient's temperature had been obtained pre-dialysis treatment.</p>		<p>to the assurance that 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 non-physician providers. All in-center staff including Employees I & M will be in-serviced on 6/2/2016 on Policy C-PT-0010: Pre Dialysis Assessment of Patient; C-ID-0010:Intradialytic Monitoring of Patient; C-TP-0060: Post Dialysis Assessment of Patient. Copies of the policies will be given to all staff & the in-service will include but not be limited to the following: "The pre-assessment and data collection includes but is not limited to: Apical pulse, Blood pressure-sitting and standing (as applicable), respirations and temperature. " "The post-assessment and data collection includes, but is not limited to: Apical pulse, Blood pressure-sitting and standing (as applicable), Respirations, and temperature." As well as, "Monitoring blood pressure every30 minutes or more frequently depending on patient needs. Monitoring pulse every 30 minutes or more frequently depending on patient needs. Observe patient for level of consciousness. Check temperature of patient's skin. Is the patient breathing normally.</p>	

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	<p>C. A hemodialysis treatment flow sheet dated 5-9-16 failed to evidence a standing blood pressure and pulse had been obtained pre-dialysis treatment.</p> <p>3. Clinical record number 6 included physician orders dated 1-30-16 that state, ""Vital Signs: Pre and post dialysis - TPR [temperature, pulse, respirations] and BP [blood pressure] (standing and sitting.)"</p> <p>A. A hemodialysis treatment flow sheet dated 5-7-16 failed to evidence a post treatment standing blood pressure and pulse had been obtained at the end of the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 5-10-16 failed to evidence a sitting blood pressure and pulse had been obtained pre-treatment.</p> <p>4. The facility administrator was unable to provide any additional documentation and/or information when asked on 5-11-16 at 11:20 AM.</p> <p>5. The facility's 6-1-14 "Pre-assessment and Data Collection" policy/procedure number 300-02 states, "The pre-assessment and data collection includes, but is not limited to: . . . apical</p>		<p>Monitoring patient's access with each check to ensure that there is no unusual bleeding or infiltration and connections are secure." The Clinic Manager or designee will monitor all staff daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM) Workbook Flow Sheet audit schedule. Any staff found not to be in compliance with these Policies will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GB meetings. All staff will be in-serviced on 6/2/2016 on Policy C-AD-0280: Grievance Policy; C-AD-0290: Patient Rights-Grievance Procedure. Copies of this policy will be given to all staff & the in-service will include but not limited to the following: "All patients have the right to have their grievances handled promptly and courteously. Within 10 business days (Monday-Friday) from date of grievance, the clinic manager will investigate and discuss the grievance with the patient, determine the validity of the grievance, and take appropriate actions toward a solution if possible. The Medical Director and/or attending Physician will be consulted as</p>	

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	<p>pulse, blood pressure - sitting and standing as applicable) . . . respirations . . . temperature."</p> <p>6. The facility's 5-1-15 "Post-assessment and Data Collection" policy/procedure number 300-56 states, "The post assessment and data collection includes, but is not limited to: . . . apical pulse, blood pressure - sitting and standing (as applicable) . . . respirations . . . temperature."</p> <p>Regarding checks at least every 30 minutes:</p> <p>1. Clinical record number 1 included a physician orders dated 1-30-16 that state, "BP [blood pressure] and pulse q30 [every 30] min [minutes] and prn [as needed] during treatment." A hemodialysis treatment flow sheet dated 4-15-16 evidenced the patient had been checked at 11:00 AM and not again until 12:00 PM.</p> <p>2. Clinical record number 3 included physician orders dated 1-29-16 that state "Vital Signs: . . . BP and pulse q30 min and prn during treatment." A hemodialysis treatment flow sheet dated 4-27-16 evidenced the patient had been checked at 4:31 PM and not again until 5:34 PM.</p>		<p>necessary. The clinic manager will record resolution of grievance on patient grievance form." Staff to be instructed that all grievances should be recorded on grievance form even when an incident report is made and MD notified. RN's, Social Worker, and Clinic manager all should address issues in medical record, grievance form as well as incident reports (as applicable). Grievance forms, medical records, and incident reports, should all address the grievance and the process taken toward resolution. All aspects of the grievance and resolution are to be documented. Per incident report, patient was contacted after disruptive behavior incident report was written on 3-24-16. Clinic manager spoke with patient and per mutual agreement clinic manager set thermometer at 72 degrees. Thermostat lock box purchased 3-25-16 at 9:53 am. Staff instructed not to manipulate room temperature on 3-25-16 and keys were given only to Clinical Manager and Biomedical Technician. Documentation of agreement and plan was done on incident report. MSW documented resolution on grievance form. The Clinic Manager or designee will present grievances and review trends, in the monthly QAPI meetings to determine and ensure all grievances have been addressed,</p>	

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	<p>3. Clinical record number 4 included physician orders dated 1-29-16 that state, "Vital Signs: . . . BP and pulse q30 min and prn during treatment." A hemodialysis treatment flow sheet dated 4-7-16 evidenced the patient had been checked at 9:05 AM and not again until 10:06 AM.</p> <p>4. Clinical record number 5 included physician orders dated 1-30-16 that state, "Vital Signs: . . . BP and pulse q30 min and prn during treatment." A hemodialysis treatment flow sheet dated 4-16-16 evidenced the patient had been checked at 8:30 AM and not again until 9:20 AM. The flow sheet evidenced the patient had been checked at 9:30 AM and not again until 10:16 AM.</p> <p>5. Clinical record number 6 included physician orders dated 1-30-16 that state "Vital Signs: . . . BP and pulse q30 min and prn during treatment."</p> <p>A. A hemodialysis treatment flow sheet dated 4-14-16 evidenced the patient had been checked at 8:30 AM and not again until 9:30 AM.</p> <p>B. A hemodialysis treatment flow sheet dated 5-5-16 evidenced the patient had been checked at 5:45 AM and not</p>		<p>documented correctly and resolved in a timely manner and identify if any other interventions are needed. The Clinic Manager or designee will audit all grievance forms (as applicable) daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly, at each QAPI meeting. The Clinic Manager or designee will review education, audit results, trends and timely resolution of grievance at the monthly QAPI and GB meetings.</p>	

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	<p>again until 6:30 AM.</p> <p>C. A hemodialysis treatment flow sheet dated 5-7-16 evidenced the patient had been checked at 7:30 AM and not again until 8:14 AM.</p> <p>D. A hemodialysis treatment flow sheet dated 5-10-16 evidenced the patient had been checked at 6:00 AM and not again until 6:54 AM.</p> <p>6. The facility administrator was unable to provide any additional documentation and/or information when asked on 5-11-16 at 11:20 AM.</p> <p>7. The facility's 6-1-14 "Monitoring During Treatment" policy/procedure number 300-24 states, "Patient will be observed at least every 30 minutes . . . Monitor blood pressure every 30 minutes or more frequently depending on patient's needs . . . Monitor pulse every 30 minutes or more frequently depending on patient's needs . . . Observe patient for level of consciousness . . . Check the temperature of the patient's skin . . . Is the patient breathing normally? . . . Monitor patient's access with each check to ensure that there is no unusual bleeding or infiltration and connections are secure."</p> <p>Regarding grievance procedure</p>			

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	<p>implementation:</p> <ol style="list-style-type: none"> 1. The facility's "Patient Report of Grievance, Complaint or Recommendation" documentation included a grievance filed on 3-24-16 by patient number 4. The documentation evidenced the patient had complained about the temperature of the treatment floor and had become very upset. The documentation failed to evidence the facility had addressed the complaint or had documented any follow-up to the complaint. 2. The facility administrator was unable to provide any additional documentation and/or information when asked on 5-11-16 at 11:20 AM. 3. The facility's 6-1-14 "Patient Rights, Responsibilities and Grievance Procedure" policy/procedure number 200-07 states, "All patients have the right to have their grievances handled promptly and courteously . . . Within 10 business days (Monday-Friday) from date of grievance, the Clinic Manager will investigate and discuss the grievance with the patient, determine the validity of the grievance, and take appropriate actions towards solution if possible. The Medical Director and/or Attending Physician will be consulted as necessary. 			

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V 0726 Bldg. 00	<p>The Clinic Manager will record resolution of grievance on the Patient Grievance Log."</p> <p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.</p> <p>Based on record review, observation, and interview, the facility failed to ensure clinical records included accurate information in 2 (#s 1 and 4) of 6 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee I, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 1 on 5-9-16 at 2:10 PM using an arteriovenous fistula (AVF) (observation # 1). The patient was observed to hold pressure over the needle insertion sites with folded gauze and wearing a glove after the PCT had removed the needles. After the bleeding had stopped, the patient was observed to remove the glove, walk to the scale, and leave the facility. The patient 	V 0726	<p>All in-center staff including Employees I & M will be in-serviced on 6/2/2016 on Policy #600-05: Medical Records. Copies of Policy #600-05: will be given to all staff & the in-service will include but not be limited to the following: "Records must be maintained in accordance with accepted professional standards and practices and shall be properly documented, completed, preserved and readily available." Emphasis will be placed on proper documentation to ensure accurate information is recorded.</p> <p>The Clinic Manager or designee will monitor all staff daily x 2 weeks or until compliance has been established per the Governing Body (GB) recommendations, weekly x 2 and then monthly as per the Quality Management (QM)</p>	06/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/11/2016
NAME OF PROVIDER OR SUPPLIER DSI NORTHWEST INDIANAPOLIS RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6488 CORPORATE WAY INDIANAPOLIS, IN 46278		
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	<p>was not observed to cleanse the hands after the gloves had been removed. The PCT was not observed to remind or encourage the patient to cleanse the hands after glove removal.</p> <p>The record included a hemodialysis treatment flow sheet dated 5-9-16. The flow sheet identified the patient had washed hands post dialysis treatment.</p> <p>2. Employee M, a PCT, was observed to discontinue the dialysis treatment on patient number 4 on 5-10-16 at 11:00 AM (observation number 2). The patient was observed to hold pressure over the needle insertion sites with folded gauze and wearing a glove after the PCT had removed the needles. After the bleeding had stopped, the patient was observed to remove the glove, pack belongings into a bag, and leave the facility. The patient was not observed to cleanse the hands after the gloves had been removed. The PCT was not observed to remind or encourage the patient to cleanse the hands after glove removal.</p> <p>The record included a hemodialysis treatment flow sheet dated 5-10-16. The flow sheet identified the patient had washed hands post dialysis treatment.</p> <p>3. The facility administrator was unable</p>		<p>Workbook Infection Control and Flow sheet audit schedule. These audits are to be done concurrently so that issues can be identified at time of incident. Any staff found not to be in compliance with these Policies will be subject to progressive disciplinary action. The Clinic Manager or designee will review education, audit results and disciplinary action in the monthly QAPI and GB meetings.</p>		

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	to provide any additional documentation and/or information when asked on 5-11-16 at 11:20 AM.				