

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/11/2012
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 S DIXON RD STE 450 KOKOMO, IN 46902
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 9/5/12 through 9/11/12</p> <p>Facility #: 005168</p> <p>Medicaid Vendor #: 100137770A</p> <p>Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor - team leader Ingrid Miller, RN, BSN, Public Health Nurse Surveyor - team member</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 70 Number of Peritoneal Dialysis Patients: 24 Number of home hemodialysis patients: 2</p> <p>Total: 96</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  September 19, 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

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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 policy review, observation, and interview, the facility failed to ensure an appropriate and adequate bleach solutions were readily available for 2 of 4 days of observation with the potential to affect all of the facility's 70 in-center patients.</p> <p>Findings include:</p> <p>1. On 9/7/12 at 10:10 AM, in the middle of the dialysis treatment room, a white cart was observed near a clean sink and nurse work counter area. This cart contained 3 white and blue thermos brand containers with lids in place and an opaque container without a lid or cover. On the 3 blue and white containers there was a piece of tape attached to each container that stated, "500 cc [cubic centimeter] add 50 cc bleach 1:10 cc bleach" and another piece of tape attached "[staff initials] 9/6/12 06:25." The lid of the opaque container also contained a piece of tape that stated, "1:100 bleach sol [solution]. There was no date, time, or initials on this lid to indicate when the bleach solution was made. On the adjacent work area, a counter, located</p>	V0111	<p>On 9/27/12 the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution</p> <p>To ensure that all staff fully complies and has available bleach disinfection solution, the Clinical Manager arranged for the Education Department to reeducate all staff on 11/5/12 to the following:</p> <ul style="list-style-type: none"> <li>·Daily assignment of bleach mixing as part of the facility's patient assignment process</li> <li>·Bleach Mixing</li> </ul> <p>FMS-CS-IC-II-155-115-C</p> <ul style="list-style-type: none"> <li>·Documentation requirements emphasizing immediate documentation by the preparer.</li> </ul> <p>Monitoring of staff compliance to the required disinfection with prepared solution will be monitored daily using the bleach preparation log. In the event that a staff member is found to continually not follow the facility procedures for infection control, the Clinical Manager will be notified and is responsible to</p>	11/05/2012			

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	<p>between the sink and the cart, was one large white 5 gallon opaque container. This container was labeled also with with tape that stated, "Fill to line and add 300 cc bleach to 5 gallon 9/7/12 7 AM [staff initials] 1:100." Another piece of tape stated, "0700 9/7/12 [staff initials]."</p> <p>A. At 10:40 AM, the opaque container labeled 1:100 bleach on the clean cart remained uncovered since 10:10 AM.</p> <p>B. On 9/7/12 at 11:40 AM, employee A indicated he made the bleach solution at 7 AM as labeled and indicated that if the staff needed bleach solution before he prepared it, they would have to use the bleach solution leftover from the previous day as there was only one container of bleach solution prepared for the unit daily.</p> <p>C. The facility provided the treatment schedule for the in-center for September 7, 2012. The schedule evidenced patients were scheduled to begin dialysis at station 2 at 6 AM, station 3 at 6:45 AM, station 4 at 5:50 PM, station 5 at 6:30 AM, station 6 at 6 AM, station 7 at 5:50 AM, station 8 at 6 AM, station 9 at 6:15 AM, station 10 at 6:30 AM, station 11 at 6 AM, station 12 at 5:50 AM, station 14 at 6:30 AM, station 15 at 6 AM, station 16 at 5:50</p>		<p>address the findings with the identified staff member. The Clinical Manager's action will be structured to reinforce by further education following through as necessary with the application of progressive disciplinary action.</p> <p>The Clinical Manager will summarize the findings and report to the QAI Committee and to the Governing Body monthly who will determine further audit frequency by decreasing the frequency incrementally. Once compliance has been established the monitoring will revert to the QAI infection control audit tool</p> <p>The Clinical Manager is responsible and the QAI Committee and the Governing Body monitor for ongoing compliance</p>				

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	<p>AM, 17 at 6:15 AM, station 18 at 6:30 AM, station 20 at 6:45 AM, station 21 at 5:50 AM, station 22 at 6:30 AM, station 23 at 6:15 AM, and station 24 at 6 AM.</p> <p>2. On 9/10/12 at 10 AM, the same 5 gallon container was observed located between the clean sink and work counter area. This container was labeled and stated, "Bleach fill to line 5 gallon add 300 cc bleach Chemical name Hydrochloride Common name bleach Manufacturer Pure Bright" and another piece of tape stated, "9/10/12 0700 AM [staff initials]." On the left side of the mid section of the dialysis treatment area, there was a red container with a lid. This container was marked with a piece of tape and stated, "Sodium Hydrochloride." This was not dated and there were no initials on this container. The container contained blue plastic hemostat clamps and about an inch of clear liquid.</p> <p>On 9/10/12 at 10:20 AM, Employee A indicated the solution was bleach water and was used for dirty hemostat clamps and should be marked with date, time, and initials.</p> <p>3. The facility's 1-4-12 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A states, "Bleach solutions should be made daily. Keep</p>						

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	<p>bleach solution in a location convenient to all dialysis stations/machines. Bleach solution will be stored in labeled covered opaque containers to prevent disintegration of the chemical (sodium hypochlorite) when exposed to sunlight and air. Bleach solution will be mixed in the appropriate dilution in accordance to the type of cleaning and disinfection required . . . Place used plastic pressure clamps and plastic hemostat clamps in a labeled opaque plastic container filled with a 1:100 bleach solution."</p> <p>4. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC,II,155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation . . . Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and storage of reused items conforming to CMS requirement for use.</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, policy review, and staff interview, the facility failed to ensure dialysis equipment was adequately cleaned following contamination of visible blood in 1 (# 2) of 4 observations creating the potential for the spread of disease causing organisms among staff and the facility's 70 in-center patients.</p> <p>The findings include:</p> <p>1. The policy dated 01-04-12 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A states, "All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glistening wet . . . Work Surface Cleaning and Disinfection with Visible Blood &lt; 10 ml ... After cleaning up all visible blood, use a new cloth with 1:100 bleach solution for a second cleaning of the surface. Make the surface glistening</p>	V0122	<p>On 9/26/12 the Clinical Manager met with all direct patient care staff to review policy # FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on adequately cleaning dialysis equipment following contamination of visible blood. All staff acknowledged understanding that all dialysis equipment must be cleaned adequately following contamination of visible blood. Agenda and attendance sheet is available within the facility.</p> <p>Clinical Manager will ensure that infection control audits are completed utilizing the QAI Infection Control audit tool weekly for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a</p>	09/26/2012			

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	<p>wet and let air dry unless specific by the manufacturer. ... Work Surface Cleaning and Disinfection with Visible Blood &gt; 10 ml ... Use 1:10 bleach solution to clean surfaces with visible blood. After cleaning all visible blood, use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface. Make the surface glistening wet."</p> <p>2. Patient care observation number 2 was completed on September 7, 2012, at 12:27 PM. Employee G was observed to initiate dialysis on patient # 12 in station 19. During the initiation, the employee placed a small white disposable sheet underneath the legs of the central venous catheter and laid the her supplies on the surface of the chairside table, without a barrier. During the initiation process, a blood spill occurred, resulting in blood on the dialysis tubing and a minimum of 10 quarter sized drops of blood on the left chair side tray. The employee obtained two dry cloths from the clean area, she saturated the cloths with the bleach solution labeled 1:100, and then, using both clothes at the same time, wiped the tubing and chair side tray of the blood. The cloths became saturated as she wiped. She concluded her cleansing by using the corner of the same cloth in her hand to soak up the last of the blood. She did not return and cleanse a second time with</p>		<p>root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p>		

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	<p>another clean cloth and with a 1:10 bleach solution.</p> <p>3. On 9/11/12 at 3:45 PM, employee D indicated the staff were to cleanse visible blood spills of more than 10 ml with the 1:10 bleach solution.</p>			

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V0126	<p>494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Hepatitis B Vaccination</p> <p>Vaccinate all susceptible patients and staff members against hepatitis B. Based on clinical record and policy review and interview, the facility failed to ensure all susceptible patients had been offered the vaccine against hepatitis B in 1 (# 6) of 4 susceptible patient records reviewed creating the potential to affect the facility's 29 susceptible current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The facility's 1-4-12 "Patient Testing and Vaccination for Hepatitis B" policy number FMS-CS-IC-155-142A policy states, "The hepatitis B vaccine shall be offered to all susceptible patient including peritoneal and home hemodialysis patients . . . Patients shall sign a vaccination consent/declination form."</li> <li>Clinical record 6 evidenced the patient transferred from another dialysis center in Georgia and began hemodialysis in-center treatment in this facility on 6/12/12.</li> </ol> <p>The clinical record evidenced the previous dialysis facility forwarded a Vaccination Report to the facility via fax report on June 8, 2012. The report</p>	V0126	<p>As a result of the citations from the Sept 5 – Sept 11, 2012 CMS Recertification survey and to ensure that the facility fully complies with the Centers of Disease Control and Prevention guidelines to decrease the transmission of infection within the dialysis facility in regards to the care and services of the Hepatitis B positive patient, the following corrective actions have been implemented by the Governing Body and facility management team:</p> <ul style="list-style-type: none"> <li>On 10/4/12, the Director of Operations presented the preliminary findings of the survey to all facility staff. Reinforced during this meeting was the requirement of all staff to fully comply with all aspects of the facility Infection Control Polices inclusive of <ul style="list-style-type: none"> <li>Vaccinating all susceptible patients and staff members against hepatitis B</li> </ul> </li> </ul> <p>To further ensure compliance and to prevent reoccurrence, on 11/5/12, the facility's Education Coordinator presented the following Infection Control reeducation to the Clinical Manager and Nursing staff:</p>	11/05/2012			

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	<p>evidenced the patient's Hepatitis B status was evaluated on 12/15/11; the Hepatitis B surface antibody was &lt; 1 and the Hepatitis B Core antibody was negative. The report evidenced the vaccine series began on 3/3/12 and the patient was given a second injection as part of a series on 6/3/12. The record failed to evidence the patient was offered to continue the Hepatitis B series once admitted to this facility.</p> <p>3. On 9/11/12 at 12:10 PM, when asked, the clinical manager indicated she did not realize the patient had not received the entire Hepatitis B series prior to admission.</p>		<p>· Reeducation and reinforcement of FMS-CS-IC-11-155-142A Policy Patient Testing and Vaccination for Hepatitis B with emphasis on: Routine testing of all patients, prompt review of results and ensuring that patients are managed appropriately based on their results inclusive of, but not limited to:</p> <ul style="list-style-type: none"> <li>o All new/transferred patients</li> <li>o Any existing patients</li> </ul> <p>A copy of the education provided is maintained available at the facility for review.</p> <p>On 9/24/12, all existing patients Hepatitis B antigens and antibodies were reviewed. Any patient found to be susceptible will be offered the Hepatitis B vaccine. The acceptance or refusal of the vaccine will be documented on the Consent/Declination form and stored as part of their medical record. It will also be tracked on the Vaccination tracking tool as a part of the QAI program.</p> <p>To ensure that each patient is offered the vaccine upon admission and receives the vaccination in accordance to prescribed orders, the Clinical Manager has initiated the following:</p> <ul style="list-style-type: none"> <li>·Reviews patient hepatitis status prior to admission</li> </ul>	

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			<ul style="list-style-type: none"> <li>·Assigns a nurse to initiate patient assessment prior to the first treatment and as part of this assessment the following occurs:                             <ul style="list-style-type: none"> <li>·Patient education on the hepatitis virus</li> <li>·Patient education on the benefit of vaccination to hepatitis virus</li> <li>·Obtains the patient consent/ declination indicated by patient signature on the appropriate form</li> </ul> </li> </ul> <p>The Clinical Manager reviews the new patient admission paper work inclusive of required consents for completion and patient preference. The Clinical Manager is responsible to update the Hepatitis Tracking Tool accordingly no less than 30 days after patient admission.</p> <p>Each month, as part of the monthly QAI process, the Clinical Manager will present the following to the QAI Committee:</p> <ul style="list-style-type: none"> <li>·A summary of patients susceptible to Hepatitis B</li> <li>·A summary of patients currently receiving Hepatitis B vaccination series</li> <li>·Any patients that have specific, documented reasons for not receiving scheduled doses of Hepatitis B vaccine.</li> </ul> <p>The QAI Committee will assess for an opportunity for improvement. If an opportunity for improvement is identified, the</p>		

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			<p>QAI Committee will initiate a formal action plan to be followed through to a resolution.</p> <p>The committee may recommend procedural or operational changes that are required to prevent reoccurrence of significant events. Target dates for implementation should be included. QAI minutes document this activity and will be available for review at the facility</p> <p>The Clinical Manager is responsible and the QAI Committee monitors for compliance</p>		

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V0407	<p>494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on clinical record and policy review and interview, the facility failed to ensure patients had been monitored at least every 30 minutes in 2 (#s 6 and 10) of 7 in-center hemodialysis records reviewed creating the potential to affect all of the facility's current 70 in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The policy dated 7-4-12 "Patient Monitoring During Patient Treatment" number FMS-CS-IC-I-110-133A states, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary."</li> <li>Clinical record # 6 failed to evidence the patient had been monitored at least every 30 minutes during treatments. <ul style="list-style-type: none"> <li>A. A post treatment flow sheet dated 6/21/12 evidenced a treatment check had been completed at 9:00 AM and not again until 10:04 AM, a period of 64 minutes between treatment checks.</li> </ul> </li> </ol>	V0407	<p>The Clinical Manager/Education Coordinator will educate and review with all staff "Patient Monitoring During Patient Treatment" FMS-CS-IC-I-110-133A by 9/26/12 with emphasis on documentation of the treatment checks every 30 minutes.</p> <p>The Clinical Manager or designee will review treatment sheets daily for 2 weeks, weekly for 4 weeks, monthly times 2, then quarterly to ensure that all treatment checks are being done and documented. Any areas of non-compliance will be addressed immediately.</p> <p>The Clinic Manager is responsible for reporting her findings of these audits to the QAI committee during the QAI monthly meetings</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p>	09/26/2012	

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	<p>B. A post treatment flow sheet dated 8/28/12 evidenced a treatment check had been completed at 9:02 AM and not again until 10 AM, a period of 58 minutes between treatment checks.</p> <p>C. A post treatment flow sheet dated 9/4/12 evidenced a treatment check had been completed at 10:37 AM and not again until 11:34 AM, a period of 57 minutes between treatment checks.</p> <p>2. Clinical record # 10 failed to evidence the patient had been monitored at least every 30 minutes during treatments.</p> <p>A. A post treatment flow sheet dated 7/21/12 evidenced a treatment check had been completed at 1:05 PM and not again until 2:05 PM, a period of 60 minutes between treatment checks.</p> <p>B. A post treatment flow sheet dated 8/2/12 evidenced a treatment check had been completed at 11:10 AM and not again until 12:35 PM, a period of 1 hour and 25 minutes between treatment checks.</p> <p>C. A post treatment flow sheet dated 8/11/12 evidenced a treatment check had been completed at 11 AM and not again until 12:02 PM, a period of 1 hour and 2 minutes between treatment checks.</p>		The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.				

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	<p>D. A post treatment flow sheet dated 8/14/12 evidenced a treatment check had been completed at 2:02 PM and not again until 2:47 PM, a period of 45 minutes between treatment checks.</p> <p>E. A post treatment flow sheet dated 8/16/12 evidenced a treatment check had been completed at 11:35 AM and not again until 1:03 PM, a period of 1 hour and 28 minutes between treatment checks.</p> <p>F. A post treatment flow sheet dated 8/23/12 evidenced a treatment check had been completed at 10:26 AM and not again until 11:37 AM, a period of 1 hour and 11 minutes: and a treatment check was completed at 1:30 PM and not again until 2:12 PM, a period of 42 minutes between treatment checks.</p> <p>3. The acting facility administrator, employee D, was unable to provide any additional documentation and/or information when asked on 9/11/12 at 4 PM.</p>				

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V0506	<p>494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Immunization history, and medication history. Based on clinical record review and interview, the facility failed to ensure the comprehensive assessment included a review of the patient's immunization history in 1 (# 6) of 10 records reviewed with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record 6 evidenced the patient transferred from another dialysis center in Georgia and began hemodialysis in-center treatment in this facility on 6/12/12. The record included a comprehensive assessment completed by the medical social worker, the registered nurse, and the registered dietician on 6/21/12. The comprehensive assessment failed to include a review of the patient's immunization history and the patient's need to continue the Hepatitis vaccine series.</p> <p>The clinical record evidenced the previous dialysis facility forwarded a Vaccination Report to the facility via fax report on June 8, 2012. The report</p>	V0506	<p>The Director of Operations met with the facility's Interdisciplinary Team on 10/4/12 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care completed and available within their medical record that meets all criteria including an assessment of the patient's immunization history.</p> <p>The Clinical Manager and Home Program Manager completed 100% review of all patients' Comprehensive Assessments by 10/5/12 to ensure that all Assessments include a medication review that is complete and current. Any patient's Assessment found to be out of compliance including patients # 6 will be presented to the IDT for completion by 10/24/12.</p> <p>The Clinical Manager and Home</p>	10/24/2012	

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	<p>evidenced the patient's Hepatitis B status was evaluated on 12/15/11; the Hepatitis B surface antibody was &lt; 1 and the Hepatitis B Core antibody was negative. The report evidenced the vaccine series began on 3/3/12 and the patient was given a second injection as part of a series on 6/3/12. The record failed to evidence the patient was offered to continue the Hepatitis B series once admitted to this facility.</p> <p>2. On 9/11/12 at 1:30 PM, when asked, employee H indicated the comprehensive assessment did not include an assessment of the patient's immunization history.</p>		<p>Program Manager will utilize the QAI tool for Assessment and Care-Plan tracking of all patients monthly to ensure that timely completion of all patients' immunization history as part of their Comprehensive Assessment.</p> <p>The Clinical Manager and Home Program Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to include the number of Assessments due, completed and missed to the QAI. Any patient missing any component of the Assessment will be scheduled for completion the following month and corrective action will be taken as appropriate.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee and Governing Body.</p>		

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V0550	<p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on clinical record review, policy review, and interview, the facility failed to ensure the interdisciplinary team provided an update to the plan of care for 1 of 5 records reviewed of patients with a central line catheter with the potential to affect all patients with a central line catheter. (8)</p> <p>Findings</p> <p>1. Clinical record #8 identified, on the plan of care, the patient had a central line catheter. The administrator spoke to the patient about a permanent access placement which the patient refused on 1/27/12. The facility was to reevaluate in 6 months. The record failed to evidence a reevaluation was completed.</p> <p>2. On 9/11/12 at 11:30 AM, the administrator indicated no follow up had occurred with the patient regarding the</p>	V0550	<p>To specifically address vascular access monitoring and appropriate, timely referrals/follow-up to achieve and sustain vascular access in the patient care plan, the following has occurred:</p> <ul style="list-style-type: none"> <li>· Reeducation of the IDT and attending physicians to facility policy</li> <li>· Review of 100% of the patient records</li> <li>· Scheduled a care plan meeting for <b>10/24/12</b></li> <li>· Implemented a monthly monitoring process</li> </ul> <p>The Clinical Manager is responsible to report a summary of findings monthly to the QAI. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p> <p>The Director of Operations is</p>	10/24/2012	

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	<p>need for a patient access placement since 1/27/12.</p> <p>3. The agency policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" and an effective date of 7/4/12 stated, "Monthly or annual completion of the Plan of Care is based upon the patient comprehensive assessment and the physician's and interdisciplinary team's determination of the stability of the patient ... The assessment / update section of the plan of care should be updated monthly for patient's identified as stable, but that are not meeting the expected goal within the established timeframe."</p>		<p>responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>	

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on clinical record and facility policy review and interview, the medical director failed to ensure initial assessments were completed by the registered nurse (RN) prior to the initiation of patient's first treatment in 5 (# 3, 6, 8, 9, and 10) of 10 clinical records reviewed of patients that received in-center hemodialysis creating the potential to affect all new admissions to the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" # FMS-CM_IC_I_110-125A stated, "A registered nurse must evaluate patients new to dialysis BEFORE initiation of their first treatment to determine immediate needs." Chairside - The RN must at a minimum, complete the nursing evaluation cascade that includes a systems assessment."</li> <li>Clinical record # 3 evidenced the</li> </ol>	V0715	<p>The Director of Operations met with the Medical Director on 10/4/12 to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individuals who treat patients in the facility emphasizing the requirement for an initial nursing assessment prior to a patient's first dialysis treatment. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below.</p> <p>The Director of Operations met with all nursing personnel on 10/4/12 to review the requirement that an initial assessment of the patient will be completed by the RN prior to the initiation of the first dialysis treatment per policy. This will be done through the completion of the Multi-Disciplinary note - Nursing</p>	11/05/2012	

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	<p>patient was a peritoneal dialysis patient, and the last PD clinic visit was on 3/15/12. Following the visit, the patient was hospitalized for scheduled abdominal surgery. The patient returned to the facility for hemodialysis via a CVC on 4/7/12. The clinical record failed to evidence patient was assessed by the registered nurse on duty prior to his 1st in-center treatment on 4/7/12.</p> <p>3. Clinical record # 6 was admitted to the facility from another dialysis unit outside the state of Indiana. The patient's first treatment was completed on 6/12/12. The record failed to evidence a registered nurse completed an initial assessment prior to the patient's first treatment in the facility.</p> <p>4. Clinical record # 10 evidenced the patient's first hemodialysis treatment in the facility was on 7/21/12. The clinical record failed to evidence the patient was assessed by a registered nurse prior to the first treatment in the facility.</p> <p>5. On September 11, 2012, at 3:30 PM, employee D indicated the nurses are to document the patient's assessment by exception in the electronic medical record system (chairside).</p>		<p>Evaluation on the Chair-side computer system and will be evidenced by being completed and signed off prior to the initiation of the new patient's first treatment.</p> <p>The facility's nursing staff will be in-serviced on the following policies, "Comprehensive Interdisciplinary Assessment" on <b>11/5/12</b> by education with a record of training reviewed by the QAI committee.</p> <p>The Clinical Manager or designee will audit 100% of all new patient dialysis flow sheets to ensure the Initial Nursing Assessment has been completed prior to the initiation of treatment. Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will be determined by the QAI Committee upon review of the audit results and resolution of the issue.</p> <p>The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the</p>				

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	<p>6. Clinical record #8 failed to evidence the registered nurse, prior to the patient's first treatment on 3/5/11, had completed an initial evaluation per policy guidelines.</p> <p>7. Clinical record #9 failed to evidence the registered nurse, prior to the patient's first treatment on 6/26/12, had completed an initial evaluation per policy guidelines.</p>		<p>monthly QAI Committee Meeting.</p> <p>The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		

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V0726	<p>494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. Based on interview and review of records, the dialysis clinic failed to ensure the patient records contained orders for all treatments for 2 of 10 (6 and 7) clinical records reviewed with the potential to affect all 96 patients.</p> <p>Findings include:</p> <p>1. Clinical record # 6 evidenced the patient's access site was an AV (arteriovenous) graft which was removed on 8/16/12 and a CVC (central venous catheter) was placed. The record evidenced post treatment records dated August 18, 21, 23, 25, and 28, 2012, which documented the patient received hemodialysis via a CVC, catheter care, and heparin bolus 2000 units per venous and arterial lumen for dwell post treatment. The clinical record failed to evidence a physician order to provide hemodialysis via the CVC, catheter care, and the heparin dosage which was administered by the assigned PCT (patient</p>	V0726	<p>The Director of Operations met with the Medical Director on 10/4/12 to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that the dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility, emphasizing the need to have orders for all treatments. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below.</p> <p>The Director of Operations met with all nursing personnel on 10/4/12 to review the requirement that all patient records must contain orders for all treatments.</p>	10/04/2012			

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	<p>care technician).</p> <p>On 9/11/12 at 3:40 PM, employee D indicated the orders were not written into the electronic record system for physician signature until 8/28/12. She indicated the post treatment records contain the catheter care, heparin dosage, and the CVC as the access site because the other electronic record system (chairside) allowed the patient care technicians assigned to the patient to enter the information into the system without a physician order.</p> <p>2. Patient record # 7 evidenced a nurse note dated 6/27/12 that stated, "PD flush 200 cc [cubic centimeters] increments to 1000 cc outflow bloody effluent 1500 cc. [physicians] aware." The record failed to evidence an order for the flush.</p> <p>On 9/11/12 at 4:10 PM, when asked, employee E and I indicated the clinical record did not evidence written physician orders for the flush of the peritoneal catheter completed on 6/27/12 by the home program staff.</p>		<p>The Clinical Manager (CM) is responsible to present all data as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the monthly QAI Committee Meeting.</p> <p>The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		