

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152651	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/06/2015
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NAME OF PROVIDER OR SUPPLIER  JEFFERSONVILLE DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 365 QUARTERMASTER CT JEFFERSONVILLE, IN 47130
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V000000	This was a Federal ESRD recertification survey.  Survey Dates: 2-14-15, 2-5-15, and 2-6-15  Facility #: 012555  Medicaid Vendor #: 201050620  Surveyor: Vicki Harmon, RN, PHNS  Quality Review: Joyce Elder, MSN, BSN, RN February 10, 2015	V000000		
V000113	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.  Based on observation, interview, and review of facility policy, the facility failed to ensure infection control policies & procedures had been followed in 2 (#s 6 and 7) of 13 infection control observations completed creating the potential to affect all of the facility's 54 current patients. (Employee N)  The findings include:	V000113	<b>V113</b> 100% of clinical teammates will be in-serviced on <i>Policy 1-04-01E "AV Fistula or Graft cannulation with NIPRO or MEDISYSTEMS safety fistula needles (SFN) and administration of Heparin"</i> on 2/19/15. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not	03/01/2015

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

TITLE

(X6) DATE

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

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	<p>1. Employee N, a patient care technician (PCT), was observed to initiate the dialysis treatment using an arteriovenous fistula (AVF) on patient number 6 on 2-4-15 at 11:20 AM. The PCT was observed to evaluate and palpate (touch) the access site with gloved hands. The PCT then cleansed and disinfected the needle insertions sites without changing her gloves or cleansing her hands.</p> <p>2. Employee N, a PCT, was observed to initiate the dialysis treatment using an AVF on patient number 7 on 2-4-15 at 11:40 AM. The PCT was observed to evaluate and palpate (touch) the access site with gloved hands. The PCT then cleansed and disinfected the needle insertions sites without changing her gloves or cleansing her hands.</p> <p>3. The above-stated observations were presented to the facility administrator (FA) and group facility administrator (GFA) on 2-6-15 at 1:25 PM. The FA and the GFA indicated the employee had not followed facility policy.</p> <p>4. The facility's October 2014 "AV Fistula or Graft Cannulation With Nipro of Medisystems Safety Fistula Needles (SFN) and Administration of Heparin" procedure number 1-04-01E states,</p>		<p>limited to the following: 1) Perform inspection, auscultation and palpation on entire length of access... With clean- gloved hands, cleanse the site by applying 70% alcohol prep using a circular rubbing motion, center out. The Facility Administrator (FA)/designee will conduct infection control audits daily for two weeks, and then weekly for one month and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).</p> <p>Completion Date: 3/01/15</p>				

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V000116	<p>"Perform inspection, auscultation and palpation on entire length of access . . . With clean-gloved hands, cleanse the site by applying 70% alcohol prep using a circular rubbing motion, center-out."</p> <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT 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. -- 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. -- 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. Based on observation, interview, and facility policy review, the facility failed to ensure non-disposable equipment had been cleaned and disinfected after each patient use in 3 (#s 1, 3, &amp; 4) of 4 cleaning and disinfecting of non-disposable equipment observations creating the potential to affect all of the facility's 54 current patients. (Employee K)</p>	V000116	100% of clinical teammates will be in-serviced on 2-19-15 regarding Policy 1-05-01 "Infection Control for Dialysis Facilities". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross	03/01/2015

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>On 2-4-15 at 2:30 PM, employee K, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 8. The PCT used a tympanic thermometer to check the patient's temperature. The PCT returned the thermometer to a clean area without cleaning it.</li> <li>On 2-4-15 at 3:55 PM, employee K, a PCT, was observed to initiate the dialysis treatment on patient number 9. The PCT used a tympanic thermometer to check the patient's temperature. The PCT returned the thermometer to a clean area without cleaning it.</li> <li>On 2-6-15 at 9:50 AM, employee K, a PCT, was observed to initiate the dialysis treatment on patient number 10. The PCT used a tympanic thermometer to check the patient's temperature. The PCT returned the thermometer to a clean area without cleaning it.</li> <li>The above-stated observations were presented to the facility administrator (FA) and group facility administrator (GFA) on 2-6-15 at 1:25 PM. The FA and the GFA indicated the employee had not followed facility policy.</li> </ol>		<p>contamination between patients...if the potential for contamination exists, the device outer-casing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient. The FA or designee will conduct infection control audits daily for two weeks and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. The FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>				

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V000122	<p>5. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients . . . If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient."</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure dialysis stations had been appropriately cleaned and disinfected between patients in 2 (#s 1 and 2) of 2 cleaning and disinfecting of the dialysis stations observations completed creating the potential to affect all of the facility's 49 current incenter patients. (Employee C)</p>	V000122	100% of clinical teammates will be in-serviced on 2-19-15 regarding Policy 1-05-01 "Infection Control for Dialysis Facilities". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including the dialysis delivery system, the	03/01/2015

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	<p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee C, a registered nurse (RN), was observed to clean the dialysis chair and surrounding area at station number 5 on 2-4-15 at 3:15 PM. The RN was observed to place 2 used blue clamps in a 1:100 bleach solution. The RN then obtained a clean, dry cloth and soaked the cloth in the bleach solution containing the used clamps. The RN was observed to clean the dialysis chair with the cloth. The RN failed to clean the outside of the sides of the dialysis chair and failed to clean the data entry station.</li> <li>2. Employee C, a RN, was observed to clean the dialysis chair and surrounding area at station number 8 on 2-6-15 at 10:30 AM. The RN was observed to clean the dialysis chair, surrounding countertop area, blood pressure cuff, and television with the same cloth used to clean the dialysis machine. The RN was not observed to clean the data entry station.</li> <li>3. The above-stated observations were presented to the facility administrator (FA) and group facility administrator (GFA) on 2-6-15 at 1:25 PM. The FA and the GFA indicated the employee had not followed facility policy.</li> </ol>		<p>interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patient and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. The FA or designee will conduct infection control audits daily for two weeks, and then weekly for one month and document via the quantitative Infection Control Audit form. Ongoing compliance will be monitored with the facility's monthly infection control audit. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>				

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V000356	<p>4. The facility's September 2014 "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patient and teammates, facility wheel chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment."</p> <p>494.50(b)(1) RECORD ADV EVENTS/DIALYZER C/O LOG 13.2.3 Recording: adverse events dialyzer complaint log Any significant events such as the occurrence of symptoms listed in [AAMI] 13.2.1 and 13.2.2 should be recorded on an incident report form which would include the results of any evaluations conducted by the physician and others, and the event should be considered for reporting to the manufacturer(s) in accordance with the FDA's Medical Device User Reporting</p>			

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	<p>procedures. The resolution of actual or suspected problems caused by reprocessed dialyzers should be indicated. This form should be kept in the complaint investigation record file (see [AAMI] 4.5).</p> <p>4 Records 4.5 Complaint investigation record Records shall be kept of all complaints by patients and staff members about failures of preprocessed and reprocessed dialyzers or possible adverse reactions to any dialyzers; the results of a comprehensive investigation of these alleged problems; and, if appropriate, the corrective actions taken. The records shall be reviewed periodically for trends of adverse reactions. Compliance with the FDA's Medical Device User Reporting procedures shall be demonstrated.</p> <p>Based on reuse quality assurance document and facility policy review and interview, the facility failed to ensure complaint investigation records had been completed for all required instances of reprocessed dialyzer failures in 2 (October and December 2014) of 6 months reviewed creating the potential to affect all of the patients that participate in the reuse program.</p> <p>The findings include:</p> <p>1. The facility's "Daily Log of Failed Dialyzers" for 10-1-14 through 10-31-14 evidenced a dialyzer had been failed due to "visual inspection" on 10-2-14 and another dialyzer had been failed due to</p>	V000356	<p>100% of reuse teammates will be in-serviced on <i>Policy 6-01-13 "Complaint Investigation Record"</i> on 2-19-2015. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) A Complaint Investigation Record is completed for the following...Not Reprocessable...Visual inspection. Reuse Technician will print Daily Log of Failed Dialyzers at the end of each week with the Complaint Investigation Logs for the week and put in the box together for the FA to review. FA will audit the Daily Log of Failed Dialyzers &amp; compare it to the Complaint Investigation Log weekly</p>	03/01/2015

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V000401	<p>"not reprocessable" on 10-23-14. The facility's complaint investigation records failed to evidence an investigation record had been completed for these 2 failed dialyzers.</p> <p>2. The facility's "Daily Log of Failed Dialyzers" for 12-1-14 through 12-31-14 evidenced 2 dialyzers had been failed to due to "not reprocessable" on 12-28-14. The facility's complaint investigation records failed to evidence investigation records had been completed for these 2 failed dialyzers.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 2-5-15 at 1:30 PM.</p> <p>4. The facility's September 2013 "Complaint Investigation Record" policy number 6-01-13 states, "A Complaint Investigation Record is completed for the following: . . . Not Reprocessable . . . Visual Inspection."</p> <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</p>		for 2 months to ensure that 100% of all Complaint Investigation Logs have been completed. Ongoing compliance will be monitored by a monthly review of the Daily Log of Failed Dialyzers and Complaint Investigation Logs. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.		

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	<p>treatment environment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure the treatment floor area had been maintained in a clean and sanitary manner in 3 (2-4-15, 2-5-15, and 2-6-15) of 3 days of environmental observation creating the potential to affect all of the facility's 49 current incenter patients.</p> <p>The findings include:</p> <p>1. On 2-4-15 at 11:20 AM, the following observations were made:</p> <p>A. A test strip was observed on the floor in front of the door to the isolation room. A tube of test strips was observed on the floor in the isolation room.</p> <p>B. A used mask, a 2" x 2" gauze package, and a 2" x 2" piece of white paper was observed on the floor at station number 3.</p> <p>C. A blue glove was observed on the floor between stations 3 and 4.</p> <p>D. A peanut butter cracker package was observed on the floor at station number 4.</p> <p>E. Two (2) blue gloves and 2 pieces</p>	V000401	<p>100% of clinical teammates will be in-serviced on 2-18-15 regarding Policy 08-04-01 "Physical Environment". Verification of attendance of the in-service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1)The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. The FA or designee will conduct observational audits of the treatment floor daily x 2 weeks, then weekly x 2 weeks to verify cleanliness. Ongoing compliance will be monitored by the monthly Infection Control Audit &amp; the monthly Biomedical Audit (Baudit). Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p>	03/01/2015

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	<p>of paper, 1/2" by 1/2", were observed on the floor at station number 6.</p> <p>F. A blue glove, a roll of paper tape, a paper towel, and a 2" by 2" foil package was observed on the floor between stations 7 and 8.</p> <p>G. A test strip was observed in front of the dialysis chair at station number 8.</p> <p>2. On 2-4-15 at 3:20 PM, the following was observed:</p> <p>A. A 1" by 2" piece of blue plastic and 1/2 of an alcohol prep pad package was observed on the floor at station number 5.</p> <p>B. A blue glove was observed on the floor at station number 4.</p> <p>C. A test strip was on the floor in front of the door to the isolation room.</p> <p>3. On 2-5-15 at 11:30 AM, the following observations were made:</p> <p>A. A 3" by 4" piece of white paper was observed on the floor at station number 4.</p> <p>B. Two (2) 1/4" by 1/4" pieces of white paper were observed on the floor at</p>				

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	<p>station number 5.</p> <p>C. A 1/2" by 1" piece of white paper was observed on the floor at station number 11.</p> <p>D. A 1/2" by 2" piece of white paper was observed on the floor at station number 12.</p> <p>E. Two (2) cough drop wrappers were observed on the floor at station number 7.</p> <p>F. A 1/2" by 2" piece of white paper was observed on the floor in front of the "change-over cart."</p> <p>4. On 2-6-15 at 9:55 AM, the following observations were completed:</p> <p>A. A betadine pad package was observed on the floor at station number 2.</p> <p>B. A twist tie was observed on the floor at station number 3.</p> <p>C. A pen was observed on the floor at station number 6.</p> <p>D. A twist tie was observed on the floor at station number 7.</p> <p>E. A blue rubber stopper from an intravenous fluid bag was observed on</p>						

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V000413	<p>the floor at station number 10.</p> <p>5. The above-stated observations were presented to the facility administrator (FA) and group facility administrator (GFA) on 2-6-15 at 1:25 PM. The FA and the GFA indicated the employee had not followed facility policy.</p> <p>6. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p> <p>494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. Based on observation and interview, the facility failed to ensure emergency equipment was readily available to patients in the home department creating the potential to affect all of the facility's 5 current home program patients.</p>	V000413	<p>100% of PD teammates will be in-serviced on 2-19-15 regarding policy 5-02-08 "PD Emergency Equipment Checks". Verification of attendance of the in-service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples</p>	03/01/2015

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V000543	<p>The findings include:</p> <ol style="list-style-type: none"> <li>On 2-4-15 at 1:45 PM, the Home Program Manager, employee P, indicated that if a medical emergency occurred in the home program area, the crash cart from the incenter treatment room would be obtained and used.</li> <li>On 2-4-15 at 1:45 PM, observation noted a crash cart located on the treatment floor. The cart was between a stationary sink and against a column. The path to get to the crash cart was obstructed by a large trash can, a sharps container, and the footrest of a patient chair.</li> <li>The group facility administrator indicated, on 2-4-15 at 1:50 PM, the crash cart would be more accessible to the home program area if re-located on the treatment floor.</li> </ol> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record and facility policy review and interview, the facility failed to ensure it had provided the</p>	V000543	<p>with emphasis on, but not limited to the following: 1) The following [weekly] equipment checks will be performed by a licensed nurse teammate to verify the designated equipment is available and functional... Crash Cart moved on 2/04/2015 for easy access for both the in-center &amp; PD teammates. FA &amp; Program Manager will verify that crash cart remains in the new location. The FA or designee will conduct an observational audit of the emergency cart weekly x 4 weeks to verify that it is accessible. Ongoing compliance will be monitored with the facility's monthly Emergency checklist. FA will report findings in the monthly FHM. The FA is responsible for ongoing compliance with this POC.</p> <p>100% of clinical teammates will be in-serviced on 2/19/15 on Policy 1-03-09 "Intradialytic Treatment Monitoring" and Policy</p>	03/05/2015			

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	<p>necessary care and services to manage the patients' volume status and blood pressure in 2 (#s 4 and 5 ) of 5 records reviewed creating the potential to affect all of the facility's 54 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 4 included physician orders dated 12-12-14 that identified the desired weight after dialysis (estimated dry weight, EDW) was 86.5 kilograms (kg). <ul style="list-style-type: none"> <li>A. A post treatment flow sheet dated 1-13-15 evidenced the patient's post treatment weight was 96 kg and the patient had complained of "cramping."</li> <li>B. A post treatment flow sheet dated 1-23-15 evidenced the patient's post treatment weight was 95.6 kg.</li> <li>C. A post treatment flow sheet dated 1-26-15 evidenced the patient's post treatment weight was 97.6 kg.</li> <li>D. A post treatment flow sheet dated 2-3-15 evidenced the patient's post treatment weight was 97 kg.</li> </ul> </li> <li>Clinical record number 5 evidenced the patient performed automated peritoneal dialysis at home with 1 manual</li> </ol>		<p>1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis". 100% of PD teammates will be in-serviced on 2/19/15 on Policy 5-15-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" and the inclusion of blood pressure parameters for the patients to use when selecting dialysate concentrates for their peritoneal dialysis therapy. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs...The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to manage the patient's volume status. A new patient EDW tracking has been added to daily schedule and will be updated by the PCTs and reviewed and signed by the Charge Nurse (CN) every day to determine if patients are obtaining their prescribed EDW. This report will be reviewed in the bi-weekly Interdisciplinary Team (IDT) Core team meetings to communicate need for patient specific assessment and plan of care</p>		

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	<p>exchange during the day.</p> <p>A. A "Monthly Peritoneal Dialysis Progress Note - December 2014", signed and dated by the physician on 12-18-14, states, "Use only 1.5% for day exchange."</p> <p>B. A "Monthly Peritoneal Dialysis Progress Note - January 2015", signed and dated by the physician on 1-20-15, states, "Dextrose instructions: Varied and determined by weight b/p [blood pressure], edema, mostly 1.5% for day and mix of 2% for night."</p> <p>C. A "Progress Note", signed and dated by a registered nurse (RN), employee Q, on 1-5-15, states, "[The patient] had to start using 2.5% again due to weight gain and very elevated BP. [The patient] is mixing 1.5 and 2.5% at times."</p> <p>D. The record included a "Daily Home Continuous Ambulatory Peritoneal Dialysis Record" for 1-3-15 to 2-1-15. The home records evidenced the patient had used 2.5% daily on 1-3-15 to 1-7-15, 1-9-15, and 1-11-15 and had used 1.5% on 1-2-15, 1-10-15, and 1-12-15. The home record for 1-13-15 to 1-22-15 evidenced the patient had alternated using 1.5% and 2.5% every other day. The record for 1-23-15 to 2-1-15</p>		<p>updates. PD RNs will educate patients going forward on the use of blood pressure parameters for dialysate concentrate selection per physician order. The FA or designee will conduct audits of 100% of post treatment flowsheets daily for two weeks, then 50% weekly for four weeks to verify compliance. Home Program Manager will audit patient orders for inclusion of blood pressure parameters relating to dialysate concentration selection and patient home records demonstrating use of these parameters bi-weekly times four weeks. Ongoing compliance will be monitored with the facility's monthly medical record audit. Results of audits will be reviewed with the Medical Director during the monthly FHM. The FA and Home Program Manager are responsible for ongoing compliance with this POC.</p>				

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	<p>evidenced the patient had alternated using 1.5% with 2.5% every other day.</p> <p>E. The record failed to evidence the plan of care included specific parameters for blood pressure readings and when to use the 1.5% or the 2.5%. The home program director stated, on 2-5-15 at 10:00 AM, "The patient should use the 2.5% if the blood pressure is high in order to pull more fluid off and use the 1.5% if the blood pressure is lower and there is no need to pull additional fluid off."</p> <p>F. Observation noted, during a clinic visit with the patient on 2-5-15 at 9:25 AM, the physician added a blood pressure medication to the patient's home medications due to the patient's blood pressure being elevated.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 2-6-15 at 11:15 AM.</p> <p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the following: . . . Dose of dialysis which addresses care and services to manage the</p>						

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V000544	<p>patient's volume status."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record and facility policy review and interview, the facility failed to ensure the prescribed dose of continuous heparin had been administered as ordered in 2 (#s 1 and 2) of 2 records reviewed of patients with continuous maintenance heparin ordered and failed to ensure blood flow rates had been maintained as ordered in 1 (# 3) of 4 incenter patient records reviewed creating the potential to affect all of the facility's 49 current incenter patients.</p> <p>The findings include:</p> <p>Regarding maintenance heparin:</p> <p>1. Clinical record number 1 included physician orders dated 12-30-15 that identified a total of 1600 units of continuous heparin was to be administered during each treatment.</p> <p>A. Post treatment flow sheets, dated</p>	V000544	<p>100% of clinical teammates will be in-serviced on 2/19/15 on Policy 1-03-09 "Intradialytic Treatment Monitoring" and Policy 1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility's interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs...The plan of care will address, but not be limited to, the following: Dose of dialysis which addresses care and services to ...achieve and sustain the prescribed dose of dialysis. FA or designee to audit 100% post treatment flowsheets daily for two weeks, then 50% weekly for four weeks to verify compliance with heparin doses and blood flow rates . Ongoing</p>	03/05/2015

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	<p>1-16-15 and 1-19-15, evidenced only 1500 units of continuous heparin had been administered during the treatment.</p> <p>B. A post treatment flow sheet dated 2-2-15 evidenced only 1400 units of continuous heparin had been administered during the treatment.</p> <p>2. Clinical record number 2 included physician orders dated 1-12 15 that identified a total of 900 units of continuous heparin was to be administered during each treatment.</p> <p>A post treatment flow sheet dated 1-23-15 evidenced only 800 units of continuous heparin had been administered during the treatment.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 2-6-15 at 11:15 AM.</p> <p>4. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the following: . . . Dose of dialysis which addresses care and services to . . . achieve and sustain the prescribed dose of dialysis."</p>		<p>compliance will be monitored by 10% medical records audited monthly per the medical record audit. Audit results will be reviewed in the monthly FHM with the Medical Director and will be addressed as necessary. The FA is responsible for ongoing compliance with this POC.</p>				

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	<p>Regarding blood flow rates:</p> <p>1. Clinical record number 3 included physician orders, dated 1-15-15, 1-28-15, 1-29-15, and 1-30-15, that identified the blood flow rate (BFR) was to be maintained at 450 cubic centimeters (cc) per minute.</p> <p>A. Post treatment flow sheets, dated 1-16-15, 1-19-15, 1-26-15, 1-28-15, and 2-2-15, evidenced the BFR had been maintained at 400 cc per minute during the treatment.</p> <p>B. Post treatment flow sheets, dated 1-21-15 and 1-23-15, evidenced the BFR had been maintained at 350 cc per hour.</p> <p>2. The facility administrator was unable to provide any additional documentation and/or information when asked on 2-6-15 at 11:15 AM.</p> <p>3. The facility's March 2013 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" policy number 1-14-02 states, "The plan of care will address, but not be limited to, the following: . . . Dose of dialysis which addresses care and services to . . . achieve and sustain the prescribed dose of dialysis."</p>				

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V000547	<p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO</p> <p>The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs. Based on clinical record and facility policy review and interview, the facility failed to ensure the interdisciplinary team had provided the necessary care and services to monitor the patient's hemoglobin level in 1 (# 3) of 5 records reviewed creating the potential to affect all of the facility's 54 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 3 failed to evidence weekly hemoglobin levels had been drawn per the facility's own protocol. <ul style="list-style-type: none"> <li>A. The record evidenced the patient's hemoglobin level was 10.3 on 12-15-14, 9.1 on 12-30-14, 9.7 on 1-5-15, 8.3 on 1-12-15, and 6.3 on 1-26-15. The record</li> </ul> </li> </ol>	V000547	<p>100% of facility's hemodialysis nurses will be in-serviced on 2/19/15 on "Stable Hemoglobin Anemia Program Effort (SHAPE) Epoetin Alfa IV Protocol (rev 4.3.1) for In-Center Hemodialysis Patients. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Hgb [Hemoglobin] will be monitored twice monthly for patients receiving Epoetin alfa, and weekly while Epoetin alfa is on hold. The FA or designee will audit 100% of in-center hemodialysis patients whose epogen is on hold hemoglobin (Hgb) results weekly x 2 months to verify that lab is drawn per protocol and doses adjusted. Audit results will be</p>	03/05/2015			

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	<p>failed to evidence a hemoglobin had been drawn the week between 12-15-14 and 12-30-14.</p> <p>B. The facility administrator stated, on 2-6-15 at 9:40 AM, "There were computer issues and we were unable to see the lab results until the 1-5-15 value of 8.3. Epogen was then started per the protocol on 1-10-15."</p> <p>C. The record evidenced the patient had received a blood transfusion in the hospital on 1-30-15 due to a hemoglobin level of 6.3.</p> <p>2. The facility's 12-23-13 "Stable Hemoglobin Anemia Program Effort (SHAPE) Epoetin Alfa IV Protocol (rev 4.3.1) For In-Center Hemodialysis Patients" states, "Hbg [hemoglobin] will be monitored twice monthly for patients receiving Epoetin alfa, and weekly while Epoetin alfa is on hold."</p>		<p>reviewed in the monthly FHM with the Medical Director and will be addressed as necessary. The FA is responsible for ongoing compliance with this POC</p>		