

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0000 Bldg. 00	<p>This was a revisit for the Federal ESRD [CORE] recertification survey conducted on 9-14-15, 9-15-15, and 9-16-15.</p> <p>Survey Date: 10-28-15</p> <p>Facility #: 004844</p> <p>Medicare Provider # 15-2604</p> <p>Medicaid Vendor #: 200881690</p> <p>Census: 24 incenter, no home program</p> <p>DSI Daleville Davis Dialysis continues to be out of compliance with the Condition for Coverage 42 CFR 494.90 Patient Plan of Care.</p>	V 0000	The DSI Governing Body, Senior Operations Management and the DSI Daleville Local Governing Body accepts responsibility for the management of the facility for the provision of all dialysis services required by the facility including but not limited to fiscal operations, allocation of necessary staff and other resources for the facilities'QAPI program to address on-going issues that threaten the health and safety of the patients. Additional responsibilities include ensuring that the clinic conforms to all applicable federal, state and local laws and regulations.	
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 record review, observation, and interview, the facility failed to ensure staff had changed gloves and cleansed hands in accordance with facility policy in 2 (#s 1 and 3) of 3 hand hygiene observations completed.</p>	V 0113	Regional Vice President (RVP) of Operations or designee will in-service all staff including Employees B (RN) & C (PCT) regarding DSI Policy & Procedures (P&P) 500-06: Medication Administration; 800-01: Dialysis Infection Control Precautions; 500-28: Hand Hygiene; 800-10: Blood Borne Pathogens (BBP); 800-13: PPE; 500-01: Administration of IV	11/28/2015

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.

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>The findings include:</p> <ol style="list-style-type: none"> 1. Employee B, a registered nurse (RN), was observed to administer intravenous Zemplar (Vitamin D) to patient number 8 on 10-28-15 at 9:55 AM (observation number 1). The RN was observed to prepare the medication, touching the syringes, the medication vial, the alcohol prep pad, the label, and a pen in the process. The RN took the medication to the dialysis station. The RN donned clean gloves without cleansing her hands and administered the medication. 2. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 10 using an arteriovenous fistula (AVF) on 10-28-15 at 9:50 AM (observation number 3). The PCT evaluated the access by listening with a stethoscope. The PCT was not observed to change her gloves and cleanse her hands prior to applying antiseptic to the needle insertion sites. 3. The Clinic Manager stated, on 10-28-15 at 10:15 AM, "We have been having inservices and I have been completing infection control audits." 4. The facility's 5-1-15 "Dialysis Infection Control Precautions" 		<p>Medications via Bolus/Drip/Infusion Pump; 300-11: Cannulation With Safety Needle Device by 11/23/15. In-service will include but not limited to: hand hygiene will be performed between glove changes; after removing gloves; before having direct contact with patients; after direct contact with potentially contaminated surfaces/patients/ supplies with non-gloved hands; glove changes and hygiene will occur when touching potentially contaminated items or surfaces; after evaluating the access with a stethoscope and prior to cleansing access insertion sites. Director of Operations (DO) or designee will monitor all staff for infection control practices daily x 4 weeks or until 100% compliance is established, weekly x 8 then monthly per the Quality Management (QM) Workbook Infection Control Staff audit schedule. Any staff found not to be in compliance will be subject to progressive disciplinary action. RVP or designee will review all monitoring daily x 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 3. Director of Operations (DO) or designee will review all education, audit results & disciplinary action in the monthly QAPI meetings & weekly LGB meetings until deficiencies are cleared.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>policy/procedure number 800-01 reads, "All healthcare workers in the dialysis setting must follow Dialysis Precautions. Dialysis Precautions, recommended by the CDC, includes both Standard Precautions and Universal Precautions . . . Hand hygiene is required after every direct contact with a patient, between patient contacts, even if the contact is casual and when un-gloved hands have touched a potentially contaminated surface."</p> <p>4. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/28/2015	
NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334			
(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			
V 0122 Bldg. 00	<p>contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the</p>	V 0122	RVP or designee will in-service all staff including Employee M (PCT) regarding DSI P&P 300-14: Cleaning the External	11/28/2015			

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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 station had been cleaned and disinfected in accordance with facility policy in 1 (#1) of 1 cleaning and disinfection of the dialysis station observation completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Employee M, a patient care technician (PCT), was observed to clean the dialysis machine and chair at station number 10 on 10-28-15 at 9:40 AM. The employee was not observed to clean the left side of the machine or the prime waste container. The employee was observed to use the same cloth to clean both the dialysis machine and the dialysis chair. The employee was not observed to open the sides of the chair to clean the inside of the chair arms. The employee was not observed to clean the external sides of the chair. The Clinic Manager stated, on 10-28-15 at 10:15 AM, "We have been having inservices and I have been completing infection control audits." The facility's 5-1-15 "Dialysis Infection Control Precautions" policy/procedure number 800-01 reads, "Clean and disinfect the treatment station . . . Disinfect the front, top, and sides of 		<p>Machine & Surrounding Areas; 800-10: BBP; 800-01: Dialysis Infection Control Precautions by 11/23/15. The in-service will include but not limited to: Disinfection of the machine will include but not limited to the front, top and sides; a separate bleach moistened wipe(s) will be used for machine & chair; prime waste bucket will be disinfected internally & externally with a 1:100 bleach moistened wipe before returning to the clean machine; the chair will be cleaned with a separate bleach moistened wipe beginning at the top and finishing at the bottom; the chair will be placed in a reclining position to clean; the external sides of the chair will be cleaned as well as the inside of the arms by swinging the chair arms out. DO or designee will monitor infection control practices daily x 4 weeks or until 100% compliance is established, weekly x 8 then per the QM Workbook Infection Control Staff audit schedule. Any staff found not to be in compliance will be subject to progressive disciplinary action. RVP or designee will review all monitoring daily x 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 3. Director of Operations (DO) or designee will review all education, audit results & disciplinary action in the monthly QAPI meetings & weekly LGB meetings until deficiencies are cleared.</p>	

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0407 Bldg. 00	<p>the dialysis machine . . . Disinfect the prime bucket internally and externally with a 1:100 bleach moistened wipe before returning the prime bucket to the machine."</p> <p>4. The facility's 5-1-15 "Cleaning the External Machine & Surrounding Areas" policy/procedure number 300-14 reads, "Clean chair/bed beginning at the top and finishing at the bottom . . . Place chair in reclining position to clean. Swing chair arms out (if applicable) to clean seat, footrest, backrest sides, inside of chair arms and chair frame."</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 record review and interview, the facility failed to ensure patients had been monitored at least every 30 minutes in accordance with facility policy in 4 (#s 2, 7, 8, and 9) of 4 records reviewed.</p> <p>The findings include:</p> <p>1. The facility's 6-1-14 "Monitoring During Treatment" policy/procedure number 300-24 states, "Patient will be observed at least every 30 minutes . .</p>	V 0407	RVP or designee will in-service all staff regarding DSI P&P 300-24: Monitoring During Patient Treatment by 11/23/15. In-service will include but not limited to: all patients will be monitored at least every 30 minutes or more often per the patient's needs during the dialysis treatment as evidenced by documentation on the patient flowsheet. DO or designee will monitor all patient's treatment flowsheets including patient clinical record #2, #7, #8 & #9 daily x 4 weeks or until 100% compliance has been established,	11/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334		
(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>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 filter . . . Verify air detector is armed at all times."</p> <p>2. Clinical record number 2 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A hemodialysis treatment flow sheet dated 10-19-15 evidenced the patient had been monitored at 8:52 AM and not again until 10:04 AM.</p> <p>3. Clinical record number 7 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 10-21-15 evidenced the</p>		<p>weekly x 8, monthly x 2, then per the QM Workbook Flowsheet audit schedule. Any staff found not to be in compliance will be subject to progressive disciplinary action. RVP or designee will review all monitoring daily x 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 2. Director of Operations (DO) or designee will review all education, audit results & disciplinary action in the monthly QAPI meetings & weekly LGB meetings until deficiencies are cleared.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>patient had been monitored at 10:30 AM and not again until 11:35 AM.</p> <p>B. A hemodialysis treatment flow sheet dated 10-23-15 evidenced the patient had been monitored at 10:30 AM and not again until 11:27 AM.</p> <p>4. Clinical record number 8 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 10-16-15 evidenced the patient had been monitored at 9:53 AM and not again until 10:42 AM.</p> <p>B. A hemodialysis treatment flow sheet dated 10-19-15 evidenced the patient had been monitored at 10:00 AM and not again until 10:47 AM.</p> <p>5. Clinical record number 9 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 10-16-15 evidenced the patient had been monitored at 7:30 AM and not again until 8:16 AM.</p> <p>B. A hemodialysis treatment flow sheet dated 10-19-15 evidenced the patient had been monitored at 9:09 AM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0540 Bldg. 00	<p>and not again until 9:55 AM.</p> <p>6. The clinic manager was unable to provide any additional documentation and/or information when asked on 10-28-15 at 11:45 AM.</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 1 total record reviewed of patients with elevated intradialytic blood pressures (See V 543); by failing to ensure staff had provided pre-treatment access care in accordance with facility policy in 1 of 1 access of arteriovenous fistula (AVF) initiation of dialysis observations completed (See V 550); and by failing 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 1 of 1 record reviewed of patients with elevated intradialytic blood pressures (See V 559).</p>	V 0540	The Condition Vtag will be addressed with detailed plans of correction under each of the standard vtags: V543; V550; V559	11/28/2015

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0543 Bldg. 00	<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. The record included physician orders dated 10-21-15 that read, "Patient Alert Limits: . . . Systolic High BP [blood pressure] 200 mmHG [millimeters of mercury] . . . Diastolic High BP: 110 mmHG."</p> <p>A. A hemodialysis treatment flow sheet dated 10-19-15 evidenced the</p>	V 0543	<p>RVP or designee will in-service all staff including all members of the IDT regarding DSI P&P 300-82: Patient Verification; 300-02: Pre-assessment & Data Collection; 300-24: Monitoring During Patient Treatment; 300-56: Post-assessment & Data Collection; 400-15: Hypertension; 600-12: POC; 600-05: Medical Records General Requirements by 11/23/15. In-service will include but not limited to: 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 flowsheet under adverse events for evaluation of the patient response to</p>	11/28/2015

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 10/28/2015	
NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334			
(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>patient's blood pressure had ranged from 170/92 to 187/110 during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 10-21-15 evidenced the patient's blood pressure had ranged from 183/92 to 214/127 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>C. A hemodialysis treatment flow sheet dated 10-23-15 evidenced the patient's blood pressure had ranged from 169/80 to 201/138 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>D. A hemodialysis treatment flow sheet dated 10-26-15 evidenced the patient's blood pressure had ranged from 177/101 to 220/112 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>2. The clinic manager was unable to provide any additional documentation and/or information when asked on 10-28-15 at 11:45 AM.</p>		<p>antihypertensives over time; individual patient treatment prescriptions will be followed per current physician orders. The Plan of Care for clinical record #2 will be updated to address the patient's elevated intradialytic blood pressure and will include documentation of investigation as to why the patient's BP is elevated and inability to achieve BP control. DO or designee will audit all patient's flowsheets including clinical record #2 daily X 4 weeks or until 100% compliance is established, weekly X 8, monthly x 2, then per the QM Workbook Flowsheet audit schedule. Any staff found not to be in compliance will be subject to progressive disciplinary action. RVP or designee will review all monitoring daily x 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 2. Director of Operations (DO) or designee will review all education, audit results & disciplinary action in the monthly QAPI meetings & weekly LGB meetings until deficiencies are cleared.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0550 Bldg. 00	<p>3. The facility's 2-1-07 "Hypertension" policy/procedure number 400-15 reads, "If the diastolic blood pressure is greater than 110 mm/Hg after one hour of treatment, the physician will be notified . . . Hypertensive patients will have their B/P monitored every 15 minutes until diastolic B/P falls below 110 mm/Hg . . . Every effort will be made to identify and correct the cause of the patients hypertension."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on record review, observation, and interview, the facility failed to ensure pre-treatment access care had been provided in accordance with facility policy in 1 (#1) of 1 access of arteriovenous fistula (AVF) for initiation of dialysis observations completed.</p> <p>The findings include:</p>	V 0550	RVP or designee will in-service all staff including Employee C regarding DSI P&P 300-11: Cannulation with Safety Needle Device; 800-01: Dialysis Infection Control Precautions; 800-28: Hand Hygiene by 11/23/15. In-service will include but not limited to: 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 bruit is	11/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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. Employee C, a patient care technician (PCT), was observed to access the AVF of patient number 10 on 10-28-15 at 9:50 AM (observation number 1). The PCT was not observed to wash the skin over the access with soap and water, or ask the patient if the patient had washed the skin over the access, prior to preparing to initiate the treatment. The patient indicated the patient had not washed the skin over the access upon arrival to the facility. The patient stated, "I take a shower in the mornings."</p> <p>The PCT was not observed to evaluate the access by palpation (examination by touch) prior to initiating the treatment.</p> <p>2. The Clinic Manager stated, on 10-28-15 at 10:15 AM, "We have been having inservices and I have been completing infection control audits."</p> <p>3. The facility's 5-1-15 "Cannulation with Safety Needle Device" policy/procedure number 300-11 reads, "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. Feel access for thrill . . . Thrill is palpated over the access site. Strong pulse should be felt."</p>		<p>absent.</p> <p>Patient education for all patients with a AVF/AVG including patient #10 will be completed by 11/28/15 regarding the importance of washing the access site prior to treatment.</p> <p>DO or designee will perform Infection Control-Staff Audit daily X 4 weeks or until 100% compliance is established, weekly X 8, monthly x 2 then per the QM Workbook audit schedule.</p> <p>RVP or designee will review all monitoring dailyx 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 2.</p> <p>Any staff found not to be in compliance will be subject to progressive disciplinary action.</p> <p>DO or designee will review all education, disciplinary action and audit results in the monthly QAPI & weekly LGB meetings until deficiencies are cleared.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
--------------------	--	---------------	---	----------------------

V 0559 Bldg. 00	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <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; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (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 elevated intradialytic (during the treatment) blood pressures had been identified and the plan of care had been adjusted to address any identified reasons in 1 (#2) of 1 record reviewed of patients with elevated intradialytic blood pressures.</p> <p>The findings include:</p> <p>1. Clinical record number 2 failed to evidence the interdisciplinary team had investigated to identify any reasons for elevated intradialytic blood pressures or had implemented changes to the plan of care to address the elevated intradialytic blood pressures.</p>	V 0559	<p>RVP or designee will in-service all staff including all members of the IDT by 11/23/15 regarding DSI P&P 300-56: Post-assessment and Data Collection; 300-24: Monitoring During Patient Treatment; 300-02: Pre-assessment and Data Collection; 600-12: Plan of Care. In-service will include but not limited to: 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 patientcurrent 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; Report to the</p>	11/28/2015
------------------------	---	--------	---	------------

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>A. A hemodialysis treatment flow sheet dated 10-19-15 evidenced the patient's blood pressure had ranged from 170/92 to 187/110 during the treatment.</p> <p>B. A hemodialysis treatment flow sheet dated 10-21-15 evidenced the patient's blood pressure had ranged from 183/92 to 214/127 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>C. A hemodialysis treatment flow sheet dated 10-23-15 evidenced the patient's blood pressure had ranged from 169/80 to 201/138 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>D. A hemodialysis treatment flow sheet dated 10-26-15 evidenced the patient's blood pressure had ranged from 177/101 to 220/112 during the treatment. The flow sheet failed to evidence the physician had been notified and that the patient's blood pressure had been monitored every 15 minutes.</p> <p>2. The clinic manager stated, on 10-28-15 at 11:00 AM, "We have not met</p>		<p>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. #1. The Plan of Care for clinical record #2 will be updated to address the patient's elevated intradialytic blood pressure and will include documentation of investigation as to why the patient's BP is elevated and inability to achieve BP control. DO or designee will audit all patients medical record including clinical record #2 for updates to the POC when the expected outcomes are not achieved for BP control by 11/28/15. IDT/POCs will be updated for any patients found to not meet expected outcomes. DO or designee will audit all patient flowsheets including clinical record #2 daily X 4 weeks or until 100% compliance is established, weekly X 8, monthly x 2 then per the QM Workbook Flowsheet audit schedule. DO or designee will audit all IDT/POCs monthly x 4 regarding documentation of updated IDT/POCs for any outcomes that are not being achieved. RVP or designee will review all monitoring daily x 4 weeks or until 100% compliance is established, weekly x 8 weeks then monthly x 2. Any staff found</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>yet to discuss the plan of care. It will be discussed at tomorrow's [10-29-15] meeting. I told the medical social worker to write a note about the patient's meds."</p> <p>3. The record included a medical social services note, signed and dated by employee F, the medical social worker, on 10-21-15 at 11:42 AM. The note reads, "Spoke to pt's [spouse] on the phone today. Asked about pt's meds per pt concern of saying could not get med? [Spouse] reports pt was on an antibiotic and that [the patient] got it fine and is no longer talking [sic] it as it is not needed. [The spouse] reports '[the patient] gets all meds from the va and may be confused at times.' [the spouse] does not report any concern of pt's meds."</p> <p>4. The facility's 6-1-14 "Plan of Care" policy/procedure number 600-12 reads, "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: a. Adjust the plan of care to reflect the patient's current condition. b. Document in the medical record the reasons why the patient was unable to achieve the goals. c. Implement plan of care changes to address the issues identified. If the current plan of care has</p>		<p>not to be in compliance will be subject to progressive disciplinary action. DO or designee will review all education, disciplinary action and audit results in the monthly QAPI & weekly LGB meetings until deficiencies are cleared.</p>	

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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
V 0638 Bldg. 00	<p>not been successful in achieving the goals within the identified there [sic] must be evidence that barriers to achievement of the goals were identified and that the plan of care was reviewed and revised."</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, 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</p>	V 0638	<p>All members of the QAPI committee met on 10/29/15 & 11/19/15. Action plans were updated & root cause analysis were completed for all areas not meeting goals. RVP or designee will in-service all members of the QAPI committee by 11/28/15 on DSI P&P 900-01: Quality Assessment and Performance Improvement Program (QAPI); 900-03: DSI's Outcomes Measurement, Monitoring & Management Program. In-service will include but not limited to: To identify opportunities for improvement and track progress the IDT must review aggregate patient data, identify any commonalities (root cause analysis) 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 including albumin & adequacy. RVP or designee will monitor RCA, action plans, outcomes & QAPI meeting minutes monthly X 3 or until 100% compliance achieved, quarterly x 3 then annually as per the QM Workbook Annual QAPI audit schedule.</p>	11/28/2015

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 10/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>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 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</p>		DO or designee will review all education and audit results in the monthly QAPI & weekly LGB meetings until deficiencies are cleared.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>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 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DSI DALEVILLE DAVIS DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 14520 W DAVIS DR DALEVILLE, IN 47334
--	--

(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>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 action plan.</p> <p>3. The clinic manager indicated, on 10-28-15 at 11:30 AM, the facility had not yet held a quality assessment performance improvement committee meeting to address the failure to update the performance improvement plans for albumin and adequacy. The manager indicated the meeting would be held on 10-29-15 to review September data.</p>			