

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE IRVINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1315 N ARLINGTON AVE STE 240 INDIANAPOLIS, IN 46219			
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 5-22-12 and 5-23-12</p> <p>Facility #: 003639</p> <p>Medicaid Vendor #: 200467560</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Facility census: 0 incenter patients, 36 peritoneal dialysis patients, and 5 home hemodialysis patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 30, 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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V0113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure staff changed gloves and performed hand hygiene appropriately during the provision of care in 2 (#s 1 and 2) of 3 patient care observations creating the potential for the transmission of disease causing organisms among the facility's 41 current patients and staff.</p> <p>The findings include:</p> <p>1. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A states, "Hands Will Be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water . . . immediately after removing gloves . . . After contact with inanimate objects near the patient."</p> <p>The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A states, "Guidelines for Dialysis Precautions . . . Hand Hygiene . . . Before putting gloves on, after removing gloves."</p>	V0113	<p>On 6/18/12 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>The Program Manager is responsible to ensure that all staff members follow "Hand Hygiene and Personal Protective Equipment" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Program Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Personal Protective Equipment" FMS-CS-IC-II-155-080A with emphasis placed on glove usage, hand-washing, and hand hygiene using hand sanitizer. Training was completed on 5/30/12 and an in-service attendance sheet is available in the facility for review in addition and audit with skills checks will be</p>	06/06/2012	

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	<p>2. Patient care observation number 1 was completed on 5-22-12 at 9:00 AM. Employee H, a registered nurse, was observed to perform a peritoneal dialysis catheter dressing change and to administer Epogen (EPO) to the patient.</p> <p>A. The employee cleansed her hands and donned clean gloves, removed the old dressing, and changed gloves and cleansed her hands. The employee prepared pieces of tape to apply to the new dressing and donned clean gloves without cleansing her hands. The employee then obtained packages of 2 x 2s from the cabinet with the gloves on.</p> <p>B. The employee was observed to wear a cover gown that tied in the back at the neck and the waist. The employee's gown was tied only at the neck and was hanging off her body as she leaned over the patient to perform the dressing change.</p> <p>C. After completing the dressing change, the employee brought in a syringe with the EPO and laid it on the counter top in the room without a barrier between the syringe and the counter top. The employee donned a clean gown and washed her hands. The employee then reached into a drawer and obtained an</p>		<p>completed by 6/6/12.</p> <p>Program Manager held a counseling session for Employee F, and H on 5/30/12 to discuss policy violations on May 22nd, 2012 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene.</p> <p>Program Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Program Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Program Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the QAI committee as noted above.</p>		

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	<p>alcohol pad and donned clean gloves without cleansing her hands. The employee cleansed the injection site and administered the EPO. The employee removed her gloves and failed to cleanse her hands. The employee handed a pen and paper to the patient.</p> <p>D. The employee then prepared to dispose of a bag of fluid from the patient's exchange. The employee donned a gown and gloves without cleansing her hands. The employee disposed of the fluid in the bathroom toilet, removed her gloves and, without cleansing her hands, assisted the patient to weigh. The employee was observed to touch the patient and the scales.</p> <p>3. Patient care observation number 3 was completed on 5-22-12 at 1:35 PM. Employee F, a registered nurse, was observed to provide care to patient number 4. The employee donned clean gloves without cleansing her hands and checked the patient's peritoneal catheter exit site. The employee removed her gloves and cleansed her hands.</p> <p>A. The employee wrote on the chart and donned clean gloves without cleansing her hands. The employee completed a foot check on the patient, removed her gloves, and cleansed her</p>						

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	<p>hands.</p> <p>B. The employee then prepared the chairside table for the administration of intravenous iron to the patient. The employee washed the table with a bleach solution. While the table was still wet, the employee laid the supplies needed for the administration of the iron on the table. The supplies included syringes, scissors, cotton balls, alcohol swabs, and a Band-Aid.</p> <p>C. Another registered nurse, employee H, drew up the medication from the vial into a syringe without cleansing her hands.</p> <p>4. The Home Program Manager, employee A, indicated, on 5-23-12 at 11:35 AM, employees F and H had not provided services in accordance with the facility's own infection control policies.</p>				

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V0413	<p>494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available.</p> <p>Based on observation and interview, the facility failed to ensure required emergency equipment was available in the facility creating the potential to affect all of the 41 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation noted, on 5-23-12 at 12:20 PM, the facility failed to have suction available on the premises and immediately available. 2. On 5-23-12 at 12:20 PM, the Home Program Manager, employee A, stated, "We do not have suction available here." 	V0413	<p>The Director of Operations will meet with the facility's staff on 6/7/12 to review their requirements detailed in Fresenius policy "Emergency Equipment/Supplies" to ensure that emergency supplies are maintained at the dialysis facility.</p> <p>The Clinical Manager under the guidance of the Medical Director will obtain the medications and equipment that is to be kept at the facility.</p> <p>The Clinical Manager will create a checklist by 6/11/12 containing all medications and supplies that are kept in the facility. The supplies and equipment will be checked monthly for expiration dates, quantities and the medications and supplies are covered and locked.</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>	06/11/2012	

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			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.	

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V0543	<p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the necessary care to manage the patients' volume status was being provided by failing to ensure plans of care addressed blood pressure management in 3 (#s 2, 3, and 4) of 4 records reviewed of patients that had been on service for longer than 30 days creating the potential to affect all of the facility's 41 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a plan of care (PoC) dated 12-19-11. The PoC failed to address blood pressure management Clinical record number 3 included a PoC dated 12-19-11. The PoC failed to address blood pressure management. Clinical record number 4 included a PoC dated 4-16-12. The PoC failed to address blood pressure management. 	V0543	<p>To specifically address inclusion of the patient's volume status to manage blood pressure in the patient care plan, the following has occurred:</p> <ul style="list-style-type: none"> Reeducation of the IDT and attending physicians to facility policy on June 6, 2012 Review of 100% of the patient records Scheduled a care plan meeting for 6/30/12 for any patient found out of compliance including patients 2, 3 and 4. Implemented a monthly monitoring process <p>The Program 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 responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>	06/30/2012	

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	<p>4. The Home Program Manager, employee A, was unable to provide any additional documentation and/or information when asked on 5-23-12 at 11:35 AM.</p> <p>5. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Dose of dialysis . . . Provide necessary care and services to manage the patient's volume status."</p>			

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V0551	<p>494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included interventions to monitor the patient's dialysis accesses in 4 (#s 2, 3, 4, & 5) of 5 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a plan of care (PoC) dated 12-19-11 that identified the patient had a "2-cuff curled Tenckhoff catheter" peritoneal dialysis catheter with a goal to "maintain functioning, infection-free PD cath [peritoneal dialysis catheter]." The plan failed to include interventions to monitor the peritoneal catheter and to achieve the desired goal. 2. Clinical record number 3 included a PoC dated 12-19-11 that identified the patient had a "2-cuff curled Tenckhoff catheter" peritoneal dialysis catheter with a goal to "maintain functioning, infection-free catheter." The plan failed to include interventions to monitor the peritoneal catheter and to achieve the 	V0551	<p>To specifically address the monitoring of the patient's vascular access to prevent access failure as part of the developed patient care plan, the following has occurred:</p> <ul style="list-style-type: none"> · Reeducation of the IDT and attending physicians to facility policy on June 6, 2012 · Review of 100% of the patient records · Scheduled a care plan meeting for 6/30/12 for any patient found to be out of compliance including patient 2, 3, 4 and 5. · Implemented a monthly monitoring process <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 responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing</p>	06/30/2012

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	<p>desired goal.</p> <p>3. Clinical record number 4 included a PoC dated 4-16-12 that identified the patient had a "2-cuff curled Tenckhoff" peritoneal dialysis catheter with a goal to "maintain functioning, infection-free catheter." The plan failed to include interventions to monitor the peritoneal catheter and to achieve the desired goal.</p> <p>4. Clinical record number 5 included a PoC dated 12-19-11 that identified the patient had an "AV Fistula" with a goal to "maintain functioning, infection-free fistula." The plan failed to include interventions to monitor the fistula and to achieve the desired goal.</p> <p>5. The Home Program Manager, employee A, was unable to provide any additional documentation and/or information when asked on 5-23-12 at 11:35 AM.</p> <p>6. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Vascular Access and PD Catheter Access . . . provide PD Catheter access monitoring for patency, catheter, tunnel,</p>		Body.		

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V0552	<p>494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included interventions to monitor the patients' psychosocial status in 4 (#s 2, 3, 4, and 5) of 4 records reviewed of patients that had been on service for longer than 30 days creating the potential to affect all of the facility's 41 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2 included a plan of care (PoC) dated 12-19-11. The PoC identifies issues with "Coping and adjustment to dialysis." The plan failed to evidence interventions to address the identified need. 2. Clinical record number 3 included a PoC dated 12-19-11. The PoC identifies issues with "Mental health concerns (depression, anxiety, panic substance 	V0552	<p>On June 6, 2012, the Education Coordinator reviewed the "Comprehensive Interdisciplinary Assessment and Plan of Care" policy with the Dietitian, Social Worker and Nursing Staff in reference to assessing patients' psychosocial status ongoing and timely measurements using a standardized measurement tool.</p> <p>The Program Manager completed a 100% chart audit of all patients' Plans of Care 6/28/12 to review the patient's necessary monitoring of their psychosocial status, focusing on specific interventions for identified issues. Any patient/Plan of Care found missing specific interventions, will be presented at the Interdisciplinary Team meeting conducted on 6/18/12, including patient's # 2, 3, 4 and 5. Patient specific issues as identified will be included in the patient's specific Plan of Care.</p> <p>The Program Manager will</p>	06/30/2012	

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	<p>abuse, etc.) Pt has been struggling with depression. Family physician prescribed anti-depressant . . . Education/Vocation pt recently lost [the patient's] job due to job restrictions . . . Insurance or financial resources." The plan failed to evidence interventions to address the identified needs.</p> <p>3. Clinical record number 4 included a PoC dated 4-16-12. The PoC identifies issues with "insurance or financial resources." The PoC failed to evidence interventions to address the identified need.</p> <p>4. Clinical record number 5 included a PoC dated 12-19-11. The PoC identifies issues with "mental health concerns (depression, anxiety, panic, substance abuse, etc.) pt struggles with depression and anxiety . . . education/vocation, changes to living situation pt has moved several times in the last year . . . community resource needs, insurance or financial resources." The plan failed to evidence interventions to address the identified needs.</p> <p>5. The Home Program Manager, employee A, was unable to provide any additional documentation and/or information when asked on 5-23-12 at 11:35 AM.</p>		<p>ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on the patient's psychosocial status and interventions. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues.</p> <p>The Program Manager is responsible to analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee 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, 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 then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>	

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	6. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Psychosocial status Provide necessary monitoring and social work interventions, including counseling services and appropriate referrals."			

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V0556	<p>494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must-</p> <p>(i) Be completed by the interdisciplinary team, including the patient if the patient desires; and</p> <p>(ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the patient had been provided the opportunity to participate in the development of the plan of care in 3 (#s 2, 3, and 5) of 4 records reviewed of patients that had been on service for longer than 30 days creating the potential to affect all of the facility's 41 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care (PoC) dated 12-19-11. The patient's signature on the plan of care failed to evidence a date to establish when the interdisciplinary team involved the patient in the development of the plan.</p> <p>2. Clinical record number 3 included a PoC dated 12-19-11. The plan of care failed to evidence the patient had been provided the opportunity to participate in</p>	V0556	<p>On June 6, 2012, the Education Coordinator reviewed the "Comprehensive Interdisciplinary Assessment and Plan of Care" policy with the Dietitian, Social Worker and Nursing Staff emphasizing the requirement that every patient and/or their representative be given the opportunity to attend each of their individual care plan meetings. Additionally, each Plan of Care must be reviewed, signed and dated by the patient in a timely manner.</p> <p>Each month any patient due for their Plan of Care review will be given an invitation in which they indicate their desire to participate in the upcoming IDT meeting by checking the appropriate box and signing the form to verify that they were notified. Documentation will be available in the patient record.</p> <p>The Program Manager will complete 100% chart audit of all patients' Plans of Care by 6/28/12 to review for patient or patient's</p>	06/30/2012			

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	<p>the development and implementation of the plan.</p> <p>3. Clinical record number 5 included a PoC dated 12-19-11. The patient's signature on the plan of care failed to evidence a date to establish when the interdisciplinary team involved the patient in the development of the plan.</p> <p>4. The Home Program Manager, employee A, was unable to provide any additional documentation and/or information when asked on 5-23-12 at 11:35 AM.</p> <p>5. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "The Plan of Care must be signed by team members including the patient or patient designee. If the patient is unable or chooses not to sign the Plan of Care, this must be documented on the Plan of Care along with the reason the signature was not provided."</p>		<p>designee timely signatures and dates or for the reason a signature was not provided. Any patient's chart found out of compliance will be presented at the Interdisciplinary Team meeting conducted on 6/30/12, the patient's will be invited to attend including patient's # 2, 3 and 5 and all corresponding signatures and dates will be obtained.</p> <p>The Program Manager will ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on the patient's participation in their Plan of Care as evidenced by their signature and date. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues.</p> <p>The Program Manager is responsible to analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee 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, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p>		

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			The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee	

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V0559	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b) (3)(ii) of this section.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure reasons for not achieving specified goals had been identified and the plan of care adjusted in 1 (# 3) of 4 records reviewed of patients that had been on service for longer than 30 days creating the potential to affect all of the facility's 41 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a plan of care dated 12-19-11 that included a goal to "be w/in [within] +2 or -2 kg [kilograms] of EDW [estimated dry weight] w/in 60 days."</p> <p>A. Clinic visit notes, dated 3-13-12 and 4-16-23, identify the fluid control goal had not been met. The visit notes</p>	V0559	<p>The Program Manager and Education Coordinator met with the facility's Interdisciplinary Team on 6/6/12 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 available emphasizing that each Plan of Care will be updated if expected outcomes are not achieved. The Home Program Manager completed a 100% chart review of all patients Plans of Care by 6/28/12 focusing on the patient's fluid control goals. Any patient found that do not meet their patient specific goals or having issues with fluid control goals, will be presented at the</p>	06/30/2012	

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	<p>included a plan of action that states, "Client education on fluid control . . . Assess for change in dextrose concentration, and education on S/S [signs and symptoms] of fluid overload / dehydration."</p> <p>B. The record failed to evidence the interdisciplinary team had identified the reasons why the desired outcome had not been achieved and failed to evidence the plan of care had been adjusted to address the identified reasons.</p> <p>2. The Home Program Manager, employee A, was unable to provide any additional documentation and/or information when asked on 5-23-12 at 11:35 AM.</p> <p>3. The facility's 2-2-11 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-138-020-091 states, "If the patient is unable to achieve the desired outcomes, the team must adjust the Plan of Care to reflect the patient's current condition, and Document in the medical record the reason(s) why the patient is unable to achieve the goal. Implement the Plan of Care changes to address the identified issues."</p>		<p>Interdisciplinary Team meeting by 6/30/12 including patient #3. Patient specific issues as identified will be included in the patient's specific Plan of Care. All members of the IDT, including the Dietitian and Social Worker, will review specific patient issues on a monthly basis. Any patients not meeting any of their specific goals, including fluid control, will be included on a monthly list of patients. The Program Manager will include patients on the list on the agenda for review by the Interdisciplinary team at the monthly care plan meeting for the purpose of making an adjustment to the Plan of Care. Recommendations of the IDT and actions taken monthly will be documented in each patient's specific Plan of Care update/progress note section. Monthly monitoring of all Plans of Care completed that month will be done by the Home Program Manager, to ensure that patients not meeting a goal have been identified, are addressed and Plans of Care are being updated timely and appropriately. Any POC's found out of compliance will be scheduled for completion within the next 30 days and corrective action will be taken as appropriate. Ongoing, the Home Program Manager will ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on all patients meeting goals and</p>		

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			<p>interventions when that does not occur.. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues. The Program Manager is responsible to analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee for oversight and review. 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. The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee The Home Program Manager is responsible to report a summary of findings monthly utilizing the medical record audit tool to the QAI committee. 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>		

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V0587	<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>Based on clinical record and facility policy review and interview, the facility failed to ensure home program staff had reviewed patients' home records and identified potential problems in 3 (#s 2, 3, and 4) of 4 records reviewed of patients on service for longer than 30 days creating the potential to affect all of the facility's 41 current patients.</p> <p>The findings include:</p> <p>1. The facility's 10-21-09 "Patient Home Record Keeping" policy number FMS-CS-HT-200-010A states, "Patient must bring Home Treatment log to each monthly clinic visit. Home records will be reviewed by Home Program nursing staff during patient monthly clinic visits to identify trends or omissions. Copies of the Home Treatment log will be kept in the patient medical record."</p> <p>2. Clinical record number 2 evidenced the patient was a home peritoneal dialysis patient. The record included a "Patient's</p>	V0587	<p>The Director of Operations met with the facility's patient care staff on 6/6/12 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care", to ensure that every home patients home record sheets will be reviewed at least every two months with documentation showing the review was completed.</p> <p>The Home Program Manager will complete 100% chart audit of all patient's monthly visit sheets by 6/28/12 to ensure that all patients have documentation showing that their home record sheets have been reviewed at a minimum of every two months. Any patient found out of compliance, including patient's # 2, 3 and 4 will be reviewed at the next monthly clinic visit on 6/30/12.</p> <p>The Home Program Manager is responsible to report a summary of findings monthly utilizing the medical record audit tool to the</p>	06/30/2012			

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	<p>Weight/Blood Pressure/Solution Report" for 2-1-12 through 3-12-12. The reports failed to evidence any blood pressure readings and all evidenced the same weight, 68 kilograms. The record failed to evidence the registered nurse had checked the reports and noted the lack of blood pressure readings and the same weight readings.</p> <p>3. Clinical record number 3 evidenced the patient was a home peritoneal dialysis patient. The record included a "CAPD Daily Flow Sheet" for 3-14-12 through 4-16-12. The flow sheets evidenced the blood pressure and weight had been recorded on only 5 of 33 days. The record failed to evidence the registered nurse had checked the reports and noted the lack of blood pressure and weight recordings.</p> <p>4. Clinical record number 4 evidenced the patient was a home peritoneal dialysis patient. The record included a a "Patient's Weight/Blood Pressure/Solution Report" for 1-1-12 through 5-6-12. The reports failed to evidence any blood pressure readings and all evidenced the same weight, 46.7 kilograms. The record failed to evidence the registered nurse had checked the reports and noted the lack of blood pressure readings and the same weight readings.</p>		QAI committee. 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.				

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	5. The Home Program Manager, employee A, stated, on 5-23-12 at 10:30 AM, "I'm not finding documentation where the nurses addressed the patients not documenting blood pressures and weights when the home treatment sheets are reviewed.			

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V0638	<p>494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE</p> <p>The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.</p> <p>Based on administrative record review and interview, the facility failed to ensure identified infection control issues were addressed and a performance improvement plan developed and implemented in 2 (March and April 2012) of 5 months reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's "Quality Assessment and Performance Improvement (QAI) Home Therapy Meeting Minutes" dated 3-12-12 and 4-16-12 identified a "declining" trend analysis for "Infection Control Observation." <p>The meeting minutes failed to evidence the facility had developed and implemented a plan to address the identified decline and to ensure performance improvement in this area.</p> <ol style="list-style-type: none"> The Home Program Manager, employee A, stated, on 5-23-12 at 12:45 PM, "I should have had an action plan in place." 	V0638	<p>On 6/18/12, the Director of Operations had a meeting with all participants of the QAI committee for the purpose of reeducation on the QAI process. This education included but was not limited to the following:</p> <ul style="list-style-type: none"> ·QAI Processes ·Infection Control Observation, reporting, analysis, trending and creating a plan <p>The Program Manager is responsible to analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee 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, 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</p>	06/18/2012			

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			resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.	