

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 07/25/2012	
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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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Survey dates: July 23, 24, and 25, 2012</p> <p>Facility #: 004844</p> <p>Medicaid Vendor #: 200070790B</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>In-center Hemodialysis 15 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 27, 2012</p>			V0000	Please see Plan of Correction for VTags below.		

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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V0501	<p>494.80 PA-IDT MEMBERS/RESPONSIBILITIES The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure patients received a comprehensive assessment in 1 of 5 records reviewed with the potential to affect all 15 patients. (#4)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 4, with a plan of care dated 3/22/12, failed to evidence a signed and dated physician assessment. 2. On 7/25/12 at 9:15 AM, the Clinical Manager, Employee A, indicated there was not a signed and dated physician assessment for this patient. 3. A policy titled "Comprehensive Patient Assessments", Policy G-59, Revised 11/11, states, "1. The 	V0501	<p>All patient charts will be audited for all IDT members signatures on IDT assessments. If any team member was found to be delinquent with signing documents in the appropriate time frame they were instructed to sign all documents immediately. Clinic Manager or designee will complete monthly chart audits X's 3 or until compliance has been established for all patients with IDT's due for those months, then per the DSI QM Workbook schedule. Anyone found not to be in compliance will face immediate disciplinary action up to and including termination. Clinic manager or designee will review all audit results in Monthly QAPI & LGB meetings.</p>	08/24/2012			

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	comprehensive patient assessment is completed by the facility's interdisciplinary team that consists of, at minimum: ... Physician treating the patient for ESRD ... "			

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V0520	<p>494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure a comprehensive reassessment was completed after a significant change in psychosocial needs in 1 of 5 patients (#1) reviewed with the potential to effect all 15 patients.</p> <p>Findings:</p> <p>1. Clinical record 1, with a plan of care for 8/25/11, failed to evidence a comprehensive reassessment after the patient was convicted of murder in January 2012 during a illegal drug buy, change of address as being incarcerated in the county jail, dietary needs being addressed in the jail, surgery and</p>	V0520	<p>All members of the IDT will be in-serviced regarding Comprehensive Patient Assessment Policy #G-59: On-going Patient Monitoring Policy #G-60. The IDT will identify needs for re-assessment and implement when the need arises per policy. Clinic Manager will communicate with the IDT team on a weekly basis regarding any problems the team have identified with the patients in order to determine needs for re-assessment. Clinic Manager or designee will complete monthly chart audits x's 3 or until compliance has been established for all patients with IDT's or deemed "unstable" that are due for those months, then per the DSI QM Workbook audit schedule. Clinic Manager or designee will review all education</p>	08/24/2012			

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	<p>treatment for prostate cancer in June 2012, subsequent house arrest for a few weeks before returning to the county jail, the spouse in and out of the relationship, and awaiting the sentencing for the conviction.</p> <p>2. A policy titled "Comprehensive Patient Assessments", Policy G-59, Revised 11/11, states, "19. The following criteria shall be used by the interdisciplinary team whenever a comprehensive patient assessment is done to determine if the patient is or has become unstable. ... Significant change in psychosocial needs "</p> <p>3. On July 24, 2012 at 3:40 PM, the Clinical Manager, Employee A, indicated she was aware of the psychosocial issues in the patients life but many of the items documented in the clinical record had not been addressed by the interdisciplinary team.</p> <p>4. On July 24, 2012 at 2:30 PM, the Social Worker, Employee B, indicated she was unaware the patient had treatment for cancer and was unaware of the reason for the house arrest being a financial decision by the county.</p>		and audits in the monthly QAPI & LGB meetings.		

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V0542	<p>494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient.</p> <p>Based on clinical record review and interview, the facility failed to ensure a signed and dated plan of care was developed for 1 of 5 patients (#2) with the potential to effect all 15 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 2, with a date of 8/15/11, failed to evidence signatures and dates by the interdisciplinary team and patient. 2. On July 25, 2012, at 9:30 AM, the Clinical Manager, Employee A, indicated the plan of care was not signed by the interdisciplinary team or the patient. 	V0542	<p>All IDT members will be in-serviced regarding Treatment Plans #G-62. All patient charts will be audited for all IDT members signatures on POC's. if any team member was found to be delinquent with signing documents in the appropriate time frame, they were instructed to sign all documents immediately. All patient charts will be audited for signed Pt. Acknowledgement POC. If any POC are found to not have been reviewed and acknowledgement signed by patient, Clinic Manager or designee will review with the patient and the Pt. Acknowledgement POC will be signed immediately. Clinic Manager or designee will complete monthly chart audits x's 3 or until compliance has been established for all patients with POC's due for those months, then per the DSI QM Workbook audit schedule. Clinic Manager or designee will review all education and audits in the monthly QAPI and LGB meetings.</p>	08/24/2012	

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on document and policy review and interview, the governing body failed to ensure policies were followed in 1 of 1 water rooms reviewed with the potential to effect all 15 patients.</p> <p>Findings:</p> <p>1. A agency document titled "Monthly Water Draw Worksheet" dated 3/1/12 evidenced the endotoxin level at action level for the Bicarb Tank/Jug Fill and Bicarb Loop Feed. The same worksheet on 4/3/2012 evidenced the endotoxin level at action level for the Bicarb Tank/Jug Fill, Bicarb Loop Feed and Bicarb Loop Return. The same worksheet on 5/1/2012 evidenced the endotoxin level at action level for the Bicarb Loop Feed and Bicarb Loop Feed. The same worksheet on 6/4/2012 evidenced the endotoxin level at action level for the Bicarb Tank/Jug fill, Bicarb Loop Feed and Bicarb Loop Return. All dates showed later redraws with non action</p>	V0715	<p>Beginning the week of 8-6-2012 the staff will be retrained on disinfection of the bicarb system and the frequency of disinfect will be increased from 1 time per week to 2 times per week. The bicarbonate system will be cultured for four consecutive weeks until acceptable results are obtained, if results are not acceptable after the first week, the ATM will escalate the action. The ATM will monitor this weekly. The cultures from that point forward will be monitored monthly by the ATM. Atm or designee will review all education, reports, and trends during the monthly QAPI & LGB meetings. Documentation of this action will be reflected in the QAPI meeting minutes. The Medical Director and Clinic Manager will ensure that any future trends are noted and acted upon. Anyone found not to be in compliance will face immediate disciplinary action up to and including termination.</p>	08/24/2012			

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	<p>levels. All four worksheets were signed by the biomed technician, Employee C, and the Medical Director.</p> <p>2. A agency document titled "RAI Care Center Daleville Medical Director/CD Meeting" dated for April and May 2012 retrieved from the governing body binder indicated the governing body was aware of the endotoxin results and the redraws that showed the appropriate levels.</p> <p>3. A policy titled "Dialysate: Bacteria, Endotoxin & Analysis", Policy W-25, Revised 6/11, states, "10. The Medical Director and Center Director are responsible for ensuring that: ... trends toward non-compliance are noted and acted upon ...</p> <p>4. On July 25, 2012, at 3:30 PM, the Biomedical Technician, Employee C, indicated it was policy to reculture and that's where it ended for him.</p> <p>5. On July 25, 2012, at 3:30 PM, the Clinical Manager, Employee A, indicated this had been discussed but a action plan had not been put into place to stop the trend.</p>						