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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000000	This was an ESRD federal recertification survey. Survey Dates: 8/12-15/2013 Facility #: 006664 Medicaid Vendor #: 200878310 Surveyor: Dawn Snider, RN, PHNS Hemodialysis In-Center: 19 Quality Review: Joyce Elder, MSN, BSN, RN August 28, 2013	V000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.			
	Based on facility policy review, observation, and interview, the facility failed to ensure equipment was cleaned and properly used before use on another patient or before returning it to a clean area for 1 of 1 observations of an employee using a Phoenix meter creating the potential to spread infectious and communicable disease to all 19 in-center patients of the facility. (employee G) The findings include: 1. Facility policy titled "MEASURING CONDUCTIVITY, TEMPERATURE AND/OR pH USING THE PHOENIX METER" revision date September 2008	V000116	Clinical Teammates (TMs) were in-serviced 8/28/13 on the following: Policy #2-04-06: Measuring Conductivity, Temperature, and/or pH using the Phoenix Meter and Policy # 1-05-01: Infection Control for Dialysis Facilities. Verification of attendance at in-service is evidenced by a signature sheet. Surveyor observations were reviewed with TM's and special attention paid to: 1) rinsing of phoenix meters with dialysis quality water after each use and in between machines and stations, 2) disinfection of phoenix meter between stations with appropriate disinfectant before being returned to clean area/used on another patient. The Charge Nurse (CN) is responsible for the oversight of infection control	09/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Procedure 2-04-06J states, "Rinse the cell and syringe interior by drawing dialysis quality water through the cell filling the syringe. Expel and discard water. The Phoenix meter should be rinsed free of dialysate between uses." 2. Facility policy titled "INFECTION CONTROL FOR DIALYSIS FACILITIES" revision date March 2013 Policy:1-05-01 states, "30. If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients. ... If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient." 3. On 8/14/13 at 10:20 AM, employee G, a registered nurse (RN), used a phoenix meter to check the conductivity on patient #6 at station #11 machine #11. Employee G failed to rinse the cell and syringe interior with dialysis quality water and clean and disinfect the meter before and after checking the conductivity. 4. On 08/15/2013 at 9:19 AM Employee E, the facility administrator/RN, indicated employee G had not followed the policy for phoenix meter testing.		practices daily. Instances of non-compliance will be addressed immediately with the TM who is responsible. The FA will conduct daily audit spot checks for one week (8/16/13-8/23/13), then weekly for two weeks (8/26/13-9/6/13), and then monthly with regular scheduled infection control audits. Results of the audits will be reviewed with the Medical Director during the monthly QAPI meetings. The FA and Medical Director are responsible for the compliance with the plan of correction (POC).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. Based on clinical record and facility policy review and interview, the facility failed to ensure initial assessments had been completed within thirty (30) calendar days or thirteen (13) outpatient dialysis sessions in 1 of 5 records reviewed (#4) creating the potential to affect all new admissions to the facility. The findings include: 1. Clinical record number 4 evidenced a start of hemodialysis as 4/22/13. The record failed to evidence the initial assessment had been completed within 30 days. 2. The facility policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" revision date March 2012 Policy 1-14-02 states, "4. A comprehensive assessment will be conducted on all new patients within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with	V000516	Clinical Teammates (TMs) were in-serviced 8/30/13 in the following: Policy #1-01-14: Patient Assessment and Plan of Care when Utilizing Falcon Dialysis. Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: ensuring initial assessments are completed within 30 calendar days or 13 treatments. The Charge Nurse (CN) is responsible for oversight of this policy. Instances of non-compliance will be addressed with the TM responsible immediately. The CN will verify that the FALCON generated due date is correct based on pt start date/13 treatments in facility. The CN will print 'future assessment report' from FALCON biweekly and review with IDT during CORE team meetings to communicate assessment due dates and to ensure assessments are completed timely. The Facility Administrator (FA) or designee will conduct monthly audits of assessments and plans of care on all new patient admissions	09/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the first outpatient dialysis treatment or per state guidelines." 3. On 8/14/13 at 4:36 PM, Employee E, the facility administrator, indicated the plan of care had been completed on the 14th treatment, day 32, after the patient's first hemodialysis treatment at the facility.		starting August 30, 2013. Results of audits will be reviewed with the Medical Director during the monthly QAPI meetings and continued frequency of audits determined by the team with supporting documentation included in the meeting minutes. The FA and Medical Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000517	494.80(b)(2) PA-F/U REASSESSMENT-WITHIN 3 MO OF INITIAL A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.			
	Based on clinical record and facility policy review and interview, the facility failed to ensure a comprehensive reassessment had been completed ninety (90) days after the initial assessment in 1 of 5 records reviewed (#3) creating the potential to affect all the patients of the facility. The findings include: 1. Clinical record number 3 was readmitted to the facility on 6/16/12. The record failed to evidence a 90 assessment had been completed. 2. The facility policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" revision date March 2013 Policy:1-14-02 states, "5. A follow up 90 day re-assessment will be completed to evaluate patient's status and provide information to adjust the patient's plan of care."	V000517	Clinical Teammates (TMs) were in-serviced 08/03/2012 in the following: Policy #1-01-14: Patient Assessment and Plan of Care when Utilizing Falcon Dialysis. Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: F/U reassessments are completed within 90 calendar days of completion of the initial plan of care/assessment. The Charge Nurse (CN) is responsible for oversight of this policy. Instances of non-compliance will be addressed with the TM responsible immediately. The CN will verify that the FALCON generated due date is correct based on pt start date/completion date of initial assessment. The CN will print 'future assessment report' from FALCON biweekly and review with IDT during CORE team meetings to communicate assessment due dates and to ensure assessments are completed timely. The Facility Administrator (FA) or designee will conduct monthly audits on 100% of assessments and plans	09/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. On 8/1513 at 11:43 AM, Employee E, the facility administrator, indicated the 90 day comprehensive assessment for patient #3 was due upon readmission to facility and there was no evidence it had been completed.		of care on all patients for 3 months to ensure completion on or prior to due date. Ongoing compliance will be monitored with the facility's monthly medical record audit. Results of audits will be reviewed with the Medical Director during the monthly QAPI meetings and continued frequency of audits determined by the team with supporting documentation included in the meeting minutes. The FA and Medical Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000556	494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (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. Based on clinical record and facility policy review and interview, the facility failed to ensure an initial plan of care was signed by the interdisciplinary team (IDT) and the patient or patient's designee for 1 of 5 (#3) records reviewed creating the potential to affect any new patients. Findings: 1. Clinical record number 3 did not include a plan of care with signatures of the members of the IDT and patient or patient's designee after the patient was readmitted on 6/12/12. 2. The facility policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" revision March 2013 Policy: 1-14-02 states, "14. The patient's plan of care will be completed by facility's	V000556	Clinical Teammates (TMs) were in-serviced 08/03/2012 in the following: Policy #1-01-14: Patient Assessment and Plan of Care when Utilizing Falcon Dialysis. Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: POC's must be signed by the patient and IDT and kept in the patients chart. The Charge Nurse (CN) is responsible for oversight of this policy. Instances of non-compliance will be addressed with the TM responsible immediately. The CN is responsible for ensuring that the signature sheet is attached to the POC prior to filing in the medical record. The Facility Administrator (FA) or designee will audit 10% of all medical records monthly to ensure that POC/assessments are included in charts. Results of audits will be reviewed with the Medical Director during the monthly QAPI	09/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interdisciplinary team, including patient or personal representative. If the patient chooses not to sign the plan of care, this choice will be documented on the plan of care, along with the reason the signature was not provided." 3. On 8/15/13 at 11:41 AM, employee E, the facility administrator, indicated the signature page had possibly been sent to medical record storage at Iron Mountain.		meetings and continued frequency of audits determined by the team with supporting documentation included in the meeting minutes. The FA and Medical Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&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 policy review, document review, clinical record review, and interview, the medical director failed to ensure the facility followed it's policies for infection control, comprehensive assessment and plan of care, and monthly documentation of water cultures/endotoxin levels for 1 of 1 program reviewed. The findings include: 1. The medical director failed to ensure the facility followed its policy titled "MEASURING CONDUCTIVITY, TEMPERATURE AND/OR pH USING THE PHOENIX METER" revision date September 2008 Procedure 2-04-06J that states, "Rinse the cell and syringe interior by drawing dialysis quality water through the cell filling the syringe. Expel and discard water. The Phoenix meter should be rinsed free of dialysate between uses." (See V 116)	V000715	A Governing Body (GB) meeting was held 9/4/13 to discuss survey findings, Statement of Deficiencies, and current plan of correction. Verification of meeting is evidenced by GB meeting minutes. The Medical Director was advised of his responsibility to ensure that all approved policies and procedures are adhered to by all individuals in the facility. The Medical Director and the Facility Administrator (FA) are responsible for the oversight of this. Any instances of non-compliance will be addressed with the responsible person immediately. The FA will ensure the plan of correction (POC) as stated in V116, V516, V517, and V556 are completed in addition to the current required monthly audits and that the POC is carried out. The FA or designee will bring all documents and water culture/endotoxin results to the monthly QAPI meeting for the Medical Director to review and sign. Results of all audits will be reviewed with the Medical Director during the monthly QAPI meetings. The FA and Medical	09/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The medical director failed to ensure the facility followed its policy titled "INFECTION CONTROL FOR DIALYSIS FACILITIES" revision date March 2013 Policy:1-05-01 that states, " 30. If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients. ... If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient." (See V 116) 3. The medical director failed to ensure the facility followed its policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" revision date March 2012 Policy 1-14-02 that states, "4. A comprehensive assessment will be conducted on all new patients within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with the first outpatient dialysis treatment or per state guidelines." (See V 516) 4. The medical director failed to ensure the facility followed its policy titled "PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS" revision date March 2013 Policy:1-14-02 that states, " 5. A follow		Director are responsible for compliance with this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152613	A. BUILDING 00 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM DIALYSIS CENTER	1201 N JIM DAY RD STE 103 SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	up 90 day re-assessment will be completed to evaluate patient's status and provide information to adjust the patient's plan of care." (See V 556) 5. The medical director failed to ensure the facility followed its policy titled "WATER CULTURE POLICY" revision date September 2012 Policy: 2-06-01 that states, "2. The Medical Director documents a review of all water culture results monthly." and its policy titled "ENDOTOXIN TESTING POLICY" revision date September 2012 Policy:2-06-02 that states, "2. The Medical Director documents a review of all endotoxin samples results monthly." The water culture and endotoxin records failed to evidence the signature of the medical director for the months of June 2012 and April 2013.			