

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152652	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/28/2013
NAME OF PROVIDER OR SUPPLIER PAOLI DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 555 WEST LONGEST STREET PAOLI, IN 47454		
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V000000	<p>This was a Federal ESRD survey for the addition of peritoneal dialysis services.</p> <p>Survey Date: 10-28-13</p> <p>Facility #: 012749</p> <p>Medicaid Vendor #: 201083460A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">October 29, 2013</p>	V000000			

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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V000541	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record review and interview, the facility failed to ensure the plan of care addressed the patient's communication needs in 1 (#1) of 1 home record reviewed creating the potential to affect the facility's 1 current home patient.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive assessment completed by the registered nurse (RN) on 8-19-13. The assessment identifies the patient has a hearing aid. 2. The home training nurse, employee A, stated, on 10-28-13 at 1:15 PM, "[The patient] is very hard of hearing. It is hard to talk to [the patient] on the phone. [The patient] gets frustrated very easily and 	V000541	V541 Interdisciplinary Team (IDT) will develop an Individualized Plan of Care for Patient #1 to reflect evaluation and address communication barriers due to patient being hard of hearing, and plan for patient to verbalize understanding of instructions or information given. Teammates (TMs) will give patient written information at clinic and plan of care meetings and education given to patient will be done verbally and in writing. Facility Administrator (FA) will hold in-service on 11/06/2013 for all members of IDT to review Policy & Procedure #1-14-02 Patient Assessment and Plan of Care When Utilizing Falcon Dialysis, with attention that the IDT or individual IDT member must develop and implement a written, individualized comprehensive plan of care that must include	11/28/2013			

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	<p>does not like to talk on the phone. You have to speak slowly and clearly. When I call [the patient] I have to keep it short and to the point."</p> <p>3. The plan of care, established by the interdisciplinary team (IDT) on 8-21-13, failed to address the identified communication needs.</p>		<p>measurable and expected outcomes and timetables for achieving goals including communication needs of patient. IDT must identify reasons for patient not meeting goal, ensuring goals and plans and interventions are patient specific. IDT must follow up and readjust plan of care as necessary and document as such in patient's medical record Verification of attendance is evidenced by TM signature on attendance sheet. FA or designee will immediately evaluate all facility patients to identify patients with communication barriers; each identified patient with a communication barrier will have an updated Individualized Plan of Care at a minimum of quarterly unless otherwise indicated by policy and/or patient status to evaluate communication barriers, and current plan for alternate communication and update plan as necessary to meet the needs of the patient. FA or designee will conduct a medical record audit fo10% of patient census monthly to ensure documentation is appropriate, and individualized plans of care and assessments are in place to meet patient needs. Results of the audits will be reviewed with the Medical Director during monthly Facility Health Meetings (FHM), minutes will reflect. FA is responsible for compliance with this plan of correction.</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 review and interview, the facility failed to ensure medications to manage anemia had been administered as ordered in 1 (#1) of 1 home record reviewed creating the potential to affect the facility's 1 current home patient.</p> <p>The finding include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a physician's order dated 7-29-13 for the administration of Epogen 18,000 units two times per month. The record evidenced the Epogen had been administered only one time during August 2013, on 8-9-13. <p>The record included laboratory results for September and October 2013 that evidenced the patient's hemoglobin levels had decreased. The results evidenced the hemoglobin level was 11.3 in August 2013, 10.8 in September 2013, and 10.6</p>	V000547	V547 FA immediately initiated tracking tool for purposes of planning and tracking medication inventory weekly to ensure an adequate supply of medication are in the facility at all times to meet patient needs and prescribed physician orders. FA or designee will conduct a weekly inventory of medications for ordering purposes to ensure patients will receive the medications as ordered per physician order. FA will immediately review any supply shortages with Medical Director to evaluate and develop immediate plan of action to ensure facility meets the needs of patients, FHM minutes will reflect. FA is responsible for compliance with this plan of correction.	11/28/2013	

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	<p>in October 2013.</p> <p>2. The home training nurse, employee A, stated, on 10-28-13 at 1:15 PM, central time, "[The patient] was in the clinic on 8-21-13. I do not recall why the EPO was not administered during that visit. It might be because we did not have the supply in the clinic."</p>				

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V000587	<p>494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record. Based on clinical record and facility policy review and interview, the facility failed to ensure self monitoring records had been reviewed and identified problems addressed in 1 (#1) of 1 home record reviewed creating the potential to affect the facility's 1 current home program patient.</p> <p>The findings include:</p> <p>1. The facility's March 2011 "Daily Home Treatment Record" policy number 5-01-29 states, "Each peritoneal dialysis patient will be instructed to complete documentation of each treatment procedure on the 'Daily Home Treatment Record' or by means of an electronic data card . . . Home training teammate will review completed 'Daily Home Treatment Records' to assist in evaluation the patient's progress and self-care decision making process. This review will be verified by the home training nurse documenting review in the medical record."</p>	V000587	V587 FA held an in-service with home modality TM on 11/06/2013 to review Policy & Procedure #5-01-29 Daily Home Treatment Record. TMs have been instructed to 1) instruct patient that they must complete the documentation of every treatment on the "Daily Home Treatment Record" which includes BPs, weight, heart rate, temperature and assessment of fluid (clear, cloudy etc.) 2) instruct patient to bring completed records to each clinic visit, 3) review, evaluate, and initial the data recorded on the "Daily Home Treatment Record" and document findings in the medical record, and 4) to alert the FA if patient fails to meet recording requirements and document findings. A medical record audit of the PD patient was performed, patients that are non-compliant with documentation identified. The patient will be given additional education with a requirement to re-sign the agreement for completing and bringing in treatment records. Educational attempts will be documented in	11/28/2013	

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	<p>The policy included an example of the "Daily Home Continuous Cycler Peritoneal Dialysis Record" that was be completed. The example record included the recording of temperature and "Effluent Clear or Cloudy."</p> <p>2. Clinical record number 1 evidenced the patient performed peritoneal dialysis daily per a cycler. The record included daily home treatment records for August 2013 and September 2013.</p> <p>A. The daily home treatment records for August 2013 failed to evidence the notation of the appearance of the effluent 8-1-13 through 8-15-13 and 8-19-13 through 8-26-13 and 8-30-13 through 8-31-3.</p> <p>B. The daily home treatment records for September 2013 failed to evidence the notation of a daily temperature or the appearance of the effluent. The records failed to evidence any notations for the month of September after 9-11-13.</p> <p>3. The record failed to evidence the home training nurse had acknowledged the self-monitoring records were incomplete or had addressed the lack of documentation with the patient.</p>		<p>the medical record. Plans of care for the identified non-compliant patient will be established to address adherence issues. Verification of attendance evidenced by TMs signature on attendance sheet. FA or designee will perform monthly audits by utilizing the "Daily Home Treatment Record Tracker." Results of audits will be reviewed with the Medical Director during the monthly FHM with supporting documentation included in the meeting minutes. FA is responsible for compliance with this plan of correction.</p>		

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	4. The home training nurse, employee A, indicated, on 10-28-13 at 1:15 PM, central time, the records were incomplete.				