

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER DSI NORTHWEST INDIANAPOLIS RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6488 CORPORATE WAY INDIANAPOLIS, IN 46278		
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V000000	<p>This visit was a (CORE) ESRD federal recertification survey.</p> <p>Survey date: July 8, 9, and 10, 2013</p> <p>Facility #: 006144</p> <p>Medicaid Vendor: #201073800</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Miriam Bennett, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 15, 2013</p>	V000000	<p>The Local Governing Body of DSI Northwest Indianapolis Renal Center takes seriously its responsibility to ensure the health and safety of its patients and staff, and to ensure that patients receive dialysis and support services in a safe and sanitary environment. As such, the Governing Body met on 7/23/2013 to review the findings of the Statement of Deficiencies and further participate in the development, evaluation, and implementation of the following Plan of Correction that resulted from the 7/10/2013 recertification survey. The Local Governing Body will hold all staff accountable for following all policies and procedures. The Clinic Manager will monitor all activities on an ongoing basis, through monthly QAPI process.</p>		

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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V000113	<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 policy review, interview, and observation, the facility failed to ensure the staff followed the facility's infection control policy and procedures for infection control during 2 of 3 observations with the potential to affect all the facility's patients. (employees E and G)</p> <p>Findings include</p> <p>1. During observation on 7/8/13 at 1:25 PM, employee G, Personal Care Technician (PCT), was observed discontinuing dialysis and providing post dialysis access care for the patient with an AV Fistula at station 15. While patient was holding pressure on first site, employee G changed gloves and preceded to place patient belongings into patient's bag. Employee G failed to change gloves or use hand hygiene before discontinuing second AV site.</p> <p>2. During observation on 7/10/13 at 9:08 AM, employee E, PCT, was observed reaching under Personal Protective Equipment (PPE) gown and into scrub top</p>	V000113	<p>All in-center staff inclusive of Patient Care Technicians and Staff Nurses were in-serviced on 7/18/2013 on policies #800-01 (Dialysis Infection Control) and policy #800-28 (Hand Hygiene; Hand Washing and Hand Hygiene) Copies of policies #800-01 and #800-28 were given to all staff nurses and patient care technicians, they were in serviced on each policies contents with special emphasis placed on policy #800-28 #11 "Medications vials, patient care items including gloves, or other supplies should not be in pockets, fanny packs, or PPE" as well as #13 "A new pair of gloves must be used each time for access site care, vascular access cannulation, administration of parenteral/IV medications. Emphasis was also placed on policy #800-28 # 5. "Alcohol-Based Hand Rub section J., "after contact with objects, including equipment, located in the patient's environment". The staff was in-serviced on policies #800-01 and #800-28 and all their contents and given opportunity to ask questions. Clinic Manager or designee will monitor all staff weekly x 4 weeks or until</p>	07/18/2013	

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	<p>pocket and pulled out a mask and applied to face.</p> <p>During an interview on 7/10/13 at 9:15 AM, employee A, Facility Manager, indicated the staff are not to be reaching under PPE and into their pockets.</p> <p>3. The policy titled "Dialysis Infection Control Precautions," #800-01, revised 1/14/13 states, "11. Medication vials, patient care items including gloves, or other supplies should not be in pockets, fanny packs, or PPE. ... 13. A new pair of clean gloves must be used each time for access site care, vascular access cannulation, administration or 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 patients' blood stream to occur."</p>		<p>compliance (defined as 100%) has been established, then monthly x 4, then as per the Quality Management Workbook schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. A copy of all audits will be included with corresponding months QAPI minutes and presented to Governing Body. Effective immediately and ongoing, the daily staff nurse in charge of each daily shift will monitor (through observation) and report any incident of staff non-compliance to Clinic Manager for follow-up. Follow up is to include progressive disciplinary action, up to and including termination, for staff person's repeated non-compliance.</p>		

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V000122	<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 policy review, interview, and observation, the facility failed to ensure the staff followed the infection control policies in 2 of 3 observations of machine cleaning with the potential to affect all the agency's patients. (employees B and F)</p> <p>Findings include</p> <p>1. During observation on 7/8/13 at 1:40 PM, employee B was observed cleaning the hemodialysis machine at station #15. Employee B failed to empty the prime waste receptacle. The machine was then set up for use with same receptacle still not emptied.</p> <p>2. The policy titled "Dialysis Infection Control Precautions," #800-01, revised 1/14/13 states, "After Each Dialysis and Between Patients ... 3. Between patients, remove the prime bucket from the side of the machine and pour residual fluid into a</p>	V000122	<p>All in-center staff inclusive of Patient Care Technicians and Staff Nurses were in-serviced on 7/18/2013 on policy #800-01 (Dialysis Infection Control), #300-14 (Cleaning the External Machine & Surrounding Area), #800-01 (Dialysis Infection Control) and #300-14 (Cleaning the External Machine & Surrounding Area) & given the opportunity to ask questions. Copies of the policies were given to all staff nurses and patient care technicians, they were in serviced on each policy which included but was not limited to removal & disinfection of the prime bucket between each patient treatment and cleaning & disinfection of the treatment station at the end of each dialysis treatment. The staff was also educated on a new process of communication to be implemented immediately to ensure proper communication is used to avoid any possibility of cross contamination while staff is assisting each other in machine</p>	07/18/2013	

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	<p>designated 'dirty' sink. Disinfect the bucket with 1:100 bleach solution before returning the prime bucket to the machine."</p> <p>3. The policy titled "Cleaning the External Machine & Surrounding Areas," #300-14, revised 1/14/13 states, "4. Clean dialysis machine including prime containers."</p> <p>4. On 7/9/13 at 9:30 PM, Employee B, PCT, and Employee F, Registered Nurse (RN), were observed taking a patient off dialysis at station # 4. Employee B disconnected the patient and Employee F removed the tubing and dialyzer. Neither employee cleaned the machine before Employee B set the machine back up for the next patient.</p> <p>A. At 9:40 PM, Employee B, PCT indicated the RN had cleaned the machine.</p> <p>B. At 9:45 PM Employee F, RN indicated the PCT had cleaned the machine.</p> <p>5. A policy titled "Dialysis Infection Control Precautions", Revised 1/14/13, 800-01, states, "Cleaning, Disinfectant and the Environment 1. Clean and disinfect the treatment station at the end</p>		<p>breakdown, cleaning, and set up procedures. Effective immediately, staff will use green sticky note to communicate disinfection/cleaning has been completed when helping in change over process. If second staff member helps by cleaning another staff member's assigned machine or chair, they will place a green sticky note on that chair/machine, to ensure proper communication that disinfection has been completed. If no green sticky note present, primary staff member should assume that equipment is not been cleaned and therefore requires cleaning. Clinic Manager or designee will monitor all staff weekly x 4 weeks or until compliance (defined as 100%) has been established, then monthly x 4, then as per the Quality Management Workbook schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. A copy of all audits will be included with corresponding months QAPI minutes and presented to Governing Body. Effective immediately and ongoing, the daily staff nurse in charge of each daily shift will monitor (through observation) and report any incident of staff non-compliance to Clinic Manager for follow-up. Follow up is to include progressive disciplinary action, up to and including termination, for staff person's repeated</p>		

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	of each dialysis treatment. ... After Each dialysis and Between Patients 1. Change non-disposable linen or dispose of disposable linen (if applicable) in the appropriate waste container, depending on whether or not visibly contaminated. 2. Bleeding tubing is not reprocessed. Post dialysis, removing tubing from the machine, cap, clamp and discard the dialyzer tubing in the nearest biohazard container at the dialysis station. do not carry the tubing across the floor. 3. Between patients, remove the prime bucket from the side of the machine and pour residual fluid into a designated 'dirty' sink. ... "		non-compliance.	

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V000147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on observation and review of documents and policy, the facility failed to ensure staff followed infection control practices for discontinuation of dialysis on patient with a Central Venous Catheter</p>	V000147	All in-center staff inclusive of Patient Care Technicians and Staff Nurses were in-serviced on 7/18/2013 on policy #300-78 (Treatment Initiation & Termination: Utilizing a Catheter with TEGO Connector Caps)	07/18/2013	

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	<p>(CVC) for 1 of 3 observations with the potential to affect all the patients with a CVC. (staff B)</p> <p>Findings include</p> <ol style="list-style-type: none"> On 7/9/13 at 9:53 AM, employee B was observed discontinuing dialysis on a patient with a CVC at station #5. At 10:05 AM, employee B failed to disinfect the Tego connector of all visible blood in threads prior to placing the cap. The policy titled "Treatment Initiation & Termination: Utilizing a Catheter with TEGO Connector Caps," #300-78, revised 1/14/13 states, "1. Disinfect the TEGO using an isopropyl alcohol swab and aggressive circular motions for three seconds prior to any access of the catheter limb." The document titled "TEGO Connector Directions for Use," revised 1/14/13 states, "3) To access TEGO Connector swab female bluer with desired disinfectant in accordance with facility protocol. ... 8) For subsequent connections repeat steps three (3) through eight (8)." 		<p>along with (TEGO Connector, Directions for Use) A Copy of policy #300-78 including TEGO Directions for Use, was given to all staff nurses and patient care technicians, they were in serviced on TEGO policy inclusive of directions for use, content, with special emphasis placed on policy #300-78 #1 "Disinfect the TEGO using isopropyl alcohol swab and aggressively circular motions for 3 seconds prior to any access of the catheter limb" . Emphasis was also placed on policy TEGO Connector directions for use #3 "To access TEGO Connector swab female luer with desired disinfectant in accordance with facility protocol". The staff was in-serviced on policy #300-78 including TEGO Connector directions for use and all its contents and given opportunity to ask questions. Clinic Manager or designee will monitor all staff weekly x 4 weeks or until compliance (defined as 100%) has been established, then monthly x 4, then as per the Quality Management Workbook schedule. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. A copy of all audits will be included with corresponding months QAPI minutes and presented to Governing Body. Effective immediately and on-going, the daily staff nurse in charge of each daily shift will monitor (through</p>		

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			observation) and report any incident of staff non-compliance to Clinic Manager for follow-up. Follow up is to include progressive disciplinary action, up to and including termination, for staff person's repeated non-compliance.		

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V000544	<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 clinical record review, interview, and policy review, the facility failed to ensure the blood flow rate (BFR) was within prescribed range for 2 of 7 clinical records reviewed with the potential to affect all the facility's patients. (#3, and 5)</p> <p>Findings includes</p> <p>1. Clinical record #3 contained treatment orders on 1/2/13 for K+ Ca 2.5 dialysate with a BFR 400 for 230 minutes. The Hemodialysis Flowsheet dated 1/2/13 evidenced the BFR was between 200-315, the Arterial Pressures (AP) exceeded -250 and failed to evidence a reason for the slower rate. The record failed to evidence the nurse was notified of the AP by the technician.</p> <p>a. AP exceeded -250 at 15:30, 16:01, 16:30, 17:03, 17:26, 18:02, and 18:37 on 1/2/13.</p> <p>b. On 7/10/13 at 2:00 PM, employee A provided a DSI Dialysis Note dated</p>	V000544	<p>All in-center staff inclusive of Patient Care Technicians, Staff Nurses and Administrative Assistant were in-serviced on 7/18/2013 on policies #300-24 (Monitoring During Patient's Treatment), #600-02 (Documentation of Medical Record), #600-05 (Medical Records General), along with PEARL Manual topics (Filing out Flow Sheets) and (Flow Sheet Entry) Copies of policies #300-24, #600-02, #600-05, and PEARL Manual topics including Filing out Flow Sheet and Flow Sheet Entry were given to all staff, they were in serviced on content, with special emphasis placed on policy #300-24 #2 "Negative arterial pressure should not exceed 250mmHg (-250)", #3 "Venous pressure should not exceed 250mmHg (+250)", and "NOTE: Report anything unusual to the Charge Nurse and follow the instructions of Charge Nurse. Document all assessments, interventions and follow up/outcome in the comment section of flow sheet. Also stressed was need to chart any variations, interventions and outcome of interventions on flow</p>	07/18/2013			

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	<p>1/2/13 stating "patient was unable to run at prescribed BFR due the fact the patient had a arterial pressure greater than -260 therefore BFR had to be turned down." This note failed to evidence a time or date of entry.</p> <p>2. Clinical record #5 contained a Hemodialysis Flowsheet dated 6/14/13 with orders for K+ 2 Ca 2.5 at BFR 400 for 240 minutes. This flowsheet failed to evidence the Blood Flow (BF), Venous Pressure (VP), and AP from start of dialysis at 5:56 AM until 9:08 AM and failed to list a reason for the missing information. On 7/10/13 at 2:00 PM, employee A indicated it was probably a computer issue and provided a hand written Hemodialysis Flowsheet dated 6/14/13 at 12:46 PM. The hand written flowsheet listed the BF at 200-400 but failed to evidence times were documented.</p> <p>3. The policy titled "Monitoring During Patient's Treatment," #300-24, revised 7/15/09 states, "2. Negative arterial pressure should not exceed 250 mmHg (-250). 3. Venous pressure should not exceed 250 mm Hg. (+250). ... NOTE: ... Report anything unusual to the Charge Nurse and follow the instructions of the Charge Nurse. Document all assessments, interventions and follow up/</p>		<p>sheet, which includes any alteration in BFR. The staff was in-serviced on policy #600-02, #600-05, and PEARL manual topics Filing out Flow Sheet and Flow Sheet Entry with emphasis on correct and thorough filing out of paper flow sheets when computer issues are present and effective, accurate and timely entering of manual flow sheets into PEARL system once system is again available. Clinic Manager will conduct random audits of Bed Side Flow Sheets on 25% of the patients weekly X 4 or until compliance (defined as 100%) has been established, then monthly X 4, then quarterly as per the Quality Management workbook. Any staff found not to be in compliance with Policy & Procedure will receive progressive disciplinary action. This audit addresses such things as, but not limited to, confirmation of settings to orders, troubleshooting, notification of RN or MD, and documentation as indicated. A copy of all audits will be included with corresponding months QAPI minutes and presented to Governing Body. Effective immediately and ongoing, the daily staff nurse in charge of each daily shift will monitor (through observation) and report any incident of staff non-compliance to Clinic Manager for follow-up. Follow up is to include progressive disciplinary action, up to and</p>		

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	<p>outcome in the comment section of the flowsheet. ... f. ... Report to the Charge Nurse trends noted in the venous pressure readings. ... i. Check the blood flow rate and document if unable to achieve prescribed rate."</p> <p>4. The policy titled "Documentation of Medical Records," #600-02, revised 4/1/12 states, "3. Medical documents pertaining to the patient are to be scanned into the PEARL System within 30 days of generation. ... 5. Do not leave blank spaces or use ditto marks. ... 7. Late entries must be entered into the patient record no later than 24 hours from the original date/time of the missed documentation. When documenting a late entry, present time should be used, followed by the words "late entry". The original time should be documented after the words "late entry".</p> <p>5. The policy titled "Medical Records General Requirements," #600-05, states, "3. All information will be entered directly into the computer or scanned into the appropriate sections of the record within 30 days of generation."</p> <p>6. On 7/10/13 at 1:15 PM, employee A, Facility Manager, indicated there were probably computer issues which would not allow entry of the BFR, AP and VP,</p>		including termination, for staff person's repeated non-compliance.	

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	<p>so the information was not available.</p> <p>7. On 7/10/13 at 12:45 PM, employee A, Facility Manager, indicated the tech should have documented the reason for the low BFR in the comments section of charting.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152524		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2013	
NAME OF PROVIDER OR SUPPLIER DSI NORTHWEST INDIANAPOLIS RENAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6488 CORPORATE WAY INDIANAPOLIS, IN 46278			
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V000626	<p>494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.</p> <p>Based on document review, interview, and policy review, the facility failed to ensure evidence of all required personnel present at Quality Assessment and Performance Improvement (QAPI) meetings for 2 of 6 months of minutes reviewed. (April and May, 2013)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The QAPI attendance sheets dated 4/24/13 and 5/20/13 failed to evidence a Technical Representative was present. 2. On 7/10/13 at 1:05 PM, employee A indicated the Technical Representative did not sign in on the attendance sheets. 3. The policy titled "Quality Assessment 	V000626	<p>A meeting of the QAPI Committee and Local Governing Body was held 7/23/13. All QAPI required committee members were present. The Director of Operations educated the members of the committee on policy 900-01 (Quality Assessment and Performance Improvement Program (QAPI). A copy of policy 900-01, was given to all committee members, including the Biomedical Technician. Special emphasis was placed on policy #900-01 #3 " The QAPI committee will consist of , but not limited to, the following members: a. Medical Director, b. Clinic Manager/or nurse in charge of clinic care, c. Master's prepared Social Worker, d. Registered Dietician, d. Biomedical Technician or</p>	07/23/2013			

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	and Performance Improvement Program (QAPI)," #900-01, revised 1/9/13 states, "3. The QAPI committee will consist of, but not limited to, the following members: ... e. Biomedical Technician or designee."		designee. e. Any additional members as applicable." The Director of Operations emphasized the importance of all QAPI committee members attending each scheduled QAPI meeting and if unable to attend a back up designee needs to be identified as far in advance as possible as this will give the primary committee member an opportunity to communicate relevant information to designee prior to the monthly QAPI meeting. It was also emphasized that all members must sign "attendance sheet" as evidence of their attendance at the QAPI meeting. Committee was given opportunity to discuss and ask questions. The Director of Operations or designee will be responsible for making certain that all members have signed attendance sheet prior to meeting adjournment. Effective immediately and ongoing, the members of committee will sign attendance sheet and the Director of Operations will monitor. Any incident of DSI staff members or designee non-compliance with attendance or signing of agreed upon attendance sheet will result in progressive disciplinary action for non-compliance.		