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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/01/2012 |
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| NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222 |
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| V0000 | <p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 7/30/12, 7/31/12, and 8/1/12</p> <p>Facility #: 010129</p> <p>Medicaid Vendor #: 200144930A</p> <p>Surveyor: Kelly Ennis, RN, BSN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 151 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 6</p> <p>Total: 157</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">August 9, 2012</p> | V0000 | | |

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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| V0111 | <p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>Based on observations and staff interview, the facility failed to ensure a sanitary environment had been maintained by failing to provide for the protection of clean supplies used to initiate and discontinue dialysis treatments in 2 of 2 days observed (7/30/12 and 7/31/12) creating the potential for the transmission of disease causing organisms among facility staff and all of the facility's 151 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 7/30/12 at 10:04 AM, the chair side table at station A-12, patient #16, had tape torn and open to air prior to patient discontinuation of dialysis treatment. On 7/30/12 at 10:08 AM, the chair side table at station A-11 evidenced supplies with no barrier to protect the supplies from potential contamination, and tape torn and open to air prior to patient initiation of dialysis treatment. The station was not yet occupied. | V0111 | <p>V111 Sanitary Environment The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012. This policy will include: 1. Educating staff to place a tape barrier on the chair side table prior to placing patient's access tape on table. It will include the mandatory time limit of 5 minutes prior to initiation or disconnection of hemodialysis. This will address items 1,2,3,5,6,7,8, and 9. 2. Staff education will also include the implementation of the use of a water resistant barrier placed on each chair side table, and on the top of the hemodialysis machine, prior to placing any supplies for patient use. This will address items 2,4,10, and 11. After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly,</p> | 08/31/2012 | | | |

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| | <p>3. On 7/30/12 at 10:13 AM, the chair side table at station A-13, patient #17, had tape torn and open to air prior to patient initiation of dialysis treatment.</p> <p>4. On 7/30/12 at 10:17 AM, employee G, Patient Care Technician (PCT), was at station A-12 and placed saline bags, dialyzer and hemostats on top the of "dirty" dialysis machine in preparation for the next dialysis patient. No barrier was placed underneath the clean supplies to protect the supplies from potential contamination.</p> <p>5. On 7/31/12 at 9:30 AM, the chair side table at station B-1, patient #23, had tape torn and open to air prior to patient discontinuation of dialysis treatment.</p> <p>6. On 7/31/12 at 9:35 AM, the chair side table at station B-13, patient #25, had tape torn and open to air prior to patient discontinuation of dialysis treatment.</p> <p>7. On 7/31/12 at 9:38 AM, the chair side table at station B-11, patient #26, had tape torn and open to air prior to patient discontinuation of dialysis</p> | | and recorded in the minutes. | | |

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| | <p>treatment.</p> <p>8. On 7/31/12 at 9:49 AM, the chair side table at station B-2, patient #24, had tape torn and open to air prior to patient discontinuation of dialysis treatment.</p> <p>9. On 7/31/12 at 9:57 AM, the chair side table at station B-4 was prepped for the next patient. Tape was torn and on chair side table and open to air prior to patient initiation of dialysis treatment.</p> <p>10. On 7/31/12 at 9:58 AM, Station B-3, patient #32, had a heparin syringe pre-drawn and placed on top of dialysis machine with no barrier to protect the supplies from potential contamination.</p> <p>11. On 8/1/12 at 5:10 PM, the clinical nurse manager, employee B, indicated, a barrier should have been used to protect the supplies from possible contamination.</p> | | | | |

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| V0113 | <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 observations, staff interview, and policy and procedure review, the facility failed to ensure 4 of 6 Patient Care Technicians (PCT) (employees F, H, Q, and R) and 1 of 3 Registered Nurses (RN) (employee I) observed provided care in compliance with infection control measures policies and procedures creating the potential to spread infection causing agents among facility staff and all 151 current in-center patients.</p> <p>The findings include:</p> <p>1. On 7/30/12 at 10:20 AM, employee F, PCT, was at station A-13, patient #17, with gloves, writing on a flow sheet on top of the "dirty" dialysis machine. Using the same gloves, the PCT then applied a tourniquet around the arm of the patient, applied alcohol, inserted needle #1, and applied the tape to the patient's access that was pre-torn and attached to the chair side table.</p> | V0113 | <p>V113 Wear Gloves/Hand Hygiene The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012. We will educate with Infection Control Policy "Hand washing and Hand Sanitizer". Techniques" issued on April 29, 2008. The Nurse Educator will update infection control policies, by August 27, 2012, to include:</p> <ol style="list-style-type: none"> 1. The purchasing of non-porous clipboards, with pen holder, to hang on the machine for the purpose of holding the paper treatment sheets. These clipboards and pens will be disinfected between treatments. This will address items 1, and 2. 2. The staff will be educated regarding placing all patient supplies (needles, syringes, tape, gauzes) on water resistant barrier at chair side only, prior to use on the patient. This will address items 2, 5, and 6. 3. The staff will be educated regarding disinfecting hands, and changing gloves, prior to contact with patient for the purpose of hemodialysis treatment. The staff will be educated to disinfect hands and change gloves after any contact with machine prior to contact with patient and insuring supplies remain on a clean surface to ensure | 08/31/2012 | |

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| | <p>2. On 7/30/12 at 10:26 AM employee I, Registered Nurse (RN), was at station A-4 initiating treatment on patient #2, who had a CVC (Central Venous Catheter). The patient's flow sheet, heparin syringe, and tape were placed on top of the "dirty" dialysis machine with no barrier. There was tape torn and attached to the chair side table. The RN reached on top of the "dirty" dialysis machine and grabbed the heparin syringe. Using the same gloves, then RN then instilled the heparin into the catheter end.</p> <p>3. On 7/30/12 at 11:24, AM, employee H, PCT, was in the isolation room with patient #22 and silenced an alarm on the dialysis machine with an undonned glove.</p> <p>4. On 7/31/12 at 10:40 AM, employee R, PCT, was getting ready to initiate treatment on patient #36 at station B-3. The patient had a CVC. The PCT removed the old dressing and then cleansed around the catheter site. The PCT then covered the site with gauze and applied the new dressing. No glove change was done.</p> <p>5. On 7/31/12 at 10:48 AM, employee Q, PCT, was getting ready</p> | | <p>contamination from machine surfaces will not be transferred to the patient. This will address items 1, 2, 5, and 7.</p> <p>4. The staff will be educated regarding placing a glove completely on the hand prior to touching machine for any reason. This will address item 3.</p> <p>5. A policy for correct CVC dressing was approved by the Governing Body on July 28, 2012, and facility nurses were educated and "signed off" during observable practice during the weeks of July 23 thru August 3, 2012. As of these dates the nurses were given charge of all CVC dressing changes, removing this responsibility from the patient care technicians, for the purpose of improving infection rates within the facility. This will address items 4, and 7.</p> <p>6. A policy for initiating hemodialysis per CVC will be written to include sanitizing hands and donning gloves prior to cleaning the catheter, prior to accessing the catheter, and again prior to connecting the catheter to the hemodialysis blood lines. This policy will be written and implemented by August 27, 2012. All staff will be educated during the week of August 27-31, 2012. This will address items 4, 5, and 7.</p> <p>7. All staff will be educated during the week of August 27-31, 2012. regarding the policy "Technical Infection Control Procedures". This policy states guidelines for PPE within the isolation room. This addresses item 9. After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these</p> | | | | |

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| | <p>to initiate treatment on patient #37 at station B-5. The patient had a CVC. The PCT obtained a heparin syringe from the top of the "dirty" dialysis machine that had no barrier and instilled the heparin into the catheter, using the same gloves.</p> <p>6. On 8/1/12 at 5:10 PM, the clinical manager, employee B, indicated a barrier should have been used to protect the supplies from possible contamination.</p> <p>7. On 8/1/12 at 5:12 PM, the nurse educator, employee C, indicated gloves should be changed after removing the catheter dressing.</p> <p>8. Facility policy titled "Handwashing and Hand Sanitizer Techniques" procedure number 7, issued on April 29, 2008, states, "Recommendations for Hand Washing: ... Before performing invasive procedures such as venipuncture, before and after dressing changes or touching wounds, after contact with contaminated materials or equipment."</p> <p>9. Facility policy titled "Technical Infection Control Procedures" procedure number 11, issued on May</p> | | audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes. | | |

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| | 1, 2008, states, "Wear PPE while in the Isolation Unit." | | | | |

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| V0114 | <p>494.30(a)(1)(i) IC-SINKS AVAILABLE A sufficient number of sinks with warm water and soap should be available to facilitate hand washing.</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure a sink for handwashing was located in, or adjacent to, 1 of 1 isolation room creating the potential to spread infection causing agents among facility staff and all 151 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 7/30/12 at 11:24 AM, employee H, a patient care technician (PCT), was in the isolation room with patient #22 and silenced an alarm with an undonned glove. The PCT then removed her gown and mask without gloves and exited the isolation room and washed hands in the main treatment floor sink located across the room. On 7/30/12 at 1:15 PM, employee C, Nurse Educator, indicated there is only one sink in the isolation area and it is "dirty". The nurse educator indicated that staff are supposed to | V0114 | <p>V114 Sinks Available Isolation room sink: To correct this deficiency, we are taking bids on creating a new sink within the isolation room separate from the patient restroom located in the isolation room. This project is under the control of the Clinic Administrator and the Technical Manager. The goal is to have a separate sink in place for hand washing by October 30, 2012.</p> <ol style="list-style-type: none"> To address the use of the current sink for hand washing referred to in item 4 we will re-locate the clean sink for hand washing outside of the isolation room, away from the patient path, until the new sink is installed within the isolation room. All staff will be educated regarding the new location of the sink for washing hands currently during the week of August 27-31, 2012. After education we will conduct daily audits for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, or the new clean sink is installed and ready for use, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings and will be adjusted accordingly. Once the new clean sink is installed and is ready for use, we will provide in-services for this process. There will be daily audits for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will | 08/31/2012 | |

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| | <p>gel and then wash hands at the sink in treatment area.</p> <p>3. On 7/30/12 at 1:25 PM, employee B, Clinical Nurse Manager, indicated the isolation room has one sink which is considered dirty. She indicated the PCTs are to apply gel to their hands prior to exiting the isolation room and then wash their hands at the sink on the treatment floor. The nurse manager acknowledged that the sink is not adjacent to the isolation room and the PCT does have to cross in front of 4 patients on the way to the hand washing sink on the treatment floor.</p> <p>4. Facility policy titled "Infection Control for Active Hepatitis B" dated 4/29/1997 states, "Equipment needed to dialyze patients with serum Hepatitis: ... Adequate soap, hot water, paper towels and convenient sink for washing hands."</p> | | <p>continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes. We will begin the in-services and the implementation for this issue immediately after the new clean sink is installed and ready for use</p> | |

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| V0116 | <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure 2 of 6 Patient Care Technicians (PCT) (employee F and P) and 2 of 3 Registered Nurse's (RN) (employee I and J) observed disinfected equipment used on other patients prior to using the same equipment on another patient or before returning it to a clean area creating the potential to spread infection causing agents among facility staff and all 151 current in-center patients</p> <p>The findings include:</p> <p>1. On 7/30/12 at 10:20 AM,</p> | V0116 | <p>V116 Station+Disp/Dedicate or Disinfect The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012</p> <p>1. We will implement a new policy that will specify the cleaning of ancillary equipment. This will be in addition to review of General Infection control Policy procedure #6 issued April 29, 2008. The equipment will be stated as conductivity meter and thermometer. This policy will state a one time use of each piece of equipment followed by disinfection with 1:100 bleach/water prior to returning to the designated clean area or being used for a different patient or machine. This addresses items 1,2,3,4,611, and 13,</p> <p>2. Staff education will also include</p> | 08/31/2012 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/01/2012 |
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| | <p>employee F, PCT, was at station A-13, patient #17, writing on a flow sheet on top of the "dirty" dialysis machine while wearing gloves. Using the same gloves, the PCT then applied a tourniquet around the arm of the patient, applied alcohol, inserted needle #1, and applied the tape to the patient's access that was pre-torn and attached to the chair side table. The PCT then applied needle #2 and removed her gloves. The PCT then applied new gloves, but did not sanitize hands prior to reaching into clean box of gloves to obtain a new pair. The PCT then obtained a thermometer from the nursing station and obtained the patient's temperature. The PCT returned the thermometer to the nursing station with no sanitation after use. The PCT then removed her gloves and obtained new gloves, with no hand sanitation prior.</p> <p>2. On 7/30/12 at 10:30 AM, a thermometer and conductivity meter were seen on the nursing station. It was unable to be determined the equipment had been sanitized before being returned to the station.</p> <p>3. On 7/30/12 at 10:34 AM, Employee I, RN, was at station A-4</p> | | <p>the implementation of the use of a water resistant barrier placed on each chair side table, and on the top of the hemodialysis machine, prior to placing any supplies for patient use. This will address item 1.</p> <p>3. The purchasing of non-porous clipboards, with pen holder, to hang on the machine for the purpose of holding the paper treatment sheets. These clipboards and pens will be disinfected between treatments. This will address item 1.</p> <p>4. The staff will be educated regarding disinfecting hands, and changing gloves, prior to contact with patient for the purpose of hemodialysis treatment. The staff will be educated to disinfect hands and change gloves after any contact with machine, prior to contact with patient, and insuring all patient supplies remain on a clean surface to ensure contamination from machine surfaces will not be transferred to the patient. This will address item 1.</p> <p>5. An Infection Control Policy will be written and initiated to specifically address the care and disinfection of stethoscopes, pre and post patient assessment. This policy will include disinfection of the stethoscope between patients and storage of stethoscope when not in use. This will address items 3,5,7,8, and 13.</p> <p>6. Facility Policy titled "General Infection Control Policies", procedure #6 "define clean and dirty areas within the patient care area". The staff will be educated regarding this policy. The areas within the patient care area will be clearly designated and marked. This will address items 14, and 15. After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100%</p> | | |

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| | <p>with a stethoscope listening to patient #2's lungs. When done, the RN placed the stethoscope on the medication preparation area with no sanitation prior. The RN then obtained a thermometer from the nursing station, took the patient's temperature, and placed the thermometer back onto nursing station with no sanitation prior.</p> <p>4. On 7/30/12 at 10:39 AM, employee J, RN, obtained a thermometer from the nursing station, took it to station A-5, and took patient #18's temperature. The RN then placed the thermometer back onto the nursing station with no sanitation prior. The RN then applied new gloves and began to listen to the patient's lungs and heart. No sanitation was done to the stethoscope after use.</p> <p>5. On 7/30/12 at 10:43 AM, employee F, PCT, was at the medication preparation area withdrawing heparin. A stethoscope used earlier by the RN, employee I, was lying by the heparin vial.</p> <p>6. On 7/30/12 at 10:45 AM, employee J, RN, was checking the conductivity of the machine at station</p> | | compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes. | | |

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| | <p>A-5 for patient #18. When complete, the RN placed the conductivity meter back on to the nursing station with no sanitation prior.</p> <p>7. On 7/30/12 at 10:55 AM, employee J, RN, was at station A-12 listening to patient #19's lungs. When complete, the RN failed to sanitize the stethoscope after use.</p> <p>8. On 7/30/12 at 11:08 AM, employee I, RN, was listening to patient #20's lungs at station A-7 with stethoscope. No sanitation was provided to the stethoscope after use.</p> <p>9. On 7/30/12 at 11:15 AM, the flow sheets that were on top of the "dirty" dialysis machine were now lying on the nursing station.</p> <p>10. On 7/31/12 at 9:35 AM, Station B-13, patient #25 had tape torn and on chair side table. The flow sheet and roll of tape was on top of the "dirty" dialysis machine. Employee P, PCT, removed the flow sheet from top of machine and placed on the nursing station.</p> <p>11. On 7/31/12 at 9:44 AM, a thermometer and conductivity meter</p> | | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>were seen lying on the nursing station by the clean supplies. It was unable to be determined the equipment had been sanitized before being returned to the station.</p> <p>12. On 7/30/12 at 1:20 PM, employee C, RN educator, stated, "The nursing station is considered a clean area."</p> <p>13. On 8/1/12 at 5:18 PM, the clinical manager, employee B, indicated the thermometer and stethoscope should be disinfected after use.</p> <p>14. Facility policy titled "General Infection Control Policies" procedure number 6 issued April 29, 2008, states, "Clean Areas: lounge, medication counter, crash cart, supply cabinet, supply carts, nurse's station, designated medication prep area. Dirty Areas: ... Charts - soft and hard, pens, thermometer ... Patient stations: ... Clean the ancillary equipment such as the B/P cuff and stethoscope."</p> <p>15. Facility policy titled "Technical</p> | | | |

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| | Infection Control Policies" procedure number 11 issued May 1, 2008, states, "Maintain nurses's desk and clean supply cart as clean, store tools and items that contact patients on dirty counter." | | | |

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| V0117 | <p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS</p> <p>Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure 6 of 6 Patient Care Technicians (PCT) (employees F, G, H, P, Q, and R) and 2 of 3 Registered Nurse's (RN) (employee I and J) observed kept clean areas clearly separated from contaminated areas creating the potential to spread infection causing agents among facility staff and all 151 current in-center patients.</p> | V0117 | <p>V117 Clean/dirty Med Prep Area, No Common Carts The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31,</p> | 08/31/2012 | | | |

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| | <p>The findings include:</p> <ol style="list-style-type: none"> On 7/30/12 at 10:08 AM, the chair side table at station A-11 evidenced supplies with no barrier to protect the supplies from potential contamination, and tape pre-torn and open to air prior to patient initiation of dialysis treatment. The station was not yet occupied. On 7/30/12 at 10:13 AM, station A-13, patient #17, had a flow sheet on top of the "dirty" dialysis machine with no protective covering. On 7/30/12 at 10:17 AM, employee G, PCT, was at station A-12 and placed a saline bag, dialyzer, and hemostats on top of the "dirty" dialysis machine in preparation for the next dialysis patient. No barrier was placed underneath the clean supplies to protect the supplies from potential contamination. On 7/30/12 at 10:20 AM, employee F, PCT, was at station A-13, patient #17, while wearing gloves writing on a flow sheet on top of the "dirty" dialysis machine. Using the same gloves, the PCT then | | <p>2012. This policy will include: 1. Education staff to place a tape barrier on the chair side table prior to placing patient's access tape on table. It will include the mandatory time limit of 5 minutes prior to initiation or disconnection of hemodialysis. This will address items 1, 19, 20, 22, and 24.2. Staff education will also include the implementation of the use of a water resistant barrier placed on each chair side table, and on the top of the hemodialysis machine, prior to placing any supplies for patient use. This will address items 1, 3, 18, 27, and 29. 3. The purchasing of non-porous clipboards, with pen holder, to hang on the machine for the purpose of holding the paper treatment sheets. These clipboards and pens will be disinfected between treatments. This will address items 2,5,11,12,13,14,17,18,19,20,21,22,23,24,25, and 26.4. The staff will be educated regarding disinfecting hands, and changing gloves, prior to contact with patient for the purpose of hemodialysis treatment. The staff will be educated to disinfect hands and change gloves after any contact with machine prior to contact with patient and insuring supplies remain on a clean surface to ensure contamination from machine surfaces will not be transferred to the patient. This will address items 4, and 27. The</p> | | |

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| | <p>applied a tourniquet around the arm of the patient, applied alcohol, inserted needle #1, and applied the tape that was pre-torn and attached to the chair side table to the patient's access. The PCT then applied needle #2 and removed her gloves. The PCT then applied new gloves, but did not sanitize hands prior to reaching into clean box of gloves to obtain a new pair. The PCT then obtained a thermometer from the nursing station and obtained the patient's temperature. The PCT then returned the thermometer to the "clean" nursing station with no sanitation after use. The PCT then removed her gloves and obtained new gloves with no sanitation prior.</p> <p>5. On 7/30/12 at 10:26 AM employee I, RN, was at station A-4 initiating treatment on patient #2 who had a catheter. The patient's flow sheet, heparin syringe, and tape were placed on top of the "dirty" dialysis machine with no barrier.</p> <p>6. On 7/30/12 at 10:30 AM, a thermometer and conductivity meter were seen on the "clean" nursing station. It was unable to be determined if the equipment was sanitized prior to placement in the</p> | | <p>"dirty sinks" located in each patient care area will be separated from the clean areas by installing a non porous barrier from counter to bottom of cabinet above. This will be installed by Bio-medical technician by August 31, 2012. Staff will be educated regarding the new placement of dirty and clean clamps.</p> <p>After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | | |

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| | <p>clean area.</p> <p>7. On 7/30/12 at 10:34 AM, Employee I, RN, was at station A-4 with a stethoscope listening to patient #2's lungs. When done, the RN placed the stethoscope on the medication preparation area with no sanitation prior. The RN then obtained a thermometer from the nursing station, took the patient's temperature, and then placed thermometer back onto the "clean" nursing station with no sanitation prior.</p> <p>8. On 7/30/12 at 10:39 AM, employee J, RN obtained a thermometer from the nursing station and took it to station A-5 and took patient #18's temperature. The RN then placed the thermometer back onto the "clean" nursing station with no sanitation prior. The RN then applied new gloves and began to listen to the patient's lungs and heart. No sanitation was done to the stethoscope after use.</p> <p>9. On 7/30/12 at 10:43 AM, employee F, PCT, was at the medication preparation area withdrawing heparin. A stethoscope used earlier by the RN, employee I,</p> | | | | |

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| | <p>was lying by the heparin vial.</p> <p>10. On 7/30/12 at 10:45 AM, employee J, RN, was checking the conductivity of the machine at station A-5 for patient #18. When complete, the RN placed the conductivity meter back onto the "clean" nursing station with no sanitation prior.</p> <p>11. On 7/30/12 at 10:55 AM, employee J, RN, was at station A-12 listening to patient #19's lungs. When complete, the RN failed to sanitize the stethoscope. The RN then began to write on the flow sheet which was placed on top of the "dirty" dialysis machine. The flow sheet had no protective covering.</p> <p>12. On 7/30/12 at 10:56 AM, employee I, RN, was at station A-7 for patient #20 writing on a flow sheet that was placed on top of the "dirty" dialysis machine. The flow sheet had no protective covering.</p> <p>13. On 7/30/12 at 11:05 AM, employee H, PCT, was at station A-6 for patient #21 writing on a flow sheet placed on top of the "dirty" dialysis</p> | | | | |

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| | <p>machine. The flow sheet had no protective covering.</p> <p>14. On 7/30/12 at 11:15 AM, completed flow sheets that were on top of the "dirty" dialysis machine with no protective covering now were on the "clean" nursing station.</p> <p>15. On 7/30/12 at 11:27 AM, clean clamps were observed being stored beside the dirty sink in the A-Bay.</p> <p>16. On 7/31/12 at 9:27 AM, clean clamps were observed being stored beside the dirty sink in the B-Bay.</p> <p>17. On 7/31/12 at 9:30 AM, Station B-1, patient #23, had a flow sheet with no protective covering on top of the "dirty" dialysis machine.</p> <p>18. On 7/31/12 at 9:32 AM, Station B-2, patient #24, had clean supplies (tape and tourniquet) on the chair side table with no barrier underneath. The flow sheet with no protective covering was located on top of "dirty" dialysis machine.</p> | | | | | | |

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| | <p>19. On 7/31/12 at 9:35 AM, Station B-13, patient #25, had tape torn and on chair side table. The flow sheet and roll of tape was on top of "dirty" dialysis machine with no barrier. Employee P, PCT, removed the flow sheet from the top of the "dirty" dialysis machine and placed it on the "clean" nursing station.</p> <p>20. On 7/31/12 at 9:38 AM, Station B-11, patient #26, had tape torn on chair side. The flow sheet was on top of the "dirty" dialysis machine with no protective covering.</p> <p>21. On 7/31/12 at 9:44 AM, a thermometer and conductivity meter were seen lying on the nursing station by the clean supplies. It was unable to be determined the equipment had been sanitized prior to placement.</p> <p>22. On 7/31/12 at 9:49 AM, employee R, PCT, was at station B-2, patient #24. The tape was torn and on the chair side table. The PCT was discontinuing treatment and applying the tape from chair side to patient access. The flow sheet was on top of</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222 |
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| | <p>the "dirty" dialysis machine with no protective covering.</p> <p>23. On 7/31/12 at 9:51 AM, employee Q, PCT, removed a flow sheet with no protective covering from the top of the "dirty" dialysis machine at station B-5, and placed it on the "clean" nursing station.</p> <p>24. On 7/31/12 at 9:57 AM, station B-4 was prepped for the next patient. Tape was torn and on the chair side table and the flow sheet was on top of the "dirty" dialysis machine with no protective covering.</p> <p>25. On 7/31/12 at 9:58 AM, Station B-3, patient #32, had a heparin syringe pre-drawn and placed on top of the "dirty" dialysis machine with no barrier. The flow sheet was also on top of the "dirty" dialysis machine with no protective covering.</p> <p>26. On 7/31/12 at 10:40 AM, employee R, PCT, was getting ready to initiate treatment on the patient #36 at station B-3. She was writing on a flow sheet located on top of the "dirty" dialysis machine with no protective covering.</p> <p>27. On 7/31/12 at 10:48 AM,</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152547 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 08/01/2012 |
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| | <p>employee Q, PCT, was at station B-5, for patient #37, getting ready to initiate treatment on a patient who had a catheter. The PCT obtained a heparin syringe from the top of the "dirty" dialysis machine that had no barrier and instilled the heparin, using the same gloves.</p> <p>28. On 7/30/12 at 1:20 PM, employee C, RN educator, stated, "The nursing station is considered a clean area."</p> <p>29. On 8/1/12 at 5:10 PM, the clinical nurse manager, employee B, indicated a barrier should have been used to protect the supplies from possible contamination.</p> <p>30. Facility policy titled "General Infection Control Policies" procedure number 6 issued April 29, 2008, states, "Clean Areas: lounge, medication counter, crash cart, supply cabinet, supply carts, nurse's station, designated medication prep area. Dirty Areas: ... Charts - soft and hard, pens, thermometer ... Patient stations: ... Clean the ancillary equipment such as the B/P cuff and</p> | | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>stethoscope."</p> <p>31. Facility policy titled "Technical Infection Control Policies" procedure number 11 issued May 1, 2008, states, "Maintain nurse's desk and clean supply cart as clean, store tools and items that contact patients on dirty counter."</p> | | | |

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| V0122 | <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, staff interview, and policy and procedure review, the facility failed to ensure 4 of 6 Patient Care Technicians (PCT) (employees F, P, Q, and R) and 2 of 3 Registered Nurse's (RN) (employee I and J) observed cleaned and disinfected contaminated surfaces, medical devices, and equipment as required creating the potential to spread infectious and communicable disease to facility staff and all 151 current in-center patients.</p> <p>The findings include:</p> <p>1. On 7/30/12 at 10:20 AM, employee F, PCT, was at station A-13, patient #17, writing on a flow sheet on top of the machine while wearing gloves. Using the same gloves, the PCT then applied a tourniquet around the arm of the patient, applied alcohol, inserted</p> | V0122 | <p>V122 Disinfect Surfaces/Equip/Written Protocol The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012. This policy will include:</p> <ol style="list-style-type: none"> The purchasing of non-porous clipboards, with pen holder, to hang on the machine for the purpose of holding the paper treatment sheets. These clipboards and pens will be disinfected between treatments. This will address items 1, and 2. The staff will be educated regarding disinfecting hands, and changing gloves, prior to contact with patient for the purpose of hemodialysis treatment. The staff will be educated to disinfect hands and change gloves after any contact with machine prior to contact with patient and insuring supplies remain on a clean surface to ensure contamination from machine surfaces will not be transferred to the patient. This will address item 1. Educating staff to place a tape barrier on the chair side table prior to | 08/31/2012 | | | |

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|--------------------|--|---------------|---|----------------------|
| | <p>needle #1, and applied the tape that was pre-torn and attached to the chair side table to the patient's access. The PCT then applied needle #2 and removed her gloves. The PCT applied new gloves, but did not sanitize hands prior to reaching into clean box of gloves to obtain a new pair. The PCT then obtained a thermometer from the nursing station and obtained the patient's temperature. The PCT returned the thermometer to the nursing station with no sanitation after use. The PCT removed her gloves and obtained new gloves with no sanitation prior.</p> <p>2. On 7/30/12 at 10:34 AM, Employee I, RN, was at station A-4 with a stethoscope listening to patient #2's lungs. When done, the RN placed the stethoscope on the medication preparation area with no sanitation prior. The RN then obtained a thermometer from the nursing station, took the patient's temperature, and placed thermometer back onto nursing station with no sanitation prior.</p> | | <p>placing patient's access tape on table. It will include the mandatory time limit of 5 minutes prior to initiation or disconnection of hemodialysis. This will address item 7.</p> <p>4. We will implement a new policy that will specify the cleaning of ancillary equipment. This will be in addition to review of General Infection control Policy procedure #6 issued April 29, 2008. The equipment will be stated as conductivity meter and thermometer. This policy will state a one time use of each piece of equipment followed by disinfection with 10:100 bleach/water prior to returning to the designated clean area or being used for a different patient or machine. This addresses items 1, 2, and 4.</p> <p>1. An Infection Control Policy will be written and initiated to specifically address the care and disinfection of stethoscopes, pre and post patient assessment. This policy will include disinfection of the stethoscope between patients and storage of stethoscope when not in use. This will address items 3, 5, and 6.</p> <p>2. Infection Control Policy "Equipment and Surface Cleaning" E1.1 will be reviewed with staff emphasizing the importance of including all of the equipment that comes into contact with the patient. This addresses items 1,2,3,4,7,8,9, and 10.</p> <p>3. Staff will be educated regarding the purchase of new Sharps containers that have only an opening for needle disposal will be purchased. This will prevent the need for taping the top of the container and allow for adequate disinfection between patients. This will address items 11, 12, and 13. After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the</p> | |

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| | <p>3. On 7/30/12 at 10:39 AM, employee J, RN, obtained a thermometer from the nursing station, took it to station A-5, and took patient #18's temperature. The RN then placed the thermometer back onto the nursing station with no sanitation prior. The RN then applied new gloves and began to listen to the patient's lungs and heart. No sanitation was done to the stethoscope after use.</p> <p>4. On 7/30/12 at 10:45 AM, employee J, RN, was checking the conductivity of the machine at station A-5 for patient #18. When complete, the RN placed the conductivity meter back on to the nursing station with no sanitation prior.</p> <p>5. On 7/30/12 at 10:55 AM, employee J, RN, was at station A-12 listening to patient #19's lungs. The RN failed to sanitize the stethoscope after use. The RN began to write on the flow sheet which was placed on top of the dialysis machine. The flow sheet had no protective covering.</p> <p>6. On 7/30/12 at 11:08 AM, employee I, RN, was listening to</p> | | <p>scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | | |

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| | <p>patient #20's lungs at station A-7 with stethoscope. No sanitation was provided to the stethoscope after use.</p> <p>7. 19. On 7/31/12 at 9:35 AM, Station B-13, patient #25, had tape torn and on chair side table. The flow sheet and roll of tape was on top of dialysis machine with no barrier. Employee P, PCT, removed the flow sheet from the top of the machine and placed it on the nursing station. The PCT then used a bleach rag to wipe down the machine but failed to clean the TV attached to the dialysis station.</p> <p>8. On 7/31/12 at 9:53 AM, employee R, PCT, was cleaning the machine at Station B-2. The PCT failed to clean the TV attached to the dialysis station.</p> <p>9. On 7/31/12 at 9:55 AM, employee Q, PCT, was cleaning the machine at Station B-5. The PCT failed to clean the TV attached to the dialysis station.</p> <p>10. On 7/31/12 at 10:08 AM, employee R, PCT, was cleaning the machine at Station B-3. The PCT failed to clean the TV attached to the dialysis station.</p> | | | | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>11. On 7/31/12 at 10:28 AM, blood was seen on the lids of the sharps containers at station B-1, B-2, B-5, B-7, and B-8. Tape was on the lids of sharps containers B-1, B-2, B-5, B-8, B-9, B-10, B-11, and B-13, potentially preventing adequate disinfection due to the porous surface of the tape.</p> <p>12. On 8/1/12 at 5:22 PM, the nurse educator, employee C, indicated tape is on the sharps containers to prevent patients from throwing trash in the larger opening.</p> <p>13. Facility policy titled "Equipment and Surface Cleaning" policy number E 1.1, issued on 8/15/00 states, "The outside of the dialysis machine, chair, BP cuff and clams (any ancillary equipment used) will be cleaned after each patient use."</p> | | | |

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|--------------------|--|---------------|---|----------------------|
| V0146 | <p>494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure 2 of 6 Patient Care Technicians (PCT) (employees Q and R) observed provided care in compliance with central venous catheter policies and procedures creating the potential to spread infectious and communicable disease which could affect all patients with a central venous catheter (CVC).</p> | V0146 | <p>V146 Catheters General The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with staff, in staff meeting 8-15-2012, the need for improved infection control practices. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and additions to, the infection control policies as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012 1. A policy for correct CVC dressing care was approved by the Governing Body on July 28, 2012, and facility nurses were educated and "signed off" during observable practice during the weeks of</p> | 08/31/2012 |

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| | <p>The findings include:</p> <ol style="list-style-type: none"> On 7/31/12 at 10:40 AM, employee R, PCT, was getting ready to initiate treatment on patient #36 at station B-3. The patient had a CVC (Central Venous Catheter). The PCT removed the old dressing and then cleansed around the catheter site. The PCT then covered the site with gauze and applied the new dressing. No glove change was done. On 7/31/12 at 10:48 AM, employee Q, PCT, was getting ready to initiate treatment on patient #37 at station B-5. The patient had a CVC. The PCT obtained a heparin syringe from the top of the "dirty" dialysis machine that had no barrier and instilled the heparin into the catheter using the same gloves. The PCT then removed her gloves, applied gel, and applied new gloves. She then touched the machine, clamped the lines, and connected them to the catheter ends. No dressing change was done. On 8/1/12 at 5:24 PM, the nurse educator, employee C, indicated they recently changed the policy on dressing changes for CVC's and now only RN's are allowed to do them. | | <p>July 23 thru August 3, 2012. As of these dates the nurses were given charge of all CVC dressing changes to be performed within the first hour of treatment, removing this responsibility from the patient care technicians, for the purpose of improving infection rates within the facility. This addresses items 1, 4</p> <p>2. A policy for Initiating and discontinuing hemodialysis per CVC which addresses infection control practices and heparin instillation will be written and implemented by August 31, 2012. This addresses item 2.</p> <p>3. Staff education will also include the implementation of the use of a water resistant barrier placed on each chair side table, and on the top of the hemodialysis machine, prior to placing any supplies for patient use. This will address item 2. After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | | |

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| | <p>The nurse educator indicated they are in the process of checking everyone off.</p> <p>4. On 8/1/12 at 5:25 PM, the Clinical Manager, employee B, indicated the dressing change is supposed to be done before treatment is started.</p> <p>5. The facility policy titled "CVC Dressing Change" procedure number 8.4, issued on June 26, 2012, states, "Loosen and remove current dressing; wash hands, replace gloves; inspect catheter site; using a sterile antimicrobial swab, begin cleaning exit site with a gentle circular scrub, circling away from the exit site for app. 2 inch diameter. Repeat with remaining swabs; allow the site to dry; apply appropriate dressing; date and initial the dressing."</p> | | | | |

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| V0401 | <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>Based on observation and staff interview, the facility failed to ensure medications were labeled correctly in 2 of 2 days of observations. (7/30/12 and 7/31/12)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 7/30/12 at 11:17 AM, two vials of pre-drawn Heparin syringes were lying on the nursing station for patient #38 with no RN initials or date/time drawn. On 7/31/12 at 9:46 AM, Heparin syringes for patients #27, #28, #29, and #30 were pre-drawn and lying on the nursing station. There were no RN initials or date/time drawn. On 7/31/12 at 9:57 AM, a Heparin syringe for patient #31 was pre-drawn and lying on the chair side table with no barrier at station B-4 with no RN initials or date/time drawn. On 7/31/12 at 9:58 AM, a Heparin syringe for patient #32 was | V0401 | <p>V401 Safe/Functional/comfortable Environment The clinical Nurse Educator and Nurse Manager as responsible parties, have discussed with staff, in staff meeting 8-15-2012, the need for improved compliance to policy. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of, and any necessary additions to, the medication administration policy as listed below. All patient care staff will be monitored for compliance during the week of August 27-31, 2012.</p> <ol style="list-style-type: none"> All medications will be labeled with date/time/and initial of person drawing the medication. This will address items 1,2,3,4, and 5. Staff education will also include the implementation of the use of a water resistant barrier placed on each chair side table, and on the top of the hemodialysis machine, prior to placing any supplies for patient use. This will address item 3, and 4. <p>After education, we will audit daily for two consecutive weeks to ensure that our policy and procedures are being followed. If the audits are 100% compliant, we will continue to conduct weekly audits for an additional two weeks. If these audits are 100% compliant, we will then conduct audits monthly for an additional three months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI</p> | 08/31/2012 | | | |

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| | <p>pre-drawn and lying on top of the dialysis machine with no barrier. The heparin syringe had no RN initials or date/time drawn.</p> <p>5. On 7/31/12 at 10:16 AM, a Heparin syringe for patients #33, #34, and #35 were pre-drawn and lying on the nursing station. There were no RN initials or date/time drawn.</p> <p>6. On 8/1/12 at 5:15 PM, employee B, clinical nurse manager, indicated the heparin must be labeled with initials, time, and date.</p> | | meetings, will be adjusted accordingly, and recorded in the minutes. | | |

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| V0516 | <p>494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure an initial comprehensive assessment was conducted on new patients within 30 days or 13 hemodialysis sessions in 3 of 15 records reviewed. (#1, #5, and #12).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care 10/19/2011, evidenced a RN Assessment that was completed on 1/12/12, greater than 30 days after the start of care. 2. Clinical record #5, start of care 7/1/10, evidenced a RN Assessment that was completed on 8/31/2010, greater than 30 days after the start of care. 3. Clinical record #12, start of care 6/21/12, failed to evidence a RN or SW Assessment was completed. 4. On 8/1/12 at 5:10 PM, employee | V0516 | <p>V516 Frequency/Initial 30 Days/13 TX The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with nursing staff, in staff meeting 8-15-2012, the need for improved compliance to CMS guidelines regarding patient initial assessments and care planning. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of a newly written policy which defines the roles of the IDT in assessment and care planning. This policy includes: 1. There will be a meeting of the IDT during the last week of each month to determine if: a. New patients have received their first assessment prior to their 1 st hemodialysis treatment b. New patients have received a Care Plan within the first 30 days or 13 treatments after admission to the hemodialysis facility.</p> <p>After education, we will audit monthly for six months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | 08/31/2012 | |

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| | B, Clinical Nurse Manager, indicated the initial assessment was not completed within 30 days of the start of care. | | | | |

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| V0519 | <p>494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR 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>(1) At least annually for stable patients;</p> <p>Based on clinical record review and staff interview, the facility failed to ensure the interdisciplinary team indicated if a patient was stable or unstable in 14 of 14 clinical records reviewed with completed Interdisciplinary Care Plans. (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, and 15)</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care 10/19/2011, evidenced an Interdisciplinary (IDT) Care Plan signed by the IDT on 1/23/12 and another on 4/9/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>2. Clinical record #2, start of care 5/17/06, evidenced an IDT Care Plan signed by the IDT on 8/29/11. A</p> | V0519 | <p>V519 Frequency Reassessment-Stable 1 YR The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with nursing staff, in staff meeting 8-15-2012, the need for improved compliance to CMS guidelines regarding patient initial assessments and care planning for stable and unstable patients. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of a newly written policy which defines the roles of the IDT in assessment and care planning. This policy includes:</p> <ol style="list-style-type: none"> Using the tools available, we will determine if a patient is considered stable or unstable per CMS guidelines. We will perform Care Plans upon initiation of hemodialysis within the facility, then again at 3 months, then yearly per CMS guidelines. If a patient is deemed unstable per CMS guidelines we will continue a monthly care plan until the problem is resolved or, after three months, pronounced uncorrectable by patient's physician. Each care plan will state Stable or Unstable which will be written on the care plan. This addresses items 1,2,3,4,5,6,7,8,9,10,11,12,13,14, and 15. After education, we will audit monthly for six months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these | 08/31/2012 | | | |

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| | <p>section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>3. Clinical record #3, start of care 8/31/05, evidenced an IDT Care Plan signed by the IDT on 9/19/11. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>4. Clinical record #4, start of care 1/3/12, evidenced an IDT Care Plan signed by the IDT on 5/8/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>5. Clinical record #5, start of care 7/1/10, evidenced an IDT Care Plan signed by the IDT on 2/23/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the</p> | | <p>steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | | |

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| | <p>medical record.</p> <p>6. Clinical record #6, start of care 6/24/11, evidenced an IDT Care Plan signed by the IDT on 7/28/11 and another signed on 10/31/11. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>7. Clinical record #7, start of care 6/10/11, evidenced an IDT Care Plan signed by the IDT on 7/29/11 and another signed on 6/22/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>8. Clinical record #8, in-center start of care 5/9/11 and Peritoneal Dialysis (PD) start of care 8/23/11, evidenced an IDT Care Plan signed by the IDT on 5/23/11 and another signed on 2/23/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> | | | | | | |

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| | <p>9. Clinical record #9, start of care 3/14/12, evidenced an IDT Care Plan signed by the IDT on 3/26/12 and another signed on 6/25/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>10. Clinical record #10, in-center start of care 3/31/11 and PD start of care 5/14/11, evidenced an IDT Care Plan signed by the IDT on 4/28/11, 6/27/11, and another signed on 2/27/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>11. Clinical record #11, start of care 1/24/12, evidenced an IDT Care Plan signed by the IDT on 5/24/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>12. Clinical record #13, start of care</p> | | | | | | |

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| | <p>2/7/12, evidenced an IDT Care Plan signed by the IDT on 3/27/12 and another signed on 6/3/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>13. Clinical record #14, start of care 3/20/12, evidenced an IDT Care Plan signed by the IDT on 4/19/12. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>14. Clinical record #15, start of care 5/19/11, evidenced an IDT Care Plan signed by the IDT on 6/20/11 and another signed on 11/17/11. A section of the report which states "Stable/Unstable" was left blank. There was no indication if the patient was considered stable or unstable found anywhere else within the medical record.</p> <p>15. On 8/1/12 at 5:12 PM, employee C, RN Educator, indicated stable/unstable should have been marked on the IDT plans of care.</p> | | | | | | |

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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 review and staff interview, the facility failed to ensure the interdisciplinary team (IDT) conducted a comprehensive assessment and plan of care at least monthly for a patient classified as unstable for 1 of 1 clinical records reviewed of unstable patients. (#11)</p> <p>The findings include:</p> <p>1. Clinical record #11, start of care 1/24/12, evidenced an IDT Care Plan signed by the IDT on 3/29/12. The IDT plan of care was marked as unstable. There is no evidence to indicate a comprehensive assessment and plan of care was completed in April. The next IDT plan of care dated 5/24/12 fails to indicate</p> | V0520 | <p>V520 Frequency Reassessment-Unstable Q MO The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with nursing staff, in staff meeting 8-15-2012, the need for improved compliance to CMS guidelines regarding patient initial assessments and care planning for stable and unstable patients. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of a newly written policy which defines the roles of the IDT in assessment and care planning. This policy includes: 1. Using the tools available, we will determine if a patient is considered stable or unstable per CMS guidelines. 2. We will perform Care Plans upon initiation of hemodialysis within the facility, then again at 3 months, then yearly per CMS guidelines. 1. If a patient is deemed unstable per CMS guidelines we will continue a monthly care plan until the problem is resolved or, after three months, pronounced uncorrectable by patient's</p> | 08/31/2012 | | | |

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| | <p>if the patient is stable or unstable.</p> <p>2. On 8/1/12 at 5:15 PM, employee B, clinical manager, indicated the patient should have been reassessed monthly if unstable.</p> | | <p>physician.</p> <p>2. Each care plan will state Stable or Unstable which will be written on the care plan.</p> <p>3. This addresses items 1&2. After education, we will audit monthly for six months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly, and recorded in the minutes.</p> | | |

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| V0557 | <p>494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure an initial plan of care was developed for new patients within 30 days or 13 hemodialysis sessions in 5 of 15 records reviewed. (#1, 4, 5, 8, and 12).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care 10/19/2011, evidenced an IDT (interdisciplinary team) plan of care was completed on 1/23/12, greater than 30 days after the start of care. 2. Clinical record #4, start of care 1/3/12, failed to evidence an initial IDT plan of care was completed. 3. Clinical Record #5, start of care 7/1/10, failed to evidence an initial IDT plan of care was completed. 4. Clinical record #8, in-center start of care 5/9/11 and Peritoneal Dialysis (PD) start of care 8/23/11, evidenced an initial IDT Care Plan signed by the | V0557 | <p>V557 POC-Initial Implemented-30 Days, 13 TX The clinical Nurse Educator and Nurse Manager as responsible parties have discussed with nursing staff, in staff meeting 8-15-2012, the need for improved compliance to CMS guidelines regarding patient initial assessments and care planning for stable and unstable patients. A mandatory training is planned for Aug. 27-29, 2012 which will include the implementation of a newly written policy which defines the roles of the IDT in assessment and care planning. This policy includes: 1. Using the tools available, we will determine if a patient is considered stable or unstable per CMS guidelines. 2. We will perform Care Plans upon initiation of hemodialysis within the facility, then again at 3 months, then yearly per CMS guidelines. 3. If a patient is deemed unstable per CMS guidelines we will continue a monthly care plan until the problem is resolved or, after three months, pronounced uncorrectable by patient's physician. 4. Each care plan will state Stable or Unstable which will be written on the care plan. This addresses items 1, 2,3,4,5, and 6. After education, we will audit monthly for six months. If these audits are 100% compliant, we will discontinue the scheduled audits. The nurse manager will be responsible to making sure these steps are followed. All results from these audits will be brought to the monthly QAPI meetings, will be adjusted accordingly,</p> | 08/31/2012 | | | |

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| NAME OF PROVIDER OR SUPPLIER DIALYSIS CLINIC INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1719 W 10TH ST INDIANAPOLIS, IN 46222 | | |
| (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>IDT on 5/23/11. The record failed to evidence a new plan of care was developed within 30 days after the patient changed modalities on 8/23/11. The next IDT plan of care was not completed until 2/23/12.</p> <p>5. Clinical record #12, start of care 6/21/12, failed to evidence an initial IDT plan of care was completed.</p> <p>6. On 8/1/12 at 12:00 PM, employee B, Clinical Nurse Manager, indicated the initial plan of care was not found for the clinical records.</p> | | and recorded in the minutes. | | |