

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152550	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2012
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE DEKALB COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1144 W 15TH ST AUBURN, IN 46706
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V0000	<p>This was a federal ESRD recertification survey and survey for the addition of peritoneal dialysis services, including home training for peritoneal dialysis and support.</p> <p>Survey Dates: 10/15/12 - 10/17/12</p> <p>Facility #: 010127</p> <p>Provider #: 152550</p> <p>Medicaid Vendor #: 1000081860F</p> <p>Surveyor: Kelly Ennis, RN, BSN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 33 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 1</p> <p>Total: 34</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 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.

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V0412	<p>494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.</p> <p>Based on clinical record review, staff interview, and policy review, the facility failed to ensure patients had been provided with appropriate orientation and training in emergency preparedness in 2 of 5 records reviewed creating the potential to affect all of the facility's 34 current patients. (#1 and #2)</p> <p>The findings include:</p> <p>1. Clinical record number 1, evidenced the patient's first date of dialysis at the facility was 9/21/2012. The record included a document titled "Education Record for New Patients." The document included a section titled "Facility Emergency / Machine Disconnect." This section had not been completed.</p> <p>On 10/16/12 at 12:45 PM, employee A, Clinical Manager, indicated the education materials should have been completed by herself or the right start representative within 6 treatments. Employee A indicated this was not done.</p>	V0412	<p>V412 On Friday, November 2, the Director of Operations will provide an in-service to the members of the IDT on policies FMS-CS-IC-I-101-007A "Patient Education", FMS-CS-IC-I-101-007D1 "Instructions for Education Record for New Patients", and FMS-CS-IC-I-101-007D2 "Education Record for New Patients", emphasizing the requirement to complete patient orientation and training in emergency preparedness within 6 dialysis treatments. Responsibility for completion of the patient education for emergency preparedness will be delegated to appropriate clinical nursing staff by the Clinical Manager, and the Clinical Manager will be responsible for ensuring it is completed and documented within 6 dialysis treatments. The Clinical Manager or her designee will complete an audit of 100% of patient charts to identify any patients who do not have emergency preparedness training documented. The IDT and QAI committee will be notified of any patient charts that are missing emergency preparedness education documentation. Any</p>	11/14/2012	

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	<p>2. Clinical record number 2 evidenced the patient's first date of dialysis at the facility was 7/04/2011. The record failed to evidence any emergency preparedness training had been completed.</p> <p>On 10/16/12 at 1:15 PM, employee A, Clinical Manager, indicated this information was not found in the medical record.</p> <p>3. Facility policy titled "Patient Education" document number FMS-CS-IC-I-101-007A with an effective date of 4/4/12 states, "Patient Education must be documented in the Patient's Medical Record as follows: New Patients-Education should be documented in the Education Record for New Patients ... It is the responsibility of the interdisciplinary team (RN, SW, RD, and, if available, the RightStart Case Manager, RSCM) to provide education on <u>all topics listed on the Education Record for New patients.</u></p>		<p>such patients will then be educated within 3 treatments of audit completion. The Clinical Manager or designee will audit all new and transferred in patient charts biweekly x 2 months, then monthly x 3 months to ensure that documentation of patient education of emergency preparedness is present. The Clinical Manager will report audit findings to the IDT and QAI committee. The QAI committee will determine the need for further auditing of new and transfer patient charts based on level of resolution. The Director of Operations is responsible for ensuring that the Clinical Manager presents all data to the QAI committee as defined within the plan. The QAI committee is responsible to provide oversight and ensure resolution is occurring.</p>		

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V0451	<p>494.70 PR-PTS INFORMED OF RIGHTS WHEN BEGIN TX The dialysis facility must inform patients (or their representatives) of their rights (including their privacy rights) and responsibilities when they begin their treatment and must protect and provide for the exercise of those rights.</p> <p>Based on clinical record review, staff interview, and policy and procedure review, the facility failed to ensure patients and/or their representative had been provided with their rights and responsibilities when they began their treatment in 2 of 5 records reviewed creating the potential to affect all of the facility's new patients. (#1 and #2)</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the patient's first date of dialysis at the facility was 9/21/2012. The record failed to evidence any information on patient rights and responsibilities had been provided to the patient and/or representatives.</p> <p>On 10/16/12 at 12:45 PM, employee A, Clinical Manager, indicated the education materials [which includes patient rights and responsibilities] should have been completed by</p>	V0451	<p>V451On Friday, November 2, the Director of Operations will provide an in-service to the members of the IDT on policies and procedures FMS-CS-IC-I-103-005A, FMS-CS-IC-I-103-005C, and forms FMS-CS-IC-I-103-005D1, FMS-CS-IC-I-103-005D2 "Patient Rights and Responsibilities", emphasizing the requirement to complete patient orientation and training in informing patients of their rights and responsibilities within 6 dialysis treatments. Responsibility for completion of the patient education for patient rights and responsibilities will be delegated to appropriate clinical nursing staff by the Clinical Manager, and the Clinical Manager will be responsible for ensuring it is completed and documented within 6 dialysis treatments. The Clinical Manager or her designee will complete an audit of 100% of patient charts to identify any patients who do not have patient rights and responsibilities training documented. The IDT and QAI committee will be notified of any patient charts that are missing</p>	11/14/2012	

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	<p>herself or the right start representative within 6 treatments. Employee A indicated this was not done.</p> <p>2. Clinical record number 2 evidenced the patient's first date of dialysis at the facility was 7/04/2011. The record failed to evidence any information on patient rights and responsibilities had been provided to the patient and/or representatives.</p> <p>A. On 10/16/12 at 1:15 PM, employee A, Clinical Manager, indicated this information was not found in the medical record.</p> <p>B. On 10/17/12 at 9:05 AM, employee A, Clinical Manager, brought in a signed copy of patient #2's patient rights that was signed in at the FMC Bluffton office, from which the patient transferred. When asked if the facility required a new signed patient's rights when a patient transfers over, the clinical manager indicated she wasn't sure because it didn't happen often. Employee A did agree that a new grievance consent should have been signed, however, since the contact information would have changed.</p> <p>3. Facility policy titled "Patient Rights</p>		<p>patient rights and responsibilities documentation. Any such patients will then be educated within 3 treatments of audit completion. The Clinical Manager or designee will audit all new and transferred in patient charts biweekly x 2 months, then monthly x 3 months to ensure that documentation of patient education of rights and responsibilities is present. The Clinical Manager will report audit findings to the IDT and QAI committee. The QAI committee will determine the need for further auditing of new and transfer patient charts based on level of resolution. The Director of Operations is responsible for ensuring that the Clinical Manager presents all data to the QAI committee as defined within the plan. The QAI committee is responsible to provide oversight and ensure resolution is occurring.</p>				

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	<p>and Responsibilities" document number FMS-CS-IC-I-103-005A, effective date 4/4/12 states, "All patients and/or their representatives will be informed of their rights (including privacy rights) and responsibilities ... Each patient will be informed of their rights and given a copy of the FMCNA Patient Rights and Responsibilities within the first six (6) treatments in the facility."</p> <p>4. Facility procedure titled "Patient Rights and Responsibilities" document number FMS-CS-IC-I-103-005C, effective date 4/4/12 states, "The patient or his/her representative is presented an Acknowledgement or Receipt of FMCNA Patient Rights and Responsibilities to sign when information is provided the first time. Document in the medical record each time patient rights information is provided or discussed with patients and/or their representative ... The signed Acknowledgement of Receipt of FMCNA Patient Rights and Responsibilities will be filed in the patient's medical record."</p> <p>5. Facility policy titled "Patient Admission" document number FMS-CS-IC-I-103-009A, effective date 4/4/12 states, "At admission or</p>			

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	within the first six (6) treatments in the facility, the patient will receive copies of Patient Rights and Responsibilities and Patient Complaints and Grievances information."			

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V0465	<p>494.70(a)(14) PR-INFORMED OF INTERNAL GRIEVANCE PROCESS The patient has the right to-</p> <p>(14) Be informed of the facility's internal grievance process;</p> <p>Based on clinical record review, staff interview, and policy and procedure review, the facility failed to ensure patients and/or their representative had been informed of the facility's internal grievance process when they began their treatment in 2 of 5 records reviewed creating the potential to affect all of the facility's new patients. (#1 and #2)</p> <p>The findings include:</p> <p>1. Clinical record number 1, evidenced the patient's first date of dialysis at the facility was 9/21/2012. The record failed to evidence any information on the facility's internal grievance process had been provided to the patient and/or representatives.</p> <p>On 10/16/12 at 12:45 PM, employee A, Clinical Manager, indicated the education materials [which includes the grievance process] should have been completed by herself or the right start representative within 6 treatments. Employee A indicated this</p>	V0465	<p>V465 On Friday, November 2, the Director of Operations will provide an in-service to the members of the IDT on policies and procedures FMS-CS-IC-I-103-006A, FMS-CS-IC-I-103-006C, FMS-CS-IC-103-009A, and forms FMS-CS-IC-I-103-006D1, FMS-CS-IC-I-103-006D2 regarding "Patient Complaints and Grievances", emphasizing the requirement to complete patient orientation and training in patient complaints and grievances within 6 dialysis treatments. Responsibility for completion of the patient education for complaints and grievances will be delegated to appropriate clinical nursing staff by the Clinical Manager, and the Clinical Manager will be responsible for ensuring it is completed and documented within 6 dialysis treatments. The Clinical Manager or her designee will complete an audit of 100% of patient charts to identify any patients who do not have patient complaints and grievances training documented. The IDT and QAI committee will be notified of any patient charts that</p>	11/14/2012			

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	<p>was not done.</p> <p>2. Clinical record number 2 evidenced the patient's first date of dialysis at the facility was 7/04/2011. The record failed to evidence any information on the facility's internal grievance process had been provided to the patient and/or representatives.</p> <p>A. On 10/16/12 at 1:15 PM, employee A, Clinical Manager, indicated this information was not found in the medical record.</p> <p>B. On 10/17/12 at 9:05 AM, employee A, Clinical Manager, brought in a signed copy of patient #2's patient rights that was signed in at the FMC Bluffton office, from which the patient transferred. When asked if the facility requires a new signed patient's rights when a patient transfers over, the clinical manager indicated she wasn't sure because it didn't happen often. Employee A did agree that a new grievance consent should have been signed, however, since the contact information would have changed.</p> <p>3. Facility policy titled "Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006A, effective</p>		<p>are missing patient complaints and grievances documentation. Any such patients will then be educated within 3 treatments of audit completion. The Clinical Manager or designee will audit all new and transferred in patient charts biweekly x 2 months, then monthly x 3 months to ensure that documentation of patient education of complaints and grievances is present. The Clinical Manager will report audit findings to the IDT and QAI committee. The QAI committee will determine the need for further auditing of new and transfer patient charts based on level of resolution. The Director of Operations is responsible for ensuring that the Clinical Manager presents all data to the QAI committee as defined within the plan. The QAI committee is responsible to provide oversight and ensure resolution is occurring.</p>		

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	<p>date 4/4/12 states, "Patients will be informed about the facility's process for addressing and resolving complaints and the grievance process available to patients if needed ... In addition to filing a grievance with the facility, patients also have the fight to file a grievance with the ESRD Network and the State Survey Agency if they wish. Facilities must provide patients a copy of the FMCNA Patient Grievance Procedure handout and review the information within the first six (6) treatments at the facility."</p> <p>4. Facility procedure titled "Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006C, effective date 4/4/12 states, "Each patient or his/her representative is presented a copy of the FMCNA Patient Grievance Procedure handout within their first six (6) dialysis treatments at the facility ... After review and discussion of the facility's grievance policy, the patient is asked to sign the Acknowledgement of Receipt of the FMCNA Patient Grievance procedure handout."</p> <p>5. Facility policy titled "Patient Admission" document number FMS-CS-IC-I-103-009A, effective date 4/4/12 states, "At admission or</p>						

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	within the first six (6) treatments in the facility, the patient will receive copies of Patient Rights and Responsibilities and Patient Complaints and Grievances information."			

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V0466	<p>494.70(a)(15) PR-INFORMED OF EXTERNAL GRIEVANCE PROCESSES The patient has the right to-</p> <p>(15) Be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency;</p> <p>Based on clinical record review, staff interview, and policy and procedure review, the facility failed to ensure patients and/or their representative had been informed of the facility's external grievance process when they began their treatment in 2 of 5 records reviewed creating the potential to affect all of the facility's new patients. (#1 and #2)</p> <p>The findings include:</p> <p>1. Clinical record number 1, evidenced the patient's first date of dialysis at the facility was 9/21/2012. The record failed to evidence any information on the facility's external grievance process had been provided to the patient and/or representatives.</p> <p>On 10/16/12 at 12:45 PM, employee A, Clinical Manager, indicated the education materials [which includes the grievance process] should have been completed by herself or the right</p>	V0466	<p>V466 On Friday, November 2, the Director of Operations will provide an in-service to the members of the IDT on policies and procedures FMS-CS-IC-I-103-006A, FMS-CS-IC-I-103-006C, FMS-CS-IC-103-009A, and forms FMS-CS-IC-I-103-006D1, FMS-CS-IC-I-103-006D2 regarding "Patient Complaints and Grievances", emphasizing the requirement to complete patient orientation and training in patient complaints and grievances within 6 dialysis treatments. Responsibility for completion of the patient education for complaints and grievances will be delegated to appropriate clinical nursing staff by the Clinical Manager, and the Clinical Manager will be responsible for ensuring it is completed and documented within 6 dialysis treatments. The Clinical Manager or her designee will complete an audit of 100% of patient charts to identify any patients who do not have patient complaints and grievances training documented. The IDT</p>	11/14/2012

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	<p>start representative within 6 treatments. Employee A indicated this was not done.</p> <p>2. Clinical record number 2 evidenced the patient's first date of dialysis at the facility was 7/04/2011. The record failed to evidence any information on the facility's external grievance process had been provided to the patient and/or representatives.</p> <p>A. On 10/16/12 at 1:15 PM, employee A, Clinical Manager, indicated this information was not found in the medical record.</p> <p>B. On 10/17/12 at 9:05 AM, employee A, Clinical Manager, brought in a signed copy of patient #2's patient rights that was signed in at the FMC Bluffton office, from which the patient transferred. When asked if the facility requires a new signed patient's rights when a patient transfers over, the clinical manager indicated she wasn't sure because it didn't happen often. Employee A did agree that a new grievance consent should have been signed, however, since the contact information would have changed.</p> <p>3. Facility policy titled "Patient Complaints and Grievances"</p>		<p>and QAI committee will be notified of any patient charts that are missing patient complaints and grievances documentation. Any such patients will then be educated within 3 treatments of audit completion. The Clinical Manager or designee will audit all new and transferred in patient charts biweekly x 2 months, then monthly x 3 months to ensure that documentation of patient education of complaints and grievances is present. The Clinical Manager will report audit findings to the IDT and QAI committee. The QAI committee will determine the need for further auditing of new and transfer patient charts based on level of resolution. The Director of Operations is responsible for ensuring that the Clinical Manager presents all data to the QAI committee as defined within the plan. The QAI committee is responsible to provide oversight and ensure resolution is occurring.</p>		

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	<p>document number FMS-CS-IC-I-103-006A, effective date 4/4/12 states, "Patients will be informed about the facility's process for addressing and resolving complaints and the grievance process available to patients if needed ... In addition to filing a grievance with the facility, patients also have the fight to file a grievance with the ESRD Network and the State Survey Agency if they wish. Facilities must provide patients a copy of the FMCNA Patient Grievance Procedure handout and review the information within the first six (6) treatments at the facility."</p> <p>4. Facility procedure titled "Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006C, effective date 4/4/12 states, "Each patient or his/her representative is presented a copy of the FMCNA Patient Grievance Procedure handout within their first six (6) dialysis treatments at the facility ... After review and discussion of the facility's grievance policy, the patient is asked to sign the Acknowledgement of Receipt of the FMCNA Patient Grievance procedure handout."</p> <p>5. Facility policy titled "Patient Admission" document number</p>				

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	FMS-CS-IC-I-103-009A, effective date 4/4/12 states, "At admission or within the first six (6) treatments in the facility, the patient will receive copies of Patient Rights and Responsibilities and Patient Complaints and Grievances information."			

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V0637	<p>494.110(a)(2)(ix) QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must-</p> <p>(A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents.</p> <p>Based on document review, staff interview, and policy review, the facility failed to ensure the quality assessment and performance improvement program addressed all infection incidents that occurred in the facility for 1 of 1 quality assurance program reviewed creating the potential to affect all of the facility's 34 current patients.</p> <p>The findings include:</p> <p>1. Review of the document titled "Adverse Event Summary for Hemodialysis" evidenced the following event occurred on 5/11/2012:</p> <p>A. On 5/11/2012 an adverse event for patient #6 was reported. The report states, "Infection at buttonhole</p>	V0637	<p>V637 On Friday November 2, the Director of Operations will review policies FMS-CS-IC-II-165-001A, FMS-CS-IC-I-101-001A with members of the IDT with emphasis on documentation of all Adverse Events, including sepsis on the QAI tools; additionally, the Infection Surveillance Log and the Adverse Events Log will be reviewed at each meeting by the QAI team to ensure appropriate review, identification of trends and implementation of changes. The Clinical Manager is responsible to present data on the Adverse Events Log and the Infection Surveillance Log to the IDT during the monthly QAI meeting for review, trending and documentation in the QAI minutes. 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>	11/14/2012			

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	<p>site. Culture sent and MRSA+. Treated with Vancomycin x 3 doses."</p> <p>B. Facility document titled "2012 Facility Quality Assessment and Performance Improvement (QAI) Hemodialysis Meeting Minutes" for data / information reviewed for the month of May 2012, was conducted on 6/22/12. The document failed to evidence the infection reported on 5/11/12 was discussed, documented, or analyzed.</p> <p>C. On 10/16/12 at 5:15 PM, employee A, Clinical Manager, indicated this should have been discussed in QAI the month following the date of occurrence but there is no evidence in the QAI meeting minutes that this was done.</p> <p>2. Review of the document titled "Adverse Event Summary for Hemodialysis" evidenced the following event occurred on 7/23/2012:</p> <p>A. On 7/23/2012 an adverse event for patient #7 was reported. The report states, "Pt [patient] admitted to clinic w/ [with] yellow drainage on [their] arterial buttonhole site. Culture of wound + for Serratia Marcenscens. Bactrim prescribed."</p>		<p>monthly QAI meeting. The Medical Director, as chairperson of the QAI Committee, is responsible to analyze the results and direct a root cause analysis with the development an action plan as identified by the data. Ongoing compliance will be monitored by the QAI committee.</p>		

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	<p>B. Facility document titled "2012 Facility Quality Assessment and Performance Improvement (QAI) Hemodialysis Meeting Minutes" for data/information reviewed for the month of July 2012, was conducted on 8/24/12. The document failed to evidence the infection reported on 7/23/12 was discussed, documented, or analyzed.</p> <p>C. On 10/16/12 at 5:15 PM, employee A, Clinical Manager, indicated this should have been discussed in QAI the month following the date of occurrence but there is no evidence in the QAI meeting minutes that this was done.</p> <p>3. Facility policy titled "Patient Adverse Event Reporting and Documentation" document number FMS-CS-IC-II-165-001A with an effective date of 1/4/12 states, "Adverse events must be documented in the following places/documents: ... QAI tools ... What type of Events are considered Adverse Events ... Infection - AV Catheter Tunnel/Exit Site Infection, Infection - AVF, Infection - AVG, Infection - Septicemia/Bacteremia ... The Clinical Manager must review all the facts surrounding an adverse or</p>			

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	<p>serious adverse event as soon as possible for review at the next QAI meeting ... Review of events at QAI is done to: Allow for appropriate follow-up; identify trends and implementation or procedural, operational, or equipment changes that many be necessary as a result of an event; In-service staff about possible procedural errors or changes needed in current practices; Ensure documentation of events is accurate and complete; Ensure Medical Device related events are reported in a timely manner; Ensure events are reported to the appropriate department for additional resources if necessary ... The CM should be responsible for completing all QAI materials."</p> <p>4. Facility policy titled "Quality Assessment and Performance Improvement Program (QAPI)" document number FMS-CS-IC-I-101-001A with an effective date of 4/4/12 states, "Elements to be reviewed in the QAI meeting include: Patient Care Outcomes, Infection Surveillance ... QAI minutes and activities will be documented on a monthly basis and will be available for review. Trending tools and any relevant data or reports will be filed with the QAI minutes and be available for review. All Adverse</p>				

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	Events will be reviewed by the QAI committee to ensure appropriate intervention. Root cause analysis will be completed as appropriate. The Adverse Event Report Log will be completed and reviewed on a monthly basis to identify issues that must be addressed by the QAI committee. The Adverse Event Report Log will be maintained with the QAI minutes for review."			

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>Based on facility policy and procedure review, the medical director failed to ensure the facility had provided services in accordance with its own policies and procedures with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. The medical director failed to ensure the following facility policy and procedures were being followed:</p> <p>A. Facility policy titled "Patient Education" document number FMS-CS-IC-I-101-007A with an effective date of 4/4/12. (See V412)</p> <p>B. Facility policy titled "Patient Rights and Responsibilities" document number FMS-CS-IC-I-103-005A, effective date 4/4/12. (See V451)</p> <p>C. Facility procedure titled "Patient Rights and Responsibilities"</p>	V0715	<p>V715 The Director of Operations met with the Medical Director Monday, October 29 to review his requirements as defined in the Conditions for Coverage and staff bylaws to ensure that all policies and procedures relative to patient education and QAPI infection control trending and action plans are adhered to by all individuals who treat patients in the facility emphasizing the requirement for patient education on emergency preparedness, rights and responsibilities, complaint and grievance processes, and trending and taking actions regarding infection reporting. The Director of Operations also reviewed the Plan of Correction to be instituted to correct these issues. The Medical Director approved and directed the implementation of the plan. The Medical Director is responsible to review the monitoring data related to the Plan of Correction to ensure that the activities and audits are documenting resolution of the deficiencies as defined throughout the Plan of Correction.</p>	11/14/2012	

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	<p>document number FMS-CS-IC-I-103-005C, effective date 4/4/12, (See V451)</p> <p>D. Facility policy titled "Patient Admission" document number FMS-CS-IC-I-103-009A, effective date 4/4/12. (See V451, V465, and V466)</p> <p>E. Facility policy titled "Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006A, effective date 4/4/12. (See V465 and V466)</p> <p>F. Facility procedure titled "Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006C, effective date 4/4/12. (See V465 and V466)</p> <p>G. Facility policy titled "Patient Adverse Event Reporting and Documentation" document number FMS-CS-IC-II-165-001A with an effective date of 1/4/12. (See V637)</p> <p>H. Facility policy titled "Quality Assessment and Performance Improvement Program (QAPI)" document number FMS-CS-IC-I-101-001A with an effective date of 4/4/12. (See V637)</p>		The Clinical Manager is responsible to present all data and monitoring/auditing results as related to this Plan of Correction to the Medical Director at the QAI meeting for oversight and review. 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 meeting. 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.		