

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373
--	--

(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
V 000  Bldg. 00	<p>This was a federal ESRD [CORE] recertification survey.</p> <p>Survey dates were February 23-26, 2015.</p> <p>Facility # 011894</p> <p>Medicaid # 200911110</p> <p>Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor</p> <p>Census: 30 InCenter Hemodialysis 2 Peritoneal dialysis</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 5, 2015</p>	V 000		
V 401  Bldg. 00	<p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT</p> <p>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, facility policy review, and interview, the agency failed to maintain a safe environment for staff for 1 of 1 facility.</p>	V 401	<p>Identified water immediately cleaned up. Facility Administrator (FA) conducted mandatory in-service for all clinical teammates (TMs) on 2/27/2015 and again on 3/11/2015.</p>	03/26/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015	
NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373			
(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>Findings include:</p> <p>1. During an observation of the water treatment/dialysate preparation area, on January 23, 2015, at 10:30 AM, a puddle of water was noted on the floor. At 3:00 PM, it was still present, leading to the drain.</p> <p>2. Da Vita HealthCare Partners Inc. Policy 4-08-10 titled "Teammate, Slip, Trip, and Fall Prevention Program," revised September 2014 states, " To identify and avoid situations that have the potential to result in teammate slip, trip, or fall incident/injury. Potential walking surface hazards include but are not limited to: water, ice, uneven surfaces, ramps, drains."</p> <p>3. The facility administrator, employee F, stated, at 10:45 AM on February 23, 2015, "The water should have been squeegeed to the drain."</p>		<p>In-service included but was not limited to: review of <i>Policy &amp; Procedure #4-08-10 Teammate Slip, Trip &amp; Fall Prevention Program</i> emphasizing TMs must keep floors dry and immediately clean up spills to assist in minimizing the potential for slips, and falls. TMs must identify, and squeegee or mop water into drain in treatment/dialysate preparation area to avoid potential walking surface hazard. Verification of attendance at in-service is evidenced by TMs signature on in-service sign in sheet. Daily hazard prevention checklist initiated on 3/11/2015. This checklist will be completed every four hours, every treatment day by TMs ensuring safe environment. Registered Nurse (RN) will be responsible to verify checklist completed and water treatment/dialysate preparation area is free of environmental hazards. Safety manager in-serviced on <i>Policy &amp; Procedure #4-08-03A Monthly OSHA and Safety Checklist</i> with attention to floors and hallways free of hazards; this check must include verifying water treatment/dialysate preparation area. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly Facility Health Meetings (FHM), minutes will reflect. FA is responsible for compliance with this plan of correction.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373
--	--

(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
V 403 Bldg. 00	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. Based on facility document review, facility policy and procedure review, and interview, the facility failed to maintain all ancillary equipment in accordance with the manufacturers recommendations for 2 of 2 documents reviewed (December 2014 and January 2015).</p> <p>Findings:</p> <p>1. In reviewing 2 months of the maintenance and calibration logs for the dialysate pH and conductivity meters used at the dialysis machines prior to patients treatments, the document failed to evidence phoenix meters were maintained daily. The facility staff failed to document end of the day care on December 8, 10, 12, 19, and 26, 2014, and January 2, 19, and 21, 2015.</p> <p>2. Da Vita HealthCare Partners Inc. InCenter Hemodialysis Equipment, Water and Testing Devices Procedure</p>	V 403	<p>Completion date: 3/26/2015</p> <p>FA took immediate steps to ensure Phoenix Meter Log documentation was accurately completed. FA conducted mandatory in-service for all clinical TMs on 3/11/2015. In-service included but was not limited to: review <i>Policy &amp; Procedure #2-08-01F Phoenix Meter Disinfection and Calibration Verification</i>. By end of every patient treatment day each Phoenix meter must be stored overnight per procedure. Phoenix meter log discussed with all clinical TMs ensuring each TMs understanding with return demonstration observed on 3/11/2015 for accurate end of day care and complete documentation. Each TM will be responsible to ensure log is completed with closing TM double checking phoenix meters are stored correctly and log verification is completed. TMs educated that improper Phoenix meter storage may result in damaged sensors. RN will check log accuracy and completeness</p>	03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015
NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373		
(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	
V 587  Bldg. 00	<p>2-08-01F titled "Phoenix Meter disinfection and Calibration Verification" dated September 2013, states, "...to store the Phoenix meter overnight, rinse the meter thoroughly by filing the syringe and expelling NEO-CARE or cell cleaning solution slowly 3 times ... The meter can not be stored with dialysate, bleach or dialysis quality water in the cell. The meter is to be stored like this, with the port capped to prevent the residual NEO CARE in the cell and syringe from drying out."</p> <p>3 The Biomed technician, employee G, on February 24, 2015, at 4:15 PM, indicated the the patient care technician that disinfects the meter at the beginning of the shift, and documents that the calibration verification is complete, is not the same person that is responsible to perform at the end of the day care. The sensor can be damaged if not cleaned or stored properly.</p> <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.</p>		<p>after every patient treatment day. RN will also initial daily log to provide documentation it was checked. Biomedical Technician also in-serviced and will check phoenix meter calibration log biweekly and discuss findings in monthly Baudit which will be reviewed with Medical Director during monthly FHM. Verification of attendance at in-service is evidenced by TMs signature on in-service sign-in sheet. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly FHM, minutes will reflect. FA is responsible for compliance with this plan of correction. Completion date: 3/26/2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015
NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373		
(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>Based on clinical record review, facility policy, and interview, the agency failed to document review of patients flowsheets for one of two peritoneal dialysis patients (#3).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record #3 failed to evidence a nurse's signature to document the record had been reviewed by staff from November and December, 2014.</li> <li>2. The Peritoneal Dialysis Policies, Procedures &amp; Guidelines Policy 5-01-29 titled "Daily Home Treatment Record", revised date, March 2011, states, "Home training teammate will review completed Daily Home Treatment Records to assist in evaluating 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."</li> <li>3. The Clinical Services Specialist, Employee E, stated, on February 25, 2015, at 2:30 PM, "The PD nurse (employee A) should have been using an updated form for the patient, which has a place for the nurse signature once it is reviewed."</li> </ol>	V 587	<p>FA took immediate steps ensuring Home RN distributed 5-01-29C Daily Home CCPD Record to home patients on 3/6/2015. FA conducted mandatory in-service for home peritoneal dialysis RN on 3/11/2015. In-service included but was not limited to review of: Policy &amp; Procedure #5-01-29, Daily Home Treatment Record and 5-01-29C Daily Home CCPD Record. PD RN instructed that all Daily Home Treatment Records must be maintained as part of the patient's medical record. RN signature and review date to be recorded at the bottom of each patient's home record page. This RN signature and date verifies the patient's home record was reviewed for accuracy with the patient. Additional documentation of RN review of patient's daily home treatment record will be noted in patient's monthly nurse's note. FA will document in monthly FHM that PD RN Falcon notes reflect patient home daily record was checked. Verification of attendance at in-service is evidenced by TMs signature on in-service sheet. FA or designee will conduct patient home record flow sheet audits monthly on all PD patients for six months. FA or designee will conduct flow sheet audits monthly on 10% of peritoneal dialysis patient daily home treatment records thereafter. FA will review results of audits with Medical Director</p>	03/26/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015	
NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373			
(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
V 634 Bldg. 00	<p>494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. Based on observation, facility policy and record review, and interview, the facility failed to follow procedures for verification of the dialyzer in one of 2 hemodialysis patient record reviewed. (#2)  Findings include:</p> <p>1. During an observation of patient #2's dialysis treatment on 2/25/15 at 9:50 AM, a 21 R dialyzer model was in use. The prescription information in the record, however, was a 24 R model, Gambro Polyflux dialyzer.</p> <p>2. Da Vita Health Care Partners, Incenter Hemodialysis Policies and Procedure 1-03-02, titled, "Prescription Verification and Safety Checks" dated September 2013 states, "Trained Teammates will verify the dialyzer prescription and perform safety checks prior to each</p>			V 634	<p>during monthly FHM, minutes will reflect. FA is responsible for compliance with this plan of correction. Completion date: 3/26/2015</p> <p>FA took immediate steps to ensure reprocessed dialyzer prescription verification and safety checks. 1) Reuse technician initiated process to highlight patient's reuse label. Highlighted label stats include: patient's last reprocessed time, date and dialyzer model with size for easier TM verification. 2) A binder listing active patient roster and reuse report listing patient's name, dialysis schedule (M/W/F), nephrologist, reuse-Y or N, and dialyzer size implemented since 3/10/2015. Patient events such as hospitalization, vacation, transfer, etc. also documented. This active patient roster and reuse report will be updated weekly and as needed according to patient events/prescription change by FA or designee. FA conducted mandatory in-service for all clinical TMs on 2/27/2015 and again on 3/11/2015. In-service included but was not limited to review of Policy &amp; Procedure #1-03-02A</p>		03/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/26/2015
NAME OF PROVIDER OR SUPPLIER  ST JOHN DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 10033 WICKER AVE UNIT 6 SAINT JOHN, IN 46373		
(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>treatment initiation."</p> <p>3. Da Vita Health Care Partners Procedure 1-03-02-A titled, "Reprocessed Dialyzer Prescription Verification and Safety Checks," dated March 2014 states, "The assigned teammate and another clinical teammate will verify the name on each label is the same and verify the dialyzer type and model with the MD order for the specific patient."</p> <p>4. The Clinical Services Specialist, Employee ,E and the Facility Administrator, Employee F, indicated on 2/25/14 at 3:00 PM, the prescription was changed from a 21R to a 24R in January. The Reuse tech, employee H, assigned a 21 R. Two dialysis technicians, employee D and employee C, signed they had performed the safety checks. Employee E reported, "employee D said it was the right patient - but he didn't look at the model number." The physician was notified by the RN and there were no further orders.</p>		<p>Reprocessed Dialyzer Prescription Verification and Safety Checks emphasizing each TM verifies, performs, and documents safety checks prior to each treatment initiation including but not limited to verification of dialyzer type/model as prescribed. Verification of attendance at in-service is evidenced by TM signature on in-service sign in sheet. FA or designee will audit dialyzer verification for every patient each treatment for 2 weeks, then 50% of patients each treatment day for 2 weeks, then weekly for 3 months. FA will continue to audit dialyzer verification monthly thereafter. FA will review results of all audits with TMs during homeroom meetings and with Medical Director during monthly FHM, minutes will reflect. FA is responsible for compliance with this plan of correction.</p> <p>Completion date: 3/26/2015</p>		