STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152575	A. BUILDING 00 B. WING	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAL CARE OF HUNTINGTON	3040 W PARK DR HUNTINGTON, IN 46750

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V0000	This was a federal ESRD recertification survey. Survey Dates: 2/4/13 - 2/7/13 Facility #: 003065 Medicaid Vendor #: 200827250K Surveyors: Ingrid Miller, RN, Public Health Nurse Surveyor - team leader Bridget Boston, RN, Public Health Nurse Surveyor - team member Census by Service Type: Number of In-Center Hemodialysis Patients: 18 Number of Peritoneal Dialysis Patients: 0 Number of home hemodialysis patients: 0 Total: 18 Quality Review: Joyce Elder, MSN, BSN, RN February 12, 2013	V0000		

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

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V0111	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on policy review and observation and interview, the facility failed to ensure the bleach solutions for clean use and dirty use were covered with opaque container lids and there was a procedure for making the bleach solution to the correct ratio for 1 of 1 dialysis facility with the potential to affect all of the facility's patients. Findings 1. Observation of bleach mixing was completed on 2/6/13 at 6 AM. Employee F, patient care technician, was observed to place 3 measuring cups labeled 1:100 parts of bleach to water that were designed to hold 4 cups of liquid each in the bottom of the handwashing sink on the corner of the hemodialysis treatment room. She then poured bleach from the 1 gallon container of bleach into these containers to approximately the 1/4 cup mark and filled the rest of the container up with water from the handwashing sink's faucet. There was no designated line on these containers to indicate the exact amount of bleach or water needed.	V0111	V111 New bleach containers with lids were purchased and marked for ease of mixing. *Policy & Procedure #1-05-8B Preparation of 1:100 Bleach Solution and Policy & Procedure #1-05-08A Preparation of 1:10 Bleach Solution* was laminated and secured to wall in designated bleach preparation area for reference by teammates. Facility Administrator (FA) conducted mandatory in-service for all clinical Teammates (TMs) on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure #1-05-08A Preparation of 1:10 Bleach Solution, Policy & Procedure #1-05-08B Preparation of 1:100 Bleach Solution, Policy & Procedure #1-05-01 Infection Control for Dialysis Facilities,* emphasizing proper measuring, labeling and mixing of 1:10 and 1:100 bleach solutions with demonstration and return demonstration. TMs instructed that bleach solutions should remain covered with lids after preparation to ensure appropriate concentration of solution, and prevent contaminates from	03/07/2013

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	She did not refer to a directions sheet while she made the bleach and water mixture. This bleach mixture was left uncovered and placed on top of the counter to the left of the handwashing sink. 2. On 2/6/13 at 11:55 AM, Employee E, administrator, indicated the bleach was uncovered, the directions were not used, and no policy existed for covering bleach containers. 3. The agency policy titled "Preparation of 1:100 Bleach Solution" with a origination of September 2007 and revision date of September 2008 stated, "Calculate final volume of 1:100 bleach solution desired e.g. [for example] 1000 ml [milliliter], 500 ml [milliliter]. Add 1 part of bleach to 99 parts of water. Fill the suitable container with water. Add bleach. Mix water and bleach. Label container with the expiration date, time, initials, and hazard communication label." 4. On 2/4/13 at 1:45 PM, at the clean sink in the front of the treatment room, two pitchers identified as containing bleach water solution 1:100 were observed. Neither container was covered. Located at the dirty sink was another container identified as holding a bleach water		entering. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA will conduct infection control audits daily x1 week, weekly x4 weeks, then monthly. FA will review audit results monthly with Medical Director during Quality Improvement Facility Management Meetings (QIFMM), continued frequency of audits will be determined by the team. QIFMM Minutes will reflect. The FA is responsible for compliance with this Plan of Correction (POC)	

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	solution 1:100 and contained clamps used during dialysis treatment. The lid was underneath the container. None of the containers of bleach solution were covered during the observation period. 5. On 2/6/13 at 11:30 AM, two plastic - opaque pitcher style containers identified as bleach water 1:100 were observed at the clean sink in the front of the treatment room. At the dirty sink, there was a opaque container that contained clamps used during the dialysis treatment. This container had a lid but it was not in use; the lid was under the container. None of the containers of bleach solution were covered during the observation period. 6. At 11:40 AM , employee E indicated that the facility does not have a policy to cover the bleach solutions and they never have covered them.			

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V0142	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P The facility must- (1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; Based on observations and staff interview, the facility failed to ensure that the dialysis did not have expired supplies for the patients' use for 1 of 1 facility with the potential to affect all 18 active patients. Findings 1. On February 5, 2013, at 11:30 AM, a storage cabinet in the dialysis treatment room was observed to hold 16 AV (Arteriovenous) Fistula twin packs 16 gauge needle sets with an expiration date of 8/2012. 2. On February 5, 2013, at 12 noon, Employee A, Registered Nurse, indicated these supplies were expired.	V0142	V142 Expired twin pack 16 gauge AV fistula needle sets were immediately removed and discarded. Expiration dates of all facility supplies were verified to not be expired by FA. FA held mandatory in-service for all TMs on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure # 1-05-01 Infection Control for Dialysis Facilities,* importance of verifying all facility medications, solutions and supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs were educated that using expired items could have the potential to affect 100% of facility patient census. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. Inventory manager will check facility inventory monthly to verify all facility solutions and supplies are checked for expiration in stock or available for use on treatment floor. Compliance will be assured by FA/designee audit of facility monthly logs. Results of	03/07/2013

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			audits will be reviewed with Medical Director during QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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V0143	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation and interview, the facility failed to ensure medications were not expired for 1 of 1 facility with the potential to affect all the 18 active patients. Findings 1. On February 5, 2013, at 11:30 AM, an emergency cart in the dialysis treatment room was observed to hold a 50 milliliter container of 50% dextrose unit of use syringe with an expiration date of 10/1/12. A medication cart was observed to hold an opened bottle of 100 acetaminophen tablets with an expiration date of 10/2012. This bottle had an opened date of 1/14/13. 2. On February 5, 2013, at 12 noon, Employee A, Registered Nurse, indicated the dextrose and tablets were expired.	V0143	V143 Expired dextrose and acetaminophen tablets were immediately removed and discarded. Expiration dates of all facility medications were verified to not be expired by FA. FA held mandatory in-service for all TMs on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure # 1-05-01 Infection Control for Dialysis Facilities,* importance of verifying all facility medications, solutions and supplies are checked for expiration dates and discarded per Policy & Procedure if found. TMs were educated that using expired items could have the potential to affect 100% of facility patient census. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. Inventory manager will check facility inventory monthly to verify all facility medications are checked for expiration in stock or available for use on treatment floor. Compliance will be assured by FA/designee audit of facility	03/07/2013

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			monthly logs. Results of audits will be reviewed with Medical Director during QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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V0196	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours. Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet. Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N.N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes. The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly. Based on observation, interview, and review of documents, the facility failed to ensure the chlorine testing had been completed in accordance with facility policy and procedure in 1 of 2 water tests observed creating the potential to affect	V0196	V196 Clock with second hand placed in water room for use during chlorine checks. Biomedical Technician (BMT) held mandatory in-service for all TMs responsible for water	03/07/2013

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	all of the facility's 18 patients. The findings include 1. On 2/4/13 at 2:44 PM, Employee G, Patient Care Technician, was observed to complete a routine water test for chlorine using a Hach Pocket Colorimeter by adding the contents of the N, N-diethyl-p-phenylene-diamine (DPD) Total Chlorine Reagent Powder Pillow to the reverse osmosis water sample in a small glass container, putting a cap on the sample, and then gently shaking the water and powder in the capped container for unknown amount of time. He conducted the water test without using a timing device to ensure the contents of the sample and powder were thoroughly mixed for 20 seconds. 2. On 2/4/13 at 2:45 PM, Employee G indicated counting the time in his head for the required 20 seconds without using a timing device while mixing the DPD Total Chlorine Reagent Powder with the reverse osmosis water sample. 3. The facility procedure with a title of "Total Chlorine Test Using Hach Pocket Colorimeter" with an origination date of 8/06 and revision date of September 2011 stated, "Open the pillow and form a spout by squeezing the side edges, pour the		treatment monitoring on 2/15/2013. In-service included but was not be limited to: review of *Policy& Procedure # 2-07-04 Daily Water System Total Chlorine Monitoring, Policy & Procedure# 02-07-04D Total Chlorine Test Using HACH Pocket Colorimeter, and Routine Chlorine Testing Log.* Return demonstration and skills check –off list completed during in-service. TMs must use clock with second hand that is available in Water Room to ensure correct time during chlorine testing. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will conduct observational audits 3 x weekly for 2 weeks, then weekly x 2, then monthly. Results of the audits will be reviewed with Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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	pillow contents into the sample cell cap, and gently shake the sample and DPD powder for 20 seconds."			

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V0214	494.40(a) BACT CONTROL DEVICE-UV LIGHT 5.3.4 Bacterial control devices: 5.3.4.1 Ultraviolet irradiators: UV dose Refer to RD62:2001, 4.3.13 Ultraviolet irradiators: When used to control bacterial proliferation in water storage and distribution systems, UV irradiation devices shall be fitted with a low-pressure mercury lamp that emits light at a wavelength of 254 nm and provides a dose of radiant energy of 30 milliwatt-sec/cm2, [except in the case described below]. The device shall be sized for the maximum anticipated flow rate according to the manufacturer's instructions. 5.3.4.1 Ultraviolet irradiators If the irradiator includes a meter as described above, the minimum dose of radiant energy should be at least 16 milliwatt-sec/cm2. To prevent the use of sublethal doses of radiation that may lead to the development of resistant strains of bacteria, UV irradiators shall be equipped with a calibrated ultraviolet intensity meter ...or with an on-line monitor of radiant energy output that activates a visible alarm, which indicates that the lamp should be replaced. Alternatively, the lamp should be replaced on a predetermined schedule according to the manufacturer's instructions to maintain the recommended radiant energy output. 6.3.4 Bacterial control devices 6.3.4.1 Ultraviolet irradiators Ultraviolet irradiators intended for use as a direct means of bacterial control shall be monitored for radiant energy output. UV irradiators should be monitored at the frequency recommended by the			

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	manufacturer. A log sheet should be used to indicate that monitoring has been performed. Based on staff interview and review of documents, the facility failed to ensure there was a policy and procedure in place to monitor the ultra violet (UV) light used for bacterial control in the water system for 1 of 1 facility with the potential to affect all the patients of the facility. Findings 1. Review of facility documents failed to evidence a document concerning the UV light used by the facility for bacterial control in the water storage and distribution system. 2. On 2/5/13 at 1:35 PM, Employee B, Biotechnician, indicated he could not find the UV log to show the UV light had been changed or monitored. He was unaware of how many hours were on this UV light and no policy exists concerning the UV light.	V0214	V214 BMT immediately replaced UV light. Ultraviolet light replacement was placed on 2013 clinic specific preventative maintenance schedule. FA held mandatory in-service for BMT on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure # 2-03-01 Water Treatment Systems Minimum Component Requirements,* importance of replacement of UV lamp on a predetermined schedule. BMT was educated that not changing the ultraviolet lamp could have the potential to affect 100% of facility patient census. Attendance of in-service is evidenced by BMTs signature on the Clinical In-Service Form. FA or designee will review 2013 clinic specific preventative maintenance schedule weekly x 4, then monthly for compliance. Results of audits will be reviewed with the Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	03/07/2013

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	3. On 2/4/13 at 4:40 PM, employee D indicated he took over 6 months ago and the maintenance logs were not up to date at that time. He indicated he was not aware of the UV light monitoring log status and stated, "I have not monitored or changed the ultra violet light since assigned to the facility."			

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V0216	494.40(a) 0ZONE-SYS REQUIREMENTS/MONITORING 5.3.4.2 Ozone generators: system requirements/monitoring Ozone can be used for bacterial control only in systems constructed from ozone-resistant materials (see AAMI 5.3.3 for suitable piping materials). 5.3.4.2 Ozone generators Refer to RD62:2001, 4.3.15 Ozone disinfection systems: When used to control bacterial proliferation in water storage and distribution systems, an ozone generator shall be capable of delivering ozone at the concentration and for the exposure time specified by the manufacturer. 6.3.4 Bacterial control devices 6.3.4.2 Ozone generators Ozone generators should be monitored for ozone output at a level specified by the manufacturer. The output of the ozone generator should be measured by the ozone concentration in the water. A test based on indigo trisulfonate chemistry, or the equivalent, should be used to measure the ozone concentration ...each time disinfection is performed. An ozone-in-ambient-air test should be conducted on a periodic basis, as recommended by the manufacturer, to ensure compliance with the OSHA permissible exposure limit of 0.1 ppm. A log sheet should be used to indicate that monitoring has been performed. Based on facility document and policy review and interview, the facility failed to ensure there was a policy and procedure in place for monitoring the ambient air level of ozone used for the disinfection of	V0216	V216 Air quality monitoring badges have ordered to be utilized during quarterly ozone air testing until new bicarbonate concentrate	03/07/2013

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	the bicarbonate mixing system for 1 of 1 facility with the potential to adversely affect all employees that used the ozone during the disinfection process. The findings include: 1. On 2/6/13 at 4:06 PM, employee D indicated the facility did not have a policy for monitoring the ambient air level of ozone used for the disinfection of the bicarbonate mixer. He indicated he did have the policy for monitoring from the previous owner, DSI. He indicated he sampled the air quarterly by wearing a badge that detected the ambient air for ozone and the patient care technicians were the staff disinfecting the bicarbonate mixer weekly. He indicated they did not wear a badge to monitor the ambient air and the facility did not have sufficient number of the badges for the staff to wear. DSI policy titled "Policy / Procedure: Air Sampling During Ozone" stated, "All facilities using ozone as a disinfectant will adhere to the OSHA regulation for permissible exposure limit (PEL) of ozone in air of 0.1 PPM over an 8 hour time weighted average. Ozone in air test will be done during the first use of an ozone generator and quarterly thereafter. ... Order appropriate badges. Verify new		system is installed in the clinic. Ozone in Ambient Air Test will be completed once badges are received during ozone disinfection and results documented on Bicarbonate Mixer Disinfection Log. FA held mandatory in-service for all TMs responsible for bicarbonate concentrate system disinfection on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure #2-04-03 Bicarbonate Concentrate System Disinfection*, importance of conducting ozone in ambient air testing quarterly during ozone disinfection. TMs instructed air quality monitoring badge must be utilized to conduct ozone air testing, TMs must record performed testing and results on Bicarbonate Mixer Disinfection Log. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will review bicarbonate concentration system disinfection log weekly x 4, then monthly for compliance. Results of audits will be reviewed with the Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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	152575	A. BUILDING 00 B. WING	02/07/2013

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	badge has not been damaged and is showing "zero" exposure. Badge to remain in close proximity of ozone generator but not on tank or lid. Complete ozone disinfection. ... Read the highest level of exposure and divide that number by "hours of exposure" to get your time weighted average. If exposure limits are above 0.1 PPM over time weighted average, immediate action must be taken to limit future exposure to staff." 2. The facility's policy titled "Bicarbonate Concentrate System Disinfection" revision date March 2012 stated, "When ozone disinfection systems are used, ambient air will be monitored for ozone as required by the U.S. Occupational Safety and Health Administration (OSHA)." 3. The facility's document "Bicarb System Ozone Log" evidenced ozone had been used to disinfect the system on 12/4/12, 12/11/12, 12/17/12. 12/26/12, 1/3/13, 1/17/13, 1/24/13, and 1/28/13. The log failed to evidence a test for the ambient Ozone was completed during the disinfection process on the day it was used to disinfect the system. 4. The facility's document "Equipment Repair Record ER - 1 Air Testing Ozone" evidenced air testing was completed by			

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	employee D on 12/6/12; there was no documentation of ozone being used for disinfection on 12/6/12.			

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V0230	494.40(a) MIXING SYSTEMS-CLEANING 6.4.1 Mixing systems: cleaning Concentrate mixing equipment should be either: (1) completely emptied, cleaned, and disinfected according to the manufacturer's instructions; or (2) cleaned and disinfected using a procedure demonstrated by the facility to be effective in routinely producing concentrate meeting [these regulations related to allowable bacterial and endotoxin levels]. The disinfection data should be recorded for each ...disinfection cycle using a dedicated log. Based on document review, interview, and policy review, the medical director failed to ensure the bicarbonate system bleaching disinfect and the bicarbonate system rinse logs were completed as required by policy for 1 of 1 facility with the potential to affect all 18 patients facility. Findings 1. A document titled "Bicarb [bicarbonate] system bleach disinfect log" with dates recorded on this log from 12/4/12 - 1/28/12 evidenced staff were to include weekly entries with the date, time, signatures, and documentation within the log that patients were off the floor, the tanks and loops were disinfected, the rinse procedure was completed, and the bleach	V0230	V230 BMT held mandatory in-service for all TMs responsible for water treatment monitoring on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure* ***#2-04-02 Daily Bicarbonate Concentrate System Mixer Cleaning****, Policy & Procedure #2-04-03 Bicarbonate Concentrate System Disinfection,* emphasizing TMs must disinfect bicarbonate mixer weekly. Disinfection of Bicarbonate system must be documented on Bicarbonate Mixer Disinfection Log to include; date, time, signature of TM performing disinfection, dwell time, type of chemical, verification of chemical presence at all points of use, verification of negative chemical residual at all points of use the next patient treatment day prior to first patient treatment for that day. TMs must complete	03/07/2013

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	level was checked. Late entries were noted on 12/26/12 and 1/17/13. The log failed to evidence the bicarb system bleach disinfect had occurred weekly as required by facility policy. 2. A document titled "Bicarb system daily rinse log" with entries between 12/2/12 and 2/1/13 failed to include a completed daily entry on 1/30/13. There was the date recorded but no other data. Missing from this entry on 1/30/13 were the completion of the rinsing of the tanks and loops, the signature of the preparer, the time the rinsing had occurred, and that the bleach was not noted in the bicarb system. 3. The agency policy titled "Daily Bicarbonate Concentrate System Mixer Cleaning" with a date of 2/4/02 and review date of March 2012 stated, "The bicarbonate concentrate system should be rinsed free of bicarbonate daily, at the end of the treatment day, and disinfected at least weekly ... the facility specific bicarbonate mixer rinsing and cleaning procedure will include ... documentation and labeling requirements." 4. On 2/5/13 at 11:15 AM, the biotechnician indicated the above documentation showed late entries occurred in the "Bicarb [bicarbonate] system bleach disinfect log" and the		rinsing procedure for bicarbonate mixing system at the end of each treatment day, and documented on Bicarbonate System Daily Rinse Log to include date, time, signature of TM performing rinse, and answer log questions verifying all patients off floor, tanks and loop rinsed. TMs were educated on potential of 100% of patient census being affected by insufficient disinfection and rinsing of bicarbonate system. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will review Bicarbonate System Disinfect, and Daily Rinse Logs weekly x 4, then monthly for compliance. Results of audits will be reviewed with the Medical Director during monthly QIFMM, continued frequency of audits will be determined by team, QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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	"Bicarb System Daily Rinse Log." This did not comply with the facility policy.			

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V0407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation and staff interview, the facility failed to ensure the treatment area was staffed so that all patients (patients #6 - 14) receiving hemodialysis could be seen at all times for 1 of 1 facility with the potential to affect all of the patients receiving hemodialysis services on the treatment floor Findings 1. On 2/6/13 at 8:29 AM, Employee J, Registered Nurse, who had been the nurse on duty on the treatment floor, was observed to be in the break room. 2. On 2/6/13 at 8:30 AM, Employee F, patient care technician, was observed to be the only staff member on the floor with patients #6 - #14. At 8:40 AM, Employee F was observed to go into an empty isolation room at the end of the treatment floor. The treatment room was set up to have 16 stations in view of the treatment desk. The isolation room has one station in it. In the isolation room, there is a wall that blocks the view of the main floor of the treatment room. Employee F was	V0407	V407 FA held mandatory in-service for all clinical TMS on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure #1-03-09 Intradialytic Treatment Monitoring,* emphasizing TMs must ensure each patient, including his/her face, vascular access site is visible at all times during treatment to ensure patient safety. TMs were educated that 100% of patients could be affected if intradialytic monitoring does not occur. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA or designee will conduct observational audits weekly x 4 weeks, then monthly. FA will review results of audits with Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. The FA is responsible for compliance with this POC	03/07/2013

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	observed to set up dialysis supplies in that room for 1 minute. Employee F was unable to see the 9 patients on the floor. No other staff member was present observing the patients on hemodialysis treatment. 3. On 2/6/13 at 1:55 PM, Employee F indicated setting up tubing in the isolation room before patient # 5's arrival scheduled for 9:40 AM and not being able to view the patients at this time.			

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V0715	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 personnel file review, policy review, and interview, the medical director failed to ensure all employees had annual tuberculosis testing as required per policy for 4 of 11 personnel files (E, F, I and J) reviewed with the potential to affect all the facility's patients. Findings 1. The agency policy titled "Tuberculosis Monitoring and Follow-up" with an origination date of August 2006 and revision dates of September 2008, September 2009, March 2011, and September 2012 stated, "The tuberculosis monitoring and follow-up consist of the following: Baseline and Annual TST [Tuberculosis Screening Test] ... Follow up TB [tuberculosis] screening using TST will occur on an annual basis, from the date of the last TST using a one step method based ... Indications for a	V0715	V715 Annual TB Screening conducted for TMs E, F, I and J per *Policy & Procedure # 4-06-05: Tuberculosis Monitoring and Follow-Up* on 2/11/2013, documentation placed in personnel record. FA developed and initiated tickler system that will be reviewed monthly to ensure ongoing compliance with TMs annual health screening requirements including ensuring Tuberculosis monitoring is complete and documentation is verified in personnel record. FA will review audit results monthly with Medical Director during QIFMM, minutes will reflect. The FA is responsible for compliance with this POC	03/07/2013

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	two-step and one - step ... Teammate situation ... negative TST on baseline or annual screening ... Type of screening and monitoring ... annual single-step TST." 2. Personnel file E, effective date as administrator 6/12/08, failed to evidence an annual tuberculosis screening was completed for 2013. The file evidenced the last screening had been completed on 1/30/12. 3. Personnel file F, date of hire (DOH) 11/8/04, failed to evidence an annual tuberculosis screening was completed for 2013. The file evidenced the last screening had been completed on 1/27/12. 4. Personnel file I, float nurse, failed to evidence an annual tuberculosis screening was completed for 2013. The file evidenced the last screening had been completed on 1/30/12. 5. Personnel file J, DOH 12/22/08, failed to evidence an annual tuberculosis screening was completed for 2013. The file evidenced the last screening had been completed on 1/16/12. 6. On 2/7/13 at 1:05 PM, Employee K, registered nurse, indicated the tuberculosis screenings were late and policy was not followed.			

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V0729	494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY (1) Current medical records and those of discharged patients must be completed promptly. Based on clinical record and policy review and interview, the facility failed to ensure physician orders were signed timely and all disciplines documented timely as per facility policy in 5 of 5 records reviewed (# 1, 2, 3, 4, and 5) with the potential to affect all 18 patients of the facility The findings include: 1. Clinical record # 1 evidenced the registered dietician documented in the electronic clinical record an entry titled "The Plan of Care Follow Up Note for Discipline: RD [registered dietician] dated 2/05/13 that stated, "Condition Low Albumin ... Pt. [patient] was called 1/23/13 ... ." The record evidenced the original physician orders for dialysis treatment in the facility dated 11/22/12 and was not signed by the ordering physician until 1/11/13. 2. Clinical record # 3 evidenced the registered dietician documented in the electronic clinical record an entry titled "The Plan of Care Follow Up Note for Discipline: RD dated 2/04/13 that stated, "Category Nutritional Status ... Pt.	V0729	V729 FA conducted in-service with Renal Dietician (RD) on 2/15/2013. In-service included but was not limited to: review of *Policy & Procedure #1-02-04 Provisions of Nutritional Services*, RD must provide documentation of nutritional interventions and the patient's nutritional progress monthly or more frequently as needed. RD must ensure comprehensive re-assessment of each patient along with revision to the plan of care evaluates and addresses current nutritional needs of patient based on timeline goals. RD must ensure all documentation including RD progress notes are completed timely and reflect current nutritional status of patient. Attendance of in-service is evidenced by TMs signature on the Clinical In-Service Form. FA reviewed *Policy & Procedure 3-02-07: Medical Record Quality Assurance* with Medical Director on 2/22/2013, emphasizing the requirements for signing all orders of patient care within 30 days of order origination. Medical Director will send notification to each facility privileged physician on 2/22/2013 regarding	03/07/2013

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	[patient] seen 1/23/13" and another entry titled the same and dated 12/4/12 and stated, "Pt. [patient] seen 11/9/12." A. Electronic entry titled "The Plan of Care Follow Up Note for Discipline: RD dated 11/06/12 stated, "Category Nutritional Status ... Pt. [patient] seen 10/26/13." B. Physician orders for dialysis treatment and included 1) Dialyzer BAXTER - Xenium - 150 - 955, 2) Duration 210 minutes, 3) Blood flow rate 500, 4) Dialysis flow rate 800, 5) Dialysate - potassium 2, calcium 2.5, BiCarb 40, and 6) Heparin dose 5000 units as bolus was dated 9/24/12. The physician order was not signed by the physician until 1/11/13. 3. Clinical record # 5 evidenced the registered dietician failed to document her assessments and findings timely and per facility policy and the attending physician failed to sign his orders per facility policy as evidenced by the following: A. The Plan of Care Follow Up Note for Discipline: RD dated 10/02/12 stated, "Condition Low Albumin ... Pt. seen 9/28/12." B. The Plan of Care Follow Up Note for Discipline: RD dated 10/02/12 stated,		requirements that attending physician must sign physician orders within 30 days of order origination. FA or designee will audit RD progress notes monthly to ensure nutrition & metabolic notes are completed, and appropriate interventions are documented to meet patient needs for indicators not meeting goal. FA will also audit 100% of physician orders monthly to ensure orders are signed timely. Results of audits will be discussed with the Medical Director during monthly QIFMM, continued frequency of audits determined by the team. QIFMM minutes will reflect. The FA is responsible for compliance with this POC	

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	"Condition High Phosphorus ... Pt. seen 9/28/12." C. The The Plan of Care Follow Up Note for Discipline: RD dated 11/15/12 stated, "Condition Low Albumin ... Pt. seen 10/12/12." D. The The Plan of Care Follow Up Note for Discipline: RD dated 11/15/12 stated, "Condition Low PTH ... Pt. seen 10/12/12." E. The Plan of Care Follow Up Note for Discipline: RD dated 12/04/12 stated, "Condition Low Albumin ... Pt. seen 11/9/12." F. The The Plan of Care Follow Up Note for Discipline: RD dated 12/04/12 stated, "Condition Low PTH ... Pt. seen 11/9/12." G. The Plan of Care Follow Up Note for Discipline: RD dated 2/05/13 stated, "Condition Low Albumin ... Pt. seen 1/23/13." H. The Plan of Care Follow Up Note for Discipline: RD dated 2/05/13 stated, "Condition Low Phosphorus ... Pt. seen 1/23/13." I. The record evidenced the original			

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	physician orders for dialysis treatment in the clinic dated 3/19/12 was signed by the physician on 5/4/12. J. The record evidenced dialysis treatment physician orders to change the patients estimated dry weight dated 8/24/12, 9/18/12, 10/5/12, and 11/2/12 were signed by the physician on 1/11/13. K. The record evidenced physician orders for the staff to collect a one time laboratory blood level for albumin, hemoglobin, and phosphorus dated 10/5/12. These orders were signed by the physician on 1/11/13. 4. The facility policy titled "Medical Record Quality Assurance" revision date September 2008 stated, "The attending physician is required to sign all orders for patient care. ... Telephone, verbal, and electronic orders will be authenticated and so-signed within 30 days or as required by state law, whichever is more stringent. ... Dietician: All progress notes are to be dated and signed at the time they are written or entered electronically." 5. Clinical record #2 evidenced a late physician signature on a 12/13/12 order for "dialyzer: Baxter - Xenium - 190 - 1140 for the duration of 270 minutes, blood flow of 500, dialysate flow of 800,			

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(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
	Potassium 3, Calcium 2.5, Bicarb 38 ... heparin: pork ... bolus 5000 ... dialysis 3 times a week." This order was signed by Employee E, Registered Nurse (RN), on 12/13/12 and not signed by the physician until 1/11/13. 6. Clinical record #2 evidenced Employee C, RD, visited patient #2 on 11/16/12 and did not write the note about the visit until 12/4/12. This was evidenced by the following: A clinical document note titled "Progress and Plan of Care Follow-up notes report" with a date of 12/4/12 stated, "Pt seen 11/16. Nutrition report reviewed with patient. Albumin 3.8 - good considering Pt. has chest wound and UTI [urinary tract infection]. Continue to encourage high protein diet. Protein supplement: encourage ... protein bars and whey ... Will monitor labs, educating / assisting pt. with diet issues as needed." 7. Clinical record #4 evidenced a late physician signature on an order for 11/16/12 "dialyzer: Baxter - Xenium - 150 - 955 for the duration of 225 minutes, blood flow of 450, dialysate flow of 700, Potassium 3, Calcium 2.5, Bicarb 34 ... dialysis 3 times a week." This order was signed by Employee L, RN, on 11/16/12 and not signed by the physician until			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152575	A. BUILDING 00 B. WING	02/07/2013

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	1/11/13. 8. Clinical record #4 evidenced Employee C visited patient #4 on 10/12/12 and did not write the note about the visit until 11/6/12. This was evidenced by the following: A clinical document note titled "Progress and Plan of Care Follow-up notes report" with a date of 11/6/12 stated, "Pt seen 10/12 and nutrition report reviewed with pt. Albumin 3.6 ... Continue to encourage high protein diet. Protein supplement: Eats zone protein bars with 14.6 protein each. Appetite good ... Dry Wt [weight] stable ... will monitor labs, educating / assisting pt with diet issues as needed." 9. On 2/7/13 at 10:35 AM, Employee K, RN, indicated the above orders and staff notes were signed and completed late.			