STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1851 CREEK DRIVE MORRIS, IL 60450

(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
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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. This STANDARD is not met as evidenced by: Surveyor: 15166 A. Based on Facility policy review, observation, and staff interview, it was determined for 2 of 3 staff observed,.(E#2 and E#3) that the Facility failed to ensure handwashing and donning of gloves as required by Facility policy. Findings include: 1. Facility policy entitled, "Infection Control Precautions and Policies," was reviewed on 6/11/09 at approximately 9:30 A.M. The policy requires, "Gloves... during any... procedure in which possible contact with body fluids may occur... A change of gloves is necessary between patients... Handwashing is to be done between patients." 2. On 6/8/09 between 9:00-10:30 A.M. a tour of the dialysis treatment area was conducted. The following was observed: * At approximately 9:05 A.M. E#3 silenced the alarm on the dialysis machine at station #2, where a patient was receiving dialysis, without first donning gloves. * At approximately 9:07 A.M. E#2 pressed a	V 113	494.30(a)(1)(i) CDC RR-5 Renal Morris coordinator will review infection control policies at next staff meeting. In addition, infection control audits will be performed by the Renal Morris coordinator. Results of infection control audits will be discussed at Medical Staff Nephrology Committee meetings.	6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Nelson
TITLE: Administrative Director Dialysis
(X6) DATE: 7-1-09

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1851 CREEK DRIVE MORRIS, IL 60450

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Nelson
TITLE: Administrative Director Dialysis
(X6) DATE: 7-1-09

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.

INFECTION AND EXPOSURE CONTROL
AUDIT TOOL

Facility: _____ Date: _____

Reviewer: _____ Threshold 100% Result: _____

Associate														
Observe associate during 10 of the following procedures:	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
1. Associate wears appropriate facial protection (includes face shield, goggles, approved side shield for glasses) during high-risk procedures, i.e. priming of dialyzer, treatment initiation, treatment termination, removal of fistula clamps, administration of medications, reuse, etc.														
2. Associate wears gloves at appropriate times to protect them from becoming soiled & to prevent transmission to patients (per unit policies).														
3. Associate uses hand hygiene between patients, between equipment contact, before donning & after removing gloves (alcohol-based rub or hand wash), after patient & machine contact, before touching clean supplies, after contamination with blood or other infectious materials, & before leaving the patient treatment area.														

	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
4. Associate washes hands when: a. Leaving patient care area b. Entering patient care area c. If hands visibly contaminated														
5. Associate wears barrier covering at appropriate times, i.e. dialyzer set up, treatment initiation, treatment termination, removal of fistula clamps, administration of medications, reuse, etc.														
6. Associate removes and stores/disposes of barrier covering per unit policy.														
7. Associate properly disposes of sharps in designated sharps containers.														
8. Associate assures that sharps containers are free from blood spatter and not overfilled.														
9. Associate properly disposes of infectious waste in designated biohazard containers.														
10. Associate properly uses/stores dialysis supplies for each patient (supplies placed on machine in use are either discarded or disinfected after treatment). Supplies used for multiple patients (i.e. tape) and will not be disinfected are not placed on machines or in close proximity to machines.														
11. Associate caps all four (4) dialyzer ports per procedure at the end of treatment (prevents leakage).														

	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
12. Associate clamps bloodlines when stripping the dialysis machine (prevents saline/blood spills).														
13. Associate thoroughly cleans patient station equipment with disinfectant solution between patient treatments.														
14. Associate wipes down hemodialysis machine after treatment initiation.														
15. Associate is ungloved when using computer keyboard.														
16. Associate does not eat, drink, chew gum, or apply make-up in patient care areas of the unit.														
17. Associate assures that if patient holds access site, they wear gloves & use hand hygiene per unit policy.														
Total														
Percent														

To calculate % met: Count total number of met per associate observed. Each associate observation is worth 10 points if 10 procedures were observed for each associate. Add the number of observations met to determine the associate % met. To calculate total % met, add individual % met and divide by the number of associates observed. Example: you observe 5 associates. Their scores are as follows:

Associate #1: 90%
Associate #2: 90%
Associate #3: 70%
Associate #4: 100%
Associate #5: 100%

450 ÷ 5 = 90% met

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	145526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 113	Continued From page 1 button on the dialysis machine at station #3, where a patient was receiving dialysis, without first donning gloves. * At approximately 9:55 A.M. E#2 disposed of the wrapper from bag of saline solution into the trash can by lifting the lid of the can with bare hands. E#2 failed to perform hand sanitization prior to proceeding to care for the patient at station # 2 and also obtaining clean supplies from a clean stock drawer. 3. The above findings were conveyed to the Administrative Directive and Unit Coordinator during an interview on 6/8/09 at approximately 2:45 P.M. B. Based on observation and staff interview, it was determined that the Facility failed to ensure a separation of clean and dirty. Findings include: 1. On 6/11/09 a tour of the dialysis treatment area was conducted. There were multiple acid and bicarbonate containers partially-filled with clear fluid, stored on the countertop. The containers were identified as previously used during patient treatments. The containers were stored alongside clean supplies. 2. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 113	V113 - 494.30(a)(1)(i) CDC RR-5 Renal Morris coordinator has designated separate carts for the storage of clean and dirty acid and bicarbonate containers. All staff inserviced.	6/16/09
V 143	494.30(b)(2) OVERSIGHT [The facility must-] (2) Ensure that clinical staff demonstrate	V 143		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 143	Continued From page 2 compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on review of the manufacturer's guidelines for Tuberculin Purified Protein (TB), observation, and staff interview, it was determined that in 1 of 1 vial of TB medication, the Facility failed ensure the expired/outdated medication was disposed of in accordance with the manufacturer's guidelines. Findings include: 1. The manufacturer's package insert for "Tuberculin Purified Protein," was reviewed on survey date 6/9/09 at 11:00 AM. The package insert required, "A vial of Tubersol which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency." 2. A tour was conducted of the Facility's treatment area on survey date 6/8/09 between 9:00 AM and 10:45 AM. During the tour, at 10:36 AM, the medication refrigerator contained one vial of Tuberculin solution opened and dated 4/15/09. 3. This finding was conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/10/09 at 2:30 PM.	V 143	V143 - 494.30(b)(2) Oversight Renal Morris coordinator immediately discarded the expired vial of Tubersol. All staff was inserviced on following package inserts.	6/9/09 6/11/09
V 187	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE	V 187		

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V 187	Continued From page 3 & Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range. This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on observation and staff interview, it was determined that the Facility failed to ensure all major components and piping involved with the water system was labeled as required. Findings include: 1. On 6/8/09 a tour was conducted in the Facility's water room. During the tour it was observed the major water room components and water piping lacked labels indicating the contents of the piping and the direction of flow, as required. 2. The findings were conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 187	V187-494.40(a) ANSI/AAMI RD52:2004 On 6-8-09, Renal Morris coordinator contacted MarCor, the water system manufacturer, regarding the need for labels indicating contents of pipes and direction of flow, as well as labels to identify each water system component. The water system manufacturer, MarCor, labeled the complete water room with labels identifying each water system component and flow direction of water. In addition, Renal Morris coordinator will ensure that labels will be made and affixed to each water system component to describe its function.	6/09/09 7/10/09
V 191	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 8.2.4 Softeners: Testing hardness/log	V 191		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1651 CREEK DRIVE MORRIS, IL 60450

(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
V 191	Continued From page 4 Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total hardness monitoring requirements of the reverse osmosis machine manufacturer. Total hardness of the water exiting the water softener should be measured at the end of each treatment day. Water hardness test results should be recorded in a water softener log. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on review of Facility policy, review of Facility water logs and staff interview, it was determined that the Facility failed to ensure total hardness of the Facility's water was checked at the end of each treatment day. Findings include: 1. Facility policy entitled, "Dialysis Water System Checklist," required, "Procedure: Checks must be made with the system running. Hardness testing for softener will be completed during last shift of patient treatments." 2. The Facility's water logs for the year 2009 were reviewed on survey date 6/8/09 at 11:00 AM. The logs lacked documentation of the time of the hardness check, ensuring the Facility checked the hardness of treatment water at the end of each treatment day. 3. The findings were conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 191	V191-494.40(a) ANSI/AAMI RD 52:2004 Renal Morris coordinator modified the Dialysis Water Purification Performance Log to indicate time (am/pm) of the hardness check at the end of each treatment day. (Log attached.) All staff inserviced on use of log.	6/11/09
V 220	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE	V 220		

A	RPZ INLET 10-50 PSI							
B	RPZ OUTLET 10-50 PSI							
	A - B = DELTA PRESSURE < 20 PSI							
C	TEMPERATURE 70 - 80 F							
D	BOOSTER PUMP 35 - 100 PSI							
	SWITCH TO BOOSTER 1 OR 2 DAILY							
E	MM FILTER OUTLET 30 - 100 PSI							
	D - E = DELTA PRESSURE < 10 PSI							
F	SOFTENER OUTLET 25 - 100 PSI							
10	HARDNESS SAMPLE < 5 PPM AM/PM	/	/	/	/	/	/	/
13	CHLORAMINE TOTAL - FREE = < 0.1 PPM							
14	CHLORAMINE TOTAL - FREE = < 0.1 PPM							
G	CARBON OUTLET 25 - 100 PSI							
	F - G = DELTA PRESSURE < 10 PSI							
H	PRE-FILTER OUTLET 20 - 100 PSI							
	G - H = DELTA PRESSURE < 10 PSI							
I	RO PUMP SUCTION 20 - 70 PSI							
J	RO PUMP DISCH 350 - 450 PSI							
K	PRESSURE TO MEMBRANE 125 - 250 PSI							
L	REJECT PRESSURE 100 - 225 PSI							
	RO PRODUCT COND < 40 US							
M	RO REJECTION > 90%							
N	RO REJECT FLOW 2.0 - 5.0 GPM							
O	RO PRODUCT FLOW 1.7 - 3.5 GPM							
P	REJECT RECIRC FLOW 8.0 - 10.0 GPM							
Q	LOOP PUMP PSI 65 - 75 PSI							
	SWITCH TO LOOP PUMP 1 OR 2 DAILY							
R	RESISTIVITY CELL A < 40 US							
R	RESISTIVITY CELL B > 2 MEG-OHM							
S	POST FILTER INLET 40 - 75 PSI							
T	POST FILTER OUTLET 40 - 75 PSI							
	S - T = DELTA PRESSURE < 25 PSI							
U	LOOP RETURN PRESSURE 35 - 55 PSI							
	ALL LIGHTS GREEN Y OR N							
	ALARMS OK Y OR N							
	SALT IN BRINE TANK - BAGS ADDED							
	DATE							
	SHIFT							
	NAME							
	NOTES:							

SEE REVERSE SIDE FOR CHLORAMINE LOG

LOG MUST BE COMPLETED EVERY DAY OF UNIT OPERATION

ALL READINGS MUST BE WITHIN THE PARAMETERS SHOWN ON LOG

SILVER CROSS HOSPITAL MORRIS DIALYSIS FACILITY SITE #02800804
WATER PURIFICATION CHLORAMINE LOG

1 FOLLOW TEST KIT INSTRUCTIONS STEP BY STEP.

2 TAKE CHLORAMINE SAMPLE FROM POST WORKER CARBON FILTER VALVE.

3 RECORD RESULTS BELOW WITH A NEGATIVE OR POSITIVE PHRASEOLOGY FROM PAST RESULTS.

4 IF CHLORAMINES ARE POSITIVE, TAKE SAMPLE FROM POLISHER CARBON FILTER VALVE.

*** IF CHLORAMINES ARE POSITIVE POST POLISHER CARBON, DIALYSIS TREATMENTS CANNOT BE PERFORMED.

*** IF CHLORAMINES ARE NEGATIVE POST POLISHER CARBON, CONTINUE WITH DIALYSIS TREATMENTS AND CALL FOR SERVICE.

PERFORM LOG BEFORE THE START OF EVERY SHIFT

RECORD RESULTS FROM TESTS	MON	TUE	WED	THU	FRI	SAT	SUN
SHIFT 1							
SHIFT 2							
SHIFT 3							

DATE: _____

NOTES: _____

FOR SERVICE CALL: MAR COR PURIFICATION 888-962-7878

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 220	Continued From page 5 7 Strategies for bacterial control 7.1 General: machine supply line disinfected Users should establish a procedure for regular disinfection of [the line between the outlet from the water distribution system and the back of the dialysis machine]. This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on review of manufacturer's guidelines, policy review, review of machine disinfection logs, and staff interview, it was determined that the Facility failed to ensure in 10 of 10 (machine #s 1-10) that residual bleach was checked following machine disinfection. Findings include: 1. Manufactures guidelines for the use of E-Z Check Residual Chlorine Tests Strips was reviewed on survey date 6/8/09 at 8:45 AM. The guidelines require, "E-Z Check Residual Chlorine Tests Strips provide a convenient, accurate means of measuring the concentration of chlorine bleach remaining in water being used to rinse out dialysate lines following disinfection of hemodialysis equipment." 2. Facility policy entitled, "Machine Disinfection,: required, "Procedure:...2. Test for residual disinfectant by sampling fluid at the dialysate port using residual chlorine test strips....Document negative residual bleach results on the machine disinfection log." 3. The Facility's Machine Sanitization Logs for year 2009 were reviewed on survey date 6/8/09 at	V 220	V220-494.40(a) ANSI/AAMI RD52:2004 Renal Morris coordinator modified the Machine Sanitization Log to include documentation of machines checked for residual bleach, following the bleach disinfection of the machines. (Log attached.) All staff inserviced on use of log.	6/11/09

MACHINE SANITIZATION LOG

DATE	PROCEDURE	1	2	3	4	5	6	7	8	9	10
MON	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
TUE	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
WED DIASAFE QOWK	VINEGAR										
	BLEACH /Negative Residual Bleach Test										
	DATE / INITIALS										
THUR	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
FRI	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
SAT	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
SUN	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										

SIGNATURE: _____

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SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 220	Continued From page 6 1:00 PM. The logs indicated that the Facility disinfected all 10 machines every Wednesday using bleach. The logs failed to indicate that the Facility checked for bleach residual following the disinfection of the machines. 4. The findings were conveyed to the to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 220		
V 228	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine. Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until the tank has been emptied. Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents. Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility. This STANDARD is not met as evidenced by: Surveyor: 15168	V 228		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1531 CREEK DRIVE MORRIS, IL 60450

(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
V 228	Continued From page 7 A. Based on observation and staff interview, it was determined that in 1 of 1 bicarbonate mixing tank, the Facility failed to ensure the tank was labeled indicating the date and chemical concentration of the ingredients. Findings include: 1. A tour was conducted of the Facility's bicarbonate mixing room on survey date 6/8/09 at 10:30 AM. During the tour the Facility's mixing tank was observed. The tank lacked a label that included the date of mixture and the ingredients of the tank. 2. The above finding was conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 228	V228-494.40(a) ANSI/AAMI RD52:2004 The Chief Certified Clinical Hemodialysis Technician amended the bicarbonate mixing tank label to include the chemical ingredients of the tank. (Ingredient label attached.) In addition, Renal Morris coordinator revised Policy #G-20, titled, "Mixing Powdered Bicarbonate." (Policy attached.) All staff inserviced on labeling of tank..	6/11/09
V 236	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4.5 Additives: labeling spiked jugs/labeling if for specific pt (5.4.4.1 Concentrate jugs): If a chemical spike is added to an individual container to increase the concentration of an electrolyte, the label should show the added electrolyte, the date and time added, and the name of the person making the addition. Containers should be labeled to indicate the final concentration of the added electrolyte .... This information should also be recorded in a permanent record. Labels should be affixed to the containers when the mixing process begins. 5.4.2 Additives	V 236		

Tear to Open

renasol®

BICARBONATE CONCENTRATE POWDER

36.83X

BC-1 PART B

NOT FOR PARENTERAL USE

This package contains: 229 grams Sodium Chloride U.S.P.
624 grams Sodium Bicarbonate U.S.P.

See SB-1000 series acid concentrate label for final dialysate concentrations when properly diluted with Purified Water (AAMI quality or equivalent) in a three stream 36.83X bicarbonate proportioning artificial kidney (hemodialysis) machine.

Mixing Instructions

1. Empty contents of one package into clean, disinfected mixing container.
2. Add Purified Water (AAMI quality or equivalent) to bring total volume to two and one-half (2.5) gallons.
3. Mix well. Keep mixing until completely dissolved.
4. Analyze dialysate for correct concentrations and read SB-1000 series acid concentrate label prior to dialysis.

CAUTION: BC-1 bicarbonate concentrate can only be used in 36.83X bicarbonate proportioning machines with Renasol® SB-1000 series acid concentrate. Refer to the hemodialysis machine operator's manual for instructions prior to starting dialysis. Do not use if package is damaged. Do not use with 45X dilution dialysate delivery systems. Bacterial growth may occur in concentrated bicarbonate solutions. Take care to avoid contamination. Disinfect all containers, machines, transfer lines, etc., which contact the solution. Use within 48 hours of preparation. Store at room temperature in a sealed container after preparation. Federal (U.S.A.) law prohibits dispensing without prescription. Failure to follow the instructions for Use may result in patient injury.

Manufactured in the U.S.A. by:
MINNTECH® renal systems
14605 28th Avenue North
Minneapolis, MN 55447 U.S.A.
Phone: (763) 553-3300
Toll Free: (800) 328-3340
Fax: (763) 553-3387

67720-495/B

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page G-20

TITLE: MIXING POWDERED BICARBONATE (FOR MORRIS UNIT)

PURPOSE:

To ensure powdered bicarbonate is mixed properly.

BICARB MIXING:

1. Open valve *V1* fill tank to batch volume level. Close valve *V1*.
2. Open valve *V2*, close valve *V5*.
3. Turn ON pump with manual switch.
4. Adjust mix flow using mix control valve *V2* to minimize vortex.
5. Slowly add bicarb powder through hinged lid.
6. Continue mixing until all powder is solubilized.
7. Turn OFF pump with manual switch.
8. If needed, adjust final volume of batch using valve *V1*.
9. Turn ON pump with manual switch and allow to circulate for 10 minutes.
10. Turn OFF pump with manual switch. Close valve *V2*.
11. Pull sample for testing from valve *V3*. Upon approval, proceed with step 12.
12. Fill jugs manually at Jug Access Port *V3*.
13. Affix label to the tank that includes the date of preparation and the chemical ingredients. This label should remain on the mixing tank until the tank has been emptied.

DEPARTMENTS AFFECTED:		Dialysis
EFFECTIVE DATE:		**REVISED DATE (S):**
December 1997		03/30/98, 07/13/07, 06/26/09
APPROVED BY:	Keith Nelson Department Head	**DATE:** 06/30/09
APPROVED BY:	Preeti Nagarkatte, M.D. Medical Director	**DATE:** 06/30/09
AUTHORIZED:	Peggy Gricus President (or designee)	**DATE:** 06/30/09

The Intent of the Silver Cross Hospital policies and procedures is to be utilized as

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

PRINTED: 06/23/2009
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
	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1581 CREEK DRIVE MORRIS, IL 60450

(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
V 238	Continued From page 8 When additives are prescribed for a specific patient, the container holding the prescribed acid concentrate should be labeled with the name of the patient, the final concentration of the added electrolyte, the date on which the prescribed concentrate was made, and the name of the person who mixed the additive. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Facility policy review, observation, and staff interview, it was determined, for 2 of 2 patients receiving altered dialysate baths, (PL #4 and #5) that the Facility failed to ensure that the bath containers were labeled in accordance with policy. Findings include: 1. Facility policy entitled, "Potassium and Calcium Additives For Dialysate," was reviewed on 6/0/09 at approximately 2:00 P.M. The policy requires, "Potassium and Calcium additives will be prepared and labeled by licensed staff." The policy failed to specify what the label should include. 2. On 6/11/09 a tour of the dialysis treatment area was conducted. There were two partially-filled containers of clear fluid, each with the following label: "3K (potassium) + 2.5 Ca (calcium)". The labels lacked documentation of the patient's name, the date on which the the concentrate was made, and the name of the person who mixed the additive.	V 236	V236-494.40(a) ANSI/AAMI RD52:2004 Renal Morris coordinator revised policy #G-14, titled, "Potassium and Calcium Additives for Dialysate" to reflect that proper additive labeling will include the added electrolyte, final concentration, date and time of additive, and name of person mixing the additive. When prescribed for a specific patient, the name of patient will be added to label. In addition, all staff have been inserviced on proper labeling of concentrate jugs.	6/26/09

Potassium and Calcium Additives for Dialysate.....G-14

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page G-14

TITLE: POTASSIUM AND CALCIUM ADDITIVES FOR DIALYSATE

Purpose:

To assure prescribed dialysate concentrations of potassium acetate and calcium chloride are mixed according to the manufacturer's instructions.

General Information:

1. **Calcium Chloride** additive is in an aqueous form and contains USP salt at a concentration of 3312 mEq/L. The product is packaged in 200ml bottles. (See attached mixing procedure as specified by additive manufacturer)
2. **Potassium Acetate** additive is in an aqueous form and contains USP salt a concentration of 8000 mEq/L. The product is packaged in 200ml bottles. (See attached mixing procedure as specified by additive manufacturer)
3. Potassium and Calcium additives will be prepared and labeled by licensed staff.
4. The label will include the added electrolyte, the final concentration, the date, and the name of the person making the addition. When prescribed for a specific patient, the label will also include the name of the patient.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: July 26, 1991

REVISED DATE (S): 01/94, 05/96, 02/2007, 08/2008, 06/26/09

APPROVED BY: Keith Nelson, Department Head — **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director — **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) — **DATE:** 06/30/09

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

PRINTED: 08/23/2009
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	143826	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 238	Continued From page 9 3. The above two containers were identified by the Unit Coordinator as dialysate baths that were used for Pt. #4 and Pt. #5 on the previous day during their treatments. 4. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 238		
V 415	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary; .	V 415		
	This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Hospital policy review and staff interview, it was determined that the Facility failed to ensure emergency and disaster plans were evaluated and updated as necessary. Findings include: 1. The Facility policy entitled, "Dialysis Safety/Emergency Response Plan," was reviewed on 6/11/09 at approximately 9:50 A.M. The policy lacked a requirement for mock drills to determine the staff's skill level and educational needs during an emergency situation. 2. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/8/09 and 6/10/09 at approximately 2:46 P.M. The Coordinator stated that they did not have documentation to indicate that any		V415-494.60(a)(4) Emergency Preparedness Policy #B-12, "Dialysis Safety/Emergency Response Plan," was revised to include evaluation of disaster plans to include mock drills (see attached policy). In addition, a log has been created to document mock drills, effectiveness of drills and needs assessment.	7/1/09

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page B-12

TITLE: DIALYSIS SAFETY / EMERGENCY RESPONSE PLAN

Policy:

The dialysis unit safety plan includes alternate sites where dialysis is provided. Guidelines for actions in the event of an emergency are as follows:

A. **FIRE PROCEDURE:**

Purpose:

To provide guidelines for action in the event of a fire to maintain order.

Objectives:

1. Know location of fire alarms and extinguishers.
2. Know procedure for communicating knowledge of fire and removing patients from danger.
3. Follow procedures for fire containment.

Location of Equipment:

1. **East:** Fire extinguishers are located at rear exit. Audible/visual alarm located on west wall.
2. **West:** Fire extinguishers are located in northwest corner of treatment area by Station #1 and northeast wall of service entrance corridor. Audible/visual fire alarm located on north wall in nurses station, which is connected with the Joliet Fire Department. Heat detectors/sprinklers located in ceiling and duct work throughout unit and building.
3. **Morris:** Fire extinguishers located at east and west exit doors. Audible/visual alarms located in treatment area and patient waiting area.

Fire Procedure:

1. All personnel should respond to fire alarm by coming to nursing station.
   A. If the fire is in your location, initiate preliminary extinguishing procedure, and call

Silver Cross Hospital

POLICIES & PROCEDURES

[redacted]

TITLE: DIALYSIS SAFETY / EMERGENCY RESPONSE PLAN

Manual Page B-12

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3. **Morris:** Fire extinguishers located at east and west exit doors. Audible/visual alarms located in treatment area and patient waiting area.

Fire Procedure:

1. All personnel should respond to fire alarm by coming to nursing station.
   A. If the fire is in your location, initiate preliminary extinguishing procedure, and call

emergency number to report.

East: Call extension 7800
West: Call 911
Morris: Call 911

B. If small fire is extinguished by dialysis staff, Fire Department should be called for follow-up evaluation.

2. Charge Nurse will assume responsibilities for delegation of duties of the nursing and non-medical personnel.

3. If fire occurs in clinical area:

A. Nurses will remove patients from immediate danger.

1. Clamp needles. Do not attempt to return blood.

2. Walk patient or pull the patient using a blanket to an area of safety.

B. One staff member will:

1. Pull the fire alarm.

2. Call the emergency number and alert others in the building, stating location and nature of fire.

3. Shut off any oxygen in the room.

4. Close all doors in the Department to confine the fire to that area.

C. Meet fire brigade and inform them of location.

4. If fire occurs in another area of building, the building alarm will sound. All doors in department should be closed.

Fire Prevention Practices:

1. Scrupulous housekeeping.

2. Routine inspection of equipment, particularly electrical.

3. A No Smoking Policy will be maintained within the Dialysis Unit.

4. Instruction of employees in the use of appliances done during Education Day.

5. Strict control over receiving, distributing and storage of volatile liquids.

6. Keep stairwell doors closed.

7. All exits well-marked, clear and accessible.

8. Fire-resistant draperies, carpeting and upholstery fabrics.

9. No storage within 36 inches (18 inches if non-flammable material) of the ceiling and/or sprinkler heads.

10. Each extinguisher has been checked for its adaptability to the hazard presented in the immediate area.

11. Know the location and assure easy accessibility to all fire emergency exits (minimum requirement of 2).

B. TORNADO

Terminology

1. Tornado Watch or Severe Warning: Conditions are favorable to produce tornadoes.

2. Tornado Warning: Severe weather conditions exist which has produced a tornado or a funnel cloud. A tornado or a funnel cloud has been reported.

Procedure:

Tornado Watch or Severe Weather Warning:

Upon knowledge of a tornado watch or severe weather warning, all staff should make themselves available for further response if necessary.

Tornado Warning or Sighting within 5 miles of the Dialysis Unit:

Employees with Patient Care Responsibility:

1. Discontinue dialysis treatment returning blood to patient by established protocol.

2. Obtain flashlights.

3. Close blinds.

4. Turn on all lights.

5. Move all patients from treatment area.

6. Move ambulatory patients and visitors to chairs or floor in corridor.

7. Obtain emergency supply box.

8. Close all room doors.

All Clear:

Upon receipt of official word that the tornado warning has passed, patients will be returned to treatment area to resume dialysis.

Important Key Information to Know:

1. "Spotters" are dispatched to certain areas to report changes in weather conditions.

2. All personnel remain in their workplace and seek shelter.
3. Patients are moved to the hallway corridor whenever possible, those that cannot, have their bed face away from the windows and protected with extra blankets.
4. No visitor or employee will be held against their will, but those people who choose to leave, do so at their own risk.
5. Do not use elevators.
6. Limit your telephone usage.

C. **EQUIPMENT/ ELECTRICAL SAFETY**

1. **Power Failure Emergency Procedure:**

Purpose:

To provide safety to patients and alleviate anxiety. All staff will confidently render care to patients during power failure.

Procedure:

1. Obtain emergency lighting if needed.
2. Reassure patients that their safety is not being compromised.
3. If assisted by Uninterrupted Power Source (UPS), discontinue treatments returning all blood. In case of UPS failure, do not return patient blood when discontinuing treatment.

D. **Monitoring at the evacuation site**

Purpose:

Assess status of patients in order to reduce incidence of complications.

Objectives:

Follow procedure for proper monitoring of patients at evacuation site.

Procedure:

1. Check blood pressure on all patients with documentation as available.
2. Remove needles on stable patients, utilizing standard procedure for manual pressure and dressing at venipuncture site.
3. Administer normal saline to patients PRN for hypotension.
4. Document condition of patients.
5. Patients will be discharged from evacuation site under the direction of the Charge Nurse.

Evacuation of Facility:

1. Decision for evaluation will be made by Dialysis Unit Charge Person with assistance from local Fire Department.

2. **East:** Patients will be evacuated using the lower level exit door, and escorted to the Maple Road parking lot.

   West: Patients will be evacuated to an area of safety outside of the building, located near pump station on Southwest corner of rear parking lot.

   Morris: Morris patients will be evacuated to area of safety directly west of the building by the arched sign.

3. Charge person will assign responsibilities at evacuation location and bring Emergency Supply Box to the evacuation location.

4. All other available personnel will assist in evacuating patients from the building.

   a. Do not remove needles or return blood.

   b. Clamp both needles, disconnect lines.

   c. Shut off power and water to machine.

   d. Assist with evacuation after all patients are off the machine.

   e. Feel the door (checking for heat). **DO NOT OPEN IF HOT.** Find an alternate exit.

   f. If smoke inhalation is a problem:

      1. Put wet cloth to mouth and nose.

      2. Crawl along the floor.

5. After all patients have evacuated, all staff members will report to the evacuation site and a census will be taken.

E. **Emergency Transfer of Patients**

Policy and/or Procedure:

In the event of equipment malfunction or other cause preventing dialysis service to be rendered, this plan will go into effect.

1. All patients will be assessed regarding need for urgent treatment.

2. Assessments will be reviewed and discussed with attending physician for orders.

3. Patients not in need of urgent dialysis will be sent home to await further instructions.

4. Patients needing dialysis the same day will be transferred to other local units with availability of service. Renal Center West location and Silver Cross Hospital will serve as the primary reciprocal back-up service areas during emergencies. The acute dialysis room in Silver Cross Hospital will be utilized to its full capacity.

5. When the facility becomes available for service, patients will be scheduled according to need and then begin usual dialysis schedule.

6. Emergency hotline phone number is 815-722-2586. The coordinator of the affected unit will record a message instructing patients of what to do and who to call to schedule their dialysis treatment.

7. Notify the Renal Network

F. **Patient Education/Emergency Care**.

It is the policy of the Dialysis unit to make a concerted effort to provide maintenance hemodialysis for its patients on a continuing basis. However, there are a number of highly unlikely potential situations which could result in the necessity to terminate dialysis at the unit such as fire, major equipment failure, etc. In the event that any occurrences happen, it is generally foreseeable that with emergency corrective action, the facility could be operational within a relatively short period of time (24 hours of less). During this time, patients would be evaluated, and those requiring immediate dialysis would be dialyzed in the hospital on acute dialysis machines. The following plans will be implemented to maintain a safe environment for both pateints and the staff.

1. Fire Emergency Plan

The Dialysis Unit takes many precautions against fires. Fire emergency equipment is available, and the staff has been trained in fire emergency procedures. In the event that a fire should occur, it is important to know what to do.

The Charge Nurse and Physician will make the decision, in the event of a fire, as to what will be done. If there is any danger, all patients will be taken off the machines immediately.

The staff will take all patients off as quickly as possible. If the danger is great enough, all dialysis lines will be clamped and disconnected. You then will be assisted out of the Dialysis Unit. If for any reason you are unable to walk, you will be assisted in either a wheel chair or by some other means. All of our staff members are trained to do this.

In the event that patients must be evacuated from the unit, an area will be set up outside the unit until additional help arrives. Emergency stock supplies are available in such an event.

2. Major Equipment Failure

In the event that a major piece of equipment should fail such as a water heater, reverse osmosis machine, etc., it would not be possible to provide fresh dialysate. The nurse supervisor and the physician will make the decision to stop dialysis.

3. Electrical Failure

In the event of a complete power failure, you may discontinue your treatment, as instructed, or wait for staff assistance. To discontinue treatment, you must first turn off your machine, close the 2 clamps on your needles, and 2 clamps on the blood lines, then twist the locks on the ends of needles to disconnect. Do not attempt to return your blood.

4. Tornado or Severe Weather Warning

In the event of a tornado or severe weather warning a staff member will return the patients blood unless the danger is too great. All dialysis lines will be clamped and disconnected. Upon receipt of official word that the danger has passed, patients will be returned to the treatment area to resume

dialysis

In the unlikely event that any of the above occurrences happen, it is generally foreseeable that with emergency corrective action, the facility could be operational within a relatively short period of time (24 hours or less). During this time, patients would be triaged (evaluated) and those requiring immediate dialysis would be dialyzed at an alternate site.

G. **Evaluation of Disaster Plans**

1. Each unit will conduct a mock drill annually and review plans for effectiveness and a needs assessment.

2. Staff will be responsible for completing the Dialysis Safety and Emergency CBL.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: October 1995

REVISED DATE (S): 01/00, 11/02, 08/04, 06/09

APPROVED BY: Keith Nelson, Department Head — **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director — **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) — **DATE:** 06/30/09

Manual Page B-12

The intent of the Silver Cross Hospital policies and procedures is to be utilized as guidelines [redacted] and goals. They are not to be considered inflexible standards or legal requirements.

Silver Cross Dialysis Renal Centers

Location: _____		Mock Drill Scenario:
Drill Date: _____		
Conducted by: _____		
Drill Attendance Roster		
Name(s):		
Remarks and Recommendations:		

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

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	143626	A. BUILDING _____ B. WING _____	06/11/2009

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SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 415	Continued From page 10	V 415		
	emergency/mock drills had been completed.			
V 504	494.80(a)(2) ASSESSMENT CRITERIA	V 504		
	[The patient's comprehensive assessment must include, but is not limited to, the following:] Blood pressure, and fluid management needs.			
	This STANDARD is not met as evidenced by: Surveyor: 15168			
	A. Based on policy review, clinical record review and staff interview, it was determined that in 2 of 6 (Pt #1 and #2) clinical records reviewed, the Facility failed to ensure that all patients' were reassessed intradialytically and post dialysis for symptoms present on the predialysis assessments.		V504-494.80(a)(2) Assessment Criteria All staff inserviced on need to record post dialysis assessment of edema in the hemodialysis patient record, Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance.	7/8/09
	Findings include:			
	1. Facility policy entitled, "Hemodialysis Standards," reviewed on survey date 6/10/09 at 11:15 AM required, "...Adequacy of Hemodialysis: Patient Outcome:..Nursing Management, Assessment: Intradialytic Monitoring: Assessment, 1. The nurse will assess the following parameters during dialysis: A. Patient, 1. Vital signs..7. Response to treatment..Intervention:..3. Notify patient's physician of any significant change or problem.. Post dialysis patient assessment includes but not limited to"..B. Weight/volume status..G. Other conditions or complications."			
	2. The clinical record of Pt #1 was reviewed on survey date 6/10/09. Pt #1 was a 71 year old			

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
Total							

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V 504	Continued From page 11 female admitted to the Facility on 4/14/04 with a diagnosis of End Stage Renal Disease. The clinical record contained treatment records dated 5/1, 5/3, 5/5, and 6/8/09 that documented lower extremity edema on the predialysis assessments. The treatment records lacked any post dialysis assessment of the edema at time of discharge. 3. The clinical record of Pt #2 was reviewed on survey date 6/10/09. Pt #2 was a 77 year old male admitted to the Facility on 11/15/08 with diagnoses of Chronic Kidney Disease and Hypertension. The clinical record contained treatment records dated 5/30, 6/2, and 6/8/09 that documented lower extremity edema on the predialysis assessments. The treatment records lacked any post dialysis assessments of the edema at the time of discharge. 4. The findings were conveyed to the Facility's Coordinator during an interview on survey date 6/10/09 at 10:30 AM.	V 504		
V 543	494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Facility policy review, clinical record review, and staff interview, it was determined, for 2 of 5, (Pt. #1 and #4) clinical records reviewed for inter and intradialytic blood pressures,	V 543		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 543	Continued From page 12 symptoms, and target weight, that the Facility failed to ensure that the patient's plan of care was altered to address the patient's symptoms. Findings include: 1. The Facility failed to provide a policy for the new plan of care process when requested. 2. The clinical record of Pt #1 was reviewed on survey date 6/10/09. Pt #1 was a 71 year old female admitted to the Facility on 4/14/04 with a diagnosis of End Stage Renal Disease. The clinical record contained the physician's orders dated 4/22/09-6/3/09, for a dry weight, (EDW) of 77 kilograms (kg) without any change ordered. The treatment records dated 5/29, 6/1, 6/3, 6/5, and 6/8/09 documented Pt #1's weight 75.3 to 75.2 kg. The record lacked documentation that the EDW and dialysis prescription was reevaluated and altered as needed. (15166) 3. The clinical record for Pt. #4 was reviewed on 6/9/09. This was a 74-year-old female admitted 6/23/08 with a diagnosis of Chronic Kidney Disease. The record included documentation of the physician's dialysis prescription orders from 5/12/09 through 6/2/09. All of the orders included an estimated dry weight (EDW) of 58.5 kg for Pt. #1. The hemodialysis records were reviewed from 5/16/09 through 6/9/09. The records included documentation that for 8 of 11 treatments reviewed, the patient was between 0.6-1.4 kg less than the ordered EDW. In addition the records included documentation that Pt. #4's blood pressures were fluctuating with systolic pressures from 92-206 mmHg and diastolic pressures from 40-109 mmHg. The	V 543	V543 - 494.90(a)(1) Development of Patient Plan of Care Policy #E-8, "Dialysis Plan of Care," was written to ensure that the patient assessment is followed by an individualized and comprehensive Plan of Care developed by an interdisciplinary team. This policy will be reviewed at the next staff meeting. KW Director 7/8/09 Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in EDW are noted on the chart as a physician order. 6/15/09 Compliance of documentation of EDW on all patient charts was completed by 6/16/09 under the supervision of the Renal Morris coordinator. 6/16/09 In addition, all licensed staff were inserviced by Renal Morris coordinator to obtain physician order for any changes in EDW. 6/17/09	

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page E-8

TITLE: DIALYSIS PLAN OF CARE

PURPOSE:

To ensure that the patient assessment is followed by an individualized and comprehensive Plan of Care (POC) developed by an interdisciplinary team.

1. Initial assessment and Plan of Care (POC) will be completed within 30 days or 13 treatments of admission for each patient who is new to ESRD and dialysis as well as for each patient transferring into the facility without a completed comprehensive assessment and POC.

    a. Patient interview and initial assessment by all interdisciplinary team members.

        1. Physician
        2. Nursing
        3. Social Worker
        4. Dietitian

    b. POC completed by all disciplines.

2. Re-assessment and POC completed within 90 days of initial POC

3. Repeat re-assessment and POC

    a. Stable – annually

    b. Unstable – monthly until stable
    Unstable as indicated below:

        1. Extended or frequent hospitalization as evidenced by hospitalization more than 8 days or more than 3 hospitalizations in one month.
        2. Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis as evidenced by Albumin less than 3.4g/l and weight loss greater than 5% in one month, Hgb less than 10g/dl, and Kt/V less than 1.2 for Hemodialysis patients and 1.7 for Peritoneal Dialysis patients.
        3. Significant change in psychosocial needs as evidenced by financial/housing loss, decline in physical or mental status, death or major illness in family, loss of emotional support, or physical or mental abuse.
        4. Marked deterioration in health status as evidenced by recurrent serious complication. Health care team to document specific reason.

4. The interdisciplinary team consists of, at a minimum, the patient or patient designee, a registered nurse, a

Dialysis Plan of Care.....E-8

physician who is treating the patient for ESRD, a social worker, and a dietitian.

5. The POC must be developed from the comprehensive assessment and must include, at a minimum the following assessments:

   a. Dose of Dialysis
   b. Adequacy of Dialysis
   c. Vascular access
   d. Fluid control
   e. Blood pressure
   f. Anemia management
   g. Nutritional management
   h. Mineral metabolism
   i. Psychosocial status
   j. Transplant status
   k. Modality evaluation
   l. Safety training
   m. Vocational rehabilitation status

6. The POC will be signed by each team member to include the patient. To ensure the development of a congruent, integrated patient plan of care, the facility will conduct interdisciplinary team conferences ensure an integrated plan. To facilitate full team participation in conferences, any member, including the patient, may participate through telecommunication.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: **REVISED DATE (S):**

June, 2009

APPROVED BY: Keith Nelson, Department Head **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) **DATE:** 06/30/09

Manual Page E-8

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143826	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 543	Continued From page 13 records also included documentation of significant fluctuations in bps during the patients change in position from sitting to standing, at the end of treatments. The record lacked documentation that the EDW and dialysis prescription was reevaluated and altered as needed. 4. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M. B. Based on Facility policy review, clinical record review, and staff interview, it was determined, for 1 of 5 clinical records reviewed for patients' blood pressures (bps), (Pt. #4) that the Facility failed to ensure that significant changes were addressed. Findings include: 1. Facility policy entitled, "Hemodialysis Standards," was reviewed on 6/10/09 at approximately 10:00 A.M. The policy requires, "The nurse will access the following parameters during dialysis... Vital signs... Notify patient's physician of any significant change or problem." 2. The clinical record for Pt. #4 was reviewed on 6/9/09. This was a 74-year-old female admitted 5/23/08 with a diagnosis of Chronic Kidney Disease. The hemodialysis records dated 6/9, 6/8, 5/28, 5/26, 5/19, and 5/16/09 included documentation that Pt. #4's blood pressures were fluctuating with systolic pressures from 92-206 mmHg and diastolic pressures from 40-109 mmHg. The records also included documentation of significant fluctuations in bps during the patients change in position from sitting	V 543	Renal Morris coordinator will review Policy #E-1, "Hemodialysis Standards" at next staff meeting to re-educate staff on the importance of proper documentation of any significant changes in blood pressures, and if necessary, increased assessment and notification of the physician. Renal Morris coordinator will conduct a retrospective audit of patient charts to document compliance.	7/8/09

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
1							
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 543	Continued From page 14 to standing, at the end of treatments. The record lacked documentation that the significant changes in blood pressures were addressed, such as increased assessment and notification of the physician. 3. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 543		
V 688	494.140(b)(4) NURSING SERVICES Each nurse who provides care and treatment to patients must be either a registered nurse or a practical nurse who meets the practice requirements in the State in which he or she is employed. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on policy review, clinical record review, and staff interview, it was determined that in 2 of 5 (Pt #2) clinical records reviewed for Heparin, the Facility failed to ensure the medication was administered by the Registered Nurse as ordered. Findings include: 1. Facility policy entitled, "Hemodialysis Standards," reviewed on survey date 6/10/09 at 1:15 PM, required, "..Initiation of Treatment"...Nursing Management...Intervention,..3. Administer anticoagulant according to treatment prescription." 2. Facility policy entitled, "Heparin Pump," reviewed on survey date 6/10/09 at 1:15 PM,	V 688	V688-494.140(b)(4) Nursing Services Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in Heparin dosages are noted on the chart as a physician order. 6/15/09 Compliance of documentation of Heparin orders on all patient charts was completed by 6/16/09 under the supervision of the Renal Morris coordinator. 6/16/09 In addition, all licensed staff were inserviced by Renal Morris coordinator to obtain physician order for any changes needed for Heparin dosages. 6/17/09 Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance. 7/8/09	

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 688	Continued From page 15 required, "Procedure:..3. Set pump for amount to be administered per hour, and for how long... 0.5 ml = 500 units per hour, 1.0 ml = 1000 units per hour." 3. The clinical record of Pt #2 was reviewed on survey date 6/10/09. Pt #2 was a 77 year old male admitted to the Facility on 11/15/08 with diagnoses of Chronic Kidney Disease and Hypertension. The clinical record contained a physician order dated 5/14/09 for, "Heparin 2000 units IV push Bolus and Heparin Pump 1 ml/hour." The clinical record contained treatment records dated 5/28, 5/30, 6/2, 6/4, 6/6, and 6/9/09 that lacked any nursing documentation that the 2000 units of Heparin IV push was given as ordered. The clinical record contained treatment records dated 5/21 and 5/28/09 that indicated Pt #2 received Heparin per pump at 0.5 ml/hr instead of the 1 ml/hr as required. The clinical record contained treatment records dated 5/30, 6/2, 6/4, 6/6, and 6/9/09 that lacked documentation of any Heparin being given per pump as ordered. The clinical record lacked any physician orders changing the Heparin dosage. 4. The findings were conveyed to the Facility's Coordinator during an interview on survey date 6/10/09 at 10:30 AM. Surveyor: 15166 5. The clinical record of Pt. #3 was reviewed.	V 688		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 688	Continued From page 16 This was a 74-year-old female admitted 6/23/08 with diagnoses of Diabetic Nephropathy and Hypertension. The record included documentation of a physician's order for dialysis prescription, dated 6/2/09. The order included Heparin Recirc + Pump. The record also included documentation of Standing Orders For Dialysis Medications, dated 2/24/09. The standing orders included, "Heparin Sodium 1000 units/ ml- maintain patency of dialyzer..." The hemodialysis record dated 6/8/09 included documentation that Pt. #1 had the heparin pump set for 0.5 ml/hr instead of 1 ml/hr as required by the standing order. The record lacked documentation to indicate why the dosage was not administered as ordered. 6. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M. 8. Based on policy review, clinical record review, and staff interview, it was determined that in 4 of 11 dialysis treatments (6/9/09,6/25/09, 5/23/09, 5/21/09) for Pt #4, the Facility failed to ensure that the blood flow rate was provided as ordered. Findings include: 1. Facility policy entitled, "Hemodialysis Standards" reviewed on survey date 6/10/09 at 11:00 AM required, "Intradialytic Monitoring...Assessment, 1. The Nurse will asses the following parameters during Dialysis... B. Delivery System.. #4. Blood flow rate... Intervention,.. #3. Notify Patient's physician of any significant change or problem." 2. The clinical record of Pt #4 was reviewed on	V 688	V688-494.140(b)(4) Nursing Services Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in Blood Flow Rate are noted on the chart as a physician order. Compliance of documentation of BFR orders on all patient charts was completed by 6/24/09 under the supervision of Renal Morris coordinator. In addition, all staff have been inserviced on proper documentation of prescribed BFR and if not maintained will document reason why. Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance.	6/23/09 6/24/09 6/26/09 7/8/09

Data Collection Tool

Department/service:___ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	143528	A. BUILDING _____ B. WING _____	08/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1651 CREEK DRIVE MORRIS, IL 60450

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V 688	Continued From page 17 survey date 6/10/09. Pt #4 was a 51 year old male admitted for Chronic Renal Disease. The clinical record contained physician orders dated 6/01/09 and 6/12/09 for, "blood flow rate 400." The hemodialysis treatment records dated 6/9/09, 5/28/09, 5/23/09, and 5/21/09 documented blood flow rates below the required rate. The clinical record lacked documentation to indicate why the blood flow rate was not achieved as ordered. 3. These findings were conveyed to the Facility's Coordinator and the Administrative Director during an interview on 6/10/09 at 2:30 PM.	V 688		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1651 CREEK DRIVE MORRIS, IL 60450

(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
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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. This STANDARD is not met as evidenced by: Surveyor: 15166 A. Based on Facility policy review, observation, and staff interview, it was determined for 2 of 3 staff observed,(E#2 and E#3) that the Facility failed to ensure handwashing and donning of gloves as required by Facility policy. Findings include: 1. Facility policy entitled, "Infection Control Precautions and Policies," was reviewed on 6/11/09 at approximately 9:30 A.M. The policy requires, "Gloves... during any... procedure in which possible contact with body fluids may occur... A change of gloves is necessary between patients... Handwashing is to be done between patients." 2. On 6/8/09 between 9:00-10:30 A.M. a tour of the dialysis treatment area was conducted. The following was observed: * At approximately 9:05 A.M. E#3 silenced the alarm on the dialysis machine at station #2, where a patient was receiving dialysis, without first donning gloves. * At approximately 9:07 A.M. E#2 pressed a	V 113	494.30(a)(1)(i) CDC RR-5 Renal Morris coordinator will review infection control policies at next staff meeting. In addition, infection control audits will be performed by the Renal Morris coordinator. Results of infection control audits will be discussed at Medical Staff Nephrology Committee meetings.	6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Nelson
TITLE: Administrative Director Dialysis
(X6) DATE: 7-1-09

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.

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

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PRINTED: 08/23/2009
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1851 CREEK DRIVE MORRIS, IL 60450

(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
V 113	494.30(a)(1)(i) CDC RR-5 AS ADOPTED BY REFERENCE 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. This STANDARD is not met as evidenced by: Surveyor: 15166 A. Based on Facility policy review, observation, and staff interview, it was determined for 2 of 3 staff observed, (E#2 and E#3) that the Facility failed to ensure handwashing and donning of gloves as required by Facility policy. Findings include: 1. Facility policy entitled, "Infection Control Precautions and Policies," was reviewed on 6/11/09 at approximately 9:30 A.M. The policy requires, "Gloves... during any... procedure in which possible contact with body fluids may occur... A change of gloves is necessary between patients... Handwashing is to be done between patients." 2. On 6/8/09 between 9:00-10:30 A.M. a tour of the dialysis treatment area was conducted. The following was observed: * At approximately 9:05 A.M. E#3 silenced the alarm on the dialysis machine at station #2, where a patient was receiving dialysis, without first donning gloves. * At approximately 9:07 A.M. E#2 pressed a	V 113	494.30(a)(1)(i) CDC RR-5 Renal Morris coordinator will review infection control policies at next staff meeting. In addition, infection control audits will be performed by the Renal Morris coordinator. Results of infection control audits will be discussed at Medical Staff Nephrology Committee meetings.	6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Nelson
TITLE: Administrative Director Dialysis
(X6) DATE: 7-1-09

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.

INFECTION AND EXPOSURE CONTROL
AUDIT TOOL

Facility: _____ Date: _____

Reviewer: _____ Threshold 100% Result: _____

Associate															
Observe associate during 10 of the following procedures:	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
1. Associate wears appropriate facial protection (includes face shield, goggles, approved side shield for glasses) during high-risk procedures, i.e. priming of dialyzer, treatment initiation, treatment termination, removal of fistula clamps, administration of medications, reuse, etc.														
2. Associate wears gloves at appropriate times to protect them from becoming soiled & to prevent transmission to patients (per unit policies).														
3. Associate uses hand hygiene between patients, between equipment contact, before donning & after removing gloves (alcohol-based rub or hand wash), after patient & machine contact, before touching clean supplies, after contamination with blood or other infectious materials, & before leaving the patient treatment area.														

	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
4. Associate washes hands when: a. Leaving patient care area b. Entering patient care area c. If hands visibly contaminated														
5. Associate wears barrier covering at appropriate times, i.e. dialyzer set up, treatment initiation, treatment termination, removal of fistula clamps, administration of medications, reuse, etc.														
6. Associate removes and stores/disposes of barrier covering per unit policy.														
7. Associate properly disposes of sharps in designated sharps containers.														
8. Associate assures that sharps containers are free from blood spatter and not overfilled.														
9. Associate properly disposes of infectious waste in designated biohazard containers.														
10. Associate properly uses/stores dialysis supplies for each patient (supplies placed on machine in use are either discarded or disinfected after treatment). Supplies used for multiple patients (i.e. tape) and will not be disinfected are not placed on machines or in close proximity to machines.														
11. Associate caps all four (4) dialyzer ports per procedure at the end of treatment (prevents leakage).														

	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
12. Associate clamps bloodlines when stripping the dialysis machine (prevents saline/blood spills).														
13. Associate thoroughly cleans patient station equipment with disinfectant solution between patient treatments.														
14. Associate wipes down hemodialysis machine after treatment initiation.														
15. Associate is ungloved when using computer keyboard.														
16. Associate does not eat, drink, chew gum, or apply make-up in patient care areas of the unit.														
17. Associate assures that if patient holds access site, they wear gloves & use hand hygiene per unit policy.														
Total														
Percent														

To calculate % met: Count total number of met per associate observed. Each associate observation is worth 10 points if 10 procedures were observed for each associate. Add the number of observations met to determine the associate % met. To calculate total % met, add individual % met and divide by the number of associates observed. Example: you observe 5 associates. Their scores are as follows:

Associate #1: 90%
Associate #2: 90%
Associate #3: 70%
Associate #4: 100%
Associate #5: 100%

450 ÷ 5 = 90% met

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 113	Continued From page 1 button on the dialysis machine at station #3, where a patient was receiving dialysis, without first donning gloves. * At approximately 9:55 A.M. E#2 disposed of the wrapper from bag of saline solution into the trash can by lifting the lid of the can with bare hands. E#2 failed to perform hand sanitization prior to proceeding to care for the patient at station # 2 and also obtaining clean supplies from a clean stock drawer. 3. The above findings were conveyed to the Administrative Directive and Unit Coordinator during an interview on 6/8/09 at approximately 2:45 P.M. B. Based on observation and staff interview, it was determined that the Facility failed to ensure a separation of clean and dirty. Findings include: 1. On 6/11/09 a tour of the dialysis treatment area was conducted. There were multiple acid and bicarbonate containers partially-filled with clear fluid, stored on the countertop. The containers were identified as previously used during patient treatments. The containers were stored alongside clean supplies. 2. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 113	V113 - 494.30(a)(1)(i) CDC RR-5 Renal Morris coordinator has designated separate carts for the storage of clean and dirty acid and bicarbonate containers. All staff inserviced.	6/16/09
V 143	494.30(b)(2) OVERSIGHT [The facility must-] (2) Ensure that clinical staff demonstrate	V 143		

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	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1861 CREEK DRIVE MORRIS, IL 60450

(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
V 143	Continued From page 2 compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on review of the manufacturer's guidelines for Tuberculin Purified Protein (TB), observation, and staff interview, it was determined that in 1 of 1 vial of TB medication, the Facility failed ensure the expired/outdated medication was disposed of in accordance with the manufacturer's guidelines. Findings include: 1. The manufacturer's package insert for "Tuberculin Purified Protein," was reviewed on survey date 6/9/09 at 11:00 AM. The package insert required, "A vial of Tubersol which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency." 2. A tour was conducted of the Facility's treatment area on survey date 6/8/09 between 9:00 AM and 10:45 AM. During the tour, at 10:35 AM, the medication refrigerator contained one vial of Tuberculin solution opened and dated 4/15/09. 3. This finding was conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/10/09 at 2:30 PM.	V 143	V143 - 494.30(b)(2) Oversight Renal Morris coordinator immediately discarded the expired vial of Tubersol. All staff was inserviced on following package inserts.	6/9/09 6/11/09
V 187	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE	V 187		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 187	Continued From page 3 8 Environment: schematic diagrams/labels Water systems should include schematic diagrams that identify components, valves, sample ports, and flow direction. Additionally, piping should be labeled to indicate the contents of the pipe and direction of flow. If water system manufacturers have not done so, users should label major water system components in a manner that not only identifies a device but also describes its function, how performance is verified, and what actions to take in the event performance is not within an acceptable range. This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on observation and staff interview, it was determined that the Facility failed to ensure all major components and piping involved with the water system was labeled as required. Findings include: 1. On 6/8/09 a tour was conducted in the Facility's water room. During the tour it was observed the major water room components and water piping lacked labels indicating the contents of the piping and the direction of flow, as required. 2. The findings were conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 187	V187-494.40(a) ANSI/AAMI RD52:2004 On 6-8-09, Renal Morris coordinator contacted MarCor, the water system manufacturer, regarding the need for labels indicating contents of pipes and direction of flow, as well as labels to identify each water system component. The water system manufacturer, MarCor, labeled the complete water room with labels identifying each water system component and flow direction of water. In addition, Renal Morris coordinator will ensure that labels will be made and affixed to each water system component to describe its function.	6/09/09 7/10/09
V 191	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 8.2.4 Softeners: Testing hardness/log	V 191		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1851 CREEK DRIVE MORRIS, IL 60450

(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
V 191	Continued From page 4 Users should ensure that test accuracy and sensitivity are sufficient to satisfy the total hardness monitoring requirements of the reverse osmosis machine manufacturer. Total hardness of the water exiting the water softener should be measured at the end of each treatment day. Water hardness test results should be recorded in a water softener log. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on review of Facility policy, review of Facility water logs and staff interview, it was determined that the Facility failed to ensure total hardness of the Facility's water was checked at the end of each treatment day. Findings include: 1. Facility policy entitled, "Dialysis Water System Checklist," required, "Procedure: Checks must be made with the system running. Hardness testing for softener will be completed during last shift of patient treatments." 2. The Facility's water logs for the year 2009 were reviewed on survey date 6/8/09 at 11:00 AM. The logs lacked documentation of the time of the hardness check, ensuring the Facility checked the hardness of treatment water at the end of each treatment day. 3. The findings were conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 191	V191-494.40(a) ANSI/AAMI RD 52:2004 Renal Morris coordinator modified the Dialysis Water Purification Performance Log to indicate time (am/pm) of the hardness check at the end of each treatment day. (Log attached.) All staff inserviced on use of log.	6/11/09
V 220	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE	V 220		

page 1

A	RPZ INLET 10-50 PSI							
B	RPZ OUTLET 10-50 PSI							
	A - B = DELTA PRESSURE < 20 PSI							
C	TEMPERATURE 70 - 80 F							
D	BOOSTER PUMP 35 - 100 PSI							
	SWITCH TO BOOSTER 1 OR 2 DAILY							
E	MM FILTER OUTLET 30 - 100 PSI							
	D - E = DELTA PRESSURE < 10 PSI							
F	SOFTENER OUTLET 25 - 100 PSI							
10	HARDNESS SAMPLE < 5 PPM AM/PM	/	/	/	/	/	/	/
13	CHLORAMINE TOTAL - FREE = < 0.1 PPM							
14	CHLORAMINE TOTAL - FREE = < 0.1 PPM							
G	CARBON OUTLET 25 - 100 PSI							
	F - G = DELTA PRESSURE < 10 PSI							
H	PRE-FILTER OUTLET 20 - 100 PSI							
	G - H = DELTA PRESSURE < 10 PSI							
I	RO PUMP SUCTION 20 - 70 PSI							
J	RO PUMP DISCH 350 - 450 PSI							
K	PRESSURE TO MEMBRANE 125 - 250 PSI							
L	REJECT PRESSURE 100 - 225 PSI							
	RO PRODUCT COND < 40 US							
M	RO REJECTION > 90%							
N	RO REJECT FLOW 2.0 - 5.0 GPM							
O	RO PRODUCT FLOW 1.7 - 3.5 GPM							
P	REJECT RECIRC FLOW 8.0 - 10.0 GPM							
Q	LOOP PUMP PSI 65 - 75 PSI							
	SWITCH TO LOOP PUMP 1 OR 2 DAILY							
R	RESISTIVITY CELL A < 40 US							
R	RESISTIVITY CELL B > 2 MEG-OHM							
S	POST FILTER INLET 40 - 75 PSI							
T	POST FILTER OUTLET 40 - 75 PSI							
	S - T = DELTA PRESSURE < 25 PSI							
U	LOOP RETURN PRESSURE 35 - 55 PSI							
	ALL LIGHTS GREEN Y OR N							
	ALARMS OK Y OR N							
	SALT IN BRINE TANK - BAGS ADDED							
	DATE							
	SHIFT							
	NAME							
	NOTES:							

SEE REVERSE SIDE FOR CHLORAMINE LOG

LOG MUST BE COMPLETED EVERY DAY OF UNIT OPERATION

ALL READINGS MUST BE WITHIN THE PARAMETERS SHOWN ON LOG

SILVER CROSS HOSPITAL MORRIS DIALYSIS FACILITY SITE #02800804
WATER PURIFICATION CHLORAMINE LOG

1 FOLLOW TEST KIT INSTRUCTIONS STEP BY STEP.

2 TAKE CHLORAMINE SAMPLE FROM POST WORKER CARBON FILTER VALVE.

3 RECORD RESULTS BELOW WITH A NEGATIVE OR POSITIVE PHRASEOLOGY FROM PAST RESULTS.

4 IF CHLORAMINES ARE POSITIVE, TAKE SAMPLE FROM POLISHER CARBON FILTER VALVE.

*** IF CHLORAMINES ARE POSITIVE POST POLISHER CARBON, DIALYSIS TREATMENTS CANNOT BE PERFORMED.

*** IF CHLORAMINES ARE NEGATIVE POST POLISHER CARBON, CONTINUE WITH DIALYSIS TREATMENTS AND CALL FOR SERVICE.

PERFORM LOG BEFORE THE START OF EVERY SHIFT

RECORD RESULTS FROM TESTS	MON	TUE	WED	THU	FRI	SAT	SUN
SHIFT 1							
SHIFT 2							
SHIFT 3							

DATE: _____

NOTES: _____

FOR SERVICE CALL: MAR COR PURIFICATION 888-962-7878

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

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	143528	A. BUILDING _____ B. WING _____	08/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 220	Continued From page 5 7 Strategies for bacterial control 7.1 General: machine supply line disinfected Users should establish a procedure for regular disinfection of [the line between the outlet from the water distribution system and the back of the dialysis machine]. This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on review of manufacturer's guidelines, policy review, review of machine disinfection logs, and staff interview, it was determined that the Facility failed to ensure in 10 of 10 (machine #s 1-10) that residual bleach was checked following machine disinfection. Findings include: 1. Manufactures guidelines for the use of E-Z Check Residual Chlorine Tests Strips was reviewed on survey date 8/8/09 at 8:45 AM. The guidelines require, "E-Z Check Residual Chlorine Tests Strips provide a convenient, accurate means of measuring the concentration of chlorine bleach remaining in water being used to rinse out dialysate lines following disinfection of hemodialysis equipment." 2. Facility policy entitled, "Machine Disinfection,: required, "Procedure:..2. Test for residual disinfectant by sampling fluid at the dialysate port using residual chlorine test strips....Document negative residual bleach results on the machine disinfection log." 3. The Facility's Machine Sanitization Logs for year 2009 were reviewed on survey date 8/8/09 at	V 220	V220-494.40(a) ANSI/AAMI RD52:2004 Renal Morris coordinator modified the Machine Sanitization Log to include documentation of machines checked for residual bleach, following the bleach disinfection of the machines. (Log attached.) All staff inserviced on use of log.	6/11/09

MACHINE SANITIZATION LOG

DATE	PROCEDURE	1	2	3	4	5	6	7	8	9	10
MON	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
TUE	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
WED DIASAFE QOWK	VINEGAR										
	BLEACH /Negative Residual Bleach Test										
	DATE / INITIALS										
THUR	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
FRI	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
SAT	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										
SUN	VINEGAR										
	HEAT DISINFECT										
	DATE / INITIALS										

SIGNATURE: _____

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

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	143626	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 220	Continued From page 6 1:00 PM. The logs indicated that the Facility disinfected all 10 machines every Wednesday using bleach. The logs failed to indicate that the Facility checked for bleach residual following the disinfection of the machines. 4. The findings were conveyed to the to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 220		
V 228	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4.4.1 Mixing systems: labeling Labeling strategies should permit positive identification by anyone using the contents of mixing tanks, bulk storage/dispensing tanks, and small containers intended for use with a single hemodialysis machine. Mixing tanks: Prior to batch preparation, a label should be affixed to the mixing tank that includes the date of preparation and the chemical composition or formulation of the concentrate being prepared. This labeling should remain on the mixing tank until the tank has been emptied. Bulk storage/dispensing tanks: These tanks should be permanently labeled to identify the chemical composition or formulation of their contents. Concentrate jugs: At a minimum, concentrate jugs should be labeled with sufficient information to differentiate the contents from other concentrate formulations used at the facility. This STANDARD is not met as evidenced by: Surveyor: 15168	V 228		

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	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1331 CREEK DRIVE MORRIS, IL 60450

(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
V 228	Continued From page 7 A. Based on observation and staff interview, it was determined that in 1 of 1 bicarbonate mixing tank, the Facility failed to ensure the tank was labeled indicating the date and chemical concentration of the ingredients. Findings include: 1. A tour was conducted of the Facility's bicarbonate mixing room on survey date 6/8/09 at 10:30 AM. During the tour the Facility's mixing tank was observed. The tank lacked a label that included the date of mixture and the ingredients of the tank. 2. The above finding was conveyed to the Facility's Administrative Director and Coordinator during an interview on survey date 6/8/09 at 1:30 PM.	V 228	V228-494.40(a) ANSI/AAMI RD52:2004 The Chief Certified Clinical Hemodialysis Technician amended the bicarbonate mixing tank label to include the chemical ingredients of the tank. (Ingredient label attached.) In addition, Renal Morris coordinator revised Policy #G-20, titled, "Mixing Powdered Bicarbonate." (Policy attached.) All staff inserviced on labeling of tank..	6/11/09
V 236	494.40(a) ANSI/AAMI RD52:2004 AS ADOPTED BY REFERENCE 5.4.5 Additives: labeling spiked jugs/labeling if for specific pt (5.4.4.1 Concentrate jugs): If a chemical spike is added to an individual container to increase the concentration of an electrolyte, the label should show the added electrolyte, the date and time added, and the name of the person making the addition. Containers should be labeled to indicate the final concentration of the added electrolyte .... This information should also be recorded in a permanent record. Labels should be affixed to the containers when the mixing process begins. 5.4.2 Additives	V 236		

Tear to Open

renasol®

BICARBONATE CONCENTRATE POWDER

36.83X

BC-1 PART B

NOT FOR PARENTERAL USE

This package contains: 226 grams Sodium Chloride U.S.P.
624 grams Sodium Bicarbonate U.S.P.

See SB-1000 series acid concentrate label for final dialysate concentrations when properly diluted with Purified Water (AAMI quality or equivalent) in a three stream 36.83X bicarbonate proportioning artificial kidney (hemodialysis) machine.

Mixing Instructions

1. Empty contents of one package into clean, disinfected mixing container.
2. Add Purified Water (AAMI quality or equivalent) to bring total volume to two and one-half (2.5) gallons.
3. Mix well. Keep mixing until completely dissolved.
4. Analyze dialysate for correct concentrations and read SB-1000 series acid concentrate label prior to dialysis.

CAUTION: BC-1 bicarbonate concentrate can only be used in 36.83X bicarbonate proportioning machines with Renasol® SB-1000 series acid concentrate. Refer to the hemodialysis machine operator's manual for instructions prior to starting dialysis. Do not use if package is damaged. Do not use with 45X dilution dialysate delivery systems. Bacterial growth may occur in concentrated bicarbonate solutions. Take care to avoid contamination. Disinfect all containers, machines, transfer lines, etc., which contact the solution. Use within 48 hours of preparation. Store at room temperature in a sealed container after preparation. Federal (U.S.A.) law prohibits dispensing without prescription. Failure to follow the Instructions for Use may result in patient injury.

Manufactured in the U.S.A. by:
MINNTECH® renal systems
14605 28th Avenue North
Minneapolis, MN 55447 U.S.A.
Phone: (763) 553-3300
Toll Free: (800) 328-3340
Fax: (763) 553-3387

67720-495/B

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page G-20

TITLE: MIXING POWDERED BICARBONATE (FOR MORRIS UNIT)

PURPOSE:

To ensure powdered bicarbonate is mixed properly.

BICARB MIXING:

1. Open valve *V1* fill tank to batch volume level. Close valve *V1*.
2. Open valve *V2*, close valve *V5*.
3. Turn ON pump with manual switch.
4. Adjust mix flow using mix control valve *V2* to minimize vortex.
5. Slowly add bicarb powder through hinged lid.
6. Continue mixing until all powder is solubilized.
7. Turn OFF pump with manual switch.
8. If needed, adjust final volume of batch using valve *V1*.
9. Turn ON pump with manual switch and allow to circulate for 10 minutes.
10. Turn OFF pump with manual switch. Close valve *V2*.
11. Pull sample for testing from valve *V3*. Upon approval, proceed with step 12.
12. Fill jugs manually at Jug Access Port *V3*.
13. Affix label to the tank that includes the date of preparation and the chemical ingredients. This label should remain on the mixing tank until the tank has been emptied.

DEPARTMENTS AFFECTED:		Dialysis
EFFECTIVE DATE:		**REVISED DATE (S):**
December 1997		03/30/98, 07/13/07, 06/26/09
APPROVED BY:	Keith Nelson Department Head	**DATE:** 06/30/09
APPROVED BY:	Preeti Nagarkatte, M.D. Medical Director	**DATE:** 06/30/09
AUTHORIZED:	Peggy Gricus President (or designee)	**DATE:** 06/30/09

The Intent of the Silver Cross Hospital policies and procedures is to be utilized as

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

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	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1581 CREEK DRIVE MORRIS, IL 60450

(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
V 238	Continued From page 8 When additives are prescribed for a specific patient, the container holding the prescribed acid concentrate should be labeled with the name of the patient, the final concentration of the added electrolyte, the date on which the prescribed concentrate was made, and the name of the person who mixed the additive. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Facility policy review, observation, and staff interview, it was determined, for 2 of 2 patients receiving altered dialysate baths, (Pt. #4 and #5) that the Facility failed to ensure that the bath containers were labeled in accordance with policy. Findings include: 1. Facility policy entitled, "Potassium and Calcium Additives For Dialysate," was reviewed on 6/0/09 at approximately 2:00 P.M. The policy requires, "Potassium and Calcium additives will be prepared and labeled by licensed staff." The policy failed to specify what the label should include. 2. On 6/11/09 a tour of the dialysis treatment area was conducted. There were two partially-filled containers of clear fluid, each with the following label: "3K (potassium) + 2.5 Ca (calcium)". The labels lacked documentation of the patient's name, the date on which the the concentrate was made, and the name of the person who mixed the additive.	V 236	V236-494.40(a) ANSI/AAMI RD52:2004 Renal Morris coordinator revised policy #G-14, titled, "Potassium and Calcium Additives for Dialysate" to reflect that proper additive labeling will include the added electrolyte, final concentration, date and time of additive, and name of person mixing the additive. When prescribed for a specific patient, the name of patient will be added to label. In addition, all staff have been inserviced on proper labeling of concentrate jugs.	6/26/09

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page G-14

TITLE: POTASSIUM AND CALCIUM ADDITIVES FOR DIALYSATE

Purpose:

To assure prescribed dialysate concentrations of potassium acetate and calcium chloride are mixed according to the manufacturer's instructions.

General Information:

1. **Calcium Chloride** additive is in an aqueous form and contains USP salt at a concentration of 3312 mEq/L. The product is packaged in 200ml bottles. (See attached mixing procedure as specified by additive manufacturer)
2. **Potassium Acetate** additive is in an aqueous form and contains USP salt a concentration of 8000 mEq/L. The product is packaged in 200ml bottles. (See attached mixing procedure as specified by additive manufacturer)
3. Potassium and Calcium additives will be prepared and labeled by licensed staff.
4. The label will include the added electrolyte, the final concentration, the date, and the name of the person making the addition. When prescribed for a specific patient, the label will also include the name of the patient.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: July 26, 1991

REVISED DATE (S): 01/94, 05/96, 02/2007, 08/2008, 06/26/09

APPROVED BY: Keith Nelson, Department Head — **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director — **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) — **DATE:** 06/30/09

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

PRINTED: 08/23/2009
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
	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 238	Continued From page 9 3. The above two containers were identified by the Unit Coordinator as dialysate baths that were used for Pt. #4 and Pt. #5 on the previous day during their treatments. 4. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 238		
V 415	494.60(d)(4) EMERGENCY PREPAREDNESS [The facility must-] Evaluate at least annually the effectiveness of the emergency and disaster plans and update them as necessary; .	V 415		
	This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Hospital policy review and staff interview, it was determined that the Facility failed to ensure emergency and disaster plans were evaluated and updated as necessary. Findings include: 1. The Facility policy entitled, "Dialysis Safety/Emergency Response Plan," was reviewed on 6/11/09 at approximately 8:50 A.M. The policy lacked a requirement for mock drills to determine the staff's skill level and educational needs during an emergency situation. 2. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/8/09 and 6/10/09 at approximately 2:45 P.M. The Coordinator stated that they did not have documentation to indicate that any		V415-494.60(a)(4) Emergency Preparedness Policy #B-12, "Dialysis Safety/Emergency Response Plan," was revised to include evaluation of disaster plans to include mock drills (see attached policy). In addition, a log has been created to document mock drills, effectiveness of drills and needs assessment.	7/1/09

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page B-12

TITLE: DIALYSIS SAFETY / EMERGENCY RESPONSE PLAN

Policy:

The dialysis unit safety plan includes alternate sites where dialysis is provided. Guidelines for actions in the event of an emergency are as follows:

A. FIRE PROCEDURE:

Purpose:

To provide guidelines for action in the event of a fire to maintain order.

Objectives:

1. Know location of fire alarms and extinguishers.
2. Know procedure for communicating knowledge of fire and removing patients from danger.
3. Follow procedures for fire containment.

Location of Equipment:

1. East: Fire extinguishers are located at rear exit. Audible/visual alarm located on west wall.
2. West: Fire extinguishers are located in northwest corner of treatment area by Station #1 and northeast wall of service entrance corridor. Audible/visual fire alarm located on north wall in nurses station, which is connected with the Joliet Fire Department. Heat detectors/sprinklers located in ceiling and duct work throughout unit and building.
3. Morris: Fire extinguishers located at east and west exit doors. Audible/visual alarms located in treatment area and patient waiting area.

Fire Procedure:

1. All personnel should respond to fire alarm by coming to nursing station.
   A. If the fire is in your location, initiate preliminary extinguishing procedure, and call

Silver Cross Hospital

POLICIES & PROCEDURES

Home | Administration Book | Safety | Departments | Search

TITLE: DIALYSIS SAFETY / EMERGENCY RESPONSE PLAN

Manual Page B-12

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3. **Morris:** Fire extinguishers located at east and west exit doors. Audible/visual alarms located in treatment area and patient waiting area.

Fire Procedure:

1. All personnel should respond to fire alarm by coming to nursing station.
   A. If the fire is in your location, initiate preliminary extinguishing procedure, and call

emergency number to report.

East: Call extension 7800
West: Call 911
Morris: Call 911

B. If small fire is extinguished by dialysis staff, Fire Department should be called for follow-up evaluation.

2. Charge Nurse will assume responsibilities for delegation of duties of the nursing and non-medical personnel.

3. If fire occurs in clinical area:

A. Nurses will remove patients from immediate danger.

1. Clamp needles. Do not attempt to return blood.

2. Walk patient or pull the patient using a blanket to an area of safety.

B. One staff member will:

1. Pull the fire alarm.

2. Call the emergency number and alert others in the building, stating location and nature of fire.

3. Shut off any oxygen in the room.

4. Close all doors in the Department to confine the fire to that area.

C. Meet fire brigade and inform them of location.

4. If fire occurs in another area of building, the building alarm will sound. All doors in department should be closed.

Fire Prevention Practices:

1. Scrupulous housekeeping.

2. Routine inspection of equipment, particularly electrical.

3. A No Smoking Policy will be maintained within the Dialysis Unit.

4. Instruction of employees in the use of appliances done during Education Day.

5. Strict control over receiving, distributing and storage of volatile liquids.

6. Keep stairwell doors closed.

7. All exits well-marked, clear and accessible.

8. Fire-resistant draperies, carpeting and upholstery fabrics.

9. No storage within 36 inches (18 inches if non-flammable material) of the ceiling and/or sprinkler heads.

10. Each extinguisher has been checked for its adaptability to the hazard presented in the immediate area.

11. Know the location and assure easy accessibility to all fire emergency exits (minimum requirement of 2).

B. TORNADO

Terminology

1. Tornado Watch or Severe Warning: Conditions are favorable to produce tornadoes.

2. Tornado Warning: Severe weather conditions exist which has produced a tornado or a funnel cloud. A tornado or a funnel cloud has been reported.

Procedure:

Tornado Watch or Severe Weather Warning:

Upon knowledge of a tornado watch or severe weather warning, all staff should make themselves available for further response if necessary.

Tornado Warning or Sighting within 5 miles of the Dialysis Unit:

Employees with Patient Care Responsibility:

1. Discontinue dialysis treatment returning blood to patient by established protocol.

2. Obtain flashlights.

3. Close blinds.

4. Turn on all lights.

5. Move all patients from treatment area.

6. Move ambulatory patients and visitors to chairs or floor in corridor.

7. Obtain emergency supply box.

8. Close all room doors.

All Clear:

Upon receipt of official word that the tornado warning has passed, patients will be returned to treatment area to resume dialysis.

Important Key Information to Know:

1. "Spotters" are dispatched to certain areas to report changes in weather conditions.

2. All personnel remain in their workplace and seek shelter.
3. Patients are moved to the hallway corridor whenever possible, those that cannot, have their bed face away from the windows and protected with extra blankets.
4. No visitor or employee will be held against their will, but those people who choose to leave, do so at their own risk.
5. Do not use elevators.
6. Limit your telephone usage.

C. **EQUIPMENT/ ELECTRICAL SAFETY**

1. **Power Failure Emergency Procedure:**

Purpose:

To provide safety to patients and alleviate anxiety. All staff will confidently render care to patients during power failure.

Procedure:

1. Obtain emergency lighting if needed.
2. Reassure patients that their safety is not being compromised.
3. If assisted by Uninterrupted Power Source (UPS), discontinue treatments returning all blood. In case of UPS failure, do not return patient blood when discontinuing treatment.

D. **Monitoring at the evacuation site**

Purpose:

Assess status of patients in order to reduce incidence of complications.

Objectives:

Follow procedure for proper monitoring of patients at evacuation site.

Procedure:

1. Check blood pressure on all patients with documentation as available.
2. Remove needles on stable patients, utilizing standard procedure for manual pressure and dressing at venipuncture site.
3. Administer normal saline to patients PRN for hypotension.
4. Document condition of patients.
5. Patients will be discharged from evacuation site under the direction of the Charge Nurse.

Evacuation of Facility:

1. Decision for evaluation will be made by Dialysis Unit Charge Person with assistance from local Fire Department.

2. **East:** Patients will be evacuated using the lower level exit door, and escorted to the Maple Road parking lot.

   West: Patients will be evacuated to an area of safety outside of the building, located near pump station on Southwest corner of rear parking lot.

   Morris: Morris patients will be evacuated to area of safety directly west of the building by the arched sign.

3. Charge person will assign responsibilities at evacuation location and bring Emergency Supply Box to the evacuation location.

4. All other available personnel will assist in evacuating patients from the building.

   a. Do not remove needles or return blood.

   b. Clamp both needles, disconnect lines.

   c. Shut off power and water to machine.

   d. Assist with evacuation after all patients are off the machine.

   e. Feel the door (checking for heat). **DO NOT OPEN IF HOT.** Find an alternate exit.

   f. If smoke inhalation is a problem:

      1. Put wet cloth to mouth and nose.

      2. Crawl along the floor.

5. After all patients have evacuated, all staff members will report to the evacuation site and a census will be taken.

E. **Emergency Transfer of Patients**

Policy and/or Procedure:

In the event of equipment malfunction or other cause preventing dialysis service to be rendered, this plan will go into effect.

1. All patients will be assessed regarding need for urgent treatment.

2. Assessments will be reviewed and discussed with attending physician for orders.

3. Patients not in need of urgent dialysis will be sent home to await further instructions.

4. Patients needing dialysis the same day will be transferred to other local units with availability of service. Renal Center West location and Silver Cross Hospital will serve as the primary reciprocal back-up service areas during emergencies. The acute dialysis room in Silver Cross Hospital will be utilized to its full capacity.

5. When the facility becomes available for service, patients will be scheduled according to need and then begin usual dialysis schedule.

6. Emergency hotline phone number is 815-722-2586. The coordinator of the affected unit will record a message instructing patients of what to do and who to call to schedule their dialysis treatment.

7. Notify the Renal Network

F. Patient Education/Emergency Care.

It is the policy of the Dialysis unit to make a concerted effort to provide maintenance hemodialysis for its patients on a continuing basis. However, there are a number of highly unlikely potential situations which could result in the necessity to terminate dialysis at the unit such as fire, major equipment failure, etc. In the event that any occurrences happen, it is generally foreseeable that with emergency corrective action, the facility could be operational within a relatively short period of time (24 hours of less). During this time, patients would be evaluated, and those requiring immediate dialysis would be dialyzed in the hospital on acute dialysis machines. The following plans will be implemented to maintain a safe environment for both pateints and the staff.

1. Fire Emergency Plan

The Dialysis Unit takes many precautions against fires. Fire emergency equipment is available, and the staff has been trained in fire emergency procedures. In the event that a fire should occur, it is important to know what to do.

The Charge Nurse and Physician will make the decision, in the event of a fire, as to what will be done. If there is any danger, all patients will be taken off the machines immediately.

The staff will take all patients off as quickly as possible. If the danger is great enough, all dialysis lines will be clamped and disconnected. You then will be assisted out of the Dialysis Unit. If for any reason you are unable to walk, you will be assisted in either a wheel chair or by some other means. All of our staff members are trained to do this.

In the event that patients must be evacuated from the unit, an area will be set up outside the unit until additional help arrives. Emergency stock supplies are available in such an event.

2. Major Equipment Failure

In the event that a major piece of equipment should fail such as a water heater, reverse osmosis machine, etc., it would not be possible to provide fresh dialysate. The nurse supervisor and the physician will make the decision to stop dialysis.

3. Electrical Failure

In the event of a complete power failure, you may discontinue your treatment, as instructed, or wait for staff assistance. To discontinue treatment, you must first turn off your machine, close the 2 clamps on your needles, and 2 clamps on the blood lines, then twist the locks on the ends of needles to disconnect. Do not attempt to return your blood.

4. Tornado or Severe Weather Warning

In the event of a tornado or severe weather warning a staff member will return the patients blood unless the danger is too great. All dialysis lines will be clamped and disconnected. Upon receipt of official word that the danger has passed, patients will be returned to the treatment area to resume

dialysis

In the unlikely event that any of the above occurrences happen, it is generally foreseeable that with emergency corrective action, the facility could be operational within a relatively short period of time (24 hours or less). During this time, patients would be triaged (evaluated) and those requiring immediate dialysis would be dialyzed at an alternate site.

G. **Evaluation of Disaster Plans**

1. Each unit will conduct a mock drill annually and review plans for effectiveness and a needs assessment.

2. Staff will be responsible for completing the Dialysis Safety and Emergency CBL.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: **REVISED DATE (S):**

October 1995 01/00, 11/02, 08/04, 06/09

APPROVED BY: Keith Nelson, Department Head **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) **DATE:** 06/30/09

Manual Page B-12

The intent of the Silver Cross Hospital policies and procedures is to be utilized as guidelines [redacted] and goals. They are not to be considered inflexible standards or legal requirements.

Silver Cross Dialysis Renal Centers

Location: _____	Mock Drill Scenario:
Drill Date: _____	
Conducted by: _____	
Drill Attendance Roster	
Name(s):	
Remarks and Recommendations:	

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

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OMB NO. 0938-0391

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	143626	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 GREEK DRIVE MORRIS, IL 60450

(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
V 415	Continued From page 10 emergency/mock drills had been completed.	V 415		
V 504	494.80(a)(2) ASSESSMENT CRITERIA [The patient's comprehensive assessment must include, but is not limited to, the following:] Blood pressure, and fluid management needs. This STANDARD is not met as evidenced by: Surveyor: 15188 A. Based on policy review, clinical record review and staff interview, it was determined that in 2 of 6 (Pt #1 and #2) clinical records reviewed, the Facility failed to ensure that all patients' were reassessed intradialytically and post dialysis for symptoms present on the predialysis assessments. Findings include: 1. Facility policy entitled, "Hemodialysis Standards," reviewed on survey date 6/10/09 at 11:15 AM required, "...Adequacy of Hemodialysis: Patient Outcome:..Nursing Management, Assessment: Intradialytic Monitoring: Assessment, 1. The nurse will assess the following parameters during dialysis: A. Patient, 1. Vital signs..7. Response to treatment..Intervention:..3. Notify patient's physician of any significant change or problem., Post dialysis patient assessment includes but not limited to"..B. Weight/volume status..G. Other conditions or complications." 2. The clinical record of Pt #1 was reviewed on survey date 6/10/09. Pt #1 was a 71 year old	V 504	V504-494.80(a)(2) Assessment Criteria All staff inserviced on need to record post dialysis assessment of edema in the hemodialysis patient record, Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance.	7/8/09

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
1							
2							
3							
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6							
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8							
9							
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11							
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13							
14							
15							
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17							
18							
19							
20							
Total							

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	143526	A. BUILDING _____ B. WING _____	06/11/2009

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SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 504	Continued From page 11 female admitted to the Facility on 4/14/04 with a diagnosis of End Stage Renal Disease. The clinical record contained treatment records dated 5/1, 5/3, 5/5, and 5/8/09 that documented lower extremity edema on the predialysis assessments. The treatment records lacked any post dialysis assessment of the edema at time of discharge. 3. The clinical record of Pt #2 was reviewed on survey date 6/10/09. Pt #2 was a 77 year old male admitted to the Facility on 11/15/08 with diagnoses of Chronic Kidney Disease and Hypertension. The clinical record contained treatment records dated 5/30, 6/2, and 6/9/09 that documented lower extremity edema on the predialysis assessments. The treatment records lacked any post dialysis assessments of the edema at the time of discharge. 4. The findings were conveyed to the Facility's Coordinator during an interview on survey date 6/10/09 at 10:30 AM.	V 504		
V 543	494.90(a)(1) DEVELOPMENT OF PATIENT PLAN OF CARE (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on Facility policy review, clinical record review, and staff interview, it was determined, for 2 of 5, (Pt. #1 and #4) clinical records reviewed for inter and intradialytic blood pressures,	V 543		

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

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V 543	Continued From page 12 symptoms, and target weight, that the Facility failed to ensure that the patient's plan of care was altered to address the patient's symptoms. Findings include: 1. The Facility failed to provide a policy for the new plan of care process when requested. 2. The clinical record of Pt #1 was reviewed on survey date 6/10/09. Pt #1 was a 71 year old female admitted to the Facility on 4/14/04 with a diagnosis of End Stage Renal Disease. The clinical record contained the physician's orders dated 4/22/09-6/3/09, for a dry weight, (EDW) of 77 kilograms (kg) without any change ordered. The treatment records dated 5/29, 6/1, 6/3, 6/5, and 6/8/09 documented Pt #1's weight 75.3 to 75.2 kg. The record lacked documentation that the EDW and dialysis prescription was reevaluated and altered as needed. (15168) 3. The clinical record for Pt. #4 was reviewed on 6/9/09. This was a 74-year-old female admitted 6/23/08 with a diagnosis of Chronic Kidney Disease. The record included documentation of the physician's dialysis prescription orders from 5/12/09 through 6/2/09. All of the orders included an estimated dry weight (EDW) of 59.5 kg for Pt. #1. The hemodialysis records were reviewed from 5/16/09 through 6/9/09. The records included documentation that for 8 of 11 treatments reviewed, the patient was between 0.6-1.4 kg less than the ordered EDW. In addition the records included documentation that Pt. #4's blood pressures were fluctuating with systolic pressures from 92-206 mmHg and diastolic pressures from 40-109 mmHg. The	V 543	V543 - 494.90(a)(1) Development of Patient Plan of Care Policy #E-8, "Dialysis Plan of Care," was written by KW Director to ensure that the patient assessment is followed by an individualized and comprehensive Plan of Care developed by an interdisciplinary team. This policy will be reviewed at the next staff meeting. Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in EDW are noted on the chart as a physician order. Compliance of documentation of EDW on all patient charts was completed by 6/16/09 under the supervision of the Renal Morris coordinator. In addition, all licensed staff were inserviced by Renal Morris coordinator to obtain physician order for any changes in EDW.	7/8/09 6/15/09 6/16/09 6/17/09

Silver Cross Hospital

POLICIES & PROCEDURES

Manual Page E-8

TITLE: DIALYSIS PLAN OF CARE

PURPOSE:

To ensure that the patient assessment is followed by an individualized and comprehensive Plan of Care (POC) developed by an interdisciplinary team.

1. Initial assessment and Plan of Care (POC) will be completed within 30 days or 13 treatments of admission for each patient who is new to ESRD and dialysis as well as for each patient transferring into the facility without a completed comprehensive assessment and POC.

    a. Patient interview and initial assessment by all interdisciplinary team members.

        1. Physician
        2. Nursing
        3. Social Worker
        4. Dietitian

    b. POC completed by all disciplines.

2. Re-assessment and POC completed within 90 days of initial POC

3. Repeat re-assessment and POC

    a. Stable – annually

    b. Unstable – monthly until stable
    Unstable as indicated below:

        1. Extended or frequent hospitalization as evidenced by hospitalization more than 8 days or more than 3 hospitalizations in one month.
        2. Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis as evidenced by Albumin less than 3.4g/l and weight loss greater than 5% in one month, Hgb less than 10g/dl, and Kt/V less than 1.2 for Hemodialysis patients and 1.7 for Peritoneal Dialysis patients.
        3. Significant change in psychosocial needs as evidenced by financial/housing loss, decline in physical or mental status, death or major illness in family, loss of emotional support, or physical or mental abuse.
        4. Marked deterioration in health status as evidenced by recurrent serious complication. Health care team to document specific reason.

4. The interdisciplinary team consists of, at a minimum, the patient or patient designee, a registered nurse, a

physician who is treating the patient for ESRD, a social worker, and a dietitian.

5. The POC must be developed from the comprehensive assessment and must include, at a minimum the following assessments:

   a. Dose of Dialysis
   b. Adequacy of Dialysis
   c. Vascular access
   d. Fluid control
   e. Blood pressure
   f. Anemia management
   g. Nutritional management
   h. Mineral metabolism
   i. Psychosocial status
   j. Transplant status
   k. Modality evaluation
   l. Safety training
   m. Vocational rehabilitation status

6. The POC will be signed by each team member to include the patient. To ensure the development of a congruent, integrated patient plan of care, the facility will conduct interdisciplinary team conferences ensure an integrated plan. To facilitate full team participation in conferences, any member, including the patient, may participate through telecommunication.

DEPARTMENTS AFFECTED: Dialysis

EFFECTIVE DATE: **REVISED DATE (S):**

June, 2009

APPROVED BY: Keith Nelson, Department Head **DATE:** 06/30/09

APPROVED BY: Preeti Nagarkatte, M.D., Medical Director **DATE:** 06/30/09

AUTHORIZED: Peggy Gricus, President (or designee) **DATE:** 06/30/09

Manual Page E-8

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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	143826	A. BUILDING _____ B. WING _____	06/11/2009

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SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 543	Continued From page 13 records also included documentation of significant fluctuations in bps during the patients change in position from sitting to standing, at the end of treatments. The record lacked documentation that the EDW and dialysis prescription was reevaluated and altered as needed. 4. The above findings were conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M. B. Based on Facility policy review, clinical record review, and staff interview, it was determined, for 1 of 5 clinical records reviewed for patients' blood pressures (bps), (Pt. #4) that the Facility failed to ensure that significant changes were addressed. Findings include: 1. Facility policy entitled, "Hemodialysis Standards," was reviewed on 6/10/09 at approximately 10:00 A.M. The policy requires, "The nurse will access the following parameters during dialysis... Vital signs... Notify patient's physician of any significant change or problem." 2. The clinical record for Pt. #4 was reviewed on 6/9/09. This was a 74-year-old female admitted 6/23/08 with a diagnosis of Chronic Kidney Disease. The hemodialysis records dated 6/9, 6/6, 5/28, 5/26, 5/19, and 5/16/09 included documentation that Pt. #4's blood pressures were fluctuating with systolic pressures from 92-208 mmHg and diastolic pressures from 40-109 mmHg. The records also included documentation of significant fluctuations in bps during the patients change in position from sitting	V 543	Renal Morris coordinator will review Policy #E-1, "Hemodialysis Standards" at next staff meeting to re-educate staff on the importance of proper documentation of any significant changes in blood pressures, and if necessary, increased assessment and notification of the physician. Renal Morris coordinator will conduct a retrospective audit of patient charts to document compliance.	7/8/09

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance – # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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Total							

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

PRINTED: 05/23/2009
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
	143526	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 543	Continued From page 14 to standing, at the end of treatments. The record lacked documentation that the significant changes in blood pressures were addressed, such as increased assessment and notification of the physician. 3. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M.	V 543		
V 688	494.140(b)(4) NURSING SERVICES Each nurse who provides care and treatment to patients must be either a registered nurse or a practical nurse who meets the practice requirements in the State in which he or she is employed. This STANDARD is not met as evidenced by: Surveyor: 15168 A. Based on policy review, clinical record review, and staff interview, it was determined that in 2 of 5 (Pt #2) clinical records reviewed for Heparin, the Facility failed to ensure the medication was administered by the Registered Nurse as ordered. Findings include: 1. Facility policy entitled, "Hemodialysis Standards," reviewed on survey date 6/10/09 at 1:15 PM, required, "..Initiation of Treatment"...Nursing Management...Intervention,..3. Administer anticoagulant according to treatment prescription." 2. Facility policy entitled, "Heparin Pump," reviewed on survey date 6/10/09 at 1:15 PM.	V 688	V688-494.140(b)(4) Nursing Services Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in Heparin dosages are noted on the chart as a physician order. Compliance of documentation of Heparin orders on all patient charts was completed by 6/16/09 under the supervision of the Renal Morris coordinator. In addition, all licensed staff were inserviced by Renal Morris coordinator to obtain physician order for any changes needed for Heparin dosages. Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance.	6/15/09 6/16/09 6/17/09 7/8/09

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: **Dialysis**

Indicator: **Compliance To Nursing Documentation on Treatment Record**

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
1							
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Total							

PRINTED: 08/23/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 688	Continued From page 15 required, "Procedure:...3. Set pump for amount to be administered per hour, and for how long... 0.5 ml = 500 units per hour, 1.0 ml = 1000 units per hour." 3. The clinical record of Pt #2 was reviewed on survey date 6/10/09. Pt #2 was a 77 year old male admitted to the Facility on 11/15/08 with diagnoses of Chronic Kidney Disease and Hypertension. The clinical record contained a physician order dated 5/14/09 for, "Heparin 2000 units IV push Bolus and Heparin Pump 1 ml/hour." The clinical record contained treatment records dated 5/28, 5/30, 6/2, 6/4, 6/6, and 6/9/09 that lacked any nursing documentation that the 2000 units of Heparin IV push was given as ordered. The clinical record contained treatment records dated 5/21 and 5/26/09 that indicated Pt #2 received Heparin per pump at 0.5 ml/hr instead of the 1 ml/hr as required. The clinical record contained treatment records dated 5/30, 6/2, 6/4, 6/6, and 6/9/09 that lacked documentation of any Heparin being given per pump as ordered. The clinical record lacked any physician orders changing the Heparin dosage. 4. The findings were conveyed to the Facility's Coordinator during an interview on survey date 6/10/09 at 10:30 AM. Surveyor: 15166 5. The clinical record of Pt. #3 was reviewed.	V 688		

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

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	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 688	Continued From page 16 This was a 74-year-old female admitted 6/23/08 with diagnoses of Diabetic Nephropathy and Hypertension. The record included documentation of a physician's order for dialysis prescription, dated 6/2/09. The order included Heparin Recirc + Pump. The record also included documentation of Standing Orders For Dialysis Medications, dated 2/24/09. The standing orders included, "Heparin Sodium 1000 units/ ml- maintain patency of dialyzer..." The hemodialysis record dated 6/8/09 included documentation that Pt. #1 had the heparin pump set for 0.5 ml/hr instead of 1 ml/hr as required by the standing order. The record lacked documentation to indicate why the dosage was not administered as ordered. B. The above finding was conveyed to the Administrative Director and Coordinator during an interview on 6/10/09 at approximately 2:45 P.M. B. Based on policy review, clinical record review, and staff interview, it was determined that in 4 of 11 dialysis treatments (6/9/09,5/25/09, 5/23/09, 5/21/09) for Pt #4, the Facility failed to ensure that the blood flow rate was provided as ordered. Findings include: 1. Facility policy entitled, "Hemodialysis Standards" reviewed on survey date 6/10/09 at 11:00 AM required, "Intradialytic Monitoring...Assessment, 1. The Nurse will asses the following parameters during Dialysis... B. Delivery System.. #4. Blood flow rate... Intervention,.. #3. Notify Patient's physician of any significant change or problem." 2. The clinical record of Pt #4 was reviewed on	V 688	V688-494.140(b)(4) Nursing Services Renal Morris coordinator spoke with the Acting Medical Director of Nephrology at Silver Cross regarding the need to ensure that any changes in Blood Flow Rate are noted on the chart as a physician order. Compliance of documentation of BFR orders on all patient charts was completed by 6/24/09 under the supervision of Renal Morris coordinator. In addition, all staff have been inserviced on proper documentation of prescribed BFR and if not maintained will document reason why. Renal Morris coordinator will conduct retrospective audits of patient charts to document compliance.	6/23/09 6/24/09 6/26/09 7/8/09

Data Collection Tool

Department/service:____ Dialysis Dates:_____

Person Collecting Data: Dialysis

Indicator: Compliance To Nursing Documentation on Treatment Record

Legend: Criteria met + Variance — # Samples_____

CRITERIA

Sample Member (patient M#, individual code)	Date	BFR documented as ordered by MD	Exceptions to BFR documented	Post-dialysis edema assessment to include EDW	BP assessment, notify MD if necessary	Changes in Heparin-MD order	List All Sections Not Completed
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Total							

FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	143528	A. BUILDING _____ B. WING _____	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS RENAL CTR MORRIS	1551 CREEK DRIVE MORRIS, IL 60450

(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
V 688	Continued From page 17 survey date 6/10/09. Pt #4 was a 51 year old male admitted for Chronic Renal Disease. The clinical record contained physician orders dated 6/01/09 and 5/12/09 for, "blood flow rate 400." The hemodialysis treatment records dated 6/9/09, 5/28/09, 5/23/09, and 5/21/09 documented blood flow rates below the required rate. The clinical record lacked documentation to indicate why the blood flow rate was not achieved as ordered. 3. These findings were conveyed to the Facility's Coordinator and the Administrative Director during an interview on 6/10/09 at 2:30 PM.	V 688		

Schedule 4.14(h)
Compliance with Laws – Environmental

- None

Schedule 4.16
Benefit Plan Compliance

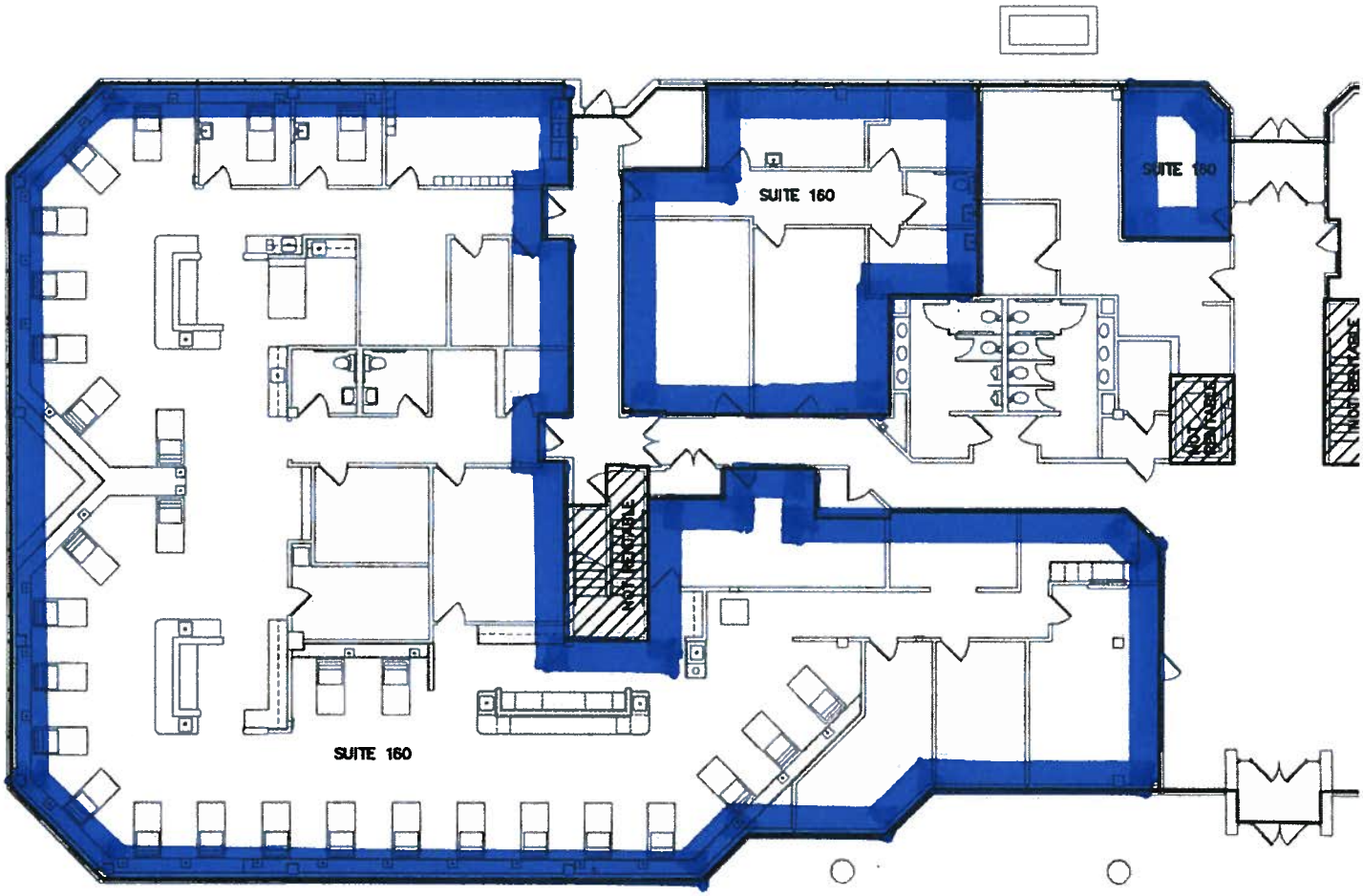
- Medical Coverage
- Dental Coverage
- Paid Time Off Bank
- Preventative & Essential Benefits
- Sick Bank
- Short Term Disability
- Long Term Disability
- Basic Life and AD&D Insurance
- Tuition Reimbursement
- Employee Assistance Program
- Flexible Spending Accounts
- Voluntary Retirement Savings Plan
- Matched Retirement Savings Plan
- Credit Union

Schedule 4.20
Dialysis Contracts

Type of Contract	Parties	Commencement and Expiration Dates	Assigned or Retained?
Dialysis Supplies	B. Braun	9/20/11-6/30/13	Retained
Water Treatment	Mar Cor	03/30/09	Retained
Dialysate	Minntech	9/1/11-8/31/12	Assigned
Water Testing	Spectra Labs	5/31/00 (no ending date)	Retained
Transfer Agreement	Morris Hospital	On-going	Assigned
Organ Tissue Donor	Gift of Hope and Tissue Donor Network	On-going	Retained
Professional Services	Provena Villa Franciscan	On-going	Retained
Transplant Patient Care Procedure	Northwestern Memorial Hospital	4/08/2009 (no ending date)	Assigned

Schedule 4.21
Real Property

- Renal Morris – The space is 4,229 square feet, a single tenant site located at 1551 Creek Dr., Morris, IL 60450 and floor plan is attached.
- Renal West – The space is 10,389 rentable square feet located at 1051 Essington Road, Joliet, IL 60435 and the floor plan is attached.
- Renal East New Lenox – The site is 8,587 rentable square feet located at 1890 Silver Cross Blvd, New Lenox, IL 60451and the floor plan is attached.



ESSINGTON BUILDING – FIRST FLOOR
EXISTING TENENT AREAS – 05/2010

0 5
1 10 20

NORTH

RENTABLE

FIRST FLOOR PLATE	22,
4 NOT RENTABLE AREAS	
FIRST FLOOR RENTABLE	22,

USABLE

SUITE 100	5,
SUITE 140 (3 AREAS)	4,
SUITE 140 (COMMON)	
SUITE 160 (3 AREAS)	8,
FIRST FLOOR USABLE	18,
FIRST FLOOR COMMON	3,

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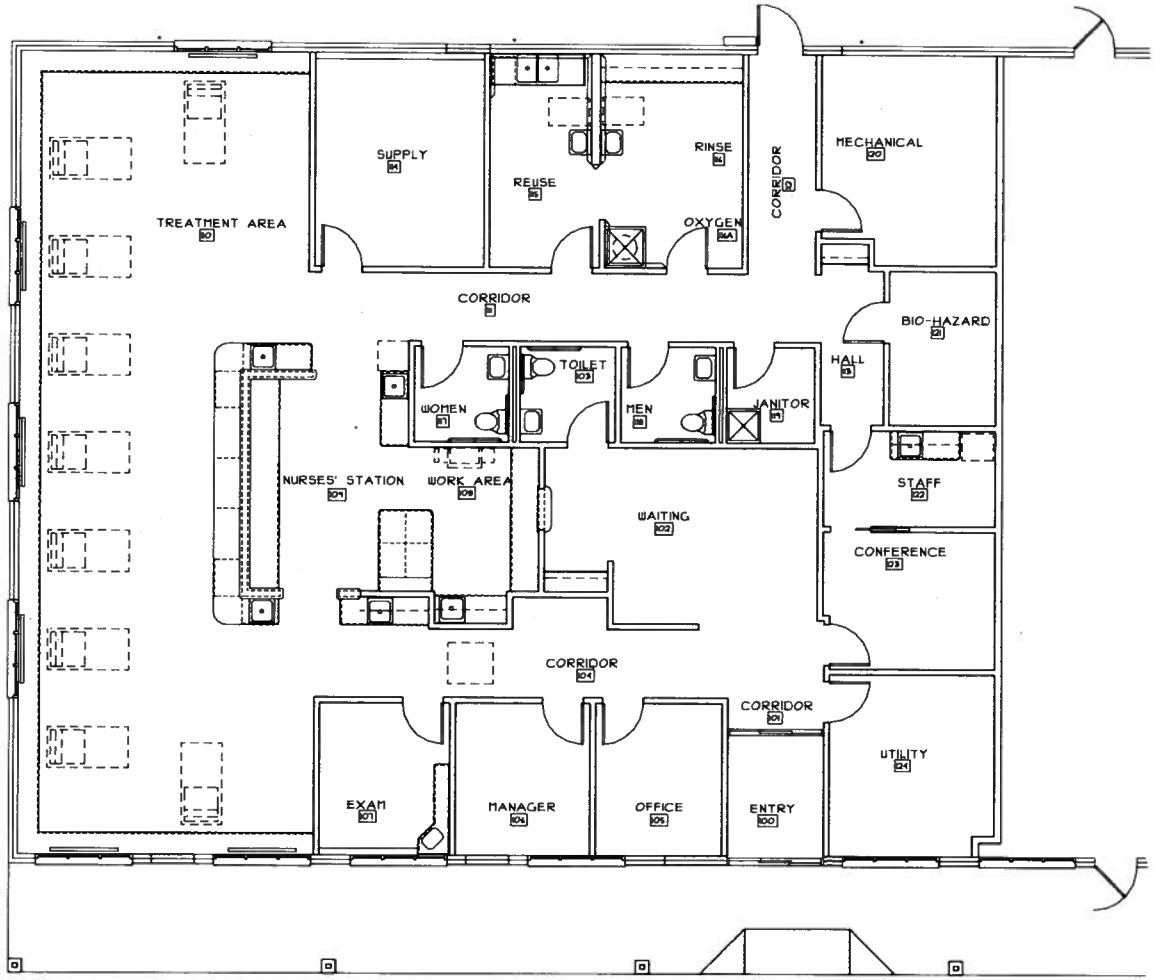

NORTH

FLOOR PLAN

MORRIS DIALYSIS

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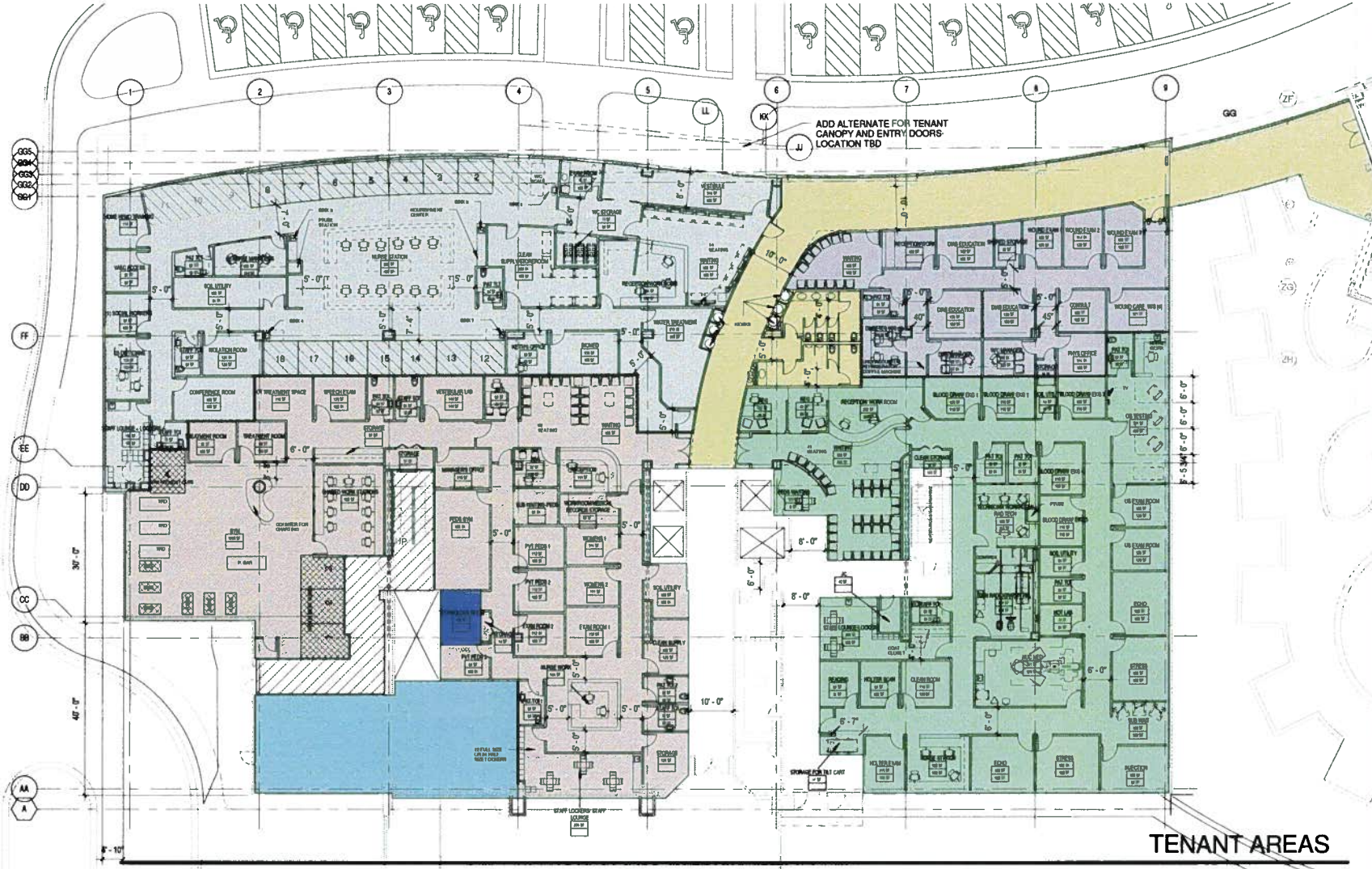

SCHEMATIC DESIGN SIGN-OFF

DEPARTMENT-		DATE-					
NAME:		NAME:		NAME:		NAME:	
SIGNATURE:		SIGNATURE:		SIGNATURE:		SIGNATURE:	

1 FIRST FLOOR PLAN
1/16" = 1'-0"

TIME: 11/11/2009 8:16:00 AM

FILE NAME: C:\Documents and Settings\vdas\Desktop\SCHNL-MSB-LOCAL.rvt

RTKL
RTKL ASSOCIATES INC
200 S. MICHIGAN AVE SUITE 1900
CHICAGO, IL 60604
312 542 5900
312 542 5901
www.rtkl.com

PROJECT NUMBER 30-09001.00

SILVER CROSS MEDICAL SERVICES BUILDING-(MSB)

1890 CLINTON
NEW LENOX, IL

SILVERCROSS FIT OUT SPACES
11.10.09

LEVEL 1

Schedule 4.24
Insurance

- Seller summary of insurance chart provided and is attached

SILVER CROSS HOSPITAL INSURANCE SUMMARY
FEBRUARY 23, 2012

Insurance Type	Policy Issuer	Policy Number	Effective Date	Expiration Date	Limits	Claims-Made or Occurance
Commercial Property	Federal Insurance Co.	3584-87-14	4/1/2011	4/1/2012	All Risk	Per Policy
Hired & Non-Owned Auto	Hartford Fire Insurance Co.	83UENRY0929	7/31/2012	7/31/2012	1,000,000	Single Limit
Professional Liability	Self-Insured Retention	n/a	12/1/2011	3/1/2013	5,000,000 - 12,000,000	Claims-Made
General Liability	Self-Insured Retention	n/a	12/1/2011	3/1/2013	5,000000 - 12,000,000	Occurrence
Healthcare Facilities Umbrella	Darwin Select Insurance Co.	0303-7590	12/1/2011	3/1/2013	10,000,000	Claims-Made
Workers Compensation and Employers Liability	Safety National Casuality Corp	SP 4045191	12/1/2011	3/1/2013	1,000,000	Each Accident

Schedule 4.26
Intellectual Property

- None

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