

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
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V 0000 Bldg. 00	<p>This was a Federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: 9-14-15, 9-15-15, & 9-16-15</p> <p>Facility #: 004844</p> <p>Medicare #: 152604</p> <p>Medicaid Vendor #: 200881690</p> <p>Census: 24 incenter, no home program</p> <p>DSI Daleville Davis Dialysis was found to be out of compliance with the Condition for Coverage 42 CFR 494.90 Patient Plan of Care.</p> <p>QR: KH, R.N.</p>	V 0000	See all further tags for POCs on specific deficiencies.	
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, interview, and record review, the facility failed to ensure staff had changed gloves and cleansed hands in accordance with facility policy in 3 (#s 7, 13 and 14) of 14 infection</p>	V 0113	V113: The Clinic Manager in-serviced all in-center staff including Employees K & B on 9/24/2015 on DSI Policy & Procedure #800-01: Dialysis Infection Control Precautions & #800-28: Hand Hygiene (Handwashing and Hand Rubs) . All staff were given copies of the policies and took part in a discussion in regards to proper hand sanitation post glove removal as well as maintaining awareness going from a 'clean' to 'dirty'	10/16/2015

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

TITLE

(X6) DATE

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

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	<p>control observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee K, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 7 on 9-16-15 at 10:00 AM (observation number 7). The PCT evaluated the arteriovenous fistula access by palpation (touching) and auscultation (listening). The PCT failed to change her gloves and cleanse her hands prior to applying antiseptic to the skin over the needle insertion sites. The registered nurse (RN), employee B, was observed to administer intravenous (IV) Zemplar and Epogen to patient number 2 on 9-16-15 at 8:40 AM (observation number 13). The RN prepared the medications, cleansed her hands, donned clean gloves, and carried the medications to the station. The RN touched the computer mouse and keyboard. Without changing her gloves or cleansing her hands, the RN cleansed the IV port and administered the medications. The RN, employee B, was observed to administer IV Epogen to patient number 6 on 9-16-15 at 11:35 AM (observation number 14). The RN prepared the 		<p>area/tasks. The in-service included but was not limited to the following: Per policy #800-01 "A new pair of clean gloves must be used each time for access site care, vascular access cannulation, administration of medications. The intention is to ensure clean gloves that will not contaminate the patient's blood stream." All staff verbalized understanding and signed continuous education log to ensure that proper procedures are performed. The Clinic Manager or designee will perform Infection Control-Staff Audit daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then bi-monthly as per QM Workbook audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>	

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	<p>medications, cleansed her hands, donned clean gloves, and carried the medications to the station. The RN touched the computer mouse and keyboard. Without changing her gloves or cleansing her hands, the RN cleansed the IV port and administered the medications.</p> <p>4. The clinic manager indicated, on 9-16-15 at 11:45 AM, the RN had not changed her gloves and cleansed her hands appropriately when administering the IV medications to patients numbered 2 and 6. The manager indicated the PCT had not changed her gloves and cleansed her hands appropriately when initiating the dialysis treatment on patient number 7.</p> <p>5. The facility's 5-1-15 "Dialysis Infection Control Precautions" policy/procedure number 800-01 states, "A new pair of clean gloves must be used each time for access site care, vascular access cannulation, administration of parenteral/IV medications. The intention is to ensure that clean gloves which have not previously touched potentially contaminated surfaces are in use whenever there is a risk for cross contamination to a patient's blood stream to occur."</p>			

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V 0122 Bldg. 00	<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 dialysis stations had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfecting the dialysis station observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee C, a patient care technician (PCT), was observed to clean the dialysis machine at station number 1 on 9-14-15 at 1:35 PM (observation number 1). The PCT was not observed to clean and disinfect the sides of the machine, the dialysate hoses or the Hansen connectors. The PCT was not observed to clean the computer mouse or keyboard. 2. Employee J, a PCT, was observed to clean the dialysis machine at station number 10 on 9-14-15 at 1:40 PM 	V 0122	<p>V122: The Clinic Manager in-serviced all in-center staff including Employees C & J on 9/24/2015 on DSI Policy & Procedure #300-14: Cleaning the External Machine & Surrounding Areas & #800-01: Dialysis Infection Control Precautions. The in-service included but was not limited to the following: The requirement to disinfect the front, top, and sides of the dialysis machine and the shunt will be opened & Hansen connectors along with the hoses will be disinfected as part of the machine disinfection process between patients; Proper steps of machine cleaning such as dumping of the prime bucket pre cleaning of external dialysis machine surfaces inclusion of the computer mouse and keyboard when disinfecting the patient station & Between patients during machine external disinfection, remove the prime bucket from the side of the machine and pour residual fluid into a designated 'dirty' sink, disinfect the prime bucket internally and externally with a 1:100 bleach moistened wipe before returning the prime bucket to the clean machine. The Clinic Manager or designee will perform Infection Control-Staff Audit daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then bi-monthly as per QM Workbook audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>	10/16/2015

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	<p>(observation number 2). The PCT failed to empty the prime waste bucket prior to cleaning the front and 1 side of the machine. The PCT was not observed to clean the other side of the machine or clean the dialysate hoses all the way back to the dialysate ports. The PCT was not observed to clean the computer mouse or keyboard.</p> <p>3. The clinic manager indicated, on 9-16-15 at 11:45 AM, the PCTs had not cleaned the dialysis machines at stations numbered 1 and 10 in accordance with facility policy.</p> <p>4. The facility's 5-1-15 "Dialysis Infection Control Precautions" policy/procedure number 800-01 states, "Clean and disinfect the treatment station at the end of each dialysis treatment . . . Disinfect the front, top, and sides of the dialysis machine, computer, mouse, keyboard, screen . . . Hansen connectors, dialysis hoses, prime bucket . . . Between patients during machine external disinfection, remove the prime bucket from the side of the machine and pour residual fluid into a designated 'dirty' sink. Disinfect the prime bucket internally and externally with a 1:100 bleach moistened wipe before returning the prime bucket to the machine."</p>			

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V 0407 Bldg. 00	<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 record review and interview, the facility failed to ensure patients were monitored at least every 30 minutes in accordance with facility policy in 3 (#s 1, 2, and 4) of 4 total records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 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 . . . 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 . . . Visually check that dialysate lines are attached properly. Trace machine lines to patient's needle lines for correct connection. Verify the normal saline line is double clamped . . . Verify venous chamber is 2/3 full . . . or completely full . . . Check venous pressure monitor line and transducer 	V 0407	<p>V407: The Clinic Manager in-serviced all in-center staff on 9/24/2015 on DSI Policy & Procedure #300-24 Monitoring During Treatment. The in-service included but was not limited to the following: Patients will be observed at least every 30 min as evidenced by documentation which includes all assessments, interventions and follow up/outcome in the comment section of the flow sheet. The Clinic Manager will audit a random 25% of all patient flowsheets daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then quarterly as per the QM Workbook Flowsheet audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in monthly QAPI & LGB meetings.</p>	10/16/2015

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	<p>filter . . . Verify air detector is armed at all times."</p> <p>2. Clinical record number 1 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-24-15 evidenced the patient had been checked at 10:47 AM and not again until 11:37 AM. The flow sheet evidenced a check had been completed at 1:02 PM and not again unit 2:34 PM.</p> <p>B. A hemodialysis treatment flow sheet dated 9-2-15 evidenced the patient had been checked at 1:37 PM and not again unit 2:34 PM.</p> <p>3. Clinical record number 2 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-17-15 evidenced the patient had been checked at 8:44 AM and not again until 11:04 AM.</p> <p>B. A hemodialysis treatment flow sheet dated 8-19-15 evidenced the patient had been checked at 9:10 AM and not again unit 10:18 AM.</p> <p>C. A hemodialysis treatment flow</p>			

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	<p>sheet dated 8-21-15 evidenced the patient had been checked at 8:43 AM and not again until 10:19 AM when the dialysis treatment had been completed.</p> <p>D. A hemodialysis treatment flow sheet dated 8-24-15 evidenced the patient had been checked at 8:39 AM and not again until 10:41 AM.</p> <p>E. A hemodialysis treatment flow sheet dated 9-4-15 evidenced the patient had been checked at 9:00 AM and not again until 10:28 AM when the dialysis treatment had been completed.</p> <p>F. A hemodialysis treatment flow sheet dated 9-9-15 evidenced the patient had been checked at 10:05 AM and not again until 11:08 AM.</p> <p>4. Clinical record number 4 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-28-15 evidenced the patient had been checked at 2:00 PM and not again until 2:57 PM.</p> <p>B. A hemodialysis treatment flow sheet dated 9-4-15 evidenced the patient had been checked at 12:36 PM and not again unit 1:30 PM.</p>						

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V 0540 Bldg. 00	<p>C. A hemodialysis treatment flow sheet dated 9-9-15 evidenced the patient had been checked at 12:08 PM and not again until 1:04 PM. The flow sheet evidenced the patient had been checked at 2:31 PM and not again until 3:31 PM.</p> <p>5. The clinic manager stated, on 9-15-15 at 10:50 AM, "Patients are to be checked every 30 minutes or less while on dialysis."</p> <p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on record review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure it had provided the necessary care and services to manage the patient's blood pressure in 1 of 4 total records reviewed (See V 543); by failing to ensure it had maintained the appropriate and prescribed dose of dialysis in 2 of 4 total records reviewed (See V 544); by failing to ensure staff had provided pre-treatment access care in accordance with facility policy in 1 of 2 access of arteriovenous fistula (AVF) initiation of dialysis observations completed (See V 550); and by failing to</p>	V 0540	This Condition deficiency V Tag will be addressed with detailed plans of correction under the standard V Tags: V543, V544, V550 & V559.	10/16/2015

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V 0543 Bldg. 00	<p>ensure reasons for not achieving desired goals had been identified and documented and that plans of care had been updated to address any identified reasons in 2 of 4 total records reviewed (See V 559).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.90 Patient Plan of Care.</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on record review and interview, the facility failed to ensure it had provided the necessary care and services to manage the patient's blood pressure in 1 (# 2) of 4 total records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 2 failed to evidence the facility had provided the necessary care and services to manage the patient's intradialytic (during the treatment) blood pressure.</p> <p>A. A hemodialysis treatment flow</p>	V 0543	<p>V543: The Director of Operations will in-service all staff including all members of the IDT by 10/16/15 on DSI Policy & Procedures # 300-24: Monitoring during Treatment, #400-15: Hypertension & #600-12: Plan of Care. The in-service will include but not be limited to the following: The plan of care must address, but not be limited to the dose of dialysis (including volume management and blood pressure control); Report to the nurse in charge B/P greater than 200 mmHg systolic and >90 mmHg diastolic, <80 mmHg systolic or any significant change or trends & Hypertension will be marked on the patient's flow sheet under adverse events for evaluation of the patient's response to antihypertensives over time. The Clinic Manager will audit a random 25% of all patient flowsheets including clinical record #2 daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then quarterly as per the QM Workbook Flowsheet audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all</p>	10/16/2015

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	<p>sheet dated 8-17-15 evidenced the blood pressure readings had ranged from 172/96 to 181/96.</p> <p>B. A hemodialysis treatment flow sheet dated 8-19-15 evidenced the blood pressure readings had ranged from 170/97 to 213/78.</p> <p>C. A hemodialysis treatment flow sheet dated 8-21-15 evidenced the blood pressure readings had ranged from 198/112 to 211/109.</p> <p>D. A hemodialysis treatment flow sheet dated 8-24-15 evidenced the blood pressure readings had ranged from 192/113 to 205/100.</p> <p>E. A hemodialysis treatment flow sheet dated 8-28-15 evidenced the blood pressure readings had ranged from 174/99 to 208/103.</p> <p>F. A hemodialysis treatment flow sheet dated 8-31-15 evidenced the blood pressure readings had ranged from 186/94 to 201/109.</p> <p>G. A hemodialysis treatment flow sheet dated 9-4-15 evidenced the blood pressure readings had ranged from 197/108 to 213/113.</p>		education, disciplinary action and audit results in the monthly QAPI & LGB meetings.				

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V 0544 Bldg. 00	<p>H. A hemodialysis treatment flow sheet dated 9-9-15 evidenced the blood pressure readings had ranged from 175/111 to 196/119.</p> <p>I. A hemodialysis treatment flow sheet dated 9-11-15 evidenced the blood pressure readings had ranged from 178/109 to 202/112.</p> <p>J. A hemodialysis treatment flow sheet dated 9-14-15 evidenced the blood pressure readings had ranged from 178/99 to 200/103.</p> <p>2. The clinic manager was unable to provide any additional documentation and/or information when asked on 9-15-15 at 4:20 PM.</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review and interview, the facility failed to ensure it had maintained the appropriate and prescribed dose of dialysis in 2 (#s 1 and 4) of 4 total records reviewed.</p> <p>The findings include:</p>	V 0544	<p>V544: The Clinic Manager in-serviced all staff including Employee L on 09/24/2015 on DSI Chronic Hemodialysis Potassium protocol, DSI Policy & Procedures # 300-82: Patient Verification & #600-12: Plan of Care. The in-service will include but not be limited to the following: The plan of care must address, but not be limited to the dose of dialysis; Only the MD/PA/NP can order nonstandard potassium Dialysate; the standard concentration for potassium is 2.0 mEq K/L; a dialysate concentration of 1K is to be used if the patient's serum potassium level is 6.0 or greater; Two staff members must verify patient</p>	10/16/2015			

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	<p>1. Clinical record number 1 included physician orders dated 9-4-15 that identified a 1K (potassium) 2.5 Ca (calcium) concentrate bath had been prescribed. The orders had been entered into the computer by a licensed practical nurse, employee L. The orders failed to evidence a physician's signature. The orders state, "This document has been sent for signature, but has not yet been reviewed."</p> <p>A. The facility's undated "Chronic Hemodialysis Potassium Protocol" states that the standard concentration for potassium is 2.0 mEq K/L (milliequivalents potassium per liter). The protocol identifies a 1K concentration is to be used if the patient's serum potassium level is 6.0 or greater.</p> <p>B. The record included laboratory results that evidenced the patient's serum potassium level was 5.4 mEq/L on 8-17-15 and 4.0 mEq/L on 9-9-15. The record failed to evidence the patient's serum potassium level had ever been 6.0 or greater.</p> <p>C. The record included a hospital history and physical dated 5-4-15 that identifies the patient has "congestive heart failure with systolic dysfunction . . . aortic valve replacement."</p>		<p>treatment orders prior to initiation of treatment which includes verifying the dialysate bath corresponds with patient's orders. . All staff members given copy of protocol and documented understanding with signatures on continuous education logs. The Clinic Manager will audit 10% of all patient flowsheets including clinical records #1 & #4 daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then quarterly as per the QM Workbook Flowsheet audit schedule. The Clinic Manager or designee will monitor for any dialysate bath order changes daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then quarterly as per the QM Workbook audit schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB meetings</p>	

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NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
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	<p>D. The record included a physician hospital note dated 8-7-15 that identifies the patient has "chronic bacterial endocarditis (a serious inflammation/infection of one of the heart valves).</p> <p>E. The clinic manager stated, on 9-15-15 at 12:30 PM, "I am glad you asked [for the potassium laboratory values]. Based on the current lab values, the bath is being changed to a 2K bath. The 1K bath order did not follow the protocol."</p> <p>The clinic manager stated, on 9-16-15 at 8:05 AM, "I investigated the 1K situation. It was a mistake. It never should have been changed to a 1K bath, especially with the patient's cardiac issues."</p> <p>2. On 9-14-15 at 2:20 PM, observation noted patient number 4 being dialyzed on a 3K 2.5 Ca concentrate bath. Clinical record number 4 included physician orders dated 9-10-15 that state, "Concentrations: K: 3 meq/L, Ca: 2.25 meq/L."</p> <p>The clinic manager indicated, on 9-16-15 at 11:45 AM, the facility does not have a 3K 2.25 Ca concentrate in the</p>			

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V 0550 Bldg. 00	<p>building. The manager stated, "The order must have been entered into the computer wrong."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS</p> <p>The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff had provided pre-treatment access care in accordance with facility policy in 1 (# 2) of 2 access of arteriovenous fistula (AVF) initiation of dialysis observations completed.</p> <p>The findings include:</p> <p>1. Employee I, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 5 using an AVF on 9-16-15 at 9:50 AM (observation number 2). Observation noted the patient's left upper arm was wrapped in plastic wrap and a white cream was observed through the plastic wrap. The patient indicated it was a "numbing cream."</p>	V 0550	<p>V550: The Clinic Manager in-serviced all staff including Employee I on 9/24/15 on DSI Policy & Procedure # 300-11: Cannulation with Safety Needle Device. The in-service included but was not limited to the following: Ask patient if they have washed their access. If not, encourage patient to wash their access and assist as needed which decreases bacteria on the skin; Prior to treatment confirm access patency by palpating access for thrill and auscultating access for bruit; Notify the nurse in charge if thrill or bruits are absent. The Clinic Manager or designee will perform Infection Control-Staff Audit daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then bi-monthly as per QM Workbook audit schedule.</p> <p>Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>	10/16/2015

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V 0559 Bldg. 00	<p>A. The PCT was observed to remove the plastic wrap and wipe the cream from the patient's arm using a dry 2 x 2 gauze. The PCT was not observed to wash the skin over the access site with soap and water prior to applying the antiseptic to the skin in preparation for inserting the needles.</p> <p>B. The PCT was not observed to evaluate the access by listening prior to preparing the needle insertion sites.</p> <p>2. The clinic manager indicated, on 9-16-15 at 11:45 AM, the PCT had not prepared the skin over the access site or assessed the access site in accordance with facility policy.</p> <p>3. The facility's 5-1-15 "Cannulation with Safety Needle Device" policy/procedure number 300-11 states, "Ask patient if they have washed their access. If not, encourage patient to wash their access and assist as needed. Decreases bacteria on skin . . . Confirm access site patency . . . Assess bruit [a sound heard over a vascular channel]. Bruit should be assessed routinely by auscultating [listening to] access site."</p> <p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p>			

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	<p>If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition;</p> <p>(ii) Document in the record the reasons why the patient was unable to achieve the goals; and</p> <p>(iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.</p> <p>Based on record review and interview, the facility failed to ensure reasons for not achieving desired goals had been identified and documented and that plans of care had been updated to address any identified reasons in 2 (#s 1 and 2) of 4 total records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 1 failed to evidence the reasons for the patient's inability to reach the physician ordered estimated dry weight (EDW) had been identified and addressed with plan of care changes. The record included multiple EDW changes but failed to include an investigation into the reasons why the patient was unable to achieve the EDW as ordered by the physician.</p> <p>A. The record included a hemodialysis treatment flow sheet dated</p>	V 0559	V559: The Director of Operations will in-service all staff including all members of the IDT by 10/16/15 on DSI Policy & Procedures #200-02: Against Medical Advice (AMA), #300-56: Post-assessment and Data Collection & #600-12: Plan of Care. The in-service will include but not be limited to the following: If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals; When a patient is unable to achieve the desired outcomes, the team must adjust the plan of care to reflect the patient's current condition, document in the medical record the reasons why the patient was unable to achieve the goals & implement plan of care changes to address the issues identified; Deviation of 1kg or more from the current treatment target	10/16/2015	

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	<p>8-24-15 that evidenced the patient's weight at the end of the treatment was 135.6 kilograms (kg). The record included a physician's order dated 8-24-15 that identified the desired weight at the end of the treatment (EDW) was 132.5 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 8-26-15 evidenced the patient's weight at the end of the treatment was 136.4 kg. The record included a physician order dated 8-26-15 that had increased the EDW to 135 kg.</p> <p>C. A hemodialysis treatment flow sheet dated 8-31-15 evidenced the patient's weight at the end of the treatment was 139.7 kg and a flow sheet dated 9-2-15 evidenced the patient's weight at the end of the treatment was 136.9. The record included a physician order dated 9-2-15 that increased the EDW to 136 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 9-7-15 evidenced the patient's weight at the end of the treatment was 139.7 kg and a flow sheet dated 9-9-15 evidenced the patient's weight at the end of the treatment was 138.2 kg.. The record included a physician order dated 9-9-15 that increased the EDW to 137 kg.</p>		<p>weight should be reported to the nurse in charge; If a patient requests to shorten his/her dialysis treatment, he/she should be encouraged to complete their entire dialysis treatment with a full explanation provided of not only the benefits of completing the dialysis treatment, but the risks associated with early termination; The Nephrologist will be notified of a patient signing off dialysis treatments earlier than ordered treatment time; documentation will include how long the patient dialyzed, what their current prescription is, what counseling was given, what physician was notified and the patient's response; the Nephrologist is responsible for regular assessment of the non-compliant patient, evidenced by written updates or progress notes. #1: The plan of care for clinical record #1 will be updated to address the patient's inability to reach their EDW & will include documentation of an investigation as to why the patient is unable to reach their EDW & actions taken. #2: The plan of care for clinical record #2 will be updated to address the reasons for the patient's inability to stay for entire ordered treatment & actions taken. The Clinic Manager will audit 10% of all patient charts for updates to POC when expected outcome is not</p>		

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	<p>2. Clinical record number 2 failed to evidence the reasons for the patient's inability to stay for the entire dialysis treatment and adjustments to the plan of care to address any identified reasons. The record included physician orders dated 8-6-15 that identified the prescribed dialysis time as 3 hours and 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-17-15 evidenced the time on dialysis was 3 hours and 2 minutes.</p> <p>B. A hemodialysis treatment flow sheet dated 8-19-15 evidenced the time on dialysis was 3 hours and 1 minute.</p> <p>C. A hemodialysis treatment flow sheet dated 8-21-15 evidenced the time on dialysis was 1 hour and 49 minutes.</p> <p>D. A hemodialysis treatment flow sheet dated 8-24-15 evidenced the time on dialysis was 2 hours and 12 minutes.</p> <p>E. A hemodialysis treatment flow sheet dated 8-28-15 evidenced the time on dialysis was 3 hours and 5 minutes.</p> <p>F. A hemodialysis treatment flow sheet dated 8-31-15 evidenced the time on dialysis was 2 hours and 2 minutes.</p>		<p>achieved including clinical records #1 & #2 daily X 2 weeks or until 100% compliance is noted and then weekly X 2, monthly X 2 and then quarterly as per the QM Workbook Medical Records/PEARL. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. Clinic Manager or designee will review all education, disciplinary action and audit results in the monthly QAPI & LGB meetings.</p>				

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V 0638 Bldg. 00	<p>G. A hemodialysis treatment flow sheet dated 9-4-15 evidenced the time on dialysis was 2 hours and 5 minutes.</p> <p>H. A hemodialysis treatment flow sheet dated 9-9-15 evidenced the time on dialysis was 2 hours and 57 minutes.</p> <p>I. A hemodialysis treatment flow sheet dated 9-11-15 evidenced the time on dialysis was 2 hours and 3 minutes.</p> <p>J. A hemodialysis treatment flow sheet dated 9-14-15 evidenced the time on dialysis was 2 hours and 4 minutes.</p> <p>3. The clinic manager was unable to provide any additional documentation and/or information when asked on 9-15-15 at 4:20 PM.</p> <p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. Based on record review and interview, the facility failed to ensure an analysis of root causes and updates to the performance improvement plans had been implemented to address a continued failure to reach facility goals in 3 (June,</p>	V 0638	<p>V638 The Director of Operations will in-service all members of the QAPI committee by 10/16/15 on DSI Policy & Procedures # 900-01: Quality Assessment and Performance Improvement Program (QAPI). The in-service will include but not be limited to the following: To identify opportunities for improvement and track progress the IDT must review aggregate patient data, identify any commonalities (root cause analysis)</p>	10/16/2015			

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	<p>July, and August 2015) of 3 months reviewed.</p> <p>The findings include:</p> <p>1. The facility's administrative records included "QAPI [quality assessment performance improvement] Meeting Minutes" dated 6-25-15, 7-30-15, and 8-20-15. The meeting minutes evidenced a decrease in the percentage of patients to attain the facility goal of an albumin level of greater than or equal to 3.8. The 6-25-15 meeting minutes evidenced the percentage of patients to attain the facility goal of an albumin of greater than or equal to 3.8 was 57%. Meeting minutes dated 7-30-15 evidenced the percentage of patients to reach the facility goal was 46%. Meeting minutes dated 8-20-15 evidenced the percentage of patients to reach the facility goal was 42%.</p> <p>A. The administrative records included a "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 6-25-15. The plan identified "probable causes" as "inadequate intake, non-compliance with supplements, new patient(s)" and "contributing factors" as "low income, lack of education, infection, hospitalization." The "action</p>		<p>among patients who do not reach the minimum expected targets, develop a plan to address those causes, implement the plan, monitor the effectiveness of the plan & adjust portions of the plan that are not successful & QAPI meeting minutes will include documentation addressing all of the above. The Director of Operations or designee will review all QAPI meeting minutes & action plans to ensure documentation of root cause analysis & updates to action plans monthly X 3 or until 100% compliance achieved. The Clinic Manager or designee will review all education and audit results in the monthly QAPI & LGB meetings.</p>	

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	<p>recommended." included an evaluation of new patients for nutritional status, education and reinforcement of importance of supplements, and education of staff on protein sources and how to educate patients.</p> <p>B. A "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 7-30-15 included the same probable causes, contributing factors, and recommended actions as the 6-25-15 action plan.</p> <p>C. A "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 8-20-15 also included the same probable causes, contributing factors, and recommended actions as the 6-25-15 action plan.</p> <p>2. The facility's administrative records included "QAPI Meeting Minutes" dated 6-25-15, 7-30-15, and 8-20-15. The meeting minutes evidenced a decrease in the percentage of patients to attain the facility adequacy goal of a Kt/V of greater than or equal to 1.2. The 6-25-15 meeting minutes evidenced the percentage of patients to meet the facility's adequacy goal of a Kt/V of 1.2 was 96%. The 7-30-15 meeting minutes evidenced 92% of the patients had attained the facility goal. The 8-20-15</p>			

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	<p>evidenced only 82% of the patients had attained the facility goal.</p> <p>A. The administrative records included a "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 6-25-15. The plan failed to identify an investigation of the root cause of the problem had been completed. The plan included "implement adequacy improvement plan, use of adequacy protocol, use of factors effecting [sic] adequacy, heparin protocol, access improvement plan, identify specific patients and patient leading needs leading to missing treatments and hospitalizations, draw up pt contracts and meet with outliers to review contracts."</p> <p>B. A "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 7-30-15 failed to include an investigation of the root causes and included the same recommended actions as the 6-25-15 action plan.</p> <p>C. A "Quality Assurance Performance Improvement Action Plan" signed by the medical director on 8-20-15 failed to include an investigation of the root causes and also included the same recommended actions as the 6-25-15</p>			

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	<p>action plan.</p> <p>3. The clinic manager indicated, on 9-16-15 at 1:30 PM, the action plans had not been updated and changes implemented when the goals had not been reached. The manager indicated the root cause for the decrease in the percentage of patients not meeting the facility's adequacy goal had been determined to be "missed treatments."</p>				