STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152645	A. BUILDING 00 B. WING	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON DIALYSIS	9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234

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V000000	This was a (Core) federal recertification survey. Date: June 15, 16, and 17, 2013 Facility #: 12543 Medicaid #: 20107560 Surveyors: Susan E. Sparks, RN, PHNS Miriam Bennett, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN July 23, 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.

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V000113	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.	V000113	**V113** FA had mandatory in service on 7/18/2013 All teammates (TM) were immediately counseled by the Facility Administrator (FA) with emphasis on importance of hand hygiene (hand washing/hand sanitizer) performed after each glove removal, in between patients, after touching patient equipment, when using gel to cover all surfaces of the hands and run until dry, and to disinfect items before returning to clean area. TM's are being in serviced on policy #1-05-01: Infection control for dialysis facilities, policy # 1-05-01A: use of Alcohol Based Hand Gel, and policy # 01-05-01B: Hand washing. Verification of attendance at in-service is evidenced by signatures on clinical in-service form. FA or designee will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. Instances of noncompliance will be addressed with the TM responsible immediately. Results of audits will be reviewed with the medical director during monthly Quality	08/16/2013

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	Based on observation, policy review, and interview, the facility failed to ensure the staff followed infection control policies for 2 of 3 observations with the potential to affect all the facility's patients. (Employees E and I) Findings include 1. During observation on 7/15/13 at 12:22 PM at station 7 with patient #11, employee E, Patient Care Technician (PCT), was observed cleaning the access for a Arterial Venous Fistula. Employee E entered information into the computer system, donned clean gloves without performing hand hygiene, and accessed the cannulation sites without applying more antiseptic. 2. During observation on 7/16/13 at 9:55 AM, Employee I, Patient Care Technician, was observed at station #2 preparing to access the patient's fistula. While gloved, the employee walked to the supply station drawer for more supplies. Employee I returned to station #2 and failed to change gloves with proper hand		Improvement Facility Management meetings (QIFMM) with supporting documentation included in the meeting minutes. The FA is responsible for compliance with this plan of correction (POC).	

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	hygiene before proceeding to access the fistula. 3. The policy titled "Infection Control for Dialysis Facilities" #1-05-01 states, "1. Hand hygiene is to be performed ... after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and before leaving the patient care area. ... 8. Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. ... 10. Glove should be changed when: ... When going from a "dirty" area or task to a "clean" area or task. 4. The policy titled "AV Fistula or Graft Cannulation with Safety Fistula Needled (SFN) and Administration of Heparin # 1-04-01A states, "8. Locate and palpate the needle cannulation sites prior to skin preparation. 9. With clean-gloved hands, cleanse the site by applying a 70% alcohol prep using a circular rubbing motion, center out. ... 12. Repeat for second insertion site. Do not palpate insertion site once area has been prepped." 5. The policy titled "Infection Control for			

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	Dialysis Facilities," #1-05-01 states, "62. Gloves are to be removed and hands washed or alcohol based hand rubs used before and after touching the keyboard." 4. 3. On 7/16/13 at 2:30 PM, employee A indicated that gloves should be removed prior to leaving stations and hand hygiene should be performed after touching computer keyboards and prior to patient care.			

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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 observation, policy review, and interview, the facility failed to ensure staff followed infection control policies and procedures for 2 of 3 observations with the potential to affect all the facility's patients. (Employees G, F, and H) Findings include 1. During observation on 7/15/13 at 12:10 PM, employee G, Patient Care Technician (PCT), was observed using the Phoenix meter. Employee G failed to disinfect meter prior to returning it to the docking station. 2. During observation on 7/16/13 at 9:33 AM, employee F, PCT, was observed using the Phoenix meter. Employee F	V000116	All teammates immediately counseled by the FA with emphasis on importance of disinfection of equipment prior to returning to a clean area and between patients, Personal protective equipment (PPE) must be changed prior to entering water room and again before returning to in center floor. Hooks are available at door to water room to hang PPE on upon entering water room or returning to treatment floor. Facility Administrator (FA) held mandatory in-service on 7/18/2013 for all Clinical Teammates (TMs). In-service included but was not limited to: Review of *Policy &Procedure #1-05-01: Infection Control for Dialysis Facilities,* TMs educated that items taken to dialysis station	08/16/2013

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	failed to clean the meter prior to returning to the docking station. 3. During observation of water check on 7/15/13 at 11:50 AM, employee H, PCT, failed to change Personal Protective Equipment (PPE) gown prior to entering the water room and failed to change same gown after water check before returning to in-center floor. a. On 7/15/13 at 11:55 AM, employee H, PCT, indicated he was not sure what the policy was for changing the gown or not prior to entering the water room. b. On 7/15/13 at 12:45 PM, employee H, PCT, indicated he checked on the policy and found out he was supposed to remove the PPE gown in center and don a new one in the water room. 4. The policy titled "Infection Control for Dialysis Facilities," #1-05-01 states, "13. Appropriate PPE will be worn whenever there is the potential for contact with body fluids, ... PPE is to be removed prior to leaving the treatment area. ... 39. Items taken into the dialysis station will be ... or cleaned and disinfected before taken to a common clean area. 40. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the		should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Dirty supplies will not placed in areas designated for clean items only. TMs instructed using surveyor observations as examples to the following: 1) TMs must disinfect phoenix meters prior to patient use and ensure meters are stored in designated dirty area away from clean supplies; Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet. Facility Administrator or designee will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly Quality Improvement Facility Management Meetings (QIFMM) with minutes reflecting. FA is responsible for compliance with this Plan of Correction.	

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	prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment. ... 44. If a common supply cart is used to store clean supplies in the patient treatment area, this cart is to remain in a designated area ... Only teammates with clean hands may remove items from supply cart. ... 47. Equipment including the dialysis delivery system, the interior and exterior of the prime container, ... will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. ... 62. Gloves are to be removed and hands washed or alcohol based hand rubs used before and after touching the keyboard." 5. On 7/16/13 at 2:30 PM, employee A, Facility Administrator, indicated Phoenix meters should be cleaned after use.			

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V000122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, interview, and policy review, the facility failed to ensure the staff followed policies and procedures for cleaning dialysis stations between patients for 2 of 3 observations with the potential to affect all the facility's patients. (Employees I and K) Findings include 1. During observation on 7/16/13 at 10:30 AM, employee I, Patient Care Technician (PCT), was observed preparing the dialysis machine for the next patient at station #1. Employee I failed to empty the prime waste bucket and proceeded to set up solution for the next patient. 2. On 7/16/13 at 11:00 AM, employee K was observed cleaning station #11. Employee K, PCT, failed to empty the prime bucket.	V000122	**V122** FA held mandatory in-service on 7/18/2013 for all Clinical TMs. In-service included but was not limited to: Review of *Policy & Procedure #1-05-01: Infection Control for Dialysis Facilities,* TMs educated that all non-disposable items and equipment such as BP cuff, inside and outside of prime container, clamps, tables, TVs, all work surfaces must be wiped with proper bleach solution between patient treatments. Dirty supplies must not be stored in areas designated for clean items only. TMs must disinfect phoenix meters prior to patient use and ensure meters are stored in designated dirty area away from clean supplies. Verification of attendance at in-service will be evidenced by TMs signature on In-service sheet. FA or designee will conduct infection control audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during	08/16/2013

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	3. The policy titled "Infection Control for Dialysis Facilities," #1-05-01 states, "40. Teammates will thoroughly wipe down all non-disposable items and equipment such as ... the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment. ... 47. Equipment including the dialysis delivery system, the interior and exterior of the prime container, ... will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment." 4. On 7/16/13 at 2:30 PM, employee A, Facility Administrator, indicated prime buckets should be emptied, cleaned and dried before next patient set up.		homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting. FA is responsible for compliance with this Plan of Correction	

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V000147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on observation and interview, the facility failed to ensure the staff followed infection control standards for 1 of 3 observations of patients with a central venous catheter with the potential to affect all the facility's Central Venous	V000147	**V147** FA will hold mandatory in-service for all clinical TMs on (date). In-service will include but not be limited to: review of *Policy & Procedure #1-04-12A Predialysis Central Venous Catheter (CVC)*	08/16/2013

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	Catheter (CVC) patients. (#8) Findings include 1. During observation on 7/16/13 at 11:00 AM, employee F, Patient Care Technician, (PCT), was observed at station 10 with patient #8 initiating dialysis on a patient with a CVC. Employee F failed to cleanse the CVC hubs prior to connecting syringes and new caps. The Arterial hub still had blood on the threads. 2. On 7/16/13 at 2:30 PM, employee A, Facility Administrator, indicated hubs should be cleansed for CVCs.		*Care Utilizing A Needleless Silicone Connector Capping Device (TEGO), Policy & Procedure #1-04-12B CVC Anticoagulation and Treatment Initiation Utilizing A Needleless Silicone Connector Capping Device (TEGO), and Policy & Procedure #1-04-12D Predialysis CVC Care Utilizing A Needleless Silicone Connector Capping Device (TEGO), Policy & Procedure 1-04-12E Utilizing and Replacing Seven (7) Day Needless Silicone Connector Capping Device (TEGO) For Central Venous Catheter (CVC) Care.* TMs educated on manufacturer recommendations for use of Alcavis 50 or Alcohol 70% as disinfectant for TEGO connector cap and lines. TMs instructed when replacing TEGO connector prior to accessing TEGO connector TMs must disinfect per manufacturer recommendations. Verification of attendance at in- service is evidenced by signatures on clinical in-service form. FA or designee will conduct observational audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with TMs during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting. FA is responsible for compliance with this Plan of Correction.	

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V000249	494.40(a) DIALYS PROPORT-MATCH MACH CONFIG W/RATIO USED 5.6 Dialysate proportioning: match machine config w/ratio in use Changing from one proportioning ratio to another requires recalibration for some models of dialysis machines. For those machines, the type of concentrate should be labeled on the machine or clearly indicated by the machine display. It is strongly recommended that facilities configure every machine to use only one type of concentrate. 6.6 Dialysate proportioning Dialysate proportioning should be monitored following the procedures specified by the equipment manufacturer. The user should maintain a record of critical parameters such as conductivity and approximate pH. When the user has specific requirements for monitoring dialysate proportioning, such as when dialysis machine settings are changed to allow the use of concentrates with a different proportioning ratio, the user should develop procedures for routine monitoring of dialysate electrolyte values. Based on observation, policy review, and interview, the facility failed to ensure the patient care technician verified the correct dialysate bath prior to dialysis initiation for 1 of 4 run reports reviewed with the potential to affect all the facility's patients. (#14) Findings include 1. Pre Treatment sheet for patient #14	V000249	**V249** FA held clinical in-service for all clinical TMs on 7/18/2013. In-service included but not limited to review of Policy & Procedure # 1-03-02 Prescription Verification And Safety Checks, emphasizing potassium bath is verified by PCT and RN prior to initiation of treatment. TMs educated on importance of prescription verification and safety checks are performed so that patient will receive a safe and effective	08/16/2013

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	dated 7/16/13 contained prescription of Dialysate Bath: K: 2, Ca: 2.5. a. On 7/16/13 at 11:35 AM at station #1, the Hemodialysis Machine (HD) was observed connected to K: 3, Ca: 2.5 at wall. b. On 7/16/13 at 11:35 AM, employee B, Registered Nurse (RN), indicated they had not checked the patient and bath yet and they would turn the machine down. c. On 7/16/13 at 11:36 AM, employee B, RN, failed to change the bath connection at the wall outlet to the prescribed bath. d. On 7/17/13 at 9:55 AM, employee C, Clinical Service Specialists (CSS), indicated the nurse should have changed the bath right away and then called the physician. e. The Post Treatment Run Report from 7/16/13 failed to evidence the RN changed the bath to the ordered prescription. f. On 7/17/13 at 10:10 AM, employee A, Facility Administrator, indicated there was no documentation in the computer that the bath was changed to the ordered		treatment. PCTs must not initiate treatment until RN verifies that correct potassium bath has been connected to machine. RN and PCTs also instructed on importance of proper documentation for an adverse occurrence FA or designee will conduct observational audits every shift daily x 1 week, then weekly x 1 month, then monthly. FA will review audit results with teammates during homeroom meetings and with Medical Director during monthly QIFMM with minutes reflecting. FA is responsible for compliance with this plan of correction.	

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	prescription. 2. The policy titled "Prescription Verification and Safety Checks," # 1-03-02, revised March 2013 states, "1. Trained teammates will verify the dialysis prescription and perform safety checks prior to each treatment initiation. ... 4. Verify on patient electronic treatment record the following prior to every dialysis treatment. Prescribed: ... Dialysate."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152645	A. BUILDING 00 B. WING	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON DIALYSIS	9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234

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V000587	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. Based on clinical record review and interview, the facility failed to ensure processes for obtaining Peritoneal Dialysis (PD) patient flowsheets were sufficient to monitor patient treatment for 1 of 1 PD clinical record with the potential to affect all the facility's PD patients. (#6) Findings include 1. Clinical record #6, a PD patient, contained physician orders for PD with cycles 5 days a week. The record failed to evidence any flow sheets since 3/31/13. 2. On 7/16/13 at 4:40 PM, employee, PD nurse, indicated the patient does not always chart and record their treatments. The patient is to bring in their card reader monthly, but sometimes it does not record and print all the information. 3. On 7/16/13 at 1:05 PM, employee L indicated the facility has recognized a problem with obtaining flow sheets from	V000587	On 7/22/13 PD RN completed home visit with patient number 6 and confirmed correct PD prescription on the ProCard and cycler. PD RN reviewed with patient the requirements for completion of paper flow sheets and/or entry of clinical data on ProCard and submission to PD RN on either lab draw day or IDT clinic day each and every month. The PD RN also reinforced with the patient that he had signed acknowledgement of the requirement for completion and submission of paper flow sheets for timely monitoring of PD therapy and indications for PD prescription changes on a monthly basis at the end of his initial CAPD and CCPD training. The patient was given the following alternatives for submitting clinical data on a weekly/monthly basis: 1 – Patient can be provided with a second ProCard to use if he decides to send in ProCard for download weekly/monthly via prepaid, pre-addressed envelope to PD RN/clinic. 2 – Patient can be provided with	08/16/2013

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	the PD patient.		paper flow sheets that can completed daily and faxed in on a weekly/monthly basis for PD RN/IDT review, monitoring and need for prescription changes. 3 – Patient can be provided with paper flow sheets that can be completed daily and mailed to PD RN/clinic on a weekly/monthly basis for PD RN/IDT review, monitoring and need for prescription changes. 4 – Home team can make arrangements with patient to pick up ProCard and/or paper flow sheets weekly/monthly so that his treatments and care can be reviewed, monitored and identification of any necessary prescription changes. Documentation of meeting and re-education placed in patient's medical record At this time the patient has opted to continue to use the ProCard and bring in himself at either lab draw day or IDT clinic each month. The PD RN, IDT and GFA will review patient compliance with this requirement on our weekly IDT calls effective 7/26/13 and with Medical Director during monthly QIFMM with supporting documentation included in the meeting minutes. FA is responsible for this plan of corrections.	