



North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section

2712 Mail Service Center • Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary http://www.ncdhhs.gov/dhsr Drexdall Pratt, Division Director Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

February 16, 2011

Lori Todd, RN, Facility Administrator Southeastern Dialysis-Wilmington 2215 Yaupin Drive Wilmington, NC 28401

Re: Follow-up Survey

ESRD CMS Certification Number (CCN): 34-2511

Dear, Ms. Todd

Thank you for the cooperation and courtesy extended during my recent visit on February 14, 2011, for the purpose of conducting a follow up to the Immediate Jeopardy (IJ condition level deficiencies 494.90 Patient Plan of Care, 494.30 Infection Control and 494.110 Quality Assurance that was cited during your Medicare recertification survey and complaint investigation on January 19-21, 2011. It was determined that the IJ was removed and the condition level deficiencies have been corrected, as well as the standard level deficiencies, and you are back in compliance with Medicare's Conditions of Coverage for End Stage Renal Disease facilities.

Enclosed is your copy of form CMS-2567B reflecting the correction,

Should you have any questions or if this office can be of other assistance, please do not hesitate to call me at (919) 855-4620.

Sincerely,

Ralph Mills

Ralph Mills, RN,BSN
Facility Survey Consultant
Acute & Home Care Licensure & Certification

Enclosure: CMS-2567B







North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section

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February 15, 2011

Arlene Mullin-Lane 24801 Northeast 219th Street Battle Ground, WA 98604

Re: Southeastern Dialysis Center - Wilmington - Complaint Investigation NC00070336

Dear Ms. Mullin-Lane:

This letter is in reference to your complaint against Southeastern Dialysis Center -Wilmington in Wilmington, NC. An unannounced visit was made to the facility on January 19, 2011 through January 21, 2011 in order to investigate your concerns.

The investigation included observations of care, interviews with staff, physicians, policy review and medical record reviews, including the record for the named patients. We were able to substantiate 2 of 2 allegation(s) in your complaint, Following is a summary of the allegations and overall findings:

The facility failed to provide adequate monitoring and assessment of vascular access sites and patient condition changes for hemodialysis patients during hemodialysis treatments.

The facility failed to prevent delays in hemodialysis treatments due to electricity and water problems. Furthermore, any deficiences realized during the investigation were cited accordingly.

We appreciate you bringing these concerns to our attention. It is through such efforts as yours that we are better able to monitor the level of patient care being provided by health care facilities. Please contact me at (919) 855-4620 if I can be of further assistance.

Sincerely,

Ralph Mills, RN, BSN Facility Survey Consultant Acute Care Licensure and Certification Section



DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 1301 Young Street, Room 833 Dallas, Texas 75202



CENTERS for MEDICARE & MEDICAID SERVICES

Division of Survey and Certification, Region VI

January 31, 2011

CMS Certification Number (CCN): 342511

Administrator Southeastern Dialysis Center - Wilmington 2215 Yaupon Drive Wilmington, NC 28407

Dear Administrator:

After a careful review of the facts on the report dated January 21, 2011, Centers for Medicare and Medicaid Services (CMS) has determined that Southeastern Dialysis Center-Wilmington no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an immediate jeopardy to patient health and safety, placing the following Medicare Conditions for Coverage out of compliance:

42 CFR 494.30 Infection control; 42 CFR 494.90 Patient plan of care; and 42 CFR 494.110 Quality assessment and performance improvement.

To participate as suppliers of services in the Medicare program, renal dialysis facilities must meet all of the Medicare Conditions of Coverage for Renal Dialysis Facilities, and be free of hazard to patient health and safety.

Unless the immediate jeopardy to patient health and safety is removed, the date on which your end stage renal disease facility's Medicare agreement terminates is February 15, 2011. No payment for dialysis services provided on or after that date will be made by the Medicare program. You must send us a letter of credible allegation and an acceptable plan of correction (PoC) within ten days of receipt of this notice in order to ensure a revisit by or before February 15, 2011. Upon written notification of how and when you actually corrected all serious deficiencies, CMS will evaluate the information provided and, if it seems possible another survey may result in a finding of compliance, we will try to arrange it before the termination date. The decision will be based on all the facts surrounding the termination, and a new survey may be authorized before the impending termination date even though not required by law or our procedures.

You are required to submit your plan of correction under the appropriate column on the Form CMS-2567. In order to allow time for a revisit, should a visit be allowed, choose the earliest reasonable correction date for each deficient practice, with no dates later than February 7, 2011. You must address each deficiency and include the month, date, and year of the expected completion. You must sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Send the CMS-2567 to: Attention, Glenda Payne or Rachel McCarty, CMS/DSC, 1301 Young Street, Room 827, Dallas, Texas 75202.

If you remain out of compliance at the time of your revisit, you will receive a notice from our office advising you of your termination and appeal rights, and notice to the public will also be issued. A legal notice will be placed in the Wilmington Star-News, Wilmington, North Carolina advising the public of both the termination date and the reasons for your termination from the Medicare program. Because the requirements for participation in the Medicaid program are substantially the same as those for Medicare, we have notified the appropriate State officials concerning termination of your Medicare approval under Title XVIII.

If you believe this determination is not correct, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. For expedited handling, such a request may be made to the Associate Regional Administrator, Division of Survey and Certification, Attention: Rachel McCarty, 1301 Young Street, Room 827, Dallas, Texas 75202. At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to the Departmental Appeals Board, Civil Remedies Division, Attention: Oliver Potts, Room G-644, Cohen Building, 330 Independence Avenue, S.W., Washington, D.C. 20201, and send a copy of your request to this office.

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Under Medicare regulation 42 CFR 405.2180(c), when a supplier of services is terminated by CMS, a new agreement will not be accepted until it has been determined that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur. The terminated facility will have to operate for a period of time determined by CMS, during which the reasonable assurance requirement must be satisfied. During this period the facility must fulfill, all of the statutory and regulatory responsibilities of the previous agreement.

If you have any questions, please contact Glenda Payne at (214) 767-4436 or Rachel McCarty at (214) 767-2082.

Sincerely,

Non-Long Term Care Certification & Enforcement Branch

Enclosure

cc: North Carolina State Department of Health





North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section 2712 Mail Service Center - Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary http://www.ncdhhs.gov/dhsr Drexdall Pratt, Division Director Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

January 26, 2011

Via Electronic Delivery

Lori Todd, Facility Administrator Southeastern Dialysis Center-Wilmington 2215 Yaupon Drive Wilmington, NC 28407

RE: Recertification Survey, Immediate Jeopardy Complaint Investigation # NC00070336

Dear Ms. Todd,

Thank you and your staff for the assistance and cooperation extended during the survey conducted January 19, 2011 through January 21, 2011. The purpose of conducting the recertification survey and complaint investigation was to evaluate the Facility's compliance with the Federal Medicare Conditions for Coverage. The recertification survey and complaint investigation resulted in Immediate Jeopardy (II) identification as of January 21, 2011 at 3:20 pm.

Specifically, the II was identified when the facility failed to provide monitoring, assessment and quality of care to a hemodialysis patient that bled out from a vascular access site after a hemodialysis treatment on 01/17/2011.

As discussed during the survey, the information gathered was forwarded to the CMS Regional Office in Dallas. Our state agency is recommending 23 day termination due to noncompliance with the Conditions for Coverage: 494.90 Patient's Plan of Care, 494.30 Infection Control and 494.110 Quality Assurance and Performance Improvement. The Immediate Jeopardy is ongoing. CMS Regional Office in Dallas will make the determination of compliance or noncompliance and will notify you of their findings and of any action to be taken.

If you have questions regarding the status of the investigation, please contact the CMS representative for North Carolina:

Ms. Glenda Payne
Division of Survey and Certification
CMS Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202
214-767-6301

If you have any questions, please do not hesitate to contact this office at (919) 855-4620.

Sincerely,

Ralph Mills

Ralph Mills, RN, BSN
Facility Survey Consultant
Acute and Home Care Licensure and Certification

CC: Azzie Conley, Section Chief





EPARTMENT OF HEALTH AND H	TIMAN SE CES	CIPITITITITI	ICARE & MEDICALD SERVICES
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(L2) .	(L5) WILMINGTON, NC		7. On-Site Visit 9. Other
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	ALTERNATIVE SANCTIONS	04-Other Reason for Withdr	awal 07-Provider Status Change
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PARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES

CAID CERTIFICATION AND TRANSMITTA MEDICARE/M. PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: TFT8

Facility ID: 956055

L'T REMARKS - CMS 1539 FORM

te recertification survey and complaint investigation NC00070336 was conducted 01/19/2011 through 01/21/2011. The survey related to the complaint investigation te recernication survey and complaint investigation include //13/2011 incomplaint investigation for complaint investigation of an immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. The Conditions for Coverage 494.90 an immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. The Conditions for Coverage 494.90 and Immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. The Conditions for Coverage 494.90 and Immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. The Conditions for Coverage 494.90 and Immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. The Conditions for Coverage 494.90 and Immediate Jeopardy (II) identification on 01/21/2011 at 1520. The II was not removed onsite during the recertification survey. altern Francis Care, 434-30 injection Common and 434-110 Quanty Assertance with not that the LI was removed on 02/14/2011 and the Conditions for Coverage 494.90 Patient Plan of 12/14/2011 as directed from the CMS Dallas Regional Office. The SA recommends that the LI was removed on 02/14/2011 and the Conditions for Coverage 494.90 Patient Plan of Pare, 494.30 Infection Control and 494.110 Quality Assurance were back in compliance. No deficiencies were found during the follow up survey.

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

blic reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, a national part of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, included to burden, to Office of Financial Management, CMS, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project (0838-058).	othering and maintaining ing suggestions for reducing i), Washington, D.C.
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Provider/Supplier Number 342511	Provider/Supplier P SOUTHEASTER	Name N DIALYSIS CENTER -W	ILMINGTON	
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	 E Initial Certification F Inspection of Care G Validation H Life Safety Code 	I Recertification J Sanctions/Hearing K State License L CHOW	
Extent of Survey (select all that apply)	A Routine/Standard Survey (all p B Extended Survey (HHA or Lor C Partial Extended Survey (HHA D Other Survey	ig Term Care Facility)		

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12sim-8am (E)	On-Site Hours · · · 8ami-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
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Facility ID: 956055

0.00

as Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

	orting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and cording burden for this collection of information, including burden for this collection of the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information.
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rojecti((838-0583), Washington, D.C. 20503.

Provider/Supplier Number 342511	Provider/Supplier Name SOUTHEASTERN DIALYSIS CENTER -WILMINGTON
Type of Survey (select all that apply)	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanctions/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life Safety Code L CHOW M Other
Extent of Survey (select all that apply)	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

	Pleas	e enter the worklo	ed information to	r		dentification mande	Travel	Off-Site Report
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Total SA Clerical/Data Entry Hours....

0.50

Total RO Clerical/Data Entry Hours

Facility ID: 956055

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

Page

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	during hemod	ialysis treatments; failed to wear	rad	- l v i i i i i i i i i i i i i i i i i i	HE OWNER COMME	2/7/11
- 1				waste disposal, cross contamin disinfectant/disposal of indivi	dual natient care	
	arms while pe	erforming patient care procedures	d to	1 second patients Wearing El	OAS ARCH HOURING	
1				1 . Tr. L of the CHC INC.	UIUIIIS IIIC L.V.	
				TOTASTIC Propriement Inc.	(KOD)' win women	d
1		ded Cippodates the while used in the a single patient while used in the iss stations at the facility; failed to		last the base amend in med	MCCVIA IN TITOTION	
l	patient dialys	is stations at the facility, tank	1			d l
	dispose of po	otentially-infections maste container, ar piohazardous waste container, ar	ıd	ongoing compliance to the Po	JC WIII DC IIIOMIOLO marteriv.	
				during GB meetings at least of This POC will also be review	ved at each monthly	
1				o the Improvement Pacifil	AlManagement	
	include prov	cess sites in 1 of 3 patients observers sites after treatr	rvea	la tratinge (OFFMM) meeting	Much me Ly am	1
\ .	holding their	vascular access site after treatr	nent		30 118111019 10	
١.			200	maintaining compliance, to	the committee. 2/1/1	1.
	systemic pr	oblems resulted in the facility's	ection			(X8) DATE
1			TID CICLIATE	DE JULE	1	0/1/11
L	PATORY DIRECTOR'S	DE PROVIDER/SUPPLIER REPRESENTATI	AEO CIOTATI	Annility (ldm	niotrator	d/4/1/
LABU		-del O1)		ne institution may be excused from co	rrecting providing it is	s determined that
:	Sou do	CRECIO de depoter a defic	iency which th	he institution may be excused from co	s stated above are di	sclosable 90 days

Any deficiency statement ending with an asterisk (") denotes a deficiency which the institution may be accused 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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 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 delicionary that the provided plan of correction is requisite to continued 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:TFT811

Facility ID: 956065

If continuation sheet Page 1 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TEMENT OF DEFICIENCIES J PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING 01/21/2011 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX. (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) TAG V 110 Continued From page 1 V 110 control practices for all the hemodialysis patients. Findings include: A. The facility staff failed to wear gloves while touching patients hemodialysis machines during hemodialysis treatments. ~Cross refer to 494,30(a)(1) Infection Control -Tag V0113 B. The facility staff failed to wear personal protective equipment (PPE) that covered arms while performing patient care procedures to patients during hemodialysis treatments ~Cross refer to 494.30(a)(1)(i) Infection Control -Tag V0115 C. The facility failed to dedicate wooded clipboards that cannot be disinfected to a single patient while used in the patient dialysis stations at the facility. ~Cross refer to 494.30(a)(1)(i) Infection Control -Tag V0116 D. The facility staff failed to dispose of potentially-infectious waste in a designated biohazardous waste container. ~Cross refer to 494.30(a)(4)(i) Infection Control -Tag V0121 E. The facility staff failed to adhere to infection control standards by providing a glove for holding pressure on vascular access sites in 1 of 3 patients observed holding their vascular access

site after treatment of hemodialysis

PRINTED: 01/31/2011

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED EMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING PLAN OF CORRECTION B. WING 01/21/2011 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL · ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG V 110 V113 Continued From page 2 Clinical Teammates (TMs) were in-serviced V 110 1/27/11 in the following: Policies #1-05-01, ~Cross refer to 494.30(b)(1) Infection Control-#1-05-0A and #1-05-01B: Infection Control for Dialysis Facilities, Use of Alcohol-Based Hand Tag V0142 V 113 494.30(a)(1) IC-WEAR GLOVES/HAND Rubs, and Handwashing. Verification of attendance at in-service is evidenced by a signature HYGIENE sheet. TMs were instructed using surveyor observations as examples with emphasis on, but Wear disposable gloves when caring for the not limited to, the following: 1) to remove gloves patient or touching the patient's equipment at the and wash hands between dirty and clean tasks, 2) dialysis station. Staff must remove gloves and to perform hand hygiene whenever gloves are wash hands between each patient or station. removed, 3) to wear gloves for all machine contact, 4) wear proper PPE covering arms while performing patient care procedures, 5) no individual patient items on machines, 6) disposing This STANDARD is not met as evidenced by: infectious waste properly, 7) provide gloves to all Based on observations, staff interview and review patients holding access sites. Clipboards have been of the facility's policies and procedures, the facility removed from facility, signs have been posted to staff failed to wear gloves while touching patients designate PPE only areas and paper towel 2/7/11 hemodialysis machines during hemodialysis dispensers near sinks have been raised to accommodating level. The Charge Nurse (CN) is treatments. responsible for oversight of infection control practice daily. Instances of non-compliance will be Findings include: addressed with the TM responsible immediately and corrective discipline action will be taken. The 1. Observation of the patient care dialysis Facility Administrator (FA) or designee will technician #1 assigned to "POD #3" in the patient conduct observational infection control audits on treatment area on 01/19/2011 at 1340 through random shifts three times daily for one week, then 1343 revealed that the staff member touched the 3x week for one month, then 2x week for one patient hemodialysis machines in stations #4, 5, 7 month, then monthly with regularly scheduled. and 8 (total of 4 separate stations) without infection control audits. An Infection Control team wearing gloves while patients were undergoing was also formulated to perform "Clean Sweep" hemodialysis treatments at the stations. The audits weekly for 4 weeks, then bimonthly for 8 observation revealed that the patient care dialysis weeks, then monthly. Results of all audits will be reviewed with the Medical Director during the technician also touched the dialysis blood lines in monthly QIFMM and continued frequency of station #7 without wearing gloves. The audits determined by the team with supporting observation also revealed that the patient care documentation included in the meeting minutes. dialysis technician went from station's #4, 5, 7 Governing Body meeting on 1/25/11 stating that it and 8 touching the face panel of the machines is mandatory for all patients to use a gloved hand with her bare hands and not hand sanitizing or to hold access sites. cont. pg 4 hand washing noted between the patient stations.

An interview on 01/19/2011 at 1345 with a facility

PRINTED: 01/31/2011

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

	RS FUR MEDICANE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION	COMPLETE	ED ED	
TEMEN 2) AN	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		C		
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	•	342511		•		U Distriction		
NAME OF	PROVIDER OR SUPPLIER		- (STREET	ADDRESS, CITY, STATE, ZIP CODE			
		CENTED JAM BAINGTON	1	2215	YAUPON DRIVE WINGTON, NC 28407			
SOUTH	LEASTERN DIALYSIS	CENTER -WILMINGTON		AAILI	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
(X4) IC PREFII TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHORES - REFERENCED TO THE APPLICATION OF THE	IUULU DE I	(X5) COMPLETION DATE	
V.1	licensed practical should wear glove dialysis machine treatments. "I will technician #1) ab without gloves." 2. Observation of technician #2 on "POD #4" in the that the staff me hemodialysis may wearing gloves the member was again to the staff m	nurse #1 revealed that all start es anytime they are touching a during patient hemodialysis talk to her (patient care dialysis out touching the machines of the patient care dialysis 01/19/2011 at 1415 assigned to patient treatment area revealed imber touched the patient eachines in station #3 without while the patient was undergoing eatment. At 1418 the same staff pain observed to touch a patient archine in "POD #5" at station #9			V113 cont. Additional supports provided to the team is as follo Teammates educated on tool: Infection Control for Dialysis Unit with verification of review signature sheet. In-service provide 2/2/11- Dirty to Clean and proper service provided by Infection Cont 2/3/11-Proper Biohazard waste additional education from an outs in-service has also been sch completed 2/10/11 on Infection dialysis setting, provided by South Council network 6. Verification in-services will be evidenced by The FA is responsible for comp POC	Recommended to At a Glance, evidenced by CSS on PPE attire, Inrol Manager on disposal. For idde resource an eduled to be Control in the heastern Kidney of attendance at signature sheets:		
•	without wearing undergoing her	gloves while the patient was nodialysis treatment.				•		
	for "Infection C (revision date (wear disposab patient or touc	facility's policies and procedures ontrol for Dialysis Facilities" 09/2010) revealed "Teammates when caring for the hing the patient's equipment at the and will remove gloves and was and will remove hims on each	ill e	٠,				
	hands or performance patient and/or when touching delivery system	orm hand hygiene between each station. Gloves should be worn g the blood lines, dialyzer or dialys m during or after dialysis treatmen	sis			٠		
	01/19/2011 at care dialysis to policy and we patient hemo dialysis treats	vith the facility administrator on 1450 revealed that the two paties technicians did not follow facility ar gloves as they touched the dialysis machines during their ments. The interview revealed "Tile been taught to wear gloves we have the machine".						
	andime they	touch the patient's machine." (i) IC-GOWNS,		V 1	15	If continuation	sheet Page 4	of 23

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

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
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15,110.			B, WING			01/21/20	44
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	ROVIDER OR SUPPLIER		s	TREET AD	DRESS, CITY, STATE, ZIP CODE		
		and personal		2215 YAL	JPON DRIVE		
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	TP VOAMME	ATEMENT OF DEFICIENCIES	ΙD		PROVIDER'S PLAN OF CORRECTION SHO		(X5) MPLETION DATE
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		<u></u>
		4	V 1	15	•		,
V 115	Continued From p	page 4		V1	15	. ,	\
	SHIELDS/MASKS	S-NO STAFF EAT/DRINK	!	Cli	nical Teammates (TMs) were in-	serviced	1
	1		i	1/2	7/11 in the following: Policies #. 05-0A and #1-05-01B: Infection	Control for	
	Staff members sh	nould wear gowns, face shields,	1	#1-	ulysis Facilities, Use of Alcohol-l	Based Hand	1
1	THE WORK OF MICE	ke to biolect themselves and		Ru	be and Handwashing. Verificati	on of	
	prevent soiling of	clothing when performing		atte	endance at in-service is evidence	d by a signature	-
	procedures durin	g which spurting or spattering of		she	ef TMs were instructed using su	rveyor	. 1
	blood might occu	tr (e.g., during initiation and alysis, cleaning of dialyzers, and		l ob	servations as examples with emp	hasis on, but	
1	termination of dia	blood). Staff members should		no	t limited to, the following: 1) to r	emove gloves	
1	centinugation of	smoke in the dialysis treatment		an	d wash hands between dirty and	clean tasks, 2)	
1	area or in the lat	onatory	1	to	perform hand hygiene whenever moved, 3) to wear gloves for all 1	gioves are	<i>17/</i> 11
	i '	•	1	rei	moved, 3) to wear gloves for all r wear proper PPE covering arms	while	
ľ	THE STANDAR	D is not met as evidenced by:	1 ' '	4)	rforming patient care procedures	(5) no	
}	I manual an obcor	nation statt interview and texten		in	dividual patient items on machin	es, 6) disposing	
1	Latina Englished M	olicide and nincequies, die lavin	·37	in	fections waste properly, 7) provi	de gloves to all	•
1	t rtt. t il	sar nareanal brosective culibries	E	ne	atients holding access sites. Clipt	oards have been	
	CONTROL Street was to	rad afine wille belieffilled beech	13-1	Te	moved from facility, signs have	been posted to	
1.	care procedure	s to patients during hemodialysis		de	esignate PPE only areas and pape	r towel	
\	treatments (Pat	ient #1).	1	ď	ispensers near sinks have been ra	ised to	•
1	# GG # 110 110			B1	ccommodating level. The Charge	ion control	
	Findings includ	e:	į	re	esponsible for oversight of infect ractice daily. Instances of non-co	mpliance will be	
1		i e	1	P	ddressed with the TM responsible	e immediately	
	1. Observation	on 01/19/2011 at 1320 in the		, ,	nd corrective discipline action w	ill be taken. The	
1	I tions transmo	THE STOP OF POLICE HE LEGACION HOUSE	5111	. 1	acility Administrator (FA) or de	signee will	
	anno dintrole fo	Chuician #3 Meaning Siecaco on		l	anduct observational infection of	ontrol audits on	·
,	har DDE gours	ralled ith and not covering her	i	١,	andom shifts three times daily fo	r one week, then	1
	l while are	widing care to a Daublic 1110		' -	Ix week for one month, then 2x v	veek for one	1
1	_ L	vesion marine sign monitor was	"	Į i	month, then monthly with regular	ry scheduled	
	t	Station HAI DEMODIAIVSIS SLOUVII	1	ļ i	infection control audits. An Infec	Clean Sween"	
1	: touching the n	atient hemodigivals illegiting par		1,	was also formulated to perform " audits weekly for 4 weeks, then b	simonthly for 8	
1	had her PPF (JUMU 2166A62 tollen ah aug	1		weeks, then monthly. Results of	all audits will be	
	exposing both	of her arms during potential			reviewed with the Medical Direc	tor during the	
1	exposure while	le the patient was receiving		1	monthly OIFMM and continued	frequency of	
1	hemodialysis	treatment. An interview on	or	1	audits determined by the team w	ith supporting	
1	01/19/2011 a	t 1450 with the facility administrat	are	. [documentation included in the m	eeting minutes.	1
1	revealed that	all of the staff providing patient c	eir	l	Governing Body meeting on 1/2	5/11 stating that it	į
1	during hemod	dialysis treatment should have the difference of	wn		is mandatory for all patients to u	se a gloved hand	
ľ	arms covered	J. They should hot have also ga	. }	1	to hold access sites, cont. pg 6		
1	sleeves rolle	u up.			the state of the s	If continuation she	et Page 50

DEPARTA	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 0	PROVED 938-0391
CENTERS	S FOR MEDICARE	& MEDICAID SERVICES	DVM 141117	noi e M	ONSTRUCTION	(X3) DATE SUR	VEY
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J PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG		C	[
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1		To get good and to get any one of the transfer		2215 Y	AUPON DRIVE		
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V 115	Continued From p	age 5	V 11	A d	15 cont. ditional supporting education pr	ovided to the	
	patient treatment 3, 4) revealed pat wearing his PPE any closure noted the staff member buttons on the gothe staff member patient hemodial 07/19/2011 at 14 the patient care that he should have it buttoned. A review of the "Infection Control date 09/2010) reworn whenever with body fluids contaminated e surfaces, for experience of the surfaces.	07/19/2011 at 1420 in the area of POD #4 (stations #1, 2, ient care dialysis technician #4 gown opened at the front without I. The observation revealed that had the gown not closed by own and it was open exposing to potential exposure during ysis treatments. An interview on 25 during the observation with dialysis technician #4 revealed ave the gown closed. "I should up. I didn't think about it." Tacility's policy and procedure for on for Dialysis Facilities" (revision evealed "Appropriate PPE will be there is the potential for contact, hazardous chemicals, quipment and environmental cample, reuse room, patient care late lab coats or gowns will be		tez on Di re pr pr Co di re bo di	in is as follows: Clinical Teams tool: Recommended Infection tool: Recommended Infection in the control of the	netes educated a Control for verification of etc. In-service to Clean and ad by Infection iohazard waste rom an outside n scheduled to Control in the eastern Kidney f attendance a ignature sheets	2/7/11 (an outside vendor presenting additional education 2/10/11)
		s when on the treatment floor."					
V	guidance was arms and apro sufficient PPE potential expo	ICJE TO	· ·	V 116			
	Items taken in be disposed of patient, or cle taken to a column another patients.	sp/DEDICATE OR DISING LOT to the dialysis station should eith of, dedicated for use only on a sin aned and disinfected before bein mmon clean area or used on	g		j		chapt Page 5.0

PRINTED: 01/31/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER:) PLAN OF CORRECTION A. BUILDING B. WING 01/21/2011 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 117 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 116 V116 Continued From page 6 V 116 Clinical Teammates (TMs) were in-serviced covered blood pressure cuffs) should be 1/27/11 in the following: Policies #1-05-01, dedicated for use only on a single patient. #1-05-0A and #1-05-01B: Infection Control for - Unused medications (including multiple dose

This STANDARD is not met as evidenced by: Based on observation, staff interview and review of the facility's policies and procedures, the facility failed to dedicate wooded clipboards that cannot be disinfected to a single patient while used in the patient dialysis stations at the facility.

vials containing diluents) or supplies (syringes,

alcohol swabs, etc.) taken to the patient's station

not be returned to a common clean area or used

should be used only for that patient and should

Findings include:

on other patients.

Observation in the patient treatment area on 01/19/2011 at 1230 revealed a total of 35 wooden clipboards that were placed on top of patient's hemodialysis machines while they were receiving hemodialysis treatments. The observation revealed that the wooden clipboards were holding the patient's paper chart information. The observation further revealed that the wooden clipboards were placed directly on top of the patient's hemodialysis machines.

An interview on 01/19/2011 at 1450 with the facility administrator revealed that she knew that the wooden clipboards were a concern because they could not be disinfected and that they were used for different patients using the patient dialysis stations. The interview also revealed that the clipboards had been in the facility since she took the role of the facility administrator in 09/2010.

Dialysis Facilities, Use of Alcohol-Based Hand Rubs, and Handwashing. Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) to remove gloves and wash hands between dirty and clean tasks, 2) to perform hand hygiene whenever gloves are removed, 3) to wear gloves for all machine contact, 4) wear proper PPB covering arms while performing patient care procedures, 5) no individual patient items on machines, 6) disposing infectious waste properly, 7) provide gloves to all patients holding access sites. Clipboards have been removed from facility, signs have been posted to designate PPE only areas and paper towel dispensers near sinks have

Nurse (CN) is responsible for oversight of infection control practice daily. Instances of noncompliance will be addressed with the TM responsible immediately and corrective discipline action will be taken. The Facility Administrator (FA) or designee will conduct observational infection control audits on random shifts three times daily for one week, then 3x week for one month, then 2x week for one month, then monthly with regularly scheduled infection control audits. An Infection Control team was also formulated to perform "Clean Sweep" audits weekly for 4 weeks, then bimonthly for 8 weeks, then monthly.

been raised to accommodating level. The Charge

continued frequency of audits determined by the team with supporting documentation included in the meeting minutes. Governing Body meeting on 1/25/11 stating that it is mandatory for all patients to use a gloved hand to hold access sites. cont. pg 7

Results of all audits will be reviewed with the

Medical Director during the monthly QIFMM and

2/7/11

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPI	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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		342511	B. WIN	IG		01/21/	2011
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V 116	A review of the face "Infection Confrol date 09/2010) revitems that cannot be dedicated for ulterns taken into the disposed of, dedic patient, or cleaned taken to a common another patient. The address the use of facility. 1 494.30(a)(4)(i) IC WASTE [The facility must standard infection implementing-] (4) And maintain with applicable Soublic health pro-	cility's policy and procedure for Dialysis Facilities" (revision ealed that "Non disposable be cleaned and disinfected will ase only on a single patient, he dialysis station will be cated for use only on a single d and disinfected before being on clean area or used on The review of the policy did not of wooden clipboards in the -HANDLING INFECTIOUS demonstrate that it follows in control precautions by ing procedures, in accordance state and local laws and accepted cedures, for the- rage and disposal of potentially	· ·	116	responsible for compliance with this V121 Clinical Teammates (TMs) were in-s 1/27/11 in the following: Policies #1- #1-05-0A and #1-05-01B: Infection C Dialysis Facilities, Use of Alcohol-Bo Rubs, and Handwashing. Verificatio at in-service is evidenced by a signate were instructed using surveyor observexamples with emphasis on, but not I following: 1) to remove gloves and whetween dirty and clean tasks, 2) to p	tes educated Control for enification of et. In-service to Clean and a by Infection or Biohazard tion from an es also been on Infection provided by network 6. vices will be The FA is POC. erviced 05-01, control for used Hand on of attendance are sheet. TMs wations as imited to, the rash hands perform hand	2/7/11 (an outside vendor presenting additional education 2/10/11)
	Based on obsertion of the facility's pastaff failed to diswaste in a design container. Findings include Observation on	D is not met as evidenced by: vation, staff interview and review olicies and procedures, the facility spose of potentially-infectious mated biohazardous waste 2: 01/19/2011 at 1330 in the patient at station # 4 in POD #1 revealed			hygiene whenever gloves are remove gloves for all machine contact, 4) we covering arms while performing pati procedures, 5) no individual patient machines, 6) disposing infectious we provide gloves to all patients holding Clipboards have been removed from have been posted to designate PPE of paper towel dispensers near sinks had to accommodating level. The Chargeresponsible for oversight of infection practice daily. Instances of non-comfaddressed with the TM responsible corrective discipline action will be to	ar proper PPE ent care items on uste properly, 7) g access sites. facility, signs only areas and twe been raised e Nurse (CN) is n control upliance will be immediately and	1

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

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'	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	(MG	DEFICIENCY)		
		and the second s			The Profiles Administra	retor (FA) or	
	V 121	Continued From p	age 8	V 121	V121 cont. The Facility Administr designee will conduct observation	nal infection	
	ł	in the hea and on	the septum area of the bag was		control audits on random shifts three t	times daily for	
Ì	ļ	placed in a waste	container not designated as a		one week then 3x week for one m	onth, then 2x	./7/11
ļ	į	highazamous was	ste container. The observation		week for one month, then monthly	with regularly - *	an outside
		revealed that the	blood tinged bag of saline was		acheduled infection control audits.	An Intection.	endor
		inside of the wast	e container with other regular		Control team was also formulate	a to betterm	oresenting
1.		waste items.			"Clean Sweep" audits weekly for bimonthly for 8 weeks, then monthly	Damite of all	additional
1			1/19/2011 at 1450 with the]	audits will be reviewed with the Me	edical Director I '	education
1		An interview on u	itor revealed that the bloody bag		during the monthly OIFMM a	and continued !	2/10/11)
1		of coling chould t	not ever be placed in a regular		framework of audits determined by	the team with ;	1
.		none higherardo	us waste container. The		amporting documentation included	in the meeting	
		interview reveale	d that the facility has dedicated		-invites Governing Body meeting	ig on 1/25/11	.
		biohazardous Wa	iste containers that should be		stating that it is mandatory for all p gloved hand to hold access site	attents to use a	
-		used by the staff			gloved hand to hold access site supporting education provided to	the team is as	.
-				1	follows: Clinical Teammates edu	icated on tool:	1
ı		A review of the f	acility's policy and procedure		Pacammended Infection Control for	r Dialysis Units	
		· "Infaction Contro	of for Dialysis Facilities (Tevision)		As a Clarge with verification of re	view evidenced	
1		date 09/2010) re	evealed "All potentially infectious		by signature sheet. In-service provi	ided by CSS on	
		waste will be pla	aced in sealable, leak proof		2/2/11- Dirty to Clean and proper	PPE attire, in-	[.
- [.		biohazard waste	bags that are clearly marked or	l	service provided by Infection Conf 2/3/11-Proper Biohazard waste	dienceal For	1
- h		colored."	O CICHT MONITOR	V 1	42 2/3/11-Proper Bionazaid waste additional education from an outs	side resource an	
- 1	V 14	2 494.30(b)(1) 10- ACTIVITY/IMPL	O-SIGHT-MONITOR		in-service has also been scheduled	to be completed	1
- 1		ACTIVITY THINKS	EMETAL C.		2/10/11 on Infection Control in the	dialysis setting,	
- 1		The facility mus	st-		provided by Southeastern Kidney	Council network	
	***************************************	/13 Monitor and	implement biohazard and		6. Verification of attendance at in	-services will be The FA is	
-		infection contro	I policies and activities within the		evidenced by signature sheets. responsible for compliance with th		
- 1		dialysis unit,	•		-	is i oo.	1.
			•		V142 Clinical Teammates (TMs) were in	n-serviced	1
- 1	•		and the state of t		1/27/11 in the following: Policies	\$1-05-01,	1
l		This STANDAR	RD is not met as evidenced by:	,	#1-05-0A and #1-05-01B: Infection	n Control for	2/7/11
1		Based on obse	ervation, staff interview and review	itv	Dialysis Facilities, Use of Alcohol-	-Based Hand	
1		of the facility's	policies and procedures, the facili		pube and Handwashing. Verifica	tion of attendance	
1		stan railed to a	providing a glove for the patient to	1	at in-service is evidenced by a sign	lature sheet. I Ms	
1		standards by p	on vascular access sites in 1 of 3		were instructed using surveyor obs	ervations as	
		nationte obser	ved holding their vascular access		examples with emphasis on, but no following: 1) to remove gloves an	d wash hands	
		site after treat	ment of hemodialysis(Patient #16).	between dirty and clean tasks, (co	ont pg 10)	}
	I		*	l	Oppy cont and and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
PLANO	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING		С	
	,	342511	B. WING		01/21/20	11
	ROVIDER OR SUPPLIER		2210	T ADDRESS, CITY, STATE, ZIP CODE 5 YAUPON DRIVE		
SOUTHE		CENTER -WILMINGTON		MINGTON, NC 28407 PROVIDER'S PLAN OF CORRECT	ETION	(%5)
(X4) ID PREFIX TAG	WACH DESIGNED	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE CO	(X5) MPLETION DATE
V 142	Observation on 0 treatment area re holding his left ar hemodialysis treate be holding his left bare hand. No gli given to the patie access site. The noted that the part was observed no before leaving the An interview on facility's clinical patients should on their vascular evealed no reate a glove to use wheeling access revealed that the encouraged to facility. A review of the "Infection Contidate 09/2010" provided to pay visitors if these such as self-cere.	1/21/2011 at 1335 in the patient vealed that patient #16 was m vascular access site after his atment. The patient was noted to tarm access site with his right over was noted to be used or ent while holding his vascular observation at 1345 further dient had blood on his right hand out of the facility's patient by a staff member. The patient of to wash or sanitize his hands are patient treatment area. 101/21/2011 at 1350 with the coordinator revealed that all be given a glove to hold pressure or access site. The interview son why the patient was not giver while holding pressure on the site. The interview further a patient should also have been wash his hands before leaving the facility's policy and procedure rol for Dialysis Facilities" (revision revealed "Gloves should be individuals assist with procedure annulation or holding access sites		V142 cont. 2) to perform hand hygiene wheneremoved, 3) to wear gloves for all means and performing patient care procedures, 2 patient items on machines, 6) dispossible training access sites. Clipboards have from facility, signs have been posted from facility are accommoded. Charge Nurse (CN) is responsible infection control practice daily. In compliance will be addressed responsible immediately and corresponsible immediat	achine contact, arms while in the individual sing infectious to all patients to all patients to all patients to been removed and to designate dispensers near lating level. The for oversight of stances of non-with the TM settive discipline by Administrator to observational shifts three times for one month, and monthly with the monthly with the Medical M and continued by the team with the meeting ting on 1/25/11 patients to use a street with the direct of the team is as educated on tool. For Dialysis Units review evidenced ovided by CSS on	2/7/11
V E	540 494.90 CFC-P	ATIENT PLAN OF CARE	V 54		er PPE attire, in- ontrol Manager on	
	This CONDITI	ON is not met as evidenced by:				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	SFC	R MEDICARE	& MEDICAID SERVICES			TO TOU	(X3) DATE SUR	VEY
TEMENT	OF DE	FICIENCIES	1Y11 PROVIDER/SUPPLIENCLIA	(X2) M	ULTIPLE	CONSTRUCTION	COMPLETE	:D .
PLAN O	FCOR	RECTION	IDENTIFICATION NUMBER:	1.	LDING		C	l
				a wik	1G	3	01/21/	2011
			342511	1			U UILLI	Bar
		ER OR SUPPLIER	Lippe to the second sec		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
						YAUPON DRIVE		
SOUTHE	ASTE	RN DIALYSIS C	ENTER -WILMINGTON		WIL	MINGTON, NC 28407		
				D	<u>' T</u>	PROVIDER'S PLAN OF CORRECT	CTION	COMPLETION
(X4) ID	Ì		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL OR IDENTIFYING INFORMATION)	PREF	FIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ROPRIATE	DATE
PREFIX TAG	١.	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAC	G	DEFICIENCY)		
. 1/10			. The state of the	}				
14540	1	Haved From D	ana 10	V	540	V142 cont.For additional education	n from an	2/7/11
V 540	Col	rtinued From p	aye to		- 1.	antide recource an in-service has	s also been !	(an
1	rev	iew, physician i	nterview, patient interview, ew and staff interview, it was	1			on infection '	outside
1	clin	ical record levi	e facility failed to adjust and		· 1	Control in the dialysis setting,	provided by	vendor
	det	emined that b	lan of care for patients to	1	1:	Southeastern Kidney Council	network of	presenting
1	ind	ividualize ule p	quality care for hemodialysis	1		Verification of attendance at in-ser evidenced by signature sheets.	The FA is	additional education
1	en	suit sait and t fionto The facil	ity staff failed to provide	1	į	evidenced by signature sneets. responsible for compliance with	this POC.	2/10/11)
		unitarina and as	sessment for an vascular			2/7/112/10/11		210/11)
	III	cee with impe	nding failure in 1 of 1 sampled		1	2111121011		
l	1	tinde /Dationts	E1) that expired alici		1	V540		·
	1	eald ballattace.	ding occurred from the vascular		1	A Coverning Rody (GB) meeting	ig was held to	
1	1	oces site, and .	failed to complete treatment	1		marriant the deficiencies received	This Condition	1. 1
1	طہ ا	nake in accord	ance with the facility a bount for	1	1	Coverage (CFC) that is not m	et as supported	1 1
	1 6	eren marriantant	in conter naments (Paucius	. .	.	the warragraeVS43 and V551, has 0	letailed Flams of	1 1 .
į.	44.	1 12) The cum	illative effect of these systemic	1		C	the specime v	1 1
1		-ablame raciilla	id in the facility's maping w			tags. Ongoing compliance to the P	OC Mili Incinde	
. !	1 -	was the proble	eion of assessment, monitoring			promoting implementation of procedures to ensure correct	policies and	
	1 ~	nd quality of ca	re as a result of the plan of core	·		procedures to ensure correct practices in vascular access	assessment and	
	fo	or all the hemod	dialysis patients on census.			monitoring, patient monitoring	and treatmen	t
	1					1 O 20 minutes nationt bl	an of care, and	, i
	F	indings include	:	-		annier acqueance in addition	the GB na	\$
1			es select to provide monitoring	- 1		implemented the following proc	esses to addres	s 2/7/11
	1	The facility st	aff failed to provide monitoring it for an vascular access with			there issues sited.		l i
\bar{1} .	18	and assessmen	re in 1 of 1 sampled patients that	t l		Dhaminian/extender will be notif	ied of all acces	is
İ	11	mpending railui	controlled bleeding occurred fro	m	*	named No verbal orders Wil	i pe accepted o	ו א
		expireu arrei un	cess site. (Patient #1)			extenders, and all verbal orders g	racii oa birasiois	
	1				_	are to be read back for verification Extender will meet with the	Vascular Acce	şs
		~Cross refer to	494.90(a)(5) Patient Plan of Ca	re			iew the One Sto	pp qq
İ		- Tag V0551				Tool which addresses CVCs a	nd new vascul	ar
						- anonger in the facility.		1 1
	1	B. The facility	staff failed to complete treatmen	it		Dougling physicians/extenders	will meet wi	th
	i	abacks in acco	ryance mill menacimy a hand),	or .		wherea muce before and after ro	moing on paner	1120
1		2 of 12 sample	d in-center patients. (Patients			to encure all patient concerns has	ve been addresse	.ա. լ
	1	#1,12).		1		TE next patient refuses to remain	in the facility	ւսյ [
-	. [= 4			an assessment by the nurse	or the physical	14
1	1	~Cross refer to	o 494.90(a)(1) Patient Plan of C	are		extender, the patient will be required form. All AMA forms will be	uncu io sign Ali	DA
i		Tan 1/05/13			V 54	form. All AMA IONES WILL D	O TOMORROW III	·
l v	543	494.90(a)(1) F	OC-MANAGE VOLUME STAT	10	V 04	monthly. cont pg 12		
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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: PLAN OF CORRECTION A. BUILDING R. WING 01/21/2011 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PRÉFIX TAG DEFICIENCY) TAG V 543 V540 cont. Continued From page 11 V 543 All substantiated chest pain will be sent to the ER The plan of care must address, but not be limited via 911. If any patient refuses, they will be 2/7/11 to; the following: required to sign AMA by the facility and the 911 (1) Dose of dialysis. The interdisciplinary team transport. This will be tracked throughout the must provide the necessary care and services to month and reviewed in QA monthly. The admitting manage the patient's volume status; physicians, extenders and clinical teammates have been informed of these practices. Members of the GB including the FA, Regional Operations Director This STANDARD is not met as evidenced by: Based on the facility's policies and procedures (ROD), and Medical Director, have agreed to meet weekly x 4 then monthly x2 to monitor the review, patient interview, clinical record review facility's progress toward compliance. Then and staff interview, the facility staff failed to ongoing compliance to the POC will be monitored complete treatment checks in accordance with during GB meetings at least quarterly. the facility's policy for 2 of 12 sampled in-center This POC will also be reviewed at each monthly patients (Patient #1,12). Quality Improvement Facility Management Meetings (QIFMM) meeting when the FA will Findings include: report progress, as well as any barriers to maintaining compliance, to the committee. A review of the facility's policy and procedure "Intradialytic Treatment Monitoring" (revision date 09/2008) revealed "To provide an effective, safe and comfortable dialysis treatment to every patient in accordance with his/her individual plan of care. Treatment checks should be completed at least every thirty (30) minutes." 1. A closed clinical record on 01/20/2011 for patient #12 revealed that the patient was admitted to the facility on 12/11/2009 for in-center hemodialysis treatments. A review of the patient treatment sheet for 06/24/2010 revealed that the patient received hemodialysis treatment from 0731 through 1142. The review further revealed that the patient care staff failed to complete a treatment check from 1031 until 1142 (total 1 hour and 11 minutes). The patient was documented as having his/er blood rinsed back and being taken off of hemodialysis at 1142. Documentation review of the patient's clinical

record revealed that the patient expired away from the clinic on 06/25/2010 after bleeding from

PRINTED: 01/31/2011

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED D PLAN OF CORRECTION A. BUILDING C B. WING 01/21/2011 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) V 543 Continued From page 12 V543 V 543 All licensed teammates in-serviced on 1/25/11 his unused vascular access site. and all clinical teammates in-serviced on 1/27/11 2/7/11 on Intradialytic monitoring of all patients. TMs An interview on 01/20/2011 at 1330 with the were in-serviced on the following: Policy facility's clinical coordinator revealed that the #1-03-09: Intradialytic Treatment Monitoring: patient did expire away from the facility by Verification of attendance at in-service is bleeding from his old graft vascular access site. evidenced by a signature sheet. TMs were The interview revealed that the facility's staff did instructed to: monitor and document vital signs at not do the treatment checks throughout his least every 30 minutes. The Charge Nurse (CN) is responsible for oversight of patient monitoring hemodialysis treatment on 06/24/2010 as required in the facility's policy for 30 minute per policy. The CN will monitor Q 30 minute monitoring of all patients daily to ensure checks. documentation is in place. Instances of noncompliance will be addressed with the TM 2. An open clinical record review on 01/20/2011 responsible immediately. The FA or designee will for patient #1 admitted to the facility for audit treatment flow sheets of 100% daily for 4 hemodialysis treatments on 02/01/2010 revealed weeks, then 10% weekly. All non-compliance will that the facility's staff failed to complete treatment be reviewed by FA, and continued nonchecks for the patient at least every 30 minutes compliance will have corrective disciplinary on 12/22/2010, 12/31/2010 and 01/03/2011. The actions delivered. Results of audits will be review of the record revealed on 12/22/2010 that reviewed with the Medical Director during the the patient received hemodialysis from 1033 monthly QIFMM and continued frequency of through 1404. The review for 12/22/2010 andits determined by the team with supporting revealed that the facility staff failed to complete a documentation included in the meeting minutes. treatment check from 1200 until 1339 (total 1 The FA is responsible for compliance with this hour and 39 minutes). On 12/31/2010, the patient POC. had hemodialysis from 1145 through 1628. The review for 12/31/2010 revealed that the facility staff failed to complete a treatment check from 1225 until 1359 (total 1 hour and 39 minutes). On 01/03/2011, the patient had hemodialysis from 1058 through 1400. The review for 01/03/2011 revealed that the facility staff failed to complete a treatment check from 1145 until 1230 (total 45 minutes). A patient interview on 01/19/2011 at 1320 with patient #1 in the patient treatment area revealed that the patient feels that staff at the facility does

not provide treatment and checks consistently. The interview revealed, "The staff I think is PRINTED: 01/31/2011

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

NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN DIALYSIS CENTER -WILMINGTON SUMMARY STATEMENT OF DESCRIPTORY NAMED PROPERLY NAMED PROVIDERS PLAN OF CORRECTION (RADIO CORRECTION PART) FREEN PLAN OF CORRECTION OR SUPPLIER SUMMARY STATEMENT OF DESCRIPTORY NAMED PROPERLY NAMED PROPE			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURV	EY .
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN DIALYSIS CENTER -WILMINGTON Continued From page 13 V 543 V 543 V 544 V 545 V 545 V 545 V 546 V 5	PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		1	
SOUTHEASTERN DIALYSIS CENTER -WILMINGTON DOWN THE STANDARD SUMMARY STATEMENT OF DEPOLICIONS WILLIAMINGTON, NC 28407 PREFER EACH DEPOLICION WINDS THE PRECEDED BY MILL TAGE STANDARD S			· ·	D MINIC		i .	544
SOUTHEASTERN DIALYSIS CENTER-WILMINGTON CAN D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FULL PRESS (EACH DEFICIENCY MUST SEP PRECEDED BY FULL PRESSUATION OF CORRECTION PROVIDED TO THE APPROPRIATE DEFICIENCY) V 543 Continued From page 13 overworked and sometimes they do not check on me during the treatments as I blink that they should. The interview revealed that the patient felt that the staff has too much work for the type of patients at the facility. An interview on 01/19/2011 at 1450 with the facility administrator revealed that the patient enough staff and she feels that they are trained appropriately. Another interview are trained appropriately. Another that the patient should have been monitored in o longs; of than every 30 minutes in the treatment checks. V 551 494.90(36) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. This STANDARD is not met as evidenced by: Based ori clinical record review, physiolant interview, and are review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with interview, and review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with interview, and review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with interview, and review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with interview, and review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with inneeding failure in of 1 sample			342511	1		01/21/2	<u> </u>
SUNTHEASTERN DIALYSIS CENTER -WILMINGTON Comparison	MANE OF PR	OVIDER OR SUPPLIER					
No. D PROVIDERS PLAN OF CORRECTION SIGNAL							
PREFIX TAG DESTRICTION STORY THE PRESCRIED BY FILL PREFIX TAG SHOPPENDENCE TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCENCE TO THE APPROPRIATE CHORS-REPERCENCE TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCECE TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CHORS-REPERCED TO THE APPROPRIATE CONTINUES. V 543 V 543 V 544 V 545 V 545 V 546 V 547 1 It teammates were in-service on the importance of providing and Disposition of the Text of the Text of the Text of Text o	SOUTHEA	ISTERN DIALYSIS (CENTER -WILMINGTON	W		<u> </u>	
V 543 Continued From page 13 V 543 Continued From page 13 V 544 Continued From page 15 Verworked and sometimes they do not check on me during the treatments as I think that they should." The Interview revealed that the patient left that the staff has too much work for the type of patients at the facility. An interview on 01/19/2011 at 1450 with the facility administrator revealed that the patient enough staff and she feels that they are trained appropriately. Another interview on 01/20/2011 at 1430 revealed that the patient appropriately. Another interview on 01/20/2011 at 1430 revealed that the patient should have been monitored no longer than every 30 minutes in the treatment checks. V 551 V 551 The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. This STANDARD is not met as evidenced by: Based on clinical record review, physician interview, staff interview, and review of the facility staff failed to provide monitoring and assessment of an access with impending failure in 1 of 1 sampled patients that expired after uncontrolled bleeding occurred from the vascular access site (patient #14). Findings include: A closed clinical record review on 01/20/2011 for course of a course of the patients. A contract the patients where access related occurrences and review for needed plans of courseos. A contract the provided on 1/2/11 with all teammates that discussed all the plans of correction, put in place during doverning Body meetings on 1/2/11. Typic: Vascular Access Monitoring and Diagnostics protocols was reviewed with all clinical teammates as of 2/3/11 and evidenced by signature sheet. An insertice of the patients was a constructed to dialysis patients, including data on bleeding from vascular access failure in 1 of 1 sampled patients that expired after uncontrolled bleeding occurred from the vascular access site (patient). The patients are site of the decided plans of care is to be done on all pati		OLDASIA DV OT	ATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRE	CTION	(X5)
V 543 Continued From page 13 overworked and sometimes they do not check on me during the treatments as I think that they should." The Interview revealed that the patient felt that the staff has too much work for the type of patients at the facility. An interview on 01/19/2011 at 1450 with the facility administrator revealed that the administrator revealed that the administrator revealed that the administrator believed the facility does have enough staff and she feels that they are trained appropriately. Another interview on 01/20/2011 at 1430 revealed that the patient should have been monitored no longic thair every 30 minutes in the treatment checks. V 551 494.90(36) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. This STANDARD is not met as evidenced by: Based on clinical record review, physician interview, staff interview, and review of the facility's policies and procedures, it was determined that the facility staff failed to provide monitoring and assessment for an vascular access with impending failure in 1 of 1 sampled patients that expired after uncontrolled bleeding occurred from the vascular access site (patient #14). Findings include: A closed clinical record review on 01/20/2011 for control to the facility and the patients that expired after uncontrolled bleeding occurred from the vascular access site (patient #14). Findings include: A closed clinical record review on 01/20/2011 for control to the facility of the patient sense of the facility of the provided of the patients that expired after uncontrolled bleeding occurred from the vascular access site (patient #14). Findings include: A closed clinical record review on 01/20/2011 for control to the facility of the patient sense of the facility of the patient sense of the facility of the patient of the facility of the patient of the facility of the patient of the facility of the facility of th	(X4) ID	JEACH DEFICIENC	Y MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APP	و سافقا استفادیات	
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A closed clinical record review on 01/20/2011 for related occurrences. FA and Gov Body to ensure compliance		Findings includ	de:		occurrences and review for	iccucu pians o	
A closed clinical record review on 01/20/2017 for compliance					correction. Children Continued w	y Body to ensur	
the state of the s		. A closed clinic	al record review on 01/20/2011 fo	or			
		patient #14 re	vealed that the patient began				

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	O Einer J France of	page 14	V	551			
V 551	Continued From p	tments at the facility ON	ĺ		V551 cont. 100% daily flow sheet audit X 4 we	eks then 10%	
	LANGOLOGO The	tments at the facility on review revealed that the patient			I was to be completed by FA	or designee,	
	I manipad a hemor	Halvsis treatment on our meori-			1 compliance in vascular acc	ess assessincin	
	I row of the formula	h nusy the ballett was	1		i a All non-compliance	Mill feami in	1 1
	decumented as h	aving a Dimary vascular access	1		disciplinary action, Kesuli	s of anoirs whi	1
	I rain that / Croff' t	n har len allii useu loi ulo			be reviewed with the Medical Dire monthly QIFMM and continued freq	nency of audits	
1	hemodialysis trea	atment. Documentation at 0552			later-ined by the team WI	լդ ջաթթուսու	
}	from the facility's	nursing staff (nurse #1) revealed vascular access site had "Large	·\		demonstration included in the meeting	ng minutes. Int	i l
		nation claims finite to ourgevin			TA is managible for compliance Wil	h this PUC.	1 1
.]	一 一 一 一 一 一 一 一 一 一 一 一 一 一 一 一 一 一 一	ALL COMPANSION WITH THE DESCRIPTION			Att Honte that have a fisfula of	graft have been	*)
	the access site (on her left affil Califfulated with			educated on post treatment bleed with post demonstration provided b	or the nationt o	r
	the hemodialysis	treatment diveir unough the	`		Verification of complet	od is extremee	u į
	nita A M	SUIDW OF THE DOST 255C35THCHI			the a signed demonstration sheet. 1	his will be don	E
}	Latin Empire retire	A #1 revealed that the vascular			and in the villegen appropriate and in the	e event of ilsiui	4
	access site as "	LLA Graft, positive bruits/thrills."			f placement Clinical coordi	nator will ensur	,
i	The patient was	s documented as leaving the ory with no other complaints.			tracking of process and FA will ens All patients that have a fistula or gr	aft are oiven an	•
	,					ecoing	1 1
	A review of the	clinical record's narrative nursing			parameter and educated on the use	of the kir, in	3 ·
1	1	that mires III an iii iii iii ac	ľ		angenous bit contains two packs (of gauze and a	- {
	I come at a mean	tad a late entry figiti V I/ (//49) !	as		11 of tone This kit will be given	on admission at	ia
1	in	Manre I I A AIXXSS. IOUIIQ IQ IIQTY	1		in the event of fistula or graft place education has been provided to all	corrent patients	1
	raised scab an	ea approximately 1/2 tall, as thou	יינע. 		avoid fietals or graft. "How to keep	your nstua/or	aft
	12 I hand ob	en picking at scab. When I asked e been picking it, she yelled and			TO Zaoizsimba was 11 A " The Control of D	shila/graft	
1	lamid an oboto he	ay not a explained we liced to the	re		I to separat will be provided same 6	ducation.	.+/
1	a curgoon ass	ess her access. One is will said			Varification of review will be evid	enced by paner	10
	1 1	a care at it neisell. A suluicul			teammate signature on education seducation poster has been placed of	n treatment flo	or
	Francis and Assess to	ant The Physician Appleton ((A)		in orea where nationts are entering	. This poster	
	wrote for antib	piotics, vancomycin the last hour	"		andring education on emergency	piecond arier	
	treatment."	•			treatment. This poster will remain	n in the centrali	zed
1		ne clinical record's narrative nursing	ng		location.		
	1	resied documentation non me	-		cont pg. 16		
1	i knatitule elimie	-al contdinator on unitaleuri de					
1	1 4047 on into	antri tor 111/1/1/2011 do 1 ducire			i i		
ĺ	محمد المسال المسال	Awart untroll fill beil. It liver	nan				
	Assistant) sa	aw patient, ordered vancomycin fo	11				hard Bono 15 of
1	i		TET044		Facility ID: 956055	If continuation	sheet Page 15 of

Event ID:TFT811

FORM CMS-2587 (02-89) Previous Versions Obsolete

Facility ID: 956055

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		4					
V 551	Continued From p	age 15	٧	551	V551 cont	of all access	\
, , , ,	core on lea and a	cess arm, which nurse had			Physician/extender will be notified concerns. No verbal orders will b	e accepted by	
		and explained to deficit alic		1	extenders, and all verbal orde	rs given by	
	should not be bick	cing at scap on the access, and		1	physician are to be read back for	r ventication.	· }
	thou conmitted a	way from the alea, paueric		\	Extender will meet with the Va	scular Access	İ
	: Formed to currier	on for evaluation of access,	į	1	manager and FA monthly to review	the One Stop	1
1	information about	scapped area and vancomyon			Tool which addresses CVCs and	new vascular	1 211111
	given. Patient had	bleeding post treatment, but			accesses in the facility. Results a	ind minutes of	
	was controlled ar	nd patient was kept 15 minutes			meeting will be reviewed in QI	kivitor minutes	
1	after bleeding ha	d stopped without problem. Was			monthly. Rounding physicians/extenders w	vill meet with	i
	informed on U1/1	8/2011 patient had expired at cess bleeding out. Talked to	1		charge nurse before and after round	ling on patients	1
	home with the ac	RIESS DIEGUING OUT TAKES TO	1		to encure all nationt concern	is have been	.
	(PA) and he w	as aware.			addressed (Ongoing) FA to ensur	e compliance	1 1
	A. tulantimize on (01/20/2011 at 1230 with the			If any patient refuses to remain in	the facility for	
	An interview on	in director for the in-center	1		an accessment by the nurse of	the physician	'
I .	hamadiahteis na	fients revealed mai Dalleill # 14			awtender the patient will be It	equired to sign	1 1
	I had evenired on f	14/18/2011 away from the facility	1		AMA form. All AMA forms will	be reviewed if	1
	after Meeding Of	if from her "AV Gibit Vascular			QA monthly. All substantiated ch	nest pain will be	
1	access site "I h	ave not had a chance to review			sent to the ER via 911. If any they will be required to sign AM.	A by the facilit	7
	the death but li	understand that the patient did			and the 911 transport. This	will be tracke	á
	hous an unfortu	nate death. She was an older in	1		throughout the month and re	viewed in QA	³ .
	dialucio n	ations and I think she was trained			monthly. FA and Gov Body are	responsible fo	or
l l	to recognize if	raffs were about to blow. I lean	<u> </u>		ongoing compliance.		
	did not know m	uch about her death as of yet."					
	ł	•	4		<u> </u>		·
	An interview on	01/21/2011 at 1120 with nurse #	nt.				1
	in reference to	patient #14's 01/17/2011 treatme llowing: "The staff LPN (licensed	· · · · ·				1
1	revealed the 10) wanted me to look at her arm.					
1	practical nurse	ed scab at her graft access. It	1				
	She had a rais	had been picking at the site.					
1	Effected the pai	tiont to help set up a suluical	-		·		1
	concult and sh	ie velied out to use no . I tom nei	.				
	i aba waada ta t	sa caann a suideoil. Tomnoci					
1	(Constinutor) to	nok care of surdery consult and			Ì		
	cchaduled it	PAIDIVSICIAN assistanti nonco	at				
	1 44	SE DELL'ARRIE HE DIGEREU					ļ
	Vanconycin s	and a wound culture but no draine	ge	•			
1	was there at t	he access site. She (the patient)					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	01/31/2011 APPROVED . 0938-0391
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	i	ing the site of hor using the site.		1			
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		look like that. We made decision cab for cannulation and it (the		1			
	11	aran an inch sidove die aces.	\				
	Linux - starty :	ACCARGON ANN SEMENOMES I SEE		.	·		
	1. 1	w about the Dallette dean or	1				
	transfer rocor	n I documented the late entry in d. We do and are allowed to do					
	ter was a black	and in the arministration abrow					
	me to go back o	n 01/19/2011 and do a late entry			Į	•	
	le le le le le le le le le le le le le l	04/21/2011 at 1240 with the					
	s un de Dhyeiri	an Accistant (PA) that saw my					
•	1 11 6 CAIA-	MONT TOURSIEN NIAL INGS	iff				
1	the second and the let	ay on 01/17/2011, the nursing sta me she (Patient #14) was on	1				
	tintuin Minon	Leaw her she had thi tape on he	r				
1	I was to a second	anian ong i was iniable to see					
	her access site	. I went ahead and ordered the sed on the nurse's description are	nd				
	I to told whatfifther	I Wanten in Make and and non		٠,			
1	offer cha	finished bet ileanned in innow	1				
	اكستسد الماليا	e of the pacility to thake and and					<u> </u>
	i II	could come back if not here and s. I told the nurses to make sure					l
	that I cover the	access affer the patient misned	ļ				
	1 10 10 10 10 10 10 10 10 10 10 10 10 10	e left before. I never saw the am not sure what would have be	en				-√
	ttee	Kut (ain ask in see ilig Dauvin					
	1 1 2 1 1 1	t and I was never companied as a.	414				
}	I the untiget ha	tore she lell bil bil tired in die	uiu				
	die of bleed o	out from her access site on					
	<u> }</u>	a a manage — bythe after a					1
	An interview	on 01/21/2011 at 1455 with the	did				•
	facility admin	on 01/21/2011 istrator revealed that the patient on 01/18/2011 from bleeding from	n				-
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E .			SECUTED IAM RENGTON	1	2215	RINGTON, NC 28407			
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1		ministrator was	not aware that the FA hever		1		•		
	1	u the motionic	acress site and that one	1	1	1			
Ì	1	I that ha	had accessed the one due were	ľ					1
1	pe	rmission for the	e access site to be used despite.		ļ				
-	1 th	e patient having	a scab on the access site. The d that the administrator was not	•					1
1	in	terview revealed	nts that occurred on 01/17/2011		-			1	1
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	lo	consequently, A	in Immediate Jeopardy (IJ) was			·		ļ ·	٠.
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1	1	I illh a menet tol	ian to tollow the utitalous:	1		,			, I .
		assistant's ins	tructions and the patient left the						- 1
1		facility on 01/1	7/2011 without the physician assing the patient. The patient dieseing the patient facility as a result	ed					
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-		heing assess	ed by the physician assistant as	was				{	İ
1		instructed to	the facility staff.	-	1100			į	1
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DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 09	
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	/Y2\ IAI	II TIPI F C	CONSTRUCTION	(X3) DATE SUR	VEY
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PLAN OF د	CORRECTION	American Co. Co. Communication Co.	A. BUIL	LUING		C	ļ
		342511	B. WIN	IG		01/21/	2011
			1	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	\
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SOUTHER		· · · · · · · · · · · · · · · · · · ·		L	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREF	ix ·	ACTION SHO)(T) RE	DATE
PREFIX	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APP DEFICIENCY)	TOFTINE	· \
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V 625	Continued From p	age 18	*	\ \ \ \ \ \	Coverning Rody (GB) meeting wa	s held to	1
				, r	wiew the deficiencies received. This	s Condition	. 1
		مربط فسيسين والمراجع المراجع		f	or Coverage (CFC) that is not met as	s supported	
	This CONDITION	is not met as evidenced by:	1	1 1	or standard V628, has detailed Plans	of	
	Based on "ESRD	(End Stage Renal Disease)		10	orrection (POC) referenced to in th	e specific V	
	Dogth klotification	" renort review, chilical record		t	ags. Ongoing compliance to the PO	will include	1
\	review, physician	Interview, the facility's "Quality		r	promoting implementation of policie	s and	
1	Improvement and	Facility Management Meeting	1	F	procedures to ensure correct and effe practices in vascular access assessm	ent and	
	Minutes" review,	and staff interview, it was the facility failed to recognize		I	monitoring, patient monitoring and t	reatment	
	determined that	ay threaten the health and safety	1]	checks Q 30 minutes, patient plan of	f care, and	1/31/11
	problems that me	ddress those problems in its		. ;	quality assurance,	•	1
	or patients and a	ce program. The facility failed to	1	1			
	Quality Assurant	ed to a patient death to identify	1	.	The Governing body meeting of 1/	25/11 included	
1 .	and many and note	antial problems related to		i	adoption of the form: Mortality Re	eview which is	Ì
	the language of the second states	ST SCOOCE CITES THE CUITILIEUVE	'	-	to be completed on all patient	deaths in all	
1	Dieeding vascuit	ystemic problems resulted in the	\	1	modalities. Mortality of each	death will be	
	Emplified a inchibite	to engine a lacilly-passe		ļ	reviewed by the quality improven	tent communes	
}	necessment 200	I improvement of care to brevery	;	1	for trends and needed action plan QA meeting monthly. A copy of	of the mortality	l i
	major problems	in the health and salety of air	1	}	QA meeting monthly. A copy of review will be kept on all deaths to	eviewed in OA	1
	hemodialysis pa	atients on its census.	ĺ		meetings and attached to the mi	inutes. Action	
	110111011101111111111111111111111111111		1	1	plans that are put in place will be	documented in	.]
	Findings include	e:			detail in OIFMM minutes and trac	ked monthly in	
	- 1				OA meetings monthly. Action	is immediate,	, \
1	A. The facility for	alled to review data related to a		2	beginning 1/27/11, FA and Gov	Body will be	
	nations doubt to	INDUITY AND DIEVELL POLECTION			removerble for ensuring compliant	ce.	- 1
	problems relate	ed to bleeding from vascular			Beginning 1/27/11, all patient	events Will De	
	access sites.		1		reviewed by the quality improve in monthly QA meetings, recog	nizino trends o	r
		Ana 440(a)(2) Qualify Assurance	e		in monthly QA meetings, recog- concerns that may threaten the h	ealth and safety	v
-	~Cross refer to	494.110(a)(2) Quality Assurance	-		of all patients and prevent pot	ential problems	.
	Performance I	mprovement - Tag V0628		V 628	Action plans that are put in	place will be	e i
V e	28 494.110(à)(2)	DEMANAL VZE/TRACK OHAL			documented in detail in QIFF	M minutes and	a ;
	QAPI-MEASU	RE/ANALYZE/TRACK QUAL	1		tracked monthly in OA meetings	monthly. Action	n ¦
	INDICATORS	•	1		is immediate and ongoing. FA ar	ad Gov Body wi	11
		callibration measure analyze an	d l		be responsible for ensuring comp	liance.	
	The dialysis for	acility must measure, analyze, an			1	•	
	track quality II	ndicators or other aspects of that the facility adopts or develop	s)]
	performance	necess of care and facility	1	•			Ĭ
	that reflect pr	ocesses of care and facility hese performance components	1			•	
1	operations.	Hear bellougues combanation				M continuation S	hoot Page 190

DERABIA	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 0 FORM A OMB NO. 0	PPROVED
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ENIERG	DE DEFICIENCIES	I WAY DROVINGERISUPPLIENCEN	(X2) M	ULTIPLE	CONSTRUCTION	COMPLET	ED \
FEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING		C	
ANDIDAG			B. WIF	ara		01/21	/2011
		342511	D. ****			1 0 0,12 -	
				STREE	T ADDRESS, CITY, STATE, ZIP CODE		Ì
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V 628	This STANDARD Based on "ESRD Death Notification review, physician Improvement an Minutes" review, determined that related to a patie potential problem vascular access Findings included A review on 01/Notification" repethat the patient at the fady of 06/25/26 "This 61 year of always remain	relate to the desired outcomes es themselves. is not met as evidenced by: (End Stage Renal Disease) n" report review, clinical record interview, the facility's "Quality described Facility Management Meeting and staff interview, it was the facility failed to review data ent death to identify and prevent ms related to bleeding from a sites (Patient #12). 20/2011 of the "ESRD Death port dated 06/28/2010 revealed was an incenter hemodialysis acility that died on an off dialysis old male has been on hemodialys or several years. This patient ed compliant with his treatment at the patient with the streatment at the second of the	i sis and on	628	The Governing body meeting of 1/2 adoption of the form: Mortality R to be completed on all patient modalities. Mortality of each reviewed by the quality improven for trends and needed action pla QA meeting monthly. A copy of review will be kept on all deaths a meetings and attached to the meetings and attached to the meetings and attached to the plans that are put in place will be detail in QIFMM minutes and tra QA meetings monthly. Action beginning 1/27/11. FA and Go responsible for ensuring compliang Beginning 1/27/11, all patient reviewed by the quality improved in monthly QA meetings, reconcerns that may threaten the of all patients and prevent po Action plans that are put in documented in detail in QIFI tracked monthly in QA meaction is immediate and ongoi Body will be responsible compliance.	deaths in all death will be then committee ans during each of the mortality reviewed in QA inutes. Action documented in cked monthly in a is immediate, w Body will be note. events will be concernizing trends or health and safety tential problems by M minutes an estings monthly ng. FA and Go	t y s e d
	an off dialysis main access.	Status post graft infection."			,		
	patient #12 remale that was from 12/11/20 revealed that treatment was 5731 through that the patie venous cath	cal record review on 01/20/2011 evealed that the patient a 61 years a hemodialysis patient at facility 009 through 06/25/2010. The review of the patient's last hemodialysis as at the facility on 06/24/2010 from 1142. The documentation revealent had an access of CVC (central eter) right jugular area. No other in was found on the patient neet that indicated that the patient	iew om aled				
1	treatment st	lest didt binnared tiet and be			Facility ID: 956055	If continuation	sheet Page 2
			. ~~~	t	CHIRTY SIL, DVVIII		

PRINTED: 01/31/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **TEMENT OF DEFICIENCIES** A. BUILDING AND PLAN OF CORRECTION 01/21/2011 B, WING 342511 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2215 YAUPON DRIVE SOUTHEASTERN DIALYSIS CENTER -WILMINGTON WILMINGTON, NC 28407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY TAG V 628 Continued From page 20 V 628 any other access site or as a secondary access site. The review revealed no documented issues on the patient treatment sheet for 06/24/2010. An interview on 01/20/2011 at 1310 with the facility's physician director revealed that patient #12 was a patient that expired on 06/25/2010 (day after dialysis treatment) by "bleeding out from his graft site in a public place." The interview further revealed that the physician director had reviewed the death and felt that the patient was trained to look for problems of his graft. The interview revealed that he as physician director did remember looking over the case. A review of the facility's "Quality Improvement and Facility Management Meeting Minutes" on 01/21/2011 revealed that facility's Quality Improvement committee had monthly meetings held in the months of 06/2010, 07/2010, 08/2010, 09/2010, 10/2010, 11/2010 and 12/2010. The review of the meeting minutes revealed that no documentation the demonstrate that the facility discussed or analyzed the patient's death from bleeding from his vascular access site on 06/25/2010. No documentation was found anywhere in the facility's quality assurance and performance improvement materials to indicate that the patient's death on 06/25/2010 was ever addressed or reviewed by the facility for potential problems or areas for improvement to prevent future vascular access site problems to prevent

similar events int he future.

An interview on 01/21/2011 at 1340 with the facility administrator revealed that the facility's quality improvement committee did not address the patient death for 06/25/2010. The interview revealed that no evidence could be produced to

	AFAIT OF UEAI TH	AND HUMAN SERVICES		•	PRINTED: (FORM A OMB NO. (PPROVED
ンドトゲストリ	SEUD MEDICARE	& MEDICAID SERVICES	4		O'S) DATE SUI	RVEY
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V 000	Continued From p	page 21	V 628			
V 628	the that	the facility examined the death				
	on a recult of the	vascular access site nieed out			•	
	L Linette matanti	al wave to improve the				
	in the show of work	cular access siles by the locking				1
	1	w further revealed that the gical dressing covering the site				1
	1	ad baan removen and the			•	
	i handage on 06/2	4/2010. This sile was nic source				
	i of the fatal bleed	out.	V 711			
V 711	494.150 MD RE	TABLE TO GOV BODY		•		
	A	and the second of the second o		V711		
	The dialysis faci	lity must have a medical director		Carraging Rody meet	ing on 1/24/11	1/31/11
	the second and the second	**************************************	€	established a single medi	ical director to be	
	1 11 Em - 1			responsible for the hemodialysis, home hemod	lialysis program and	
	outcomes in the	facility. The medical director is the governing body for the quality	, \	hama peritoneal program	n. The designated	
	of medical care	provided to patients.		- dient director Will	oversee activities	
1	Of Thealoat Sala			processes, and sign off documents in the stated	programs. FA and	l l
1				Coverning Body Will	ensure compliance.	1
	THE DEAD OF	RD is not met as evidenced by:	ļ	Tattor of communica	tion with above	1
		ふっぱんき べいくさいけい ひひひり いいしはいでき	it i	notification sent to all p medical group by Governi	ihysician parmers or ina Rodu	
				medical group by Govern	ing Dody.	\
			me		·	
	for both the fa	nedical directs by the collists in center hemodialysis, ho program and home peritoneal			•	
1	program.	Achien and the second				
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1	Findings inclu	de:				
	A mustaur mm M	1/21/2011 of the facility's govern	ing			
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1						:
1	i abveician ditt	SCIULS" I US I GAIGM I GAGGICA MINE.	ile			
1						
		ian A) that was listed as the med ne in-center hemodialysis program			-	
1	director for the	other physician Dr (physician	B)	, ,	If continuation	

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		342511	B. WINC	3		01/21	/2011
		1 072.011		STREET	ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER		ľ	2215	YAUPON DRIVE		
SOUTHE	ASTERN DIÁLYSIS (CENTER -WILMINGTON	l	WILI	AINGTON, NC 28407		
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V 711	Continued From p	age 22	V7	711			·
	as the facility's me	edical director for the facility's					
	I Lama bamadiake	ie and home beliibliedi				•	
	norman Na suide	ance was toling anywhere in the	•				
	documentation re	view for the governing body that it reported to Dr(physician A).	1				
	No documentatio	n was found where	}		·		
	Dr. /Dhysician /	(1) ever reviewed any of the					
	home hemodialys	sis and home peritoneal		· .	*		1
	program.		1				
	An interview on 0	1/20/2011 at 1335 with the		1			
	facility's perifone	al nurse revealed that the sne			•		
	reported to DE	(Dhysician B) as the medical	1	ľ			
	director for the h	ome program. The interview physician B) was the		1			
l	and recognized	as the nome pioulains inculver		1			1
	dimeter and was	the one responsible for the					
	entire home pro	gram with him reporting to no		. }			
	other physician.						
	An interview on	/01/20/2011 at 1420 with the					
	facility administr	rator revealed that the facility did					
	auronthy have t	we medical directors will VI					
	l	esponsible for the hemodialysis center and Dr. (physician B)					
_	bondling the ho	me morams, "I dio nol unuk w a	at_			······································	
	i national right	hilf that is the way we have use			1		
	directors at the	tachin I mink mar nich com acc	. 15				
1	written that way	y and the home program is Dr.)'s specialty." The administrator					1
	dec revealed	n interview no evidence unat	1				
	Dr (physicia	n A) ever reviews the nome					
1	hemodialysis a	and home peritoneal programs.	ļ				
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Post-Certification	Revisit	Re	port

in morting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and in 1 data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information luc.uggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork duction Project (0938-0390), Washington, D.C. 20503.

Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/14/2011	
342511 lame of Facility SOUTHEASTERN DIALYSIS CE		Street Address, City, State, Zip Code 2215 YAUPON DRIVE WILMINGTON, NC 28407		

his report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously sported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each equirement on the survey report form),

	(Y5) Date (Y4) Item	(Y5) Date (Y4)	item (Y5)	Date
ID Prefix V0110 Reg. # 494.30 LSC	(Y5) Date (Correction Completed 02/14/2011	ID Prefix V0113 Reg.# 494.30(a)(1) LSC	Correction Completed 02/14/2011	ID Prefix V0115 Reg. # 494.30(a)(1)(i) LSC	
ID Prefix V0116 Reg. # 494.30(a)(1)(ī) LSC	Correction Completed 02/14/2011	ID Prefix V0121 Reg. # 494.30(a)(4)(i) LSC		ID Prefix V0142 Reg. # 494.30(b)(1) LSC	
ID Prefix V0540 Reg. # 494.90 LSC	Correction Completed 02/14/2011	ID Prefix <u>V0543</u> Reg. # .494.90(a)(1) LSC		ID Prefix V0551 Reg. # 494.90(a)(5) LSC	Correction Completed 02/14/2011
ID Prefix	Соггесtion Completed 02/14/2011	ID Prefix V0628 Reg. # 494.110(a)(2 LSC	Correction Completed 02/14/2811	ID Prefix <u>V0711</u> Reg. # 494.150 LSC	Correction Completed 92/14/2011
ID Prefix Reg. #		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
State Agency Reviewed By	Reviewed By		nature of Surveyor:	Min AN	Date: / / /// Date:
CMS RO. Followup to Survey Co	mpleted on:	Chec	k for any Uncorrected De corrected Deficiencies (C	ficiencies. Was a Summary of MS-2567) Sent to the Facility?	YES NO

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

iblic reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and intrinsion, including antique and information of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimates or any other aspect of this collection of information. Send comments regarding this burden estimates or any other aspect of this collection of information.

Provider/Supplier Number	Provider/Supplier Name SOUTHEASTERN DIALYSIS CENTER -WILMINGTON	
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Extent of Survey (select all that apply) A	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey	

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 5pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
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Total SA Supervisory Review Hours....

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Total SA Clerical/Data Entry Hours....

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Total RO Clerical/Data Entry Hours.....

Facility ID: 956055

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

Page

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

ablic reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and antifund data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including agreeions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction roject(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 342511	Provider/Supplier Name SOUTHEASTERN DIALYSIS CENTER -WILMINGTON
Type of Survey (select all that apply) AD D	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanctions/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life Safety Code L CHOW
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Total SA Supervisory Review Hours.....

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Total RO Supervisory Review Hours....

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Facility ID: 956055

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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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DEPARTMENT OF HEALTH AND HUMAN TRVICES

CENTERS ** - MEDICARE & MEDICAID SERVICES

MEDICA. AEDICAID CERTIFICATION AND TRANSM. AL

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PART I- TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 956055 4. TYPE OF ACTION: 4 (L8) 3. NAME AND ADDRESS OF FACILITY 1. MEDICARE/MEDICAID PROVIDER NO. (L3) SOUTHEASTERN DIALYSIS OF WILMI I. Initial . 2. Recertification 342511 (L4) 2215 YAUPON DRIVE 3. Termination 4. CHOW 2.5 , ATE VENDOR OR MEDICAID NO. (1.6) 28407 6. Complaint 5. Validation (L5) WILMINGTON, NC (L2)7. On-Site Visit 9. Other (L7) 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 8. Full Survey After Complaint 13 PTIP 09 ESRD (1.9) 04/01/2000 01 Hospital OS TITA 14 CORF 10 NF (1.34)02 SNF/NF/Dual 06 LAB 6. DATE OF SURVEY FISCAL YEAR ENDING DATE: (1.35)15 ASC 11 IMR (L10) 63 SNF/NF/Distinct 07 X-Ray 8. ACCREDITATION STATUS: 12/31 16 HOSPICE 12 RHC 08 OPT/SP 04 SNF LICAHO 0 Unaccredited 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10. THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: X A. In Compliance With From (a): ____ 2. Technical Personnel __ 6. Scope of Services Limit Program Requirements To (b): ___ 3, 24 Hour RN Compliance Based On: 7. Medical Director 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size (L18) Acceptable POC 12. Total Facility Beds ___ 5. Life Safety Code __ 9. Beds/Room Not in Compliance with Program (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: A* 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN (L15)IMR 1861 (e) (1) or 1861 (j) (1): ICF 18 SNF 18/19 SNF 19 SNF (L43) (1.42)(1.39)(L37) (1.38)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): CHOW effective April 1, 2000. (New owner: Total Renal Care of North Carolina, LLC) 18. STATE SURVEY AGENCY APPROVAL Date: SURVEYOR SIGNATURE (L20) (L19)PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 1, Statement of Financial Solvency (HCFA-2572) 20. COMPLIANCE WITH CIVIL 19. DETERMINATION OF ELIGIBILITY 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: 3, Both of the Above: 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)26. TERMINATION ACTION: (L30)24. LTC AGREEMENT 22, ORIGINAL DATE 23, LTC AGREEMENT VOLUNTARY 00 INVOLUNTARY ENDING DATE BEGINNING DATE OF PARTICIPATION 01-Merger, Closure 05-Fail to Meet Health/Safety 03/26/1979 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (1.25)(LAI) (L24)03-Risk of involuntary Termination OTHER 27. ALTERNATIVE SANCTIONS 25. LTC EXTENSION DATE: 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)(L27) B. Rescind Suspension Date: (L45)30, REMARKS 29. INTERMEDIARY/CARRIER NO. 28. TERMINATION DATE: Send to DRO 00454 (L31) (1.28)32, DETERMINATION OF APPROVAL DATE 31. RO RECEIPT OF CMS-1539 (L33) DETERMINATION APPROVAL (L32)

END STAGE RENAL DISEASE APPLICATION/N	NOTIFICATION AND SURVEY AND CERTIFICATION REPORT
PART I - APPLICATION	N - TO BE COMPLETED BY FACILITY 2. Provider Number
Southeastern Dialysis b	dilmington 342511
3. Street Address 2215 Yaupon Drive	
4. City Wilmington	5. County New Hanover
6. State NC	7. ZIP Code 28401
8. Telephone No. 910 343 - 0664	9. Facsimile No. 10. Fiscal Year Ending Date 12/31/11
11. Name/Address/Telephone Number of Authorized Official Name: Lori Todd RN	Address: PO Box 98 Telephone No. Clarendon, NC 28472 910840-2581
12. Type of Application/Notification: (vi) (check all that all 1. Initial ☐ 2. Expansion to new k ☐ 4. Change of location ☐ 5. Expansion in currer ☐ 7. Other (specify) Complaint recerti	ification U.6. Change or services roperations
13. Ownership (vz)	For Profit
14. Is this Facility Hospital-Based (check one)	(V3) Yes 14to If Yes, hospital provider number
15. Is this Facility SNF-Based (check one)	(vs) ☐ Yes ☑️No If Yes, SNF provider number
we: Davita Inc- (va) 17. Services Provided: (va) (check all that apply and specify in the control of the contr	Address: Downto Toc. Address: Downto Toc. 1551 Hewatto 5t. Denver Co. 80 20 2 in Remarks section [see item 27]) Ansplantation Hemodialysis Peritoneal Dialysis Peritoneal Dialysis
18. Is Reuse Practiced?	(V10) Ves UN0
	1. Manual 60 2. Semi-Automated 1.3. Automated
20. Germicide (viz) (check all that apply)	
21. Number of Dialysis Patients (V13) 261 Total Patients = 197 (V14) Hemo	AND THE RESIDENCE OF THE PARTY
22. Number of Stations (check all that apply and include iso	rodation stations under Total Stations) nodialysis + 2 (v18) — Hemodialysis Training
ng Dans the facility have isolation stations?	(vie) Pres No
24 Total Number of Patients (enter number of dialysis facility	y patients treated on each shift for full week prior to submission of this form) C. TUESDAY D. WEDNESDAY
A. SUNDAY B. HONDAY	2 2 4 1 2 3 4
E, THURSDAY F, FRIDAY 1 2 3 4 1 2 3	4 45 37 46 45 12 G, SATURDAY 3 4 1 2 3 4
46 37 46 45 15	
25. Total Number of patients followed at home (vzo) (p4)	

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•	(V25) Technicians	_24.0	2(v26)	Others		bioticine mannage beniums.	•
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Page 7.0

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 1301 Young Street, Room 833 Dallas, Texas 75202



Division of Survey and Certification, Region VI

June 8, 2009

CC: CON

MFP

CMS Certification Number CCN#: 342511

Administrator
Southeastern Dialysis Center -Wilmington
2215 Yaupon Drive
Wilmington, NC 28407

Dear Administrator:

We have been notified that effective April 1, 2000, your organization became the new owner of the facility listed above. You should use the certification number, shown above, on all Medicare claims and correspondence. Payments will continue to be made for covered services unless evidence is received which indicates your facility is not in compliance with the requirements for participation. Your Medicare Administrative Contractor (MAC), Palmetto GBA, will be notified via email by form CMS-2007.

Southeastern Dialysis Center -Wilmington has been approved for the following stations and services: forty-nine (49) performing hemodialysis, peritoneal dialysis (CAPD, CCPD), home training (hemodialysis and peritoneal dialysis (CAPD, CCPD)), and home support (hemodialysis and peritoneal dialysis (CAPD, CCPD)).

If you have any questions, please call Rachel McCarty at (214) 767-2082.

Sincerely,

Singer Odle, Mahager

Non-Long Term Care Certification & Enforcement Branch

cc:

Palmetto (email)/NCarolina 18/NCarolina Medicaid/ESRD CMS CO/

Network 6-Fac #(910)555-5555



North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section

2712 Mail Service Center # Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary Jeff Horton, Acting Division Director http://www.ncdhhs.gov/dhsr

Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

March 30, 2009

Chelsey Byrum, RN, GFA
Dialysis Care of Richmond County
South NC HWY 177
Hamlet, NC 28345

RE: Medicare Complaint Survey

CMS Certification Number (CCN): 342539

Dear Ms. Bryum:

Thank you and your staff for the assistance and cooperation extended to me during the survey conducted March 23-24, 2009. The purpose of the visit was to conduct a Medicare complaint survey. The allegations reported were substantiated and deficiencies were cited. On March 24, 2009, at 2:43 p.m. an immediate jeopardy to the health and safety of patients was identified related to patient care. The Immediate Jeopardy was related to licensed staff's failure to assess and notify medical staff of patients sustaining hypertensive episodes post hemodialysis treatment. This was discussed with appropriate staff and immediate measures were taken to correct the deficient practice. The immediate jeopardy was abated on March 24, 2009 at 6:10

As a result of this survey, it was determined that this facility was not in compliance with one (2) of Medicare's Conditions of Coverage:

494.150-Responsibilities of the Medical Director 494.180-Governance

Federal Regulations prohibit us from recertifying a provider when the provider has been determined to be out of compliance with one or more Conditions of Participation. We are unable to recertify your facility in the Medicare program. For this reason, deficiencies affecting the Condition of Participation must be corrected within 30 days of the survey date; and a follow-up visit will be conducted within 45 days of the survey, if a "Credible Allegation of Compliance" is received by the State Agency within 10 days of receipt by the provider. If not in compliance, a recommendation for termination from the Medicare/Medicaid program will be made effective within 45days from the last date surveyed.



. Ms. Chelsey Byrum, RN, GF. March 30, 2009 Page Two

Please find enclosed both "standard" and "condition" level deficiencies cited as a result of the survey. These are recorded on the enclosed Statement of Deficiencies (Form CMS-2567). A written plan of correction should be submitted to this office and should include the following:

- (a) A description of the correction action(s) and the systems that have been or will be implemented to correct the deficiency.
- (b) A description of the monitoring system that has been or will be implemented including the person(s) responsible for the monitoring to assure compliance; and
- (c) The date by which all correction actions will be completed and in place. This date must be included on the CMS Form 2567.

The enclosed CMS form 2567 must contain an original signature, with the date signed, and returned to me at the above mailing address WITHIN 10 WORKING DAYS OF RECEIPT. Do not fax this form. We must have the original form returned. The plan of correction will be reviewed, and if additional information is needed, we will contact you.

Should you have any questions please do not hesitate to contact me at (919) 550-0870, or (919) 855-4623.

Sincerely,

Kay D. Cuaton, RN

Kay D. Cuaton, RN

Acute and Home Care Licensure & Certification

Enclosures: CMS-2567 (w/patient/staff list)





North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section

2712 Mail Service Center • Raleigh, North Carolina 27699-2701 http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary Drexdal Pratt, Director

Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

January 10, 2011

Charles Sheppard, Facility Administrator Charlotte East Dialysis 3204 Sharon Amity Road Charlotte, NC 28205

Re: Follow-up Survey
ESRD CMS Certification Number (CCN):34-2627

Dear Mr. Sheppard

Thank you for the cooperation and courtesy extended during my recent visit on December 21, 2010, for the purpose of conducting a follow up to the condition level deficiencies 494.180 Governance, 494.30 Infection Control and 494.60 Physical Environment that was cited during your Medicare recertification survey on October 1, 2010. It was determined that the condition level deficiency has been corrected, as well as the standard level deficiencies, and you are back in compliance with Medicare's Conditions of Coverage for End Stage Renal Disease facilities.

Should you have any questions or if this office can be of other assistance, please do not hesitate to call me at (919) 218-2638.

Sincerely,

Ralph Wills

Ralph Mills,RN,BSN , Facility Survey Consultant Acute & Home Care Licensure & Certification

RECEIVED NOV 2 9 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202



Division of Survey and Certification, Region VI

November 15, 2010

CMS Certification Number (CCN): 342627

Charlotte East Dialysis 3204 Sharon Amity Charlotte, NC 28205

Dear Administrator:

The Centers for Medicare & Medicaid Services (CMS) has been notified your facility had a survey on October 26, 2010, and that while the immediate and serious threat to patient health and safety has been removed Charlotte East Dialysis remains out of compliance with the following Medicare Conditions for Coverage:

42 CFR 494.30

Infection Control

42 CFR 494.60

Physical Environment; and

42 CFR 494.180

Governance.

The date on which your hospital's Medicare agreement terminates is December 30, 2010. A listing of deficiencies for the October 26, 2010, survey is enclosed for your response. Note that the on-site visit of October 26, 2010 was conducted to determine whether or not the immediate jeopardy situation had been abated. Correction of the deficiencies not related to the immediate jeopardy was not assessed; these deficiencies are included in the attached report as cited on the resurvey and complaint investigation of October 1, 2010. You must submit a plan of correction to include corrective action dates no later than December 23, 2010, to ensure time for another revisit by the North Carolina Department of Health and Human Services prior to the termination date. Please submit these your plans of correction within 10 days of receipt of this letter to:

Azzic Conley
North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Cartification Section
2712 Mail Service Center
Raicigh, North Carolina 27699-2712

An acceptable plan of correction must contain the following elements:

1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.

- 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.
- The monitoring procedure to ensure that the plan of correction is effective and that specific
 deficiency cited remains corrected and/or in compliance with the regulatory requirements.
- 4. The title of the person responsible for correcting the deficiency and/or for implementing the acceptable plan of correction.

Compliance with all Conditions for Coverage must be achieved at the time of this second revisit if termination is to be avoided. If the deficiencies have not been satisfactorily corrected at the time of this revisit, you can expect to receive a letter advising you of your termination and appeal rights. No further revisits will be authorized at that time. In addition, a legal notice will be placed in The Charlotte Observer in Charlotte, North Carolina advising the public of your termination from the Medicare program. Please be advised that, under Medicare, a provider is not entitled to a formal hearing before termination, but only after adverse action actually takes place.

If you have any questions concerning this action, please contact Glenda Payne at (214) 767-3350 or Rachel McCarty at (214) 767-2082.

Sincerely,

Ginger Odle, Manager

Non-Long Term Care Certification & Enforcement Branch

cet

North Carolina Department of Health and Human Services





North Carolina Department of Health and Human Services Division of Health Service Regulation

Acute and Home Care Licensure and Certification Section 2712 Mail Service Center Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary http://www.ncdhhs.gov/dhsr Drexdall Pratt, Division Director Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

** VIA FASCIMILE **

October 4, 2010

Charles Sheppard, Facility Administrator Charlotte East Dialysis 3204 Sharon Amity Charlotte, NC 28205

RE: Recertifiction Survey Immediate Jeopardy]

Dear Mr. Sheppard,

Thank you and your staff for the assistance and cooperation extended to the Acute Care team during the survey conducted September 22, 2010 through October 1, 2010. The purpose of conducting the complaint survey was to evaluate the Facility's compliance with the Federal Medicare Conditions for Coverage. The complaint investigation resulted in an Immediate Jeopardy (IJ) identification as of October 1, 2010 at 1130am as a result of survey findings from a Life Safety Code survey occurring on 09/30/2010.

Specifically, pursuant to 494.60 Physical Environment-Life Safety Code, the facility failed to have a fire alarm system or battery powered smoke detector in the building to ensure patient, staff and visitor safety in the event of a fire.

As discussed during the survey, the information gathered was forwarded to the CMS Regional Office in Atlanta (Region IV). Our state agency is recommending 23 day termination due to noncompliance with the Conditions for Coverage: 494.60 Physical Environment, 494.30 Infection Control and 494.180 Governance.. The Immediate Jeopardy is ongoing. CMS Regional Office in Dallas will make the determination of compliance or noncompliance and will notify you of their findings and of any action to be taken.

If you have questions regarding the status of the investigation, please contact the CMS representative for North Carolina:

Ms. Glenda Payne

Division of Survey and Certification
CMS Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202
214-767-6301







Page two of two Charles Sheppard, Facility Administrator, CEO October 4, 2010

If you have any questions, please do not hesitate to contact this office at (919) 855-4620.

Sincerely,

Ralph Mills, R,BSN Facility Survey Consultant Acute and Home Care Licensure and Certification

CC: Azzie Conley, Section Chief



North Carolina Department of Health and Human Services Division of Health Service Regulation Acute and Home Care Licensure and Certification Section

2712 Mail Service Center & Raleigh, North Carolina 27699-2712

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary

http://www.ncdhhs.gov/dhsr Drexdall Pratt, Division Director Azzie Y. Conley, Chief Phone: 919-855-4620 Fax: 919-715-8476

October 4, 2010

Charles Sheppard, Facility Administrator Charlotte East Dialysis 3204 Sharon Amity Charlotte, NC 28205

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Division of Survey and Certification CMS Dallas Regional Office 1301 Young Street, Room 827 Dallas, Texas 75202 214-767-6301





Page two of two Charles Sheppard, Facility Administrator, CEO October 4, 2010

If you have any questions, please do not hesitate to contact this office at (919) 855-4620.

Sincerely,

Ralph Mills, RABSN

Facility Survey Consultant

Acute and Home Care Licensure and Certification

CC: Azzie Conley, Section Chief

DEPARTMENT OF HEALTH AND I	IUMAI	NSE CES		market & M	CENTERS FOR ADI	CARE & MEI	DICAID SERVICES	
ME	DICAL	CE/MEDICAD (TED BY TH	E STATE	ID TRANSMITTAL SURVEY AGENCY		Facility ID: 001554	
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(L32)

EPARTMENT OF HEALTH AND HUMAN SEPTICES

CENTERS FOR

DICARE & MEDICAID SERVICES

MEDICARE/M. CAID CERTIFICATION AND TRANSMITTA. PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WB31

Facility ID: 001554

C&T REMARKS - CMS 1539 FORM

'ification survey was conducted onsite September 22-October 1, 2010. As a result of the survey in conjunction with a Life Safety Code survey, an immediate jeopardy (II) entified on October 1, 2010 at 1130. The IJ was no removed during the recertification survey. Condition level deficiencies were identified in 494.180 Governance, 494.30 Infection Control and 494.60 Physician Environment. Standard level deficiencies were also identified in 494.40 Weter and Dialysate Quality, 494.50 Reuse, 494.80 Patient Rights and 494.140 Personnel Qualifications. A plan of correction was requested

An onsite follow up was conducted at the facility October 26, 2010. The State Agency recommended removal of the IJ at 1250 based on compliance with a fire alarm system in place. The CMS Dallas regional office was notified of the recommendation. THe conditions in 494.30 Infection Control, 494.60 Physical Environment and 494.180 Governance were not recommended to be in compliance based on the plan of correction not completed during follow up survey. (RM)

Another follow up survey was conducted December 21, 2010. The State Agency recommends that the condition level deficiencies in 494.30 Infection Control, 4894.60 Physical Environment and 494.180 Governance are back in compliance. No other deficiencies were found during the follow up survey.

olic prorting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information ud. __uggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Juction Project (0938-0390), Washington, D.C. 20503.

(1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wina		(Y3) Date of Revisit 12/21/2010
342627		Street Address, City, State, Zip Code	
lame of Facility		3204 SHARON AMITY	
CHARLOTTE EAST DIALYSIS		CHARLOTTE, NC 28205	

his report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously ported on the CMS-2557, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each equirement on the survey report form).

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ID Prefix V0120 eg. # 494.30(a)(1)(i) LSC	Correction Completed 12/21/2010	ID Prefix V		Correction Completed 12/21/2010			V0196 194.40(a)	Correction Completed 12/21/2010
iD Prefix V0331 Reg. # 494.50(b)(1) LSC	Correction Completed 12/21/2010	ID Prefix _\ Reg. # 44 LSC _	/0340 94.50(b)(1)	Correction Completes 12/21/2019	d	ID Prefix Reg. # LSC	494.60	Correction Completed 12/21/2010
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ID Prefix <u>V0463</u> Reg. # 494.70(a)(12) LSC	Correction Completed 12/21/2010	ID Prefix Reg. # LSC	494.80(a)(1)	Correctic Complet 12/21/20	ed	Reg. #	V0686 494.140(b)(3)(i	Correction Completed 12/21/2010
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10/1/2010

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number 342627	Provider/Supplier Name CHARLOTTE EAST DIALYSIS	
Type of Survey (select all that apply) I D	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanctions/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life Safety Code L CHOW M Other	
Extent of Survey (select all that apply) A	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey	

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
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Total RO Clerical/Data Entry Hours.....

Facility ID: 001554

0.00

was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 11/16/2010 FORM AFPROVED

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Any deficiency statement entiting with an extensity of directs a deficiency which we institution may be procused from conceiling providing it is determined that other safetyperal provide adjiction projection to the passent. (See instructions.) Except for making logics, like findings stated above are descinable 20 days following the data of source which or got a pign of correction is provided. For making houses, the days of some first of consisten are discovered by the data of contraction is requisite to the tackley. If designables are also an appearance plan of contraction is requisite to configurate program participation.

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D. The findlify failed to ensure that patient used dislyzers were adequately refrigerabled to inhibit beoleful growth before reprocessing. -Cross refer to 494.60(b)(1) Rieuse of Hamodillyzers and Bloodines - Tag V0331 E. The facility failed to monitor and maintain refrigerator temporatures to inhibit patiential inclining growth in stoned reprocessed (reuse) dislyzers. -Cross refer to 494.60(b) Physical Environmential inclining growth in stoned reprocessed (reuse) dislyzers. -Cross refer to 494.60(b) Physical Environmential inclining growth in stoned reprocessed (reuse) dislyzers. -Cross refer to 494.60(b) Physical Environmential inclining growth in stoned reprocessed (reuse) dislyzers. -Cross refer to 494.60(b) Physical Environmential inclining growth in stoned reprocessed does not make the second that this refrigerator tended in monthly infection control audit going forward. Upon inspection was unable to maintain temperature within acceptable limits as propriety of paper towels available environmential country of the maintain temperature within acceptable limits. The reuse refrigerator has been replaced and verified to be within acceptable limits as propriety of Policy 6-10-10 fer Reuse Policy* and reviewed refrigerator log with temp ranges. Paper towel dispenser at patient prep area is a battery powered bands fire style dispenser. The dispenser was found to be importantive to ensure and ensuring that the same very day for 3 days, weekly on each shift x 3 weeks and then this will be reviewed a been refrigerator to go with temp ranges. Paper towel dispenser and verified operation 10/14/10. -Cross refer to 494.60(b) Physical Environmential temperature within acceptable limits as propriety of paper towels available to handwashing towel from the flow in section of the team on policy 6-10-10 fer Reuse Policy* and reviewed refrigerator log with temp ranges. Paper towel dispenser at patient prep area is a battery powered bands fire style dispenser. The dispenser was found to be importanted to be within accept	(X4) ID PREMX TAG	CEACH DEFICIENC	Y MUST BE PRECEDED BY ALLL	Ca XFERY	PAOSELES MAN OF CORRECT BAIN CORRECTIVE ACTURE BAIN CORRECTIVE ACTURE BAIN OF CORRECTIVE ACTURE BAIN OF CORRECTIVE ACTURE BAIN OF CORRECTIVE ACTURE BAIN OF CORRECTIVE ACTURE ACT	边连	(CI) COLUMNITION CATE
patients had a supply of paper towels available at ensuring implementation and ongoing handwesting sinks in the patient treatment area. The findings include: A review of the facility's policy "infection Control		D. The facility failed in dialyzers were adequive the provide before the 494. Hemodialyzers and the facility failed artificial growth in a dialyzers. Cross refer to 494. Hemodialyzers and the facility failed satisfied growth in a dialyzers. Cross refer to 494. Tog VIV403 F. The facility failed supply of paper tow dials in the patient of 494. Tag VIV403 A sufficient number apa should be away washing. This STANDARD is No rayleyed challed the facility posterior interview, the patients had a supplement had a supplement had a supplement and a s	to crisure that pattent used unicly refrigerated to inhibit one reprocessing. 50(b)(1) Ricige of Stocking - Tay V0331 to monitor and maintain three in inhibit potential tored reprocessed (reuse) 50(b) Physical Environment- to ensure that pattents had a sic available at handwashing treatment area. 50(a)(1)(1) Infection Commol- INKS AVAILABLE of sinks with warm water and illable to facilitate hand a not met as evidenced by: on 10/26/2010.		V110 cont. The CSS in-serviced the importance of maintaining a clenvironment and ensuring trash is from the floor. Facility Administ designee will monitor team everydays, weekly on each shift x3 we then this will be included in montimfection control audit going forv Upon inspection, it was determin refrigerator was unable to mainte temperature within acceptable lin reuse refrigerator has been replay verified to be within acceptable in policy 6-01-08 "Reuse Policy" refrigerator log with temp range towel dispenser at patient preparatery powered hands free style. The dispenser was found to be in Replaced batteries and verified 10/14/10. Facility Administrator or designonitor team everyday for 3 decach shift x 3weeks and then the included in monthly infection of going forward. Results of audit reviewed in Quality Improvem Management Meetings (QIFM addressed as necessary. FA is ongoing compliance with POC. The Governing Body will me to ensure compliance with POC compliance to the POC will be during monthly QA meetings the Governing Body no less the annually. The Facility administration and	ean picked up rattor or day for 3 eks, and hily rard. ed that this in mits. The sed and limits as pf lie team on and reviewed s. Paper rea is a e dispenser. moperative. operation mee will lys, weekly on is will be control audit ts will be ent M) and responsible for c. et mouthly x 3 C. Further e reviewed and reported to lant semi- fictivator (FA) esponsible for	

		ND HUMAN SERVICES MEDICAID SERVICES		·	FORM	APPROVED
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(√114)	revealed "The facility for patients to wach to be the treatment and their in and a supply of paper contamination must in Chresvallon on 00/22 treatment since reversible the super towels for use chastration revealed in a machine towels. After was a patient and gurrany out to paper towels.	the incompany of the paper lower and the paper lower the paper lower the paper lower the paper lower the paper lower to paper lower to paper lower tower tower tower tower tower tower tower the patient and that a paper lower the patient and the paper lower the patient to patient the paper lower the patient to another lower was their wit area had no available after handwashing. The lither the paper lowers were with a cansor to dispense which made was a baserved by or, it was noted that the ling and no paper lowers	(V 114)	Paper towels in the dispenser wer replaced and threaded properly. Per towel dispenser at patient prep are battery powered hands free style dispenser. The dispenser was four inoperative. Replaced batteries an verified operation 10/14/10. Faci Administrator or designee will me team everyday for 3 days, weekly shift x 3 weeks, and then this will included in monthly infection cor going forward. Results of audits reviewed in Quality Improvement. Management Meetings(QIFMM) addressed as necessary. FA is refor ongoing compliance with PO	aper . a is a d to be d lity onitor on each be strol andit will be it and sponsible	10/18/10.
{V 117]	during the chaervaline revealed that the pay working. The interview would have to be obtained the sensor was 484.30(a)(1)(i) IC-Ci AREA; NO COMMO! Clean areas should preparation, handling and unused supplies ahould be clearly as areas where used at transition. Do not hand clean supplies in the that where used equipment of the clean supplies in the that where used equipments.	EANDIRTY;MED PREP I CARTS The clearly designated for the pand storage of medications and actifement. Clean areas parable drom conteminated upplies and active medications or a some or an adjacent area to ipment or blood samples are	{v 117}			
	When multiple doze	madication visits are used		i i		

PRINTED: 11/16/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-0991 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDENGOPPHERALIA IDENTIFICATION MULEDER: PAR MULTIPLE CONSTRUCTION (XX) DATE SURVEY DOMPLETED A BULLANIS 'R el wing 342627 10/28/2010 NAME OF PROMOER OR SUPPLIER STREET ADDRESS CITY, STATE ZIP CODE 3204 BHAHON AMTY CHARLOTTE EAST DIALYBIS CHAPLOTTE, NO 20208 Summary Statement of Deficiencies (Each Dericency Must be preceded by full regulatory or use Identipying Information) PROVIDERS MAN OF CORRECTION REACH CORRECTIVE ACTION SHOULD BE CKA) ID ID PREFIX bya Computica (ca) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (V 117) Continued From page 4 (¥ 117) (including visis containing diluants), prepare individual patient doses in a clean (contralized) area away from dialysis stations and deliver separately to each pullent. On not carry multiple dose medication vials from station to station. Do not use common medication cans to deliver madications to patients, if trays are used to deliver medications to individual patients, they must be desired between patients. This STANDARD is not met as evidenced by: Not reviewed ansite on 10/28/2010. Based on facility policy review, observations and stall interview, the facility failed to ensure that a clean area was designated to prevent potential cross-conternination of medications/supplies and for staff to prepare, handle and store medications Eliminated the use of a medication cart and to be administered to patients. the medication station has been relocated. A designated clean area was created for The findings include: 10-18-10 medication prep on one of the island nurse stations in the treatment area 09/29/10. A 1. A review of the facility's policy "Infection plan is in place to also install separation Control for Dialysis Fadililes" (revision date barriers 12" in height around the 03/2010) revealed *Clean areas should be medication prep area to further designate designated for the preparation, handling, and this space as a clean area. alongs of medications and unused aupplies and FA is responsible for ongoing compliance equipment. Clean breas should be clearly with POC. separated from contaminated areas where supplies and equipment are hendred." Observation on 09/22/2010 at 1025 in the petient treatment area revealed that a medication curt filled with medications and other unused supplies along with syringes was lucated directly healds the handwashing sink used by patients to wash

their access sites. The silvit was designated for patient hand weeking and had a sign that was

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	facility's nursing state inscribed in the cart was kept be The interview raveat kept due to lack of space conflimed that the safety wet from patient The interview raveat the lack of space conflimed that the safety wet from patient the interview raveat	upplies and medications can is and staff washing hands. Ind that the staff had not shiel contemination of the						
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	Control for Dialysis 03/2010) revealed designated for the storage of medicational equipment. Disance experied from concupiles and equip	acility's policy "Infection Facilities" (revision date "Clean areas should be preparation, handling, and long and unused supplies and areas should be clearly reans should be clearly reaningted areas where ment are handled." (22/2010 at 1550 revealed the		-				
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(V 117)	revealed the matices was evaluated to wach their access that the facility had a written as "Patients tocated at the base further revealed that was present to prevent annual to during the present to prevent annual to during the present to prevent annual to during the present to prevent annual to during the present to prevent annual to during the present to prevent annual to during the present to prevent annual to during the present to prevent annual to the pr	d area noted. Observation tion preparation area (cart) casted careolly baside of the transversions and the patients sples. Observation reveated a tign on the sink that was must wash account altest of the sink. The observation the barries and splesh guard ark potential cross g madication preparation. No was observed for patient	*	117)			
	observation with the carefully a number of activity a number of activity a number of the medications. The innever thought of the from handwashing preparation area.	22/2010 at 1555 during the officially's registered name of was the ease where the off prepares patients as was the test of the district revealed that she a potential splashing of water such on the clean medication 22/2010 at 1650 with the					
{V 120}	facelly's administra potential cross con and that lack of spu 404.30(a)(1)(i) IC-1	ilve staff revealed that Une termination has to be conscied ace is a problem at the facility.	ı	/ 12D			
	transducer filteralp treatment to preve	is and arismal pressure relactors for each patient ni blood contamination of the pressure monitors.					
	replace framediate faid is visible on the	aducer profestor becomes wet, ly and inspect fine profestor. If ne side of the transducer a the machine, have qualified					

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	palient in station if a pelient's external to be contaminated 1610 through 1845 impected or charge. 2. Observation on C patient in station if to be contaminated to be contaminated 1510 through 1645 impected or change. 3. An interview on C facility's registered created that proceded that bloody transducers.	9/22/2010 at 1608 for the challeng tour revealed the challeng tour revealed the challeng tour revealed the challeng tour revealed that no staff mamber at the transducer protector. 9/22/2010 at 1610 for the challeng tour revealed the challeng tour revealed the challeng the challeng the challeng that the transducer protector. 9/22/2010 at 1650 with the challenge the challenge the c					
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·	standard infection implementing- (4) And maintelnin with applicable Sta- public health proce (ii) Cleaning and standard	lamonstrate that it follows control precautions by g procedures, in accordance the and local laws and accepted sures, for the-light features and accepted devices, and equipment.	e forest and the second second second second second second second second second second second second second se				

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	color and chalky)as 1. b. Observation of trach (paper wrapp treatment area flood \$11. Objervation 1	ad distribute populari (anti- a) Dél22/2010 at 1605 reversed ers) acetered on the pation? If near patient stations \$4 and lather revealed three trash trestment area that were full			

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	and overflowing will	trach.						
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	09/22/2010 reveals free from cluster an supplies. The Intern	ne facility administrator on d that the area should remain a diffy bulktup around now also revealed that the						
		uned up by the stall. No us to why the areas were not f.						
	patient treatment a clamps used for pa were located in a c	39/22/2010 at 1020 in the rear revealed that vaccular itient vascular access elles onteiner of 1:100 bleach d visible clotted blood on the						
	clemp heads. The	observation further revealed						
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	patient treatment : bacide the patient bacide the patient patient treatment patient treatment patient treatment patient treatment patient treatment patient treatment treatment patient treatment treatment patient treatment treatment treatment patient treatm	OGZ2/2010 at 1015 in the area revealed blood status on idapts container located directly distyring in station #16. The located on top of the sharps to through 1155 without state the state.						

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1001	FREQUENCY	Manager (Simplificated that					
	Testing for free chio chloring should be p each treatment day treatment and again patient shall if there	ollon: monitoring, lesting freq rine, chloramine, or total enformed at the beginning of prior to patients initiating prior to the beginning of each ere no set patient shills, enformed approximately every			: : : :		
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	chlorine can be son N.Ndicklyl-p-phon test kits or dip-and- monitors can be us	wine, chloramine, or total complished using the ylane-diamine (DPD) based mad test strips. On-line ed to measure chloramine		,		,	
	must have sufficient restrive the maximum 4.1.1 (Table 1) [with right].	ichever test system is used, it it sensitivity and specificity to um lavets described in [AALII] ich is a maximum lavel of 0.1		•			
	bean operating for enelysis should be	e deman when the system has at least 15 minutes. The penformed on-eits, since will domeste if the cample is pay.					
	This STANDARD Not reviewed onei	is not met as evidenced by: te on 10/26/2010.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES					PRINTED: 11/15/2010 FORM APPROVED OMB NO. 0938-0391		
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	Based on facility policy review, the facility's total obtoine tasting log review and stell interview, the facility falled to ensure regularly performed testing to monitor the total obtoine in its water system used in patient hemodialysis and faled to provide color bindreau testing in 2 of 4 sampled staff members that test the facility's water system for the presence of chlorine (Staff #1,3). The findings include: A review of the facility's policy "Daily Water System Total Chlorine Monitoring" (revision date 03/2010) revealed "Total Chlorine insting it dorse on a daily basis prior to the fact patient treatment and every four (4) hours until all activities that frequire use of dialysis quality water are completed." A review on Derzalzono of the facility's "Routing Total Chlorine Testing Log" for 02/15/2010. The revealed that the facility staff falled to document document to the facility at 0300, 0540, 1345 and 1740. The review further revealed that the facility at 0300, 0540, 1345 falled to document any results, initials or eignatures for the Chlorine testing. The review revealed that the 0545 testing for Chlorine was not documented as completed. An interview with the facility's Biomed technician on 09/23/2010 at 1400 revealed that the total or 09/23/2010 at 1400 revealed that the total or 09/23/2010 at 1400 revealed that the total who had a time the should be done every 4 hours with a 15 minute extra wholew of time given. The interview revealed that some times the nursing with a 15 minute extra wholew of time given. The interview revealed that some times the nursing			V196- The CSS in-serviced the teammimportance of completing the w total chlorine monitoring every policy 2-07-04 "Daily Water To Chlorine Monitoring" and doe on the appropriate log. FA/des be checked daily for 7 days the on going. Color blindness testic completed on the 2 RN's cited found that they did have testin are in teammates files. Color testing will be done on all new annually there after. Facility A will spot check 25% of teamm monthly for 3 months and annuafter. Results of audits will be Quality Improvement Manage Meetings (QIFMM) and addrincetssary. FA is responsible compliance with POC.		ter system hours per lad al menting gnee will weekly g was nd it was and results indness hires and hininistrator tes file ally there reviewed in ment ssed as	10-18-10

		ND HUMAN BERVICES MEDICATO SERVICES				FORN	: 11/18/2010 I APPROVED L 0938-0391
STATEMENT OF AND PLAN OF	of Deficiencies Connection	INTO PROVIDENCE SPINIFFICIA	(XZ) M A. ISUT		E CONSTRUCTION	(X3) DATE BUT COMPLETI	ÉO
		342827	B. WAT	ű	And the second s	R 10/28/2010	
NAMEDER	HOYIDER OR BUPPLIER		4	GIRRET ADDRESS, CITY, STATE, 21P CODE			
CHARLOT	TE PAST DIALYSIS	•		•	HARLOTTE, NO 20205		
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(√ 198)	Continued From pag record.	8 13	ĺλ.	翩			,
	System Total Chlorid 03/2010) revealed the "Lamate SL-MAV Te children testing in its also revealed that the "Holding the Octa-Si light enters the back test tube color stund read the porn value	ly's policy "Dally Water we Monitoring" (revision data set the facility uses the set Kit Coloninster" for the water system. The policy a set if instructions include lide Viewer so that non-direct of the compension. Match the end on the Octa-Slide and on the Octa-Slide standard if the test tube sample."					
	nurse #1 on 09/23/2 registered runse did ayatem for total chio review revealed that	cility's personnel file for stalf O'th revealed that the test line facility's water rine when needed. The tight registered raws falled to ed color bilindness testing					
	rurse #3 on 09/29/2 registered nurse did system for fotal chic review revealed that	celly's personnel file for staff (1010 revealed that the 1010 revealed that the test the facility's water time when needed. The 1 the registered nurse falled to ad color blindness testing	Additional of the party of the				
		0/23/2010 at 14(A) with the revented that these staff		•			

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numers during material to respond that has numers did not have any dominanted octor blindrage feeting in her personnel file. The interview revealed no reason as to why fleete dieff nitrees did not have any testing done. The interview also revealed that these numer do

chack the water system for chlorine and should have color blind testing to ensure that each nurse

		: VD HUMAN SERVICES MEDICAYD SERVICES		•		OME NO	PPROVED 1938-0391		
	LOUSECTION COURSECTION	CHIPCATION PLANTS	V Briti (XS) říj		CONSTRUCTION	COMPLETED COMPLETED R	ir ·		
		342627	R, WNG			1025/2010			
	CANDER OR SUMPLIES	1	•		ef address, city, state, 21p code 14 sharch abity				
CHARLOT	CHARLOTTW HAST DIALYSIS PAO D SUMMERY STATEMENT OF BERCHNELS				CHARLOTTE, NC 28205				
DKO PP PREFIX TACE	(EACH DEFICIENT	red identia. And Haldenstion) In Ande de Luggeded Hallon In Tennes de Dungsberger	PREF	איי איי	PROMBERIE PLAN OF CONTRECT (EACH CONTRECTIVE ACTION SHOU CROBS-REFERENCED TO THE APPR DEFICIENCY)	ADBE 1	PALE POSTECTOR PALESTON		
(V 198)		•	₹ V	195)					
(V 331)	can read the color n 494.80(b)(1) REPROCESSING-T HANDLING	redics. RANSPORTATION &	(v	331)	<u>:</u>				
	transportation shall manner maintaining the distyzer is disin externally. To inhibit all cannot be reprotonged delays in this recommend and documented in this standard on this standard on the second of the standard of the	sed dialyzars duting do so in a clean and sanitary i Standard Precautions until lected both internally and it bacterial Precautions until lected both internally and it bacterial growth, dialyzars occased within 2 hours should in of allowed to freeze. Other hardling lawces (such as a reprocessing) not described an reprocessing has validated by the responsible party. Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is not man as evidenced by: Is adjusted to ensure that patient Is adequately refrigerated to befrigerated in a refrigerator to retard bacterial at begun. Refrigerated stored for up to 36 hours prior to			Upon inspection, it was determine frigerator was unable to maint temperature within acceptable liveus refrigerator has been replayerified to be within acceptable o9/29/10. The CSS in-serviced teammates on Policy 6-01-08 R Dialyzers with emphasis on dia in reuse refrigerator including it temperature required to be mainbetween 36-50 degree Fahrenhactions to take if temperature in Proper documentation of a sing temperature to be recorded was reviewed. Facility Administration will review the log everyday for weekly on each shift x3 weeks log will be monitored daily by nurse on an on-going basis. R. will be reviewed in Quality in Management Meetings (QIFM addressed as necessary. FA is for ongoing compliance with	ain mits. The ceed and limits as of the carse of dyzer storage the carse of and sout of range. The cor or designee or 3 days, and then the the charge esults of audits approvement of Man and s responsible	9-30-10		

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				•		PRIMITE	ED: 11/15/2010	
		ND HUMAN SERVICES			•	FOR	MAPPROVED 10, 0938-0391	
O MEMBERA	ocauschion L deliciencies Lou Wethmane &	MEDICALD SERVICES (X1) PROVIDENSIA PLENGIA (DENTIFICATION NUMBER:		ULTPLE LUNG	CONSTRUCTION	(X3) DATE S	URVEY	
•	-	342827	B. Var			70	R 10/28/2010	
	DADER OR EVPPLIER TE EAST DIALYSIS	- Hard A. Constitution of the Constitution of		STREET ADDRESS, CITY, STATE, ZIP CODE JULY SHARON ABOTY				
arearce)11	remai hweiwa			OH	ANLOTTE, NO 20208	-		
CHAID PREFIX TAG	(BACH DEFICIEN	foc dentinano mechationa na unal de bueleded da litit na unal de percendia	PRS: TA	PIK	PROVIDERTS PLAN OF CORP (EACH CORRECTIVE ACTION S ORCES-REFERENCED TO THE A DEPICENCY)	HOLLD BE	power to measured (co)	
(A 334)	Continued From pag	ye 15	{∨	331)				
	Febranipali."			- 1			1	
	ever serie inemiseur	202010 at 1700 in the pallent elec a total of seven (?)						
		retite storage. Inspection of		1				
	the finermometer re	varied that the temperature						
		hrenheli at 1105. The Hitalde of the refrigerator	1					
	revealed that a han	becelq asw notation was placed		l				
		eldgerator frail was written as id be 35 dagrees F		}				
	(Fatranhelt) - 50 d	agrees F. * An interview during 1105 with a patient dialysis		٠.	•			
•	care stall mamber	confirmed that the						
•		\$ degrees F and it should not half member revealed that the			• •			
	temperature in the	refrigerator had been elevated a not able to give specific detes			•			
	A review on 09/22	2010 of the refrigerator log for						
	Minister India	hat the fecility's rationalism ehould be "36 degrees I" to 46 view of the 08/2010 log		:			,	
	rovepled that the s	taff had documented			* *		. }	
		x at ranges instead of a single mature. Raview for 09/01/2010			•			
		dation by stail of the rature to be a ration of 32-38	1					
	degroes F. On 09	07/2010 the range of the	1					
		locismented as 32-42 deglees og for 09/22/2010 (dete of						
	observation) reve	aled that the temperature mented as 20-48 degrees F.		•		•		
		the registered nurse in the erea on 08/22/2010 at 1166						
		refrigerator has constantly been						

P.20

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES				71/15/2010
		MEDICAID SERVICES				approved 0938-0391_
STATELENT L	F DEFICIENCIES CORRECTION	KI) PROMOBROUPPLERKLIA DENTPRANTON NUMBER	a building	ECOMPRESSION	DOS DATE SURVEY	
		542527	a ways		10/28/	
NAME OF PR	CALCULA OF PTISHTER	· ·	XTRI	ILT ADDRESS, CITY, STATE, ZIP COPE	I IDIAN	ans (h
CHARLOT	TE BART DIALYSIS		i	D4 SHARON AUSTY 14 PLOYTE, NC 28795		
(Xa) id Predix Yağ	(EACH DEPTOR NO	TEC DENTUYING INFORMATION) THUST BE PRECEDED BY YULL THE BETTE STEELED BY THE STEELED BY THE STEELED BY THE STEELED BY THE STEELED BY THE STEELED BY THE STEELED BY THE STEELE	PREFIX YAG	Promotes PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-HEFERENCED TO THE APPRI CREATERCY)	NDHH	CRES PROTESPERIOR DEAD DEAD
(V 331)	a concern with the te interview revenled to in that refrigerator, th 50s."	mpetature rendings. The Verythre we put hot distans a tempetature goes in the	{V 381}			ettranges du
(V 340)	Obizzizo (n. 1210) aware of the elevate reprocessing storage revealed that the ob the elevated terrepor	ER GERM=90%	{V 340}	·		
	conclosit caps disiniti applicable, the har the germicide solution the harmodistyzer is concentration. The parts of chemicide and the disinfected and the disinfected caps. The with dilute bleach, we desired the heart germicide approved that does not advertidallyzer.	redisiyaer shall be tilled with en until the concentration in at least 90% of the prescribed ally distributed distrans shall hen capped with new or e caps may be distributed lift the chemical used for policityaer, or with any other by the FDA as a distributant of the electrical and the materials of the not mel as evidenced by:		V340- The CSS in-serviced reuse teams policy 6-04-03 Cleaning and Disi of Reuse Supplies with emphasis need to fully immerse the caps be germicide surface level. Facility Administrator will monitor submease per policy for 7 days then owek for 2 weeks, then monthly of audits will be reviewed in Quantiprovement Management Mee (QIFMM) and addressed as need FA is responsible for ongoing or with POC.	nfection on the clow the ersion of nce a Results ality ings ssary.	10-15-10
	Hessed on facility pol scall interview, the fa scause that seuse di	icy review, observations and actity's review staff failed to alyzer cape ware cleaned and update immersion in a accomplish immersion in a				

PRINTED: 11/15/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DETICENCIES AND FLAN OF CORRECTION (XI) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: PLY MEATINE CHANGE PLACTION YSVIPLIE STAD (CX) COMPLETED A SULUNG R B. WING 342627 10/28/2018 HAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE SHARON AND T CHARLOTTE EAST DIALYSIS CHARLOTTE NO 28205 GUMBLIST STATEMENT OF DEPCIFICATES (EACH DEPCEMOY MIGH BEPTIFICADED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) CONTRACTION CONTRACTION PROVIDER'S PLAN OF CORRECTION REACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX TAG PRÉFIX CHOYS REFERENCED TO THE APPROPRIATE TAG DEFICIENCY (V 340) Continued From page 17 (V 340) V400-Physical Environment Members of the Governing Body (GB) The findings include: have met to review the Statement of Deficiencies (SOD) and formulate the following Plan of Correction (POC). The A neview of the facility's policy "Cleaning and standards under the Conditions of Disinfection of Reuse Supplies Policy* (origination Infection Control (V110); Physical data 08/2008) revealed "Reuse supplies will be. Environment (V400); and Governance cleaned and disinfected with a 1% persoalic acid (V750 that are not met as well as other zolution for a minimum of 30 minutes. Blood end standards, contain specifics of corrective dialysate port caps, burrier adapters, extension plans. The facility will ensure that the GB CE to boiled a 101 battelniaib ed fetum Bridget 10-22-10 provides oversight and has systems in minutes but no greater from 24 hours prior to place to see that the facility is equipped for Fire пвф. and maintained to provide a safe, system functional and comfortable environment Observation on 09/22/2010 at 1006 in the facility's and an effective infection control program is in place. The facility has been reprocessing from revealed that reprocessing diligently working on correcting all the caps and port caps used for patient reprocessed issues cited since the survey. The fire dialyzors were placed in two 1% personic acid alarm has been installed as required. *In (germicide) solution biastic containers tocated in addition the physical plant issues will the designated dirty section for disinfection. The require more time as they are also observation revealed that the caps in both dependent upon permits and vendor containers of the disinfectant were not fully availability as well the fact that much of immerced below the disinfectant germicide the work will have to be completed during surface leval. The observation was during a time non-operational hours. These issues have when no staff was present in the reprocessing been evaluated by an architect and a plan to move forward is in place. Estimated anas. time frame to complete is 9-12 weeks. We request your consideration in these 12-31-10 An interview on 09/22/2010 at 1620 with the particular issues. for facility's rouse technician revealed that the additiona cont pg 19 ocintainears with the cape should have the cape l physical

FORM CASS-2567(02-99) Previous Versions Charlete

districtant ouriscs level. (V 400) 494.50 CFC-PHYSICAL ENVIRONMENT

fully below the level of the disinfection surface.

The interview revealed no reason as to why the caps in both containers were not below the

This CONDITION is not mot as evidenced by: Not reviewed applie on 10/28/2010.

EVAN (EVAN) 117

Facility FD: DO1554

(V 400)

If continuation street Page 16 of 14

plant

		ND HUMAN SERVICES				FORM A	PPROVED		
STATEMENT (ENTERS FOR MEDICARE A MEDICAD SERVICES (AN PROVIDENCIPALENCIA D PLAN OF CORRECTION (PENTIFICATION MARKER)		OCT MUL		CONSTRUCTION	DON DATE SURVI COMPLETED	CY		
		342621	n. wuxa			R : 10/28/2010			
	Ovider or supplier The East Dialysis	The state of the s	18	BTARET ADRESS, CITY, STATE, 20 CODE 1204 SHAROM ASSITY					
LITHERLY I	IN SPEAK INDICE (A)4	and the second s		GH	IARLOTTE, NC 28205				
PH) ID PREFIX TAG	(EACH DEFICIENC	tac identilars bloshyllow A protess blayt The identilars bloshyllow	Prefix Tag	4	Providens PLANOF CORRECTI CROSS-REFERENCED TO THE APPRO DEVICENCY DEVICENCY	TO BE	completion Bate		
{v 400}	Based on observations Shiety Report of a completed Opisuzer observations, refriger and staff interviews, facility failed to main that decreased the pand safety of pations facility failed to have the building into two compartments for a 7600 equare feel in emergency battery of the na-use norm water feel in emergency battery of the na-use norm water drills at unexperconditions each quanter staff on an effective emerge facility a patients, at the strong a patients, and refrigerator temper teached a provint in the facility farm of the health a victions at the distributions	the sa referenced in the Life complaint investigation 10, facility policy review, rator temperature log review it was determined that the state a physical environment to consultal risks to the health obtential risks to the health sociential risks to the health sociential risks to the health occurrence and state. The separation and the separation facility that is approximately size, failed to ensure that an operation, failed to held cled times under varying uter in phace of only the first arrival, failed to censure and contains under the phace of only in the service of the one fire exit. I taked to monitor and maintain names to which potential stored reprocessed (reuse) underweath of pellents, staff and its safety of pellents, staff and its facility.	{V 40	(100)	V400 cont. Upon inspection, it was determined that this refrigerator wat to maintain temperature within accommendation of the problem of the	ptable ten coceptable criviced ceuse of cristorage med and actions ge. Proper there to be try iew the log ch shift x3 complished regoing riewed in at Meetings sary. FA is the try complished ed partitions the attached and actions the attached at key med da key med de trior wall, ssage latch the, and Closer d light was by an outside aomitored to	\$12-31-10 for additional physical plant wo		

		NEDICAID SERVICES					APPROVED _0938-0391_
diale described	F DESCRIBACIES	DAI) PROVIDENCIA DENTIFICATION NUMBER:	V-871871 0X51 NK1		CONSTRUCTION	OC) DATE SUR COMPLETE	VEY D
		342577	B. WING	;		10/2	{ 5/2010
NAME OF PA	DVIDER OR BUPPLIER		1	STRE	et address, city, state, zip code		
CHARLOT	TE EAST DIALYSIA				h sharon arity Iarlotte, no 28206		
exay id Prefix Tag	(BACH DEFICIENC	reo identibano angorayatoyi A mara be biscriped al lait Aturana or deliciencies	D PREFF TAG		PROVIDERS PLAN OF CORRECT CROSS-REFERENCED TO THE APPEC CROSS-REFERENCED TO THE APPEC CROSS-REFERENCED TO THE APPEC	JD 82	Drite constitue DIE
{V 400}	remove storage in the next to the tobby at the next to the tobby at the next to the tobby at the next to the tobby at the next to the tobby at the next to the tobby at the next to the ne	ter in place of only ter fine tritis; and failed to te front corridor of the facility the side exit door. SO(e)(1) Physical fely and the Sariety Code- te eneure an effective on route for the facility's solice to include an alternative solice to include an alternative solice to include an alternative solice the patient beatment the crue fine exit passageway special. SO(d) Physical Environment - to monitor and maintain tures to infinit potential tored reused distyzers. SO(b) Physical Environment - PMENT MUFACTURER'S DFU must insplement and maintain and, dishysis machines and water beatment system) are water beatment system) are water beatment system) are water beatment system) are water beatment system) are	(V.	. 403}	V400 cont. *The current Patient Station #7 wil relocated. A minimum 5-0" portio Treatment Chase will be demolished provide a clear path to a New 3'-0" Door with Panie Hardware. A min 5-0" ADA Accessible Sidewalk with stalled to connect this new door existing parking area. After install emergency evacuation plan will be reflect the exit routes. Fire drill was conducted on 10/1/2 will be conducted quarterly at the times by the Facility Administrate designee. These fire drills will be and evaluated in QIFMM. Storage items have been removed corridor and relocated to the reco area as of 09/30/10. Route will be daily for 7 days then weekly for 7 monthly for 3 months by Facility Administrator or designee. The Governing Body will meet not ensure compliance with POC. compliance to the POC will be reduring monthly QA meetings and the Governing Body no less than annually. The Facility administrate representing the GB will be responsible to the POC.	n of the ed to Exit Only immum ill be to the ed the e updated to 2010 and expected or or documented from the rds storage e monitored 2 weeks then nonthly x 3 Further exiewed d reported to esemi-ator (FA) onsible for	09/30/10.
	This STANDARD Not reviewed one in	not met as evidenced by: an 10/26/2010,					

CENTER!		DD HUMAN SERVICES MEDICAID SERVICES ONI) PROVIDENSUPPLIENCUA INSHMINICATION NUMBER:	,	CJL'11PI	LE CONSTRUCTION	OMB NO. ((XE) DATE SLEW! COMPLETED	A38-0381 A38-0381 ABBONED
		342827	p. 1400	n, who		10/26/20	
	OMDER OR BUPPLER TE EAST DIALYSIS		•	2	ret acorese, city, state, 2P code 201 shirich aritt Harlotte, NC 28205		
CACIA BESELN EVIL	IEACH CEFICIENC	FOS IOEMILAARSINLOSINVIIOSE U. MTRI ER MACCENEO EA MITT VICHTHILOL DELKIENCIES	PRE TA	FX	PROVIDERS PLANCE ODRIGGT (EACH CORRECTIVE ACTION SHOU CREES REPERSION OF THE APPRE COMMISSION OF THE APPRE	TORE	(PA) (KCHTMLPHA) TARD
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NO PLAN OF C	CERCOTION	IDENTIFICATION NUMBER:	A. BUR	DING.		i		
			B.Win	IF		,	R	
	A CONTRACTOR OF THE CONTRACTOR	347627				28/2010		
NAME OF PRO	WOER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
milla Fill origin	TE EAST DIALYSIS		i		SHARON ABETT			
GRANGO	IE EWOI PHYTIAID			CHA	RLOTTE, NC 28205		- Andrew Barbara	
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		-	A	403)				
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	th beloaver 0 h05/80	rat the lacility's retrigerator	1.	1	•			
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	revealed that the st	affired documented	1	1				
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	dedres F. On 09/	07/2010 the range of the	1		•			
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į	F. Review of the to	g for 09/22/2010 (data of	ļ	ł	•			
İ	constration) rever	ded that the temperature	1	- 1			1	
	reading was docu	nented as 30-48 degrees F.					.	
	1	annumede at ensure with the						
(An Interview on Ca	1/22/2010 at 1350 with the	1				1	
	ISCHIV BOMINETER	or revealed that the m retrigenetors should be	1					
	CHICKLES OF A	isy and that the exact						
1	temperature atos	ld be documented. The					Į	
İ	Interview piso rev	ealed that the rouse sicrage						
1	refrigerator should	i not be prester from 50 dégrées						
1	F. The Interview I	urther revealed that the log used						
1	by the staff was n	arolarapida tol esu tol meen	-					
1	containing medica	ations, and that the limits on the						
	log were set for n	radication storage, instand of					1	
.1		est degree of 50 F.		(V 408)	1)	
[V 40	8) 494,60(d) PE-EM	EKGENCY		(A GOO)				
1	PREPAREDNES	S-PROCEDURES						
i	The of the fact	ly must implement processes						
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CHARLO)	te east dialysis		4 - 6 - 10 - 10 - 10 - 10 - 10 - 10 - 10		CHA	SOLOTTE, NG 28205	and the second s	andayaya — y widolicaticalaya
QI GK) XI ZARY DAT	FACH DEFICIENC	rec idente and incommulation A wrel be disceded ba ent Venent of dispublicies		PREFIX TAG		CHOSS-HSESSION OF CONSECT CEACH CORRECTIVE ACTION SHOW PROMODERS IN AN OF CONSECT	TD 95	SYNE SCHAFELEN SON
(V 405)	and procedures to magandes the health of talety the public. These en not limited to, fire, et care-reliend energy interruption, and nat in the facility's geogram of the color of the color of the color of the color of the facility's patients, and staff interview, effective energency facility's patients, at alternative fire exit treatment area in the passage way was be the facility's patient in facility had a to for hemodialysis static four (4) walls of the execution of the evacuation of the evacuation father than patient in a door with a fine facility's lobby great passayation further patient further to a door with a fine passayation further passayation further passayation further to a stary attention further than the passayation of the passayation further than the passayation of the passayation further than the passayation of	angue medical and non a that are likely to threaten of the patients, the staff, or the patients include, but are uniquest or power failures, water supply und disasters likely to occur applic area. Incument or power failures, water supply und disasters likely to occur applic area. Incument as evidenced by: on 10/26/2010. The safety reports revisite facility fails to ensure a macro the facility fails route for the ensure and and visitors to include a patient of the patient of the overlie for an inside the patient of the count of th	ir ad at tract and a land at the state of th	₹V 4H		V408-*The current Patient Station relocated. A minimum 5'-0" portion freatment Chase will be demolished provide a clear path to a New 3'-0". Door with Panie Hardware, A min 5'-0" ADA. Accessible Sidewalk winstalled to connect this new door existing parking area. After install emergency evacuation plan will be reflect the exit routes. * A copy of Certificate of Occupan requested from the city of Charlot architect and general contractor. Of forward any fire inspections will file in the facility. FA is responsiongoing compliance with POC. *The facility has been diligently correcting all the issues cited sin The fire system has been installed The physical plant issues will retime as they are also dependent and vendor availability as well if much of the work will have to be during non-operational hours. Thave been evaluated by an archito move forward is in place. Es frame to complete is 9-12 week your consideration in these part	n of the ed to be exit Only imum ill be to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to the ed the to t	*12-31-10 for additional physical plant work
	in the patient treet	ment eres. Observation one (1) exit routs/ogress					is also a product that the control of the control o	

D	EPARTME	INT OF HEALTH A	ID HUMAN BERVICES			•	FORM AF OMB NO. O	
<u>C</u>	ENTERGI	OR MEDICARE &	VEDICAD SERVICES			popularitation and the state of	(X3) DATE SURVE	
ATS Qua	TEMENT OF CO	PERICIENCIES PROFECTION	(X1) PROMIEROGUPPLIERICLIA IDENTIFICATION (MIMPER)		LDINIR LDINIR	IN CONSTANCTION	COMPLETED	
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		Continued From pag		٧.	406)	V417-		
	1.	menseq ern ni pensixt Nata hoc sevilak	i trealment area for patients, other doors or exits were	1		1		1
		observed in the path	औं एक सोगान्त्रने केंग्रेस.			1. The fire system has been install	ed as	.
1		An Interview on 09/2	2/2010 at 1110 with the			required. 2. The Server Room's Plywood w	ll be	
	1.	facility's registered r	treatise in the pation freetiment	1		manued The currently non-rated	Walls will	1
			not the there was only one			be upgraded to Minimum 1 Hour Partitions, in accordance with the	Fire Rated	
		MEN OUT OF THE DESIGN	n trodineni alea et ihe N trodineni alea et ihe	}		Partitions, in accordance with the sketches. This will allow the 1 Ho	our Fire	
	1	racinly. The interview	i il thure wer a five, the city	1		Rating to run behind the plywood	finishing	1
ŀ	-	no et stock hillionit	portigh the that area (staff	1		material once reinstalled.	1	1
	}	Indicating by points	ig to the one exit) them." The	1		3 Since the Facility is approxima	ucly 7,600	1
1		Interview revealed !	hel the staff were trained in	1		sq. ft. in size, the required Smoke Compartmentalization will be ac	complished	
	i	fire drills to use the	one exit in the treatment grea	1		by extending the existing non-rat	ed continued	*10-22-10 for Fire
1	}	to everamine the part	iunts. The interview also	partitions to the Roof Deck, as indicat				system
1	}	revealed that the fa	at the facility administration did not the attached Sketches. This will provide the				provide the	3,3
1		instruct the staff wh	at to do if that one fire exit	1		minimum 1.140 S.F. in either co	mpartment	1
		rocia was blocked	with fire of other objects.			as well as the minimum exiting requirements. New 1 Hour Smo	ke/Fire	
-			of file marshall reports on	İ		Partition and 20 Minute Fire Ra will be installed at key locations	ted Doors	1
1			ed that no report could be	1		will be installed at key locations provide the needed pathway fro	m exterior	1
1		found at the facility	Where any the marafull or	1		wall to exterior wall. Each door	will also	
١		department for sale	was done at the facility to	-		include a passage latch system,	1 Hour Fire	
- 1		AAMAHIR NIR COL	id be produced by the facility	}		Rated Frame, and Closer device	١,	
ı		i di al taunaiori privi	Tre natety inspections were	1		 The Facility Bio Hazard Stornot self closing nor fire-rated. 	age room is	
- 1		conducted at the fa		.]		Bio Hazard Storage room will	ne senarated	
1						from the Corridor by upgrading	g and	
- 1		An interview on DB	12312010 at 1000 with the	- [extending the existing non-rate	d partition to	
- [facility administrate	or and regulatory staff revealed	- 1		the roof deck as a minimum I	Hour Fire	٠
- 1		that the recitiy cor	iki not find or produce a fire			Resistant assembly. The Door Bin Hazard Storage room and	between the	
- 1		marghall or local o	ounty/city raport for any past			Bio Hazard Storage room and will be upgraded to a minimur	n 45 min. rated	
- 1		inspection of my i	he facility's fire ealety. The that the facility should have			door with a minimum 1 hour F	tated Frame	
		MAN AN AND PINE	ethninistrative staff ware			and Closer devise.		
ı		unable to produce	this docriment dripal gies	1		cont pg 25	•	
ı		Britania es biogram	A district was a series of the			į.		
	(V 417)		TRE SAFETY-LIFE SAFETY	,	₹V 4°	173		
	ī.	1			water with	the second property of the second second second second second second second second second second second second		-,

DEPARTA	MENT OF HEALTH A REGIR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES	*****		di-q-	ONB NO.	PPROVED
ETATERHINT O	F DEFICIENCES CORRECTION	DENTIFICATION HUMBER:	A BIR		CONSTRUCTION	ESTANCE STRUCT (EXT)	
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	OVIDER OR GUPPLIER			330	et andrebb, city, staye, eip code 4 Ghardh amity		
CHARLOT	TE EAST DIALYSIS	A. C. C. C. C. C. C. C. C. C. C. C. C. C.	CHARLOTTE, NC 28205				
UR (AX) XPENY EAT		nationent of Denciències Il trop de Preceded Ballit Rec'identialno inacempaioni	PRES TA	₹X	PROVIDERS PLANOF CORRECT (CACH GORRECTIVE ACTION SHOR CROSS-REFERENCED TO THE APPR DOVICERNOY)	11.30 1022	DESE CONTRIBUÇA TOB
{V 417}	(1) Except as provised in a provised in the property with a 2009 existen of the National Fire Protein corporated by reliable that standard in the standard. This STANDARD Not reviewed ones between 8:30 AM noted: 1) The Server Rollstandard finish on the with the required area. 2) Facility is appropriately a post following into two 3) The facility has self closing nor if the tendent in the required fine area. 4) The emergent reaction of the required in the required area. 5) The facility in a section outside.	ded in paragraph (e)(2) of this y e, 2009. The dialysis facility policiple provisions of the Life Safety Code of the Life Safety Code of the other Association (which is renormal §409.744 (a)(11)) of is not most as evidenced by: the on 10/28/2010. If not most as evidenced by: the on 10/28/2010. If not most as evidenced by: the on 10/28/2010. If not most as evidenced by: the on 10/28/2010. If not most as evidenced by: the on 10/28/2010. If not most as evidenced by: the line white which does not comply fire resistance rating for the oximately 78/00 ag. ft. In stee and shocke barrier separating the separate annote comparing out. If the Nexus Storage room is not	2	417)	V417 cont. 5. This emergency battery operate repaired and operation verified by vendor 10/07/10. This will be mo ensure it is in working order durin facility audits. 6. Fire drill was conducted on 10, will be conducted quarterly at un times by the Facility Administrat designee. These fire drills will be documented and evaluated in QI. 7. Storage items have been remet the corridor and relocated to the storage area as of 09/30/10. Roumonitored daily for 7 days then weeks then monthly for 3 month Administrator or designee. *The facility has been diligently correcting all the issues cited sissurvey. The fire alarm has been required. In addition the physic will require more time as they a dependent upon permits and ve availability as well the fact that work will have to be completed operational hours. These issue evaluated by an architect and a forward is in place. Estimated complete is 9-12 weeks. We reconsideration in these particulars.	an outside initioned to high mittered to high monthly (1/2010 and expected for or or or or or or or or or or or or o	*12-31-10 for additional physical plant work
{V 4	6) There is close looky to the side exit.	ge in the front corridor next to the exit door, partially blocking the R-RECEIVE SERVICES OC		[V46	a)	,	

DEPARTA	TENT OF HEALTH A	ND HUMAN SERVICES				PRINTED: FORM A OMB NO. (PPROVED
CENTERS FOR MEDICARE & MEDICAID BERVICES TATEMENT OF DEFICIENCES WID PLAN OF CONNECTION (X1) PROMIDERATION NUMBER:		(X1) PROMOGRASIA PLIENCLIA	IX2) MILTIPLE CONSTRUCTION A. RUADING		PATE SUPPLETED R		
		347477	B. VUNG 10/20/2			2040	
	MELTAID THAN Y	Appendix opposition on the second second second second second second second second second second second second		320	et address, city, state, zip code n shakon abity		
CI (PA) XTEMP DAT	BUMMARY &	TRO MENULA INCHANTION) N. HYRL RE HACODORD BY LEVIT VLEMENL DI. DEMOIENDIER	ID PRET	रूप्र.	ARLOTTE, NC 28208 PROVIDERS PLANTS CORRECT LEACH CONVECTOR ACTION SHOW ONDSS REPURENCED TO THE APPRO DEFICIENCY	PHATE LD RE LD RE	isis) Experiench Date
(V 463)	This STANDARD i Not reviewed quelts to reviewed quelts interdisciplinary to the patient interdisciplinary to the patient records (Partie include A review of the factor include A review of the factor include A review of the factor include and be completed by the term, including patient or the patient of the factor of the fa	response services cutimed in an executived in §494.90; and medies evidenced by on 10/28/2010. Ilicy review, clinical record view and similification facility's manual meeting involving a care for 2 of 7 sampled literit's. B. Why policy "Patient Plan of care will be facility's brender plan of care will be petient plan of care will be facility's brender plan of care will be facility's brender plan of care will be facility's brender plan of care will be facility's brender to presentative cam members including the cam members including the cam members including the cam members including the cam members including the cam members including the cam members including the cam members including the came of the open clinical travalled that an "Avunual grass scheduled for victor of the patient. A review of the patient was found in the facility's distilician signed.		4B3)	V463- Policy #1-01-07 Patient Assessment Plan of Care" was reviewed with interdisciplinary team (IT) with each to include the patient/padesignee in the development of it care unless the patient declines. It will be given a written and verbato the care plan meeting as care placeome due. Patients will be ask invitation and note if they will a patient declines the invitation the care a member of the IDT will not them and ask for their signature. If the patient refuses to sign, this noted in the record as well. FA will audit all plans of care compliance and then 10% of those quarterly. Results of audits will in Quality Improvement Manag Meetings (QIFMM) and addres necessary. FA is responsible for compliance with POC.	the mphasis on tient are plan of Each patient I invitation solans ed to sign ttend. If e plan of eview with on the plan s will be designee oleted x completed I be reviewed generat seed as	10-18-10
	but falled to obtai	position and dated it 03/03/2010 It patient signature that she id or not atland the meating. The					

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PRINTED: 11/15/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0838-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES! CONVIETED (X2) MULTIPLE CONSTRUCTION CXII PROVIDERSUFFUERCIJA STATEMENT OF DEPKLENCES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 人的此功的 R b. WING 107577010 342827 OTHERT AUDRESS, CITY, STATE, ZIP CODE HAVE OF PROVIDER OR SUPPLIES 220s BHAROH ABSTT CHARLOTTE, NO 28205 CHARLOTTE EAST DIALYBIS PROMDERS PLAN OF CORRECTION GACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DATE DATE DATE BURNARY STATISHENT OF DEVICTENCIES (EACH DEPICIPACY MIST BE PRETERED BY FULL REGULATORY OR LEC IDENTITY OF THE ORIGINATION) ID PREFIX (144) (1) (1747) (1747) (1747) (1747) (V 483) (V 483) Continued From page 28 epace was not completed and laft blank but the staff member (disticten) had signed the shall eignaturo wimasa saction. No documentation was found where the patient received individualized care and a chanca to participate in her plan of care meeting, An interview with patient #8 on D9/22/2010 at 1040 during the facility tour and observation revealed that the patient had not been invited by the factiny staff to her plan of care meetings. The interview revealed "I am usually told they . happened, but the staff does not really invite me to sitend. I would by to make it if possible. I namen's ajou the baber after the weeping happens." An interview with the facility administrator on 09/22/2010 at 1629 revealed that that this form should have indicated whether the petiant was ion blueds thate end that to no bhette at golog sign the form before the petient algred, and that The Required documentation for the patients are invited to the meetings and usually administration of PRN medication to sign the form. include the reason given and effectiveness 10-15-10 (V 502) 494.80(a)(1) PA-ASSESS CURRENT HEALTH of the medication was reviewed with (V 302) RN's. Facility Administrator will monitor STATUS/COMORBIDS documentation of PRN meds once a week The patient's comprehensive assessment must for 3 weeks then complete random audits quarterly. Results of audits will be include, but is not implied to, the following: reviewed in Quality Improvement Management Meetings (QIFMM) and (1) Evaluation of current health stakes and addressed as necessary. FA is responsible medical condition, including co-morbid conditions. for ongoing compliance with POC. This STANDARD is not met as evidenced by: Not reviewed posite on 10/26/2010.

Based on facility policy roview, clinical record

DEPARTM	ENT OF HEALTH A	ND HUMAN SERVICES		24.94		v approved 2. <u>9838-9391</u>
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(V 502)	ensure that register	erview, the facility falled to and nunses mel thu clinical v failing to document and	(v eos)			
	receiving PRN med The findings include	lication (Patients #1,2,3,4,6).				-
	for patient #1 raves admitted to the fac hemodialysis. A restract for 08/16/2 that the facility numerication to the documentation for and the resease offectiveness. The patient was administened most from medication 1400 with the fact the patient should fine nursing stell medication was a difficultient of the patient should fine nursing stell medication was a difficultient of the patient should fine nursing stell medication was a difficultient of the patient should fine nursing stell medication was a difficultient of the patient should fine nursing stell medication was a difficultient of the patient should fine nursing stell medication was a difficultient of the fact of the patient should fine nursing stell medication was a difficultient of the fact of					
	for patient #2 re- edinated to the f re-modialysis. A sheets for DH24 numing staff act the peaken with	9/23/2010 of the clinical record vealed that the pations was facility on 10/20/2008 for chronic review of the patient treatment V2010 revented that the facility ministered a PRN medication to out any documentation for the whiletened and the reassessment				

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[√ 502)	nursing staff adminitive patient without a reason with administration a revealed that on one was administration of the medication administration medication. 1400 with two facilities are patient should the nursing staff in edication was a effectiveness of the patient should the nursing staff in patient should the patient should the patient should the patient should the patient should the patient should the patient withe patient withe patient withe meach with shall	stered a PRN medication to any documentation for the flexibleness. The review (20)2010 at 1807 the patient he medication by mouth No an was found asystoling the cation and/or his effectiveness. An interview on 09/23/2010 at these had documentation from or the peakent that they had documentation from or the peakent that the PRN diministered and the semalication. 1/23/2010 of the clinical record eased that the patient was citify on 07/21/2009 for chronic eased that the patient headment to the peakent that facility inlatered a PRN medication to ut any documentation for the inlatered and the reseasement in affectiveness. The review 09/19/2010 at 1443 the patient distribution was found reparable edication) 2 milligrams by mouth estication and/or the effectiveness on An Interview on 09/23/2010 at 1410 at the medication that the PRN if for the reason that the PRN is combilatered and the	(V Si	M m (SC)	embers of the Governing Body et to review the Statement of De SOD) and formulate the followin ortection (POC). The standards conditions of Infection Control (hysical Environment (V400); as Sovernance (V750 that are not not the standards, contain specific corrective plans. The facility withe GB provides oversight and hyplace to see that the facility is emaintained to provide a safe, for comfortable environment and an infection control program is in Eliminated the use of a medication that the medication station has been designated clean area was creamedications in the treatment area of plan is in place to also install a barriers 12" in height will also around the medication prep and designate this space as a clear The Clinical Services Special serviced the teammates on po "Changing Transducers Prote 10/07/2010 with emphasis or change and inspect wet and/of contaminated external transch Administrator or designee we everyday for 3 days, weekly weeks, and then this will be monthly infection control and forward. The CSS in-serviced the test 1-04-08 "Utilizing Vascular and policy 1-05-01 "Infection in 10/10 emphasis on the need approand disinfecting of vascular and policy 1-05-01 "Infection control and the distance of the distance of vascular and policy 1-05-01 of vascular and disinfecting of vascular and policy 1-05-01 of vascular and policy 1-05-01 of vascular and policy 1-05-01 of vascula	included in the village of village of the village of the village of the village of the village of the village of the village of village of the village of village	licy ps"

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CHICANTER PROPERTY.	agricum operations.	A	A STATE OF THE PARTY OF THE PAR	1	RIBET	T ACOPRESS, CITY, STATE, 70F CODE		1
NAME	OF PRO	VIDER OR SUPPLIER		- 1	3:304	PARIA KISRAHA		. }
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n/A	210	SUBSARY B	INTEREST OF DETICIONERS	(D) FR革行	, İ	MARIE AND COMMENTAL AND AND AND AND AND AND AND AND AND AND	8131925 1	Prater Prace
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17	AG	REGULATORY ON	FPC IDEACH I MED NA ENANGIONS	1	- 1	DEFICIENCY)		
			- Committee of the Comm	1		V750 cont.Facility Administrator	or designee	1
N	685]	Continued From pag	je 30	1 to	686)	will monitor team everyday for 3	days.	
'"	,,,,,,	The shame night fo	- Parint filts dose not exceptionade	1			ed then this	
1		OLDA A PANISIATARI KI	urea, a licensed disculdu	1.	- 1	will be included in monthly infec	tion control	l
1	1	RUMB PLEASURE PROPERTY AND A PROPERT	I NIMBA WIND ITTERNI IND INGLAND	1	- 1	andit amon forward.	1	ļ
1		regularments in the	State in which he or she is	1	1	The CSS in-serviced the team on	the	1
Ì		emblokeg:	manufacture for formatter	1	1		ן מ	10-18-10
1		i en Haus al least 12	months experience in	1	1	dash grinning frash and engining frash	spicked up]	\$
1		moundation muraling it	ne edition 3 months of		1	from the floor. Facility Adminis	trator or	1
1		highlish wand	ding nursing care to pallents	1	1	designee will monitor team ever	yday 101 5	1
}		on malmonanco di	Ping		1	days, weekly on each shift x3 w	infection	. 1
1		I'm sterifetentiet and an		1		this will be included in monthly	писсион	
1				1		control audit going forward. Upon inspection, it was determined	ned that this	1
1		TWA STRINGARD	la not met de enigences py:			refrigerator was unable to main	tain	
]		Not reviewed anail	na on 10/26/2010.	1	•	temperature within acceptable	units. the	
1		Mart in transmission with	Set with this control of			refrigerator has been repl	aced and	} '
l		Dogget on tariffy to	olicy roview and staff interview.	1		Sad to be within acceptable	: limits as of	1 1
1		t trailet uttion and	resciencia a chalca filiso idi			background The CSS in-serviced	the team on	
l		ach shift during	romodialysis peatments.	1		policy 6-01-08 "Reuse Policy"	and reviewed	
1		Commercial desired by		1		refrigerator log with temp rang	es. Paper lower	1
- 1		The findings lack	der	1	•	dispenser at patient prep area i powered hands free style dispe	s a battery	{
		1		ı		dispenser was found to be ino	nerative.	1
1		A review of the fa	cility policy "Tearnmate			Replaced batteries and verifie	operation.	
1		Occasionations, Lie	rengura and Adaquala	1		Taken A Aministrator or dest	mee will	
}		Toumparia Staffa	no" (myleion date of 12/2000)	}			lays, weekly on	
ł		revealed Charge	Nurse Standards: The charge	1		med then a seems which are and then	ibis will de	*10-22-10
		nurse responsibil	B for each shift will be a	- 1		included in monthly infection	control audit	for Fire
1		Ashin Farefulan	ficensed practical	- 1		going forward	ma naishmuu wta	System
- 1		BROHESAMANA	nurse who meets the ordunes	- 1		*The facility has been diliger correcting all the issues cited	my working on	,]
1		ni strementaper	oach State in which he or she is	1		The fire alarm has been insta	lled as required.	
1		employed."		1		ont pg 32		1
1		1		l		cont pg 52		Ì
1		An Interview on	09/22/2010 at 0900 with the	1			•	Į.
ł		ราคาสาราช เสริกาการ	APPLICATION BIST INVITED INCIDENT HOUSE					
1		not currently has	ve a designated charge nuite	١		1		!
I		during the herric	allalysis treatments. The interview	1				;
1		TRYBaled Vila ti	o hed have enough patients to	1		·		1
i		inave an establi	wheel charge muste. All of the staff					
- 1		knows we have	a nurse that can handle things	l		1		
1		qui of orky bus	on problems to."	Ì				l
- 1				1				

CDD JUNE

PRINTED: 14/16/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB HO, 0838-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XZ) DATE BURVEY DOS METABLE CONSTRUCTION DEHINGATION NUMBER: ETATEMENT OF DEFICIPACIES F BULDING R AND PLAN OF CORRECTION 10/26/2010 348627 STRUCT ADDRESS, CITY, STATE, ZIF CODE NAME OF PROVIDER OR SUPPLIER VIOLE SHARDH ABOUT CHARLOTTE NG 28208 CHARLOTTE EAST DIALYSIS PROVIDERS FLAVOR CORRECTION
PRACH CORRECTIVE ACTION SHOULD BE
OROEST RETERENCED TO THE APPROPRIATE PALE CONTINUES (XB) ENNIVALA ELYLERANI DE DEVICIENCED LECH DELCERKA, PITAL SE EKECEDEN BA EATT LECH VELORA DE TORONOMO DE LECHOLES LECH VELORA DE TORONOMO DE LECHOLES LECHOLES DE LEC PREFIX TAG (XA) ED PARPIX TAG DBYKHEKCY) V750 cont. *The physical plant issues will (V 888) require more time as they are also dependent Continued From page 31 (866 V) upon permits and vendor availability as well An interview on 09/22/2010 at 1300 with the facility administrator revealed that the facility does the fact that much of the work will have to be completed during non-operational hours. not have a official charge nurse but everyone These issues have been evaluated by an knows the runse role. The Interview revealed that architect and a plan to move forward is in cach whilt does not have any formal or assigned place. Estimated time frame to complete is 9-12 weeks. We request your consideration in charge nume. (V 760) 484 180 CFC-GOVERNANCE (V 760) these particular issues. *The Server Room's Plywood will be removed. The currently non-rated Walls will This CONDITION is not mad as evidenced by: *12-31-10 be upgraded to Minimum I Hour Fire Rated Not reviewed oneils on 10/26/2010. Partitions, in accordance with the attached lanoribbs sketches. This will allow the 1 Hour Fire Based on facility policy review, observations, physical Rating to run behind the plywood finishing refrigarator lamparature log review and stall plant work material once reinstalled. interviews, it was delongined that the facility's Since the Facility is approximately 7,600 sq. governing body lailed to provide oversight and ft. in size, the required Smoke have systems in place to ensure the facility Compartmentalization will be accomplished evitions as bankhulary ban betreamplem by extending the existing non-rated partitions infection control program; and falsed to ensure . to the Roof Deck, as indicated in the attached that the facility maintained a physical environment Sketches. This will provide the minimum that decreased the potential risk to the health and 1,140 S.F. in either compartment as well as the minimum exiting requirements. New 1 salely of patients, visitors and staff. The facility Hour Smoke/Fire Partition and 20 Minute falled to have a smoke barriar separating the Fire Rated Doors will be installed at key building into two separate amoke compartments locations in order to provide the needed for a facility that is approximately 7600 square pathway from exterior wall to exterior wall. feet in size; felled to have a hecondour storage Each door will also include a passage latch area that is 1 hour tire rated construction and system, 1 Hour Fire Rated Frame, and Closer aprinklated when storing twelve (12) cases of highly flammable material (Renally that is used nevice. The Facility Bio Hazard Storage room is not for disinfection of Malyzeral, failed to ensure that self closing nor fire-rated. The facilities Bio an emergency battery operated light inomics need Hazard Storage room will be separated from to the ra-tree room was in operation; failed to the Corridor by upgrading and extending the existing non-rated partition to the roof deck conduct fire drills at unexpected times under Asilying conditions each quarter in place of only as a minimum I Hour Fire Resistant assembly. The Door between the Bio Hazard insorvioling siell on the fire drills; falled to snaure an effective emergency avacuation route for the Storage room and the Corridor will be upgraded to a minimum 45 min. rated door tactilly's patients, staff and visitors to include an with a minimum I hour Rated Frame and atternative fire exit routs after the patient

tive and end to those out of the one fire exit

Closer devise.

cont pg 33

DEPARTM	ent of health ab	ID HUMAN SERVICES				PRINTED: 17 FORMAP OMB NO, DE	PROVED
CENTERS	FOR MEDICARE &	NEDICATO BERXICES	Tamas N	S TOLE :	COMPUTATION	(X3) DATE SLEVEY	•
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		342827			THE PARTY AND THE PARTY AND ADDRESS OF THE PAR	The second secon	1
was on the 10th	WIDER OR BUPPLICH			STREE	T ADDRESS, CITY, STATE, ZIP CODE		1
					A SHARON ANTT		1
OHERLOT	re Past Dialysis			CH	ARLOTTE, NG 28308	rainb)	CER
	2 VO2411/12	TATEMENT OF DEFICIENCIES	D		PROVIDERS PLAN OF CORRECTIVE ACTION SHOW		PARTE DATE
Dist 10		AVIANT DE PREIXONU DI FULL	PRE		CROSS-REFERENCED TO THOUGHT A	OPRIATE	V/A14
PREFIX	RECOULATORY OF	(TEC IDEHILE AND UNCOUNTION)	1 "	~ l	Distribate()		-
		to the state of th		- in	V750 cont This emergency batter	v operated	1
(V 750)	Continued From pa	as 82	∤ ₹V	760)	1) light was repaired and operation	verified by	1
In soot	Collithiciate a tenu les	fajled to monitor and maintain	1	-	an outside vendor 10/07/10. This	will be	1
1	DIDCKED DY ING. END	antes to luminit are many	1	1	monitored to ensure it is in work	ing order	
1.	remigerator temper	aloung tablacessed (tense)	1		design contribute facility audits.	· ·	10/07/10
1	pageuel down is	armen structul troca	1		the drill was conducted on 10/3	/2010 and	1
	dialyzete the cim	mativo affect of these	1		will be conducted quarterly at ur	expected	1
1	evicionic problems	resulted in the facility's	. [1 L. the Eartline Administra	tor or	
1	luspilish to sulfine :	ब्रिक कार्य व्यक्तियोग्डे ठडाडे कि सी	-		designee. These fire drills will b	e documented	-
1		nd the salety of staff said	1		I meduated in OIFMM.		
1	visitors.		- [O items have been remov	ed from the	
			١		corridor and relocated to the rec	ords storage	
	The findings inclu	des ·	1		area as of 09/30/10. Route will	De monitored	
			- 1		daily for 7 days then weekly for	F.Z WEEKS DEG	
]	A For findings C	rusing the Condillon for Infection	ļ		monthly for 3 months by Facili	ry	
	Control to be not	met, see V110 and its	1		Administrator or designee.		i
	egrapoiated tage.	Lablocatelud, and lalled to	- 1		Please review the attached MS	DS Sheet for	1
	commune theat a class	別 表现罗 机氯化 自会和沿班的战略 50	- 1		n Cachon 16 for Other	nformation.	09/30/10
1	Military transport	CLOSS-COURSELLE BRIDGE OF	- 1		- ATCD A Flammability Class	stheanon for	1
1	and referrishing	allog and for stell to the bare.	1		in a second of the second of t	htving as a low	{
	handle and slore	medications to be roministered	- 1		hazard in accordance with NP	FA 101 Section	İ
1	Alleh uhwallon os	to change and inspect	}		622.2.		1
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1	andornal transfer.	ust projectors, isned in allehia	1		Hazardous contents are descr	ibed as the	1
1	the could be read	iented standard mischon camul	}		c. Transac Contents include C	ecupancies	1,55
1	morphings by	TOBUILD SCRIDINGLE ETHIRCHE AND			assemption able limited are	handled of used	12-31-10
I	rameural of treat	from floors in the Daughi	- 4		or are stored under condition	e manne mpere minning	for addition
1	Landonskert WHEE.	REPORTED CHESTING DIV	}		possible release of flammable grain dust, wood flour, or ple	e vapois, mueic estic dust	physical
1	dialoguedan of w	おきにも いっぱん いっぱん こういん はんしゅうしん しゅうしょうしょう	1		grain dust, wood flour, or pro ahminum or magnesium dus	at or other	physical
1	handen at he store	MARKING PYCOCO SUBSECUTION WITH	-		explosives are produced; wh	ere hazardous	work
1	MINITE SANGEAU	mattern hermodialysis bestitetile.	1		STR 29Visofeve or evolosives are	manufactured,	1
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1	TON 1 Markettening	HOROGODA TO INTIDIA DECIDIO DE PORTOS DEPORTOS DE PORTOS	İ		flammable flyings; and other	r situations of	1
I	kafara taninisi	action, and legist to allenia him	1		similar hazards."		1.
j	mullante beed to	anny of DECEL DWGIE 6/4/19/18 or	ŀ		cont pg 34		1
	handwaahing s	links in the pallant treatment stea.	- 1				1
[1	494.30 infection Control	1				
1	Condition Te	- AUSU	ı		•		
- 1	1		}				1
	B. The facility	falled to maintain a physical					40000

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THERS	LANGUAGE DE	CAN BEVERRY PROPERTY CONTRACTOR	OCCI MULTIPLE	DOMETRUCTION	CONTRETED	i l
PLAN OF C	derection derection	IDENTIFICATION NUMBER:	Y BRITTING		R	1
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MF OF PRO	NDER OR BUPPLIER	, F.	STREE	HEHARCH ANITY		1
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HTMTOLL	e eval diversaiq		-dominant-purch	THE PARTY OF THE P	RECTION	COPTS-PILIDAN [X2]
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	the health and nafe could be health and nafe could be parating the bulk compartments for a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason and a reason a reaso	receased the potential risk to by of patients, visitors and indice to have a smoke barrier and interest and the months expressed to have a interest and to have a interest and to have a interest and to have a interest and the months at the interest when atomy twelve, where the material (Renation of delyzers); failed to respect to a delyzers; failed to respect to the sunexpected times as unexpected times as unexpected times under the sunexpected times under the sunexpected times under the sune of only on the first atom the facility next to the facility next to the sune from the facility next to such a sune from the facility next to such a sune from the facility next to the sune from the sune fire the sune first the one time and failed to monitor and maintain and failed to monitor and maintain in whose Physical Environment.	{V 750)	*The Storage Room is classiff Hazard area in accordance wi 6.2.2.2. Due to this, NFPA 10 will require this area as well: Closet to be upgraded to the Hour Fire Resistant Rating. I accomplished by upgrading the Non-Rated Partition and Dot the attached Sketches. The Governing Body will not compliance to the POC will during monthly QA meeting the Governing Body no less annually. The Facility and representing the GB will be ensuring implementation a compliance with this POC	th Section 1. Section 8.4.1 as the Janitor's Minimum 1. This will be the existing for according to the existence of the	*12-31-10 for additional physical plant work
	1				[FEF-0276-54 B]	on theolipega Si
	SUS-2007(00-90) PROVING V	Perce Perce State	IDENOMALIA P	LEGIN DE BUIEN	主 医学生对于 1000-0	ALT RESAULTS AND

P.38

DEPARTMI	ent of Health an For Medicahe & I	ID HUMAN SERVICES MEDICAID SERVICES			ONB NO.	VPPROVED 0938-0391
TATIONINT (P ND PLAN OF O	PACHONISAN	echtilicalicum uprocu. (x) ekomperspeciencia	CONTROLITE C A BUILDING B. WHB	ONETRUCTION OH - CHARLOTTE EAST DIALYEIS	DC3) DATE FURN COMPLETE R	
	h and the same of	192527		A DESCRIPTION OF THE PROPERTY	10/28	[2019
	PEAST DIALYSIS	•	1204	address, dity, etate, 2p code Sharch abity Rlotte, NG 20205		
CXA) BY PREFIX TAG	WANTED MEANS	Teo deligration description 3, Afret de l'excepto el latif Alenena de d'ellegenere	PAGETX TAG	CHOSS-HANGSHOED TO THE AFF (BACH CORRECTING ACTION BIK PROVIDENS PLAN OF ECCURACY PROVIDENS PLAN OF ECCURACY	MORE 1	DYLE CONNECTION EXP
(K 014)	416.44(b)(1) LIFE B	AFETY CODE STANDARD	(K 014)			
	Interior finish on Wal enclosed corridors, Chass A or B (officer 38,3.3.2, 39,3.3.2	is and ceilings of exts, and exit access furnishing are s Class A. B. O'C).			•	
{K 038	Bared on observation between 8:30 AM a noted. 1) In the server roo plywood, Fedility is compliance with Ni "Interior wall or oat sleawhere in the Classe C, shall be of from NFPA 255, Souriace Burning C Materials." 416,44(b)(1) LIFE Hazardous areas the building by fire traditions and with partitions and with partitions on with no automatic.	s not met as evidenced by: on on Thursday 2/30/10 and 11:00 AM the following was in the wells were covered with to insure that the wells are in PPA 401 Chapter "10.2.3.1 ling finish that is required code to be Class A, Class B, or tastelfied based on test results tapidad Method of Test of theractionistics of Building SAPETY CODE STANDARD taparated from other parts of e barriers have at least one hour ing or such areas are enclosed i doors and the area is provided expirited ayarem. High hazard d with both fire barriers and	{K (1229)			
lk as	Based on observ between 8:30 AA noted, 1) The facility ha and the doors at	the not met as evidenced by: allian on Thursday \$130/10 A end 11:00 AM the following was a ni Bio Hazard Storage Recent a not sell closing of the false. E SAFETY CODE STANDARD	{K 835	2)		

Any desidency statement shows with an assemble (7) denotes a desidency which the instantion may be executed from connecting providing it is determined that other properties and the properties of the properties

	DEFICIENCES	MEDICAID SERVICES (XI) PROVIDENSUPPLISHOUN BENTY RATION NUMBER	,		CONSTRUCTION	COMPLET	RVEY FED
åts Lathaud rol. r	containment lead		A PIM		64 - CHENTOLLE EVAL DISTAND	1	R
-		\$42827			- Martin Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria - Maria	1 1972	2010
	Mider or Buffler Fe hant dialysis			500	it addrees, city, etate, sip code 4 eharomassity Arlotte, No. 20205		
(X4) ID PREFIX TAG	ERCH DESIGNED	The destilation prouvelies? National de désignements Eviendes de désignements	PRED TA	u,	FRONDERS FLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-HEFERENCED TO THE APPROPRIEMENT)	AND BE	DELE OCESTEDON SOI
(K (132)	other, are provided	re 1 called remote from each for each floor or fire section of .4.1, 21.2.4,1, 7.5.1.4	8c	032)	- ppdistrette -		
(K 045)	Based on observed between 8:30 AM a holed. 1) There is storage jobby that exits to t 418:A4(b)(1) LIFE	SAFETY CODE STANDARD BLIGH IS provided in accordance	0	C ()48}			
įk dėc	Based on observa between 8:30 AM noted. 1) The battery option is re-use room. 416.44(b)(1) LIFE Fire drills are held varying conditions. The staff is familia.	is not met as avidenced by: tion on Thursday 9/30/10 and 11:00 AM the following was wated emergency lights located in did not operate when betted. SAFETY CODE STANDARD at unexpected times under in all least quarterly on each child. If with procedures and is sware of established routing.	1	K 050			
	Based on observe between 8:30 AN noted.	ts not mak as evidenced by: stion on Thursday 9/30/10 I and 11:00 AM the following was services the staff on tire drills					

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-	unexpected times un	8 2 of noting fire drills at der verying conditions, AFETY CODE STANDARD		050)			
the said	Ambutatory health of all the transfer having at the rating. Doors in entire positive latcher. Dos than 1% inch thick a squiyalant. Vision p fixed with place in the profit of the profit	are facilities are divided into compartments with stroke set 1 hour fire resistance she harriers are equipped with create constructed of not less which bonded core wood or enels are provided and are of led to 1,256 or inch per 20,3,7,2, 20,8,7,3, 21,3,7,1,		C			
	Based on observation to the color of the facility is apared the facility is apared the facility does	is not met as evidenced by: ion on Thursday \$30/10 and 11:00 AM the following was proximately 7600 eq. fi. is size a not have a emoke bander ding into two emoke		•			
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		·					
	Jakras (ta) Pravious Version	in Christia Evaix (D.	WHIZ		Scholin Colonia	# continuation	show Page 3

•		CENTERS F. MEDIC	CARE & MEDICATO SERVICES
DEPARTMENT OF HEALTH AND HUMA	N. VICES	TRANSMITTAL	(D - WB31 Facility ID: 001554
MEDICA	REMEDICALD CERTIFICATION TO BE COMPLETED BY THE STATE	SURVEY AGENCY	
PART I-	3. NAME AND ADDRESS OF FACILITY		4. TYPE OF ACTION: 2 (1.8)
JICAREMEDICAID PROVIDER NO	(L3) CHARLOTTE EAST DIALYSIS	•	1. Initial 2. Recertification 4. CHOW
(1.1) 342627	(LA) 3204 SHARON AMITY	(L6) 28205	3. Termination 4. CHOW 5. Valldation 6. Complaint
2.STATE VENDOR OR MEDICALD NO.	(L5) CHARLOTTE, NC	(L6) 28203	7. On-Site Visit 9. Other
(1.2)	7. PROVIDER/SUPPLIER CATEGORY	<u>09</u> (L7)	8. Full Survey After Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	OF ESRD	13 PTTP	
(L9) 10/01/2010 (L34)	01 Hospital 05 LAB 10 NF	14 CORF	FISCAL YEAR ENDING DATE (L35)
6. DATE OF SURVEY	63 SNE/SE/Distinct 07 X-Ray 11 IMR	15 ASC 16 HOSPICE	12/31
8. ACCREDITATION STATUS	04 SNF 08 OPT/SP 12 RHC	16 11031 1012	i
0 Unaccredited 1 TJC 2 AOA 3 Other			•
11, LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS	And/Or Approved Waivers O	fThe Following Requirements
	A. In Compliance With	Technical Personne	6. Scope of Services (-min)
From (a):	Program Requirements Compliance Based On:	3 24 Hour RN 4. 7-Day RN (Rural S	7. Medical Director NF) 8. Patient Room Size
To (b):	2 Agentable POC	4. 7-Day RN (Rulai S	9. Beds/Room
12. Total Facility Reds Hotrock (LI	· '		,
(L) (L)	7) X B. Nor in Compliance with Program Requirements and/or Applied Waivers	; * Code: B*	(L12)
13. Total Certified Beds Althori	Requirements barrets	15. FACILITY MEETS	
TO DREAUDOWN			(L15)
14. LTC CERTIFIED BED BREAKDOWN	ENF ICF IMR	1861 (e) (1) or 1861 (j) (1):	
18 SNF 18/19 SNF 19	3141		
7.40)	39) (L42) (L43)		
16 STATE SURVEY AGENCY REMARKS (IF A	PPLICABLE SHOW LTC CANCELLATION DATE		
The Attached Remarks		18. STATE SURVEY AGE	NCY APPROVAL Date.
	Date:	18. 31/12	h
17. SURVEYOR SIGNATURE	10/26/2010	1 Char C	mleix 11/0/000 11:
(Kolph Mas R)) — OR CINCI	E STAYE AGENCY
DIRECT TO	D BE COMPLETED BY HCFA REGION	AL OFFICE OR SUNGI	AD GIALD:
	20. COMPLIANCE WITH CIVE	21. 1. Statement of	f Financial Solvency(HCFA-2572) Control Interest Disclosure Start (HCFA-1513)
19. DETERMINATION OF ELIGIBILITY	RIGHTS ACT:	3. Both of the	Above.
X 1. Facility is Eligible to Participate			
2. Facility is not Eligible	(L21)		
	COYPLONI	26. TERMINATION A	CHON: (L30)
22. ORIGINAL DATE 23. LT	C AGREEMENT 24. LTC AGREEMENT	VOLUNTARY	00 <u>INVOLUNTARY</u>
OF PARTICIPATION BI	EGINNING DATE ENDING DATE	01-Merger, Closure	05-Fail to Meet Health Safety
01/30/2003		02-Dissatisfaction W/R	eimbursement 06-Fail to Meet Agreement
(I	41) (L25)	03-Risk of Involuntary T	ermination OTHER
(L24) 25. LTC EXTENSION DATE 27. A	LIERNATIVE SANCTIONS	04-Other Reason for Wit	hdrawal 07-Provider Status Change
25, LTC EXTENSION DATE	Suspension of Admissions (L44)		00-Active
d 557	Rescind Suspension Date:		
(L27) E	Rescind Suspension Date. (L45)		
		30. REMARKS	
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		
CO. ALLELIAN POPULA	00101	g 211	
	.28)	(1.311	
		DATE	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL	The same of the sa	ON APPROVAL
•	L32)	(L33) DETERMINAT	WAY I I ALL

DEPARTMENT OF HEALTH AND HUMAN TO VICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE ... EDICAID CERTIFICATION AND TRANSMI. .L PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility 110, 601554

ertification survey was conducted onsite September 22-October 1, 2010. As a result of the survey in conjunction with a Life Safety Code survey an immediate jeopardy C&T REMARKS - CMS 1539 FORM was indentified on October 1, 2010 at 1130. The II was no removed during the recertification survey Condition level deficiencies were identified in 494.180 Governance, 494,30 Infection Control and 494.60 Physician Environment, Standard level deficiencies were also identified in 494,40 Water and Dialysate Quality, 494.50 Reuse, 494,80 Patient Rights and 494,140 Personnel Qualifications. A plan of correction was requested

An onsite follow up was conducted at the facility October26, 2010. The State Agency recommended removal of the 11 at 1250 based on compliance with a fire alarm system in place. The CMS Dallas regional office was notified of the recommendation THe conditions in 494.30 Infection Control, 494.60 Physical Environment and 494.180 Governance were not recommended to be in compliance based on the plan of correction not completed during follow up survey(RM)

DEPARTMENT OF HEALTH	AND HUN. SERVICES						FORM OMB NO.	11/02/2010 APPROVED 0938-0391
CENTERS FOR MEDICARE	& MEDICAID OCITATION	(X2) MUL	TIPLE CC	NSTRUCT	ON		(X3) DATE SU COMPLE	JRVEY TED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD					1	R
APIL STAN OF CORRECTION		B. WING				••	10/2	6/2010
	342627		ATREET A	nneess. (CITY, STATE,	ZIP CODE		
NAME OF PROVIDER OR SUPPLIER	•		3204 S	HARON A	MITY			
CHARLOTTE EAST DIALYSIS	•	1	CHAR	LOTTE,	VC 28205	A= 0000TE	CTION	(X5)
(X4) ID ! SUMMARY ST PREFIX ! (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x :		'IDER'S PLAN CORRECTIVE EFERENCED DEFICI	TO THE API	ひひとひ ひた	COMPLETION DATE
{V 000} INITIAL COMMEN		\ \{\sum_{1}\}	00}					±
An onsite follow to October 26, 2010 recommended recompliance with CMS Dallas regirecommendation Infection Control and 494.180 Go to be in complia correction not confection (V 110) 494.30 CFC-INITATION This CONDITION A sufficient nursoap should be washing.	up was conducted at the facility The State Agency moval of the IJ at 1250 based or a fire alarm system in place. The onal office was notified of the The conditions in 494.30 494.60 Physical Environment overnance were not recommende nce based on the plan of ompleted during follow up survey FECTION CONTROL ON Is not met as evidenced by: IC-SINKS AVAILABLE mber of sinks with warm water ar e available to facilitate hand	d {V	110}					
{V 117} 494.30(a)(1)(AREA;NO CO	ARD is not met as evidenced by: i) IC-CLEAN/DIRTY;MED PREP DMMON CARTS	!	{V 117}	·				1
preparation, and unused should be clear where handled. Do clean supplitude that where the handled.	should be clearly designated for the handling and storage of medication supplies and equipment. Clean arearly separated from contaminate a used supplies and equipment are not handle and store medications in the same or an adjacent are used equipment or blood samples	reas ded		•				
When multi (including v	ple dose medication vials are use rials containing diluents), prepare OR PROVIDER/SUPPLIER REPRESENTATION	ed VE'S SIGN/	ATURE		TIT	LE		(AC) DAT

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 day other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 1 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 1 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. program participation.

						DICARE & MED	ICAID SERVICES	
ARTMENT OF HEALTH AN	D HUMAF	as aces		TONI AND	TRANSMITI		ID: WB31	
ARTMENT OF HEALITIE	MEDICAR	E/MEDICAID	ERTIFICA.	E STATE	D TRANSMITIAL SURVEY AGENCY		Facility ID: 001554	-
CARTO I	ARTI-TO	O BE COMPUE	IED DZ XXX			4. TYPE OF AC	CTION: 2 (L8)	
7 (19)		TOTAL OF STREET	RESS OF FACI	LALL		1. Initial	2. Recertification	
EDICARE/MEDICALD PROVIDER NO.	1	(L3) CHARLOTTE	EAST DIAGI	, DAD		3. Termination	R 4. CHOW	
342627	1	(L4) 3204 SHARON	AWILY		(L6) 28205	5. Validation 7. On-Site Vis	6. Complaint et 9. Other	
ALL VENDOR OR MEDICAID NO.		(L5) CHARLOTTE				1	-	
2)	wnormo	7. FROVIDER/SUF	PLIER CATEGO	ORY	<u>09</u> (L7)	8. Full Survey	y After Complaint	
FFECTIVE DATE CHANGE OF OWN	EKSDII	01 Hospital	OS HIHA	09 ESRD	13 PTP		TATIONNICE DATE: (L35)	
(اف)	- 720	02 SNE/NE/Docal	06 LAB	10 NF	14 CORF	FISCAL YEAR	ENDING DATE: (L35)	
DATE OF SURVEY 10/01/201		63 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	12/31	ι,	
ACCREDITATION STATUS:	(L10)	84 SNF	08 OPT/SP	12 RHC	16 HOSPICE			
Unaccredited 1 TIC 3 Other							•	
2 AOA		10.THE FACILITY	(IS CERTIFIED	AS:	And/Or Approved Waive	- Of The Following Re	ennicinents;	•
LTC PERIOD OF CERTIFICATION		A. In Complia	nce With		2. Technical Person	Americal D. SCOT	DE OT OCTATIONS THE	
From (a):		Program R	connements		3. 24 Hour RN	7. Med	tical Director	
		Compliant	Based On:		4. 7-Day RN (Ru	mai SNF) 8. Pari	ent Room Size	
	(L18)		Acceptable POC		5. Life Safety Co	ode9. Ber	ds/Room	
2 Total Facility Betts Stations 16	ν.			*	-	. (1.12)		٠
- Cata ulb	(L17)	X B. Not in Co	mpliance with Pro nents and/or App	lied Waivers:	* Code: B*	(1.12)		
3. Total Certified Deals Stations 16					15. FACILITY MEETS			
	NT.			-	•	a a	L15)	
4. LTC CERTIFIED BED BREAKDOW		nz ICF	IMR	. \	1861 (c) (1) or 1861 (j)) (1);	·	
18 SNF · 18/19 SNF	19 SN	IF ICE			,			
	•	~ 450	(L43	3)		•		
	(L39	(L42)	•	•				
(L37) (L38) 16. STATE SURVEY AGENCY REM A recertification survey was conducted was indentified on October 1, 201	(ARKS (IF AP) ucted onsite Se 0 at 1130. Th	PLICABLE SHOW L: eptember 22-October te IJ was no removed		CION DATE esult of the r rtification su ere also iden				II) i.30 ight
16. STATE SURVEY AGENCY REM A recertification survey was conducted was indentified on October 1, 201	(ARKS (IF AP) ucted onsite Se 0 at 1130. Th	PLICABLE SHOW L' epiember 22-October te IJ was no removed ament. Standard leve of correction was req	uested.	HON DATE esult of the s rtification su ere also iden		a Life Safety Code su ciencies were identifie I Dialysate Quality, 4 AGENCY APPROVA		IJ) i.30 ights
16. STATE SURVEY AGENCY REM A recertification survey was conducted was indentified on October 1, 201 Fection Confrol and 494.60 Phy 494.140 Personnel Qualificat	(ARKS (IF AP) noted onsite Se 0 at 1130. Th sician Enviror tions. A plan c	PLICABLE SHOW L: eptember 22-October te IJ was no removed	uested.					
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16. STATE SURVEY AGENCY REM A recertification survey was conditived on October 1, 201 Fection Confrol and 494.60 Phy 494.140 Personnel Qualificat 17. SURVEYOR SIGNATURE PAR 19. DETERMINATION OF ELIGIP X 1. Facility is Eligible to 2. Facility is not Eligib 22. ORIGINAL DATE OF PARTICIPATION 01/30/2003	ARKS (IF AP) noted onsite Se 0 at 1130. The sician Environ itons. A plan of RT II - TO SHATY Participate le 23. LTC BEG	PLICABLE SHOW L' eptember 22-October le IJ was no removed ment. Standard leve of correction was req Da BE COMPLETE 20. (L21) AGREEMENT EINNING DATE	10/11/2010 ED BY HCFA COMPLIANCE RIGHTS ACT: 24. LTC A ENDE	(LI) A REGIO WITH CIVI GREEMENT	NAL OFFICE OR SI 21. 1. Statem 2. Owner 3. Both of 26. TERMINATIO VOLUNTARY 01-Merger, Closure 02-Dissatisfaction V 03-Risk of Involuntary	NGLE STATE A Lent of Financial Solveno Inchip/Control Interest Dis of the Above: ON ACTION: 00 W/ Reimbursement any Terministion	GENCY y (HCFA-2572) glosure Stmt (HCFA-1513) (L30) NVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement	(L)
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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

blid. Along burden for this collection of information is estimated to average 10 minutes intraining data needed, and completing and reviewing the collection of information. Send aggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box and a gent at Machington D.C. 20503.	per response, including time for d comments regarding this burds	r reviewing instructions, searching ex on estimate or any other aspect of this or to the Office of Management and	isting data sources, gathering and collection of information, including Budget, Paperwork Reduction
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oject(0838-0583), Washington, D.C. 20500		_
Provider/Supplier Number	Provider/Supplier Name CHARLOTTE EAST DIALYSIS	
Type of Survey (select all that apply)	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanctions/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life Safety Code L CHOW M Other	
Extent of Survey (select all that apply)	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey	

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

		Please	enter the worklo	d mformation for			lentification number On-Site	Travel	Off-Site Report
Surveyor D	D Number (A)	First Date Annived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	Hours 6pm-12am (G)	Hours (H)	Preparation Hours (I)
*		·			0.00	1.00	0.00	4.00	0.50
1.	14819	09/22/2010	10/01/2010	0.50	0.00	19.00	0.00	13.00	10.50
2.	15546	09/22/2010	10/01/2010	1.00	0.00	4.00	0.00	1.50	0.50
3.	26594	09/22/2010	10/01/2010	0.50	0.00				
4.			· .						
5.	100000000000000000000000000000000000000		<u></u>						
6.				1	<u>· </u>				
7.									
8.									
9.									
10.									
11.									
12.									
13.	Special Commence of the Specia						Supervisory Rev	ion Hours	0.00

Total SA Supervisory Review Hours.....

1.00

Total SA Clerical/Data Entry Hours....

0.50

Total RO Clerical/Data Entry Hours.....

0,00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

FORM CMS-670 (12-91)

102000

EventID: WB3111

Facility ID: 001554

Page

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

blic 1007/orting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources. gathering and intraining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, intraining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, intraining and completing and reviewing the collection of information, Send comments regarding this burden estimate or any other aspect of this collection of information, intraining and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, and completing and reviewing the collection of information, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information.

duction Project(0838-0363), Washington	
rovider/Supplier Number	Provider/Supplier Name CHARLOTTE EAST DIALYSIS
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit E Initial Certification F Inspection of Care G Validation H Life Safety Code L CHOW Recertification J Sanctions/Hearing K State License L CHOW
Extent of Survey (select all that apply)	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

	Please	enter the worklos			On-Site	lentification numbe		Off-Site Report Preparation
Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	Hours 8am-6pm (F)	Hours 6pm-12am (G)	(H)	Hours (I)
					3.00	0.00	5.00	2.00
Team Leader ID 1. 15546	10/26/2010	10/26/2010	1.00	0.00	1.00	0.00	0.00	0.00
1. 15546 2. 13743	10/26/2010	10/26/2010	0.50	0.00	1.00			
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13.							Jun Tloure	
1.4.					Total RC	Supervisory Rev	new Hours	0.00

Total SA Supervisory Review Hours.....

1.00

Total SA Clerical/Data Entry Hours....

0.50

Total RO Clerical/Data Entry Hours.....

Facility ID: 001554

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

P.84

OCT-88-2010 15:01

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CHARLOTT	eelst dalybis		, iii	1		and be	COMPLETANT DATE	
(KO ID PREFIX TAG	EACH DEFICIE RECLATORY C	n pac becaus abyo ba cumalicas Una pedal es signedos ba blit Elanement de disables ba	PRE	FIK [PROMERS PLAN OF CONTROL (PACH CORRECTIVE ACTION SEC CHOSS HEFERSHIZED TO THE APP GEFCLERCH) VOOD-			
A 000	INITIAL COMMEN			V DOD	Members of the Governing Body to review the Statement of Defic and formulate the following Plan	n of Correction Conditions of	n f	
·	on September 22 During the survey on September for a lease young generated for a lease young facility folled to pattery powers of a first That is the facility falled to pattery powers of a first That is the facility falled to pattery powers of a first That is the facility falled to pattery powers of a first the first that is the facilities in the condition of the facilities of the facili	interior auvrey was conducted through October 1, 2010. Incough October 1, 2010. Incough were found in the and a complaint Inlead was life Sofiety Code aurrey. The most 50, 2010 from the Life way team feathed in an October 1, 1716 II was identified when the have a tree stant settled in an October 1, 1716 II was identified when the have a tree stant system or a staff and visites safely in the event of the feather of the fe	For the state of t	TURE	Infection Control (V110); Pays. (V400); and Governance (V750) as well as other standards, control corrective plans. The facility is the GB provides oversight and place to see that the facility is maintained to provide a safe, I comfortable environment and infection control program is in facility has been diligently we correcting all the issues cited. This report was received on I completion dates could be no 10-18-10. The fire system we of the survey. The installation is subject to the availability of working with the facility to An agreement is in place withinstall a smoke detection system that meets local code addition the physical plant is more time as they are also dead the survey of the work will thuring non-operational hou have been evaluated by an to move forward is in place frame to complete is 9-12-your consideration in these. The Governing Body will more often as required to with POC. Further complete reviewed during monte environmentation in the compliance with this POC.	that are not in aim specifics o ail ensure that has systems in equipped and metional and an effective splace. The observed in the survey of the vendor very of the vendor vendor very of the vendor very of the vendor very of the vendor vendor very of the vendor	day stem who is occss. or to larm inc inc a plan ime test aplan ime (x 3 or ance OC will ags and than ator (FA) a for	ANDARIA D-15-10
	Special and date of the	A many with an assarbit () denotes a defent a participant promotion in the politicity (fees hab- ney whether or not a pleas of connection is pro- tiness documents one mixes available to the los- thess documents.	ded, Po	Physical Control of the Control of t		o destapard	rankinustion sh	Ad Page 1 of M
	fundants bargetageur		EVALE	n terror	1 Feeling for building .	`	()	CT 18 20

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EPARTM	ent of Health an	ID HUMAN SERVICES				OVBNO	
ENTERS	FOR MEDICARE &	HEDICARI BERVICES	DOWN SEE	1417 d	CONSTRUCTION	CONTRACT SURVE	#
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d plan of s	KOTOBURG	EAST //	A.B.A	THAT	A section and the section of the sec	1	
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	Memorial de la company de la c	To story		4709	et mogresi, ent, ethie, do expa		1
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of his man			PA	-	VIGENA SA Isa na postaca sa na	TION	COMPLETION
0(4) (1)	s west & Prosperson	CA CATEL BY WERE GREEN BA LINT LYLINGHAL CA DRIKKEN COST	PRE		CHOIL APPORTUTE ACTION BY		DATE OF THE PARTY
PARAIX	REGILATORY CO	I PC INSHIBLIBIT BACKSTALOID	TA	3	DENCIENCY		
,,,,,				Attended	V110-		
U 15h	Continued From pa	pe 1	١,	110	Members of the Governing Body	(GB) bave	1
4 110	Linus Bornes avenu	aj transdiktar profectora; falisci	1		met to review the Statement of D	eficiencies	
	Hafa larif arcona At	indianantal alancer	1		(SOD) and formulate the following Correction (POC). The standards	ng riun oi Sunder the	
	I tutumbless employed the	sentina of Corner	1		Conditions of Infection Control (V110);	
	I am terror of stiffsts	FAMILIANO OF MEET FOUR	1.		Physical Environment (V400); at	nd Governance	
	floors in the potion	I Venerela erea, appropriata	1		(V750 that are not met as well as	other	
	closning and main	geting of vaccinist craube need	1		standards, contain specifics of co The facility will ensure that the C	inecuve plans. iB provides	
	to battery cosmission	t duing palent hamadalysis	1		oversight and has systems in pla	ce to see that	1
	I was a way of a sall and	ra araina irai cibrera (1886)			the facility is equipped and mair	tained to	1
	-K-1-YASH WASH BIT	sminish remoderated to import	1		provide a safe, functional and co	omfortable	1
	to and and the first to	BEATH PROTECTIONS STATE TO PROSE			environment. Eliminated the us medication cart and the medicat	e or a ion station has	
	किया विक्रिया क्षाप्रकार करें	fords had a stropty or paper			been relocated. A designated of	can area was	
· .	न सिर्वाधिकाल क्रांकारक	a princessorial suice in Da			created for medication prep on t	one of the island	1
1	pedant peaning	erga. The cumulative affect of	1		nurse stations in the treatment a	rea 09/29/10. A	<u>:</u> 1
1	these systems: P	the brospiou of drawn specifics uppour testified in the prophys			plan is place to install acparation height around the medication p	n dernets (2)! ren ares to	1
1	ilizoath a seasa	for distysh patients.			further designate this space as a	clean area.	
1	COMPL hunganan	and mindle on the control	- 1		Plexiglas barriers will be place	to prevent	
	The findings incl	udec	- 1		potential cross contamination.	at (CGE) in	1
	1		1		The Clinical Services Specialiserviced the teammates on poli	er (Cas) ne ev #1-03-11	
. [A. The facility fi	illed to ensure that a cican area	- 1		"Changing Transducers Protec	tors" on	10-15-10
	MSE GOS BUILDO	to prevent potential			10/07/2010 with emphasis on t	he need to	
1	CYOBS-CONTENTINE	ite" pauge and stole wagicanous			change and inspect wet and/or	blood	
1	TO PR SQUALIFIED	sheita de la company	- 1		contaminated external transdu- Administrator or designee will	monitor team	1
1	l l				everyday for 3 days, weekly or	n each shift.3	1
	-Cross refer to	494.30(2)(1)() Infection Control •	1		weeks, and then this will be in	cluded in	
	Tag V0117		1		monthly infection control and	it going forward	
1	1	and branch to abandon and branch	1		The CSS in-serviced the team 1-04-08 "Utilizing Vascular A	nuics on poncy ceess Clamps**	
1	B. The facility a	tati faked to change and inspect odernal transducer protectors in 2	١		and policy 1-05-01 "infection	Control for	
1	conteminated t	Septicing mily and of proby radied	1		Triniveis Facilities" on 10/7/2	010 with	
į.	CI & Observed	LOST protectors.	- 1		emphasis on the need for app	ropriate cleanin	g
1	l l		Ì		and disinfecting of vascular c Administrator or designee wi	lamps, Facility	
1	-Cross refer to	494.30(8)(1)(I) Infaction Control •			Administrator or designed will everyday for 3 days, weekly	n monnor ream on each shift x3	
1	Teg V0120	•	1		weeks and then this will be i	ncluded in	1
1	1		1		monthly infection control au	lit going forwar	d.
1	C. The fecility	falled to ansare that obtil	- 1		cont pg 3		
1	betnemelded	elendard infection control	1				t epot made no

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PRINTED: 10000010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN GERVICES OVE NO CHEST CAN CENTERS FOR MEDICARE & NEDICARD SERVICES CONSTRUCTO (KZ) CRUS CHIPNEY DES EXEMPLE CONSTRUCTION OU PROMOENSUPATINGUA ETATEMENT OF DEPAREMENT OF r bydyng 4010112010 B, VANG 342837 STREET ADDRESS. CATY, STATE RIS COOK STON ENARON PERTY HAVE OF PROJUCES OR SUPPLIES CHARLOTTE Nº 22303 CHARLOYTH FAST DIALYSIS PROPAGERS PLAN OF CORRECTION EACH COPPRETIVE ACTION SHOULD SE CHOCK RIF STANKER TO THE APPROVINGE STREAMS REVIEWED IN DATE OF CHILD BY LIST CYCH DENCINED MYDI EN DATE OF THE STREAM STREAMS REVIEWED IN DATE OF THE STREAM STREAMS REVIEWED IN DATE OF THE STREAM STREAMS REVIEWED IN THE STREAM OF THE PENX YAG DEFXEE STY TAR V110 cont. The CSS in-serviced the team on V.1101 the importance of maintaining a clean Continued From page 2 V 110 buscerupous ph cleaning admixment analysisa migh environment and ensuring trash is picked up from the floor. Facility Administrator or nedeed out his aroog most thesis to levolusi designee will monitor team everyday for 3 प्रकारी भारत क्षेत्रकानामा द्रवस्तामा स्त्र days, weekly on each shift x3 weeks, and then dalujering of vescriat damps freed in ballant this will be included in monthly infection trestments and cleaning blood stains from work control audit going forward. surfaces during patient hamodistysis treatments. Upon inspection, it was determined that this refrigerator was unable to maintain -Cross refer to 494.30(a)(4)(ii) Infection Control temperature within acceptable limits. The reuse refrigerator has been replaced and Ted V0122 verified to be within acceptable limits as pf D. The facility falled to ensure that patient used 09/29/10. The CSS in-serviced the team on distyrers were adequately rehitpateted to inhibit policy 6-01-08 "Reuse Policy" and reviewed refrigerator log with temp ranges. Paper towel pactarial Growth before reprocessivity. dispenser at patient prep area is a battery 10-18-10 powered hands free style dispenser. The -Cross refer to 494.50(b)(1) Rouse of dispenser was found to be inoperative. Hemodistyzers and Bloodines - Tag V0331 Replaced batteries and verified operation 10/14/10. E. The facility falled to monitor and maintain Facility Administrator or designee will refrigerator temperatures to inhibit potential monitor team everyday for 3 days, weekly on pacterial growth in stored reprocessed (nesse) each shift x 3 weeks and then this will be included in monthly infection control audit distrects. going forward. Results of audits will be -Cross refer to 494.60(b) Physical Environmentreviewed in Quality Improvement Management Meetings (QIFMM) and Teg V0403 addressed as necessary. FA is responsible for ongoing compliance with POC. F. The lackly falled to ensure that patients had a The Governing Body will meet monthly x 3 embbly of babet paners excepted at Indicate such to ensure compliance with POC. Further siples in the patient treatment area, compliance to the POC will be reviewed during monthly QA meetings and reported to -Cross refer to 484.30(a)(1) Infection Control the Governing Body no less than semiannually. The Facility administrator (FA) Yag VO114. ADA SO(a)(1)(0) IC-SINKE AVAILABLE representing the GB will be responsible for V 114 ensuring implementation and ongoing A sufficient number of sixty with warm water and compliance with this POC. soup should be available to facilities hand Missplading. This STANDARD is not met as avidenced by: Househouseon sheet Page 3 of 34 Facilities solded Every ED; (North

P.87

FORM APPROVED ONB NO 0808-0381 DEPARTMENT OF HEALTH AND HUMAN SERVICES MAI DATE WHYEY CENTERS FOR MEDICARE & MEDICARD SERVICES DOS HALTIPLE CONSTRUCTION INI) PROVIDENTA PLEAKLIA STATEMENT OF DEPONDENCES NATI PLAN OF CORRECTION e bulding 10/01/2019 343537 STREET ADDRESS, CITY, STATE, ZP CODE YTELR HORAKS MELL HAME OF PROVIDER OR EXPRISE CHANG DITTE, HE YEARS DELYERS IN THE COUNTRY OF THE WOOD BE CHARLES WITH THE WOOD BY THE CHARLOTYE EAST DIALYSIS PROFIES TAGE BENTATURE STATEMENT OF DEPICIENCES

BENTATURE STATEMENT OF DEPICIENCES 0(4)(0 PREFIX TAGE Paper towels in the dispenser were replaced Continued From page 3 and threaded properly. Paper towel dispenser Based on facility posicy traviary, odercive long and at patient prep area is a battery powered staff interview, the receity taked to minute that hands free style dispenser. The dispenser was bagauta used a aribbly of brains, romess sanitages of 10/18/10. found to be inoperative. Replaced batteries handwathing tinks in the patient became these and verified operation 10/14/10. Facility Administrator or designee will monitor team everyday for 3 days, weekly on each shift x 3 The findings localists: weeks, and then this will be included in A raview of the facility's posicy "Intection Control monthly infection control audit going for Dialysia Facilities" (1949) in date 03/2010) forward, Results of audits will be reviewed in revealed The facility should have a sink available Quality Improvement Management Meetings (QIFMM) and addressed as necessary. FA is for balleting to many plan encess sters bais, to responsible for ongoing compliance with treatment and their hands shar treatment. Scap and a erobly of baltes toware businesses stow contamination must be everage at each with Observation on 09/20/2010 at 1300 in the patient treatment area revealed that a paper lovel dispenser located for the patients to wash their social sites of the east was held no translation paper towels for use after handwasting. The Openiangou is needed that the becom powers multilocated in a machine with a sensor to depense the foreign Viller meeting parties were opposeded by a pallant and auryayor, I was noted that the sensor was not working and no paper towals ware available. An inderview with the facility's regulated that to draws are openiation on the 127 11 of 1300 levianisch nier has backer towal cyabalism was inch Modeled . The publisher lowes and their babel tower would have to be obtained in a different facilion unti the censor was fixed. V 117 494.90(e)(1)(i) IC.CLEAN/TARTY; MED PREP AREA; HO COMMON CARTS Clean speak should be deany designated for the preparation, harding and storage of medications and unused supplies and equipment. Clean areas A Bouth Agen spent bede 4 of 24 PRODRY NO. DONESSA EMMIN HOMIL POPUL CLUB (2007 (GL-94) Provious Versions Obsolvin

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PRINTED: 10082010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CATE NO. DESE-CIRI CENTERS FOR MEDICARE & MEDICARD SERVICES US) DATE SURVEY PER BULLIFAL CONSTRUCTION (XI) PROVIDENCIA (IX) P BIATEMENT OF DEPICIENCIES A SUILORG PART BY CHI OF CORRECTION 100110010 DAW, F 342527 ETHEST ADDRESS. CITY, STATE, PA CODE huli of producer or experien SIDA BIARON ASSTY CHARLOTTE HE SEALE CHARLOTTE BAST DIALYSIS PROVIDERS PLAN OF CONTECTION (FACH CONTECTION AND AND DE CROSS-FORMERICE TO THE APPROPRIATE DESCRIPCION) ecapitatica ecapitatica exte BUDBLERY STATEMENT OF DESCRIPTIONS
RECULATION CRUES DESCRIPTIFIE DE ORMATIONO
RECULATIONS CRUES DESCRIPTIFIE DE ORMATIONO HEN peg (d) Friedrix Tag TAG V 117 Continued From page 5 V 117 peabnent area revealed that a medicalion car Med with medications and other unused supplies stong with sydness was located directly beside heav of alnester yet bean kins goldscrebhard act their seconds tiles. The sink was designated for patient hand washing and had a sign gial was willen as 'Patenia musi wash करवार केरिक" कार्य located at the base of the sink. The observation further revealed that no splesh punit of bearies was noted to prevent water splantes on the medications and supples. An interview on 09/22/2010 at 1000 with the feolity's numerical staff reversied that the patient Madications and tenned supplies are stored on the cart was kept beside the handweeling sink. The interview revealed that the stuff has studys kept the medications and supplies in the location due to back of space. The interview elso confirmed that the supplies and medicalizate can get wet from petitaria and staff weating hands. The interview revealed that the stall had not considered the potential contamination of the medications or supplies. William Aith are laight squipletising ou 09/22/2010 at 1240 neves led that the explain and medications should be prevented from being wet or contaminated from people washing their hands at the nearby sink. 2. A review of the facility's policy "intection Control for Dialysis Facilities" (revision date 03/2010) revealed "Clean sense should be designated for the preparation, handling, and storage of medications and unused expoles and equipment Closm smas should be deady separated from conteminated areas whom supplies and oculoment are handled."

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PRINTED: 10/08/2010 FORM APPROVED CALB NO. DESH-0381 DEPARTMENT OF HEALTH AND HUMAN SERVICES DENTERS FOR HEDICARE & HEDICARD SERVICES COMPLEMENT COMPLEMENT DESCRIPTION OF CHARACTERS OF THE PARTY OF TH ku) Mondenhali Begy PARTEMENT OF DEPICIONOUS A BRIDGES ... 10101/2010 a wing HMI ETHERT ADDRESS ONY, BYATE, JIP COCK HAVE OF PROVIDER OR SUPPLIED FOUR BHANCON VIERLA CHARLOTTE, NG SERVE PROJECTS MAN OF CONJECTION (PACH CONJECTION ACTION SHOULD BE CHOSEN FEBRUARY) FOR APPROPRIATE CHOSEN FEBRUARY) CHARLOTTE EAST DIALYOR . KECTYLOUA OU FOR REALLAND MACHANICH EVYLOUALING ATRI SE LEGISION MAINT STRING SINCERNI ON DESCRICE AS PREFIX (XA) ID Presidik PAT V 198 Cominued From page 12 V 195 THE STANDARD IS TEXT THREE BY CHARGEST BY: Based on leavily policy review, the fertily's total chloring treting log raview and staff interview, in facility failed to ensure regularly performed beauting to manifest the total childrens in its water system used in parent transchilysis and inied to provide color blininess leaving in 2 of 4 sumpled staff The CSS in-serviced the teammates on the importance of completing the water system Usupers that that the tacald a major adeput for total chlorine monitoring every 4 hours per the presents of chicking (Start \$1,5)policy 2-07-04 "Daily Water Total Chlorine Monitoring" and documenting on the 10-18-10 The Indings include: appropriate log. FA/designee will be checked daily for 7 days then weekly on A review of the feesely's policy "Daily Water going. Color blindness testing was completed System Tetal Chlorine Mentoring (revision data on the 2 RN's cited and it was found that they C12010) Nashed Total Chicke Paing is done did have testing and results are in teammates on a duly basis paint to the first patient mademant files. Color blindness testing will be done on कार्य every form (4) hours until बी स्टोशीस्त्र पानी all new hires and annually there after. Facility Administrator will spot check 25% ledrice this of qishing dially mater our of teammates file monthly for 3 months and completed. annually there after. Results of audits will be A 1949w on 09/23/2010 of the facility's "Routine reviewed in Quality Improvement Management Meetings (QIFMM) and Total Chlorine Testing Log* for 02/15/2010 revealed that the facility shall falled to document addressed as necessary. FA is responsible for ongoing compliance with POC. Chloring being every 4 hours. The ravious revealed that for 02/15/2010, the focally start documented Chilprins testing at 0300, 0540, 1846 and 1740. The raview further revealed that the tacilly stall wrote a time of 0948 on the log but falled to document any results, hittals of elignatures for the Chiprine testing. The review sometimes on the country touch for Chipring was not documented as completed. An intendess with the tarable Ekoned Schrikter On CO/23/2010 at 1400 (Burelled Bred the lotal chloring checks should be done every 4 hours with a 16 minute exce window of time given. The principal inversed that assume that the driver of stan does not but document on the water log

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PRINTED: 10/08/2010 FORM APPROVED CMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CA DUTE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES CONSULTIFIE CONSTRUCTION CORPLETED MI PROVIDERSTRATERIOLIA WENTERCATION MILIEER STATEMENT OF DOTCENCES NED FLAN OF CORRECTION A HILL DATE 1010112010 R WANT \$41817 STREET ADDRESS, CITY, STATE, 329 COAS SOM BUARON ASSTY. HARR OF PROVIDER OR HUPPLER CHARLETTIE NO 20109 PROMOGRA HAN OF COMMECTION
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DOPINGS NOT CHAILUTTE EAST DIALYBIS DTA COORDINA SEE HENNYLON, ON FEE EIGHING HEGHNAINN FRON DELICENTA WAL BY LARCENED BY LITT AND MAN ELYLENETLE E DELICENCE D PROFIX PREFIX TAT V 188 Continued From page 14 V 196 can read the color matches. V \$31 494.60/b)(1) REPROCESSING-TRANSPORTATION & ree v HANDLING V331 11 Paprocesting 11.1 Transportation and handling Upon inspection, it was determined that this Persons handling used dislysens during refrigerator was unable to maintain transportation shall do so in a closen and sanitally temperature within acceptable limits. The manner maintaining Standard Precardons until the distyrer is districted both tramety and reuse refrigerator has been replaced and 9-30-10 verified to be within acceptable limits as of externally. To inhight bacterial growth, distyrant 09/29/10. The CSS in-serviced the teammates that called po Lebiocooned Allipli 5 ponte epong on Policy 6-01-08 Reuse of Dialyzers with he refigeraled and not allowed to freeze. Other emphasis on dialyzer storage in reuse refrigerator including the temperature transportation and handling leaves (each as required to be maintained between 36-50 biolouded costale is tobsoccessind) and questigned degree Fahrenheit and actions to take if in this recommended practice wheil he validated temperature is out of range. Proper and dominanted by the responsible body. documentation of a single temperature to be recorded was also reviewed. Facility This BTANDARD is not met as evidenced by: Administrator or designee will review the log Based on facility policy review, chaptyrellon, everyday for 3 days, weekly on each shift x3 licingerator temperatura pol naview and stall weeks, and then the log will be monitored Interview, the facility fedled to ensure that patient daily by the charge muse on an on-going read get/sels have adaditively topicalized to basis. Results of audits will be reviewed in Quality Improvement Management Meetings lishbit bactarial growth beinto respectations. (QIFMM) and addressed as necessary. FA is responsible for ongoing compliance with The Andings Include: A review of the feculty policy "Reuse of Diolycon" (revision data 03/2003) revealed "Dialysers are Lebrocesard within this (S) licens on strated in a designated trained to release series between Growth rang series to pagnar Key Salayed distyrms may be stored for up to 38 hours prist to being reprecessed. The refrigerator used for conteminated delycer storaga is maintained balvisen 36-50 degrees Fabrarinell."

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PREMIED: 10/18/2010 FORM APPROVED ONTO NO. 0978-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSTRUCTOR CONSTRUCTOR CENTERS FOR MEDICARE & MEDICARD BERVICES IN HILLIPLE CONSTRUCTION MU LACADEMENDATESCIN ETATEMENT OF DEPTREMOTES AND PLAN OF CORRECTION A BLELDING 10010012 n. WING. 2426II STREET ADDRESS, CITY, STATE, OF CORE NAME OF PROVIDER ON SUPPLIER ALEEST NOWARD FOLK CHARLOTTE, NG 22201 PROVERS PLAYOF CORRECTION (EAST CONSECTIVE ACTION BECAUSE REFERENCED TO THE APPROPRIATE DESIGNATION OF THE APPROPRIATE DESIGNATION OF THE APPROPRIATE CHARLOTTE EAST DIALYSIS BUMMAN, CHATCHEN, OF DELCONDER RACHMANN ib PREFIX TAG V 331 Continued From page 16 V 331 in that refresenter, the temperature goes in the 50s." An inservious with the facility administrator on 09/22/2010 at 1210 revealed that he was not avers of the elevated temperature reactings of the reprocessing storage temperatur. The interview tenced that the stall had not kilomed him of the elevated temperature manages. V 340 494.50(b)(1) DIALYZER GERN-80% CONCICAPE DISINFECT 11.4.1.4 Chemical germicidal procedure: = 90% conciput caps disinfacted il spricable, ha hemodalpret shell be filed with ¥340the gennicide solution until the concentration in The CSS in-serviced reuse teammates on policy 6-04-03 Cleaning and Disinfection of the hamedalyzer is at lead MYK of the prescribed Reuse Supplies with emphasis on the need to 10-15-10 fully immerse the caps below the germicide roncentration. surface level. Facility Administrator will The ports of chemically distributed distribute shall monitor submersion of caps per policy for 7 pe diginjected and then expired with hely or days then once a week for 2 weeks, then districted caps. The caps may be districted with divisible select, with the channess used for monthly. Results of audits will be reviewed in Quality Improvement Management Meetings delificing the hemodistres, or with any other (QIFMM) and addressed as necessary. FA is connectes approved by the FDA as a district and that does not adversally affect the metantals of the responsible for ongoing compliance with distyzer. This ETANDARD is not med as evidenced by: Based on lacing policy review, observations and syet, supervised the series that prive to deutsche paine teersouppig of he displaced by obsolving transcipul a suithe this terre gistlest cats assume resund and aren unatives, averand by serve some wash to reprocessed distyrans. The findings include: A review of the facility's pollog "Classing and

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FRINTED: 10/08/2010 PORM APPROVED OMB NO CEST-1391 DEPARTMENT OF HEALTH AND HUMAN SERVICES OXA DYJE STEAMEN CENTERS FOR MEDICARE & MEDICARD SERVICES HONTONOMENHOU BATTE BELL (EX) COMPLICATO (X1) PROVIDENCE PRESENTA STATEMENT OF CORRECTION EXEMPTEATION PLANTER DIKLERY A 10101/2010 E WHITE 342527 KTREET ADDRESS, CITY, STATE, 22º COOR STAN SHURGEN APATY HAVE OF PROVIDER OR SUPPLIER CHARLOTTE NO 2323 PROJECTS IT ALCO CORRECTION (CACH CONTROLLE ACTION ENOUGH DE CROSS-RE-EIRAN ED TO THE APPROXIMATE DEPOSITION COMPLETED TATE CHARLOTTE EAST DIALYSIS SUMMARY STATEMENT OF DEFICIENCES (EACH DEPOSITED MAST SE PRECEDED BY FULL REQUESTORY OR LEC STRATUM BY CRAMITED PREFIX DATE PA TAS V400 cont. V 400 The current Patient Station #7 will be Continued From page 19 relocated. A minimum 5'-0" portion of the V 400 conditions apply quarter in place of only Treatment Chase will be demolished to provide *12-31-10 inservicing stell on the fire drifts; and failed to a clear path to a New 3'-0" Exit Only Door for remove storage in the front conider of the facility with Panic Hardware, A minimum 5'-0"ADA additional next to the lobby at the side exit door. Accessible Sidewalk will be installed to physical connect this new door to the existing parking plant -Cines roler to 494.60(a)(1) Physical area. After installed the emergency evacuation work Environment Fire-Sidely and Life Safety Code. plan will be updated to reflect the exit routes. Tag V0417 Fire drill was conducted on 10/1/2010 and will 10-1-10 be conducted quarterly at unexpected times by B. The facility failed in eneme on effective swedeway execusion range in the lecality's the Facility Administrator or designee. These patients, walf and visitors to include an alternative fire drills will be documented and evaluated in the authorite from inside the patient resimant QIFMML Storage items have been removed from the काराम मा मेख स्थलात प्रांत्रिक ठारेल हैं है कार्स एकस्वर है स्थान corridor and relocated to the records storage 07/07/08 area as of 09/30/10. Route will be monitored Was ploched or HUDRESSING daily for 7 days then weekly for 2 weeks then -Cross rates to 494.60(d) Physical Environment. monthly for 3 months by Facility Administrator or designee. The Governing Body will meet monthly x 3 to ensure compliance with POC. Further SOLON BELL C. The facility failed to mortion and maintain compliance to the POC will be reviewed during monthly QA meetings and reported to refregatator fumperatures to inhibit potential the Governing Body no less than semibechallel grows in stored roused dialyzare. annually. The Facility administrator (FA) representing the GB will be responsible for ~Cross rates to 484.80(b) Physical Emmonment ensuring implementation and ongoing Teg VO403. V 403 compliance with this POC. 494,60(b) PE-EQUIPMENT HAINTENANCE HANLEACTURER'S DEU V 403 The distract reciting must implement and maintain a program to ensure that all equipment (including a hathard edibility (halves wechine and adributing end for same hautured shapes) are Unicipated and obsiding to eccycleage with the manufacturel's recommendations. This STANDARD is not mot us saidsnood by: Based on facility policy raview, observations,

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RECEIPMENT OR LESS DESIGNATIONS

OF MAINTY STATEMENT OF DEFICE RESEARCH D PRSFIX CAN PROPIX TAG V 408 Continued From pege 23 An Interview on 00/22/2010 at 1110 with the facility's regionared nurse in the patient treatment V417they remained that that the trains was card one May and of the patient meanness area at the 1. The fire system was ordered on the day of facility. The bactriose revealed, I have never the survey. An agreement is in place with a thought about it but if there was a fire, the only local vendor to install a smoke detection way out would be through the that gree (shall system and fire alarm system that meets local indicating by pointing to the one exit) there." The code on 10-22-10 Michiga to bested that the state and pessed in 2. The Server Room's Plywood will be The diffe to use the one and in the treatment area removed. The currently non-rated Walls will to evertals the patients. The interview star be upgraded to Minimum I Hour Fire Rated revealed that the facility edministration did not Partitions, in accordance with the attached instruct the staff what to do it that one has exit sketches. This will allow the I Hour Fire *10-22-10 Rating to run behind the plywood finishing routs was blocked with fire or other relacts. for Fire material once reinstalled, system 3. Since the Facility is approximately 7,600 A review of the local are material reports on sq. ft. in size, the required Smoke ODVZIVZD10 revested that no report could be Compartmentalization will be accomplished found at the facility where any fire marchall of by extending the existing non-rated partitions to the Roof Deck, as indicated in the attached lecs he habsetton was done at the laced, to Sketches. This will provide the minimum determine the existy compliance. No documentation could be produced by the facility that revealed any five autisty inspections were 1,140 S.F. in either compartment as well as the minimum exiting requirements. New I Hour Smoke/Fire Partition and 20 Minute Fire conducted at the facility. Rated Doors will be installed at key locations An interview on 03/23/2010 at 1000 with the in order to provide the needed pathway from exterior wall to exterior wall. Each door will facility administrator and requisitory stail raysoled also include a passage latch system, 1 Hour that the facility could not find or produce a fire Fire Rated Frame, and Closer device. weigheld on local countyletty report for any past 4. The Facility Bio Hazard Storage room is inspection of the the feelility's fire earlety. The not self closing nor fire-rated. The facilities Injection leading first gas jecyth sporty justs Bio Hazard Storage room will be separated one on the, but the administrative stall were from the Corridor by upgrading and extending unable to preduce this document during the the existing non-rated partition to the roof V417 deck as a minimum | Hour Fire Resistant 404-90(=)(1) PE-FIRE BAFETY-LIFE SAFETY assembly. The Door between the Bio Hazard :Storage room and the Corridor will be V417 suppraced to a minimum 45 min. rated door CODE 3000 with a minimum I hour Rated Frame and (1) Except as provided in paragraph (0)(2) of this section, by February 9, 2009. The dalysis facility Closer devise. wing county with sobjection browniage of gas cont pg 25

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417 Continued From page 24 2000 edition of the Life Baiety Continued Fire Protection Association as fell incorporated by reference at §40 the chapter). This STANDARD is not met as Based on observation on Thurst between 8:31 AM and 1:30 AM noted: 1) The family did not have a fire was there am battery powers found in the building. 2) The Servar Room is lived interior finish on the waste which interior finish on the waste which with fine required fire realization. 3) Facility is approximately 7 cose and have a sense team building into two coparates and cosing nor fire-rated. 5) The facility has Bio Hazes and closing nor fire-rated. 5) The emorgancy battery is tested. 8) The tability inservices the each quarter in piece of hone and as unexpected times a conditions. 7) There is storage in the wait. 433 4643 of the Indian India	is evidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced by: sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced sevidence sevidenced	V417	V417 cont. 5. This emergency battery operatorepaired and operation verified by vendor 10/07/10. This will be measure it is in working order durifacility audits. 6. Fire drill was conducted on 10 will be conducted quarterly at us times by the Facility Administrated esiguee. These fire drills will be and evaluated in QIFMM. 7. Storage items have been rencorridor and relocated to the rearea as of 09/30/10. Route will drill for 7 days then weekly for monthly for 3 months by Facil Administrator or designee. *The facility has been diligent correcting all the issues cited a This report was received on 10-18-10. The fire system will day of the survey. The installs system is subject to the available to the survey. The installs system is subject to the available working with expedite the process. An agraphace with a local vendor to detection system and fire ala meets local code on 10-22-1 physical plant issues will retain a meets local code on 10-22-1 physical plant issues will retain a meets local code on 10-22-1 physical plant issues will retain a meets local code on 10-22-1 physical plant issues will retain a move forward is in place. If the work will have to be non-operational hours. The been evaluated by an archit move forward is in place. If the formation in these formation in these formations in these formations in the survey of the work in place.	y an outside y an outside y an outside y an outside mig monthly of 1/2010 and nexpected after or se documented to be monitored from the cords storage be monitored or 2 weeks then the facility of the facility to the facilit	*12-31-10 for additional physical plant work y. 3. it the te as ich ing

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POSESSE PROSESSES. CHARLOTTE EAST DIALYSIE ENTRONA ELVERNA CE DESCRIPTOR DE L'ANTONIO D erefix DA) ID PREFIX PAG V750 cont. Pacility Administrator or designee V 684 will monitor team everyday for 3 days, Continued From page 30 weekly on each shift x3 weeks, and then this experience in providing numbers care to passing 383 V will be included in monthly infection control pu majutananca gajuna; audit going forward. 10-18-10 The CSS in-serviced the team on the importance of maintaining a clean This STANDARD is not mad as evidenced by: environment and ensuring trash is picked up Resea on facility policy review and start interview, from the floor. Facility Administrator or the facility falled to dealgrade a charge muse for designee will monitor team everyday for 3 days, weekly on each shift x3 weeks, and each this eating hemodelysts to street it. then this will be included in monthly infection control audit going forward. Upon inspection, it was determined that this The findings include: refrigerator was unable to maintain A review of the facility policy "Tealminate temperature within acceptable limits. The Qualifications, Licentume and Adequate reuse refrigerator has been replaced and Teamede Stating (revision date of 17/2008) verified to be within acceptable limits as of revealed "Charge Nurse Standards: The charge 09/29/10. The CSS in-serviced the team on policy 6-01-08 "Reuse Policy" and reviewed Unite topocumpia for eact, ship mit pa a refrigerator log with temp ranges. Paper registered nurse, leaneed precibal uniter/company unite who mosts the biacyce towel dispenser at patient prep area is a requirements in each State in which he or she is battery powered hands free style dispenser. The dispenser was found to be inoperative. Replaced batteries and verified operation. employed." Facility Administrator or designee will An interview on 08/22/2010 at 0900 with the monitor team everyday for 3 days, weekly on facility administrator revealed that the facility dose each shift x 3weeks and then this will be not currently have a davignated charge nurse included in monthly infection control audit during the hemodialysis treatments. The interview going forward. toward was the de not have enough patients to *10-22-10 The facility has been diligently working on have an established charge mures. All of the staff correcting all the issues cited since the for Fire survey. This report was received on 10-11-10 knows we have a ninee that can hange things system stating completion dates could be no later and who to report problems to." than 10-18-10. The fire system was ordered the day of the survey. The installation of the An interview on 09/22/2010 at 1900 with the fire system is subject to the availability of the facility administrator revenied that we facility does vendor who is working with the facility to vos vana a otyciaj cuarda uraza pre enst. Aoua expedite the process. An agreement is in knows the nurse tole. The letoprises revealed that place with a local vendor to install a smoke each eith does not have any former or excipned detection system and fire slarm system that meets local code on 10-22-10. cont pg 32 charge nurse. V 750 404.180 CFC-GOVERNANCE U confinentian Hard Page 31 of 54

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V 750 Continued From the production of the produ	The same of the sa		A LED	The Storage Room is classific Hazard area in accordance wi 6.2.2. Due to this, NFPA 10 will require this area as well Closet to be upgraded to the Fire Resistant Rating. This vaccomplished by upgrading Rated Partition and Doors at attached Sketches. The attached Sketches are submitted for your review Should you require addition please contact our office. The Governing Body will ensure compliance to the POC with Governing Body no 1 annually. The Facility a representing the GB will ensuring implementation compliance with this PC	DI Section 8.4. as the Janitor's Minimum 1 Howill be respectfully and comments. The continuous and information of the respectfully occ. Further will be reviewed ings and report ess than semi-dministrator [F. be responsible a and ongoing occ.	tour for for additional physical plant work x 3 to

TEDICARE & MEDICAID SERVICES CENTERS FC EPARTMENT OF HEALTH AND HUMAN. ID: OB2211 MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL VICES Facility ID: 001554 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY 4. TYPE OF ACTION: 6 (L8) 3. NAME AND ADDRESS OF FACILITY 2. Recertification METICARE/MEDICAID PROVIDER NO. (L3) CHARLOTTE EAST DIALYSIS 1. Initial 4. CHOW 3. Termination (LA) 3204 SHARON AMITY 342627 6. Complaint (L6) 28205 5. Valldation STATE VENDOR OR MEDICAID NO. 9. Other (L5) CHARLOTTE, NC 7. On-Site Virit (LI) 8. Full Survey After Complaint (1.2)7. PROVIDER/SUPPLIER CATEGORY EFFECTIVE DATE CHANGE OF OWNERSHIP 13 PTIP no ESRD 05 HHA 01 Hospital 14 CORF (L35) FISCAL YEAR ENDING DATE: 10 NF (L9) DE LAB 02 SNF/NF/Duch 04/15/2009 (L34)15 ASC DATE OF SURVEY 11 IMR 03 SNF/NF/Distinct OT X-Ray 12/31 (L10) 16 HOSPICE ACCREDITATION STATUS: 12 RHC 08 OPT/SP 04 SNF 1 JCAHO O Upaccredited 3 Other 2 AOA 10. THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: 1. LTC PERIOD OF CERTIFICATION __ 6. Scope of Services Limit X A. In Compliance With ___ 2 Technical Personnel ___7. Medical Director Program Requirements From (a): 3. 24 Hour RN Compliance Based On: 8. Patient Room Size 4: 7-Day RN (Rural SNF) To (b): X 1. Acceptable POC __ 9, Beds/Room (L18) 5. Life Safety Code 2. Total Facility Bods B. Not in Compliance with Program (L12) A1* * Code: Requirements and/or Applied Waivers: (L17) 13. Total Certified Beds 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN (L15) 1861 (c) (1) or 1861 (j) (1): IMR. ICF 19 SNF 18/19 SNF 18 SNF (LA3) (LA2)(L39) (L38) (1.37) A complaint investigation was conducted onsite at the facility April 15, 2009. As a result of the investigation, a standard level deficiency was found in 494.30 Infection Control. A 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): plan of correction was requested. Refer to intake #NC00054102. 18. STATE SURVEY AGENCY APPROVAL Date: RVEYOR SIGNATURE (1.20)06/01/2009 (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Strat (HCFA-1513) 20, COMPLIANCE WITH CIVIL 19. DETERMINATION OF ELIGIBILITY 3. Both of the Above : RIGHTS ACT: 1. Facility is Eligible to Participate 2 Facility is not Eligible (L21) (1.30)26. TERMINATION ACTION: 24. LTC AGREEMENT INVOLUNTARY 23. LTC AGREEMENT 00 22 ORIGINAL DATE VOLUNTARY ENDING DATE 05-Fail to Meet Health/Safety BEGINNING DATE 01-Merger, Closure OF PARTICIPATION 06-Fail to Meet Agreement 02-Dissatisfaction W/ Reimbursement (L25)03-Risk of Involuntary Termination OTHER. (L41) (1.24)07-Provider Status Change 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 25. LTC-EXTENSION DATE: 00-Active A. Suspension of Admissions: (L44)

(LA5)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

00000

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

B. Rescind Suspension Date:

(1.28)

(L32)

(L27)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

- Denial of Payment for New Admissions
- License Revocation
- 14 Injunction 15
- Civil Monetary Penalty

	License Revocation	16 Civil Mone	elary remains	15. Date Forwarded to CMS RO or
8	Receivership	Party	Date	Medicaid SA (MSA)
	14. Parties Notified and Dates		041609	(Attach HCFA-2567)
13. Date of Proposed Action	1 Facility	1. 2. 2	0 4 2 1 0 9	
Proposed Acadon	2 Complainant	2 1 1		
	3 Representative	٠ اسيا	MMDDYY	M MD DY Y
041509	4 Other (Specify)			
Y ND DY Y			One Action (RO/MS	A)

041509	4 Other (Specify)	3. [_]	MMDDAA	M MD	DY Y
M MD DY Y	ompleted By Component Taking	Final Close	-Out Action (RO/MS/	<u>, </u>	18. Date of Final Action Sign-of
	17. CMS RO/MSA Action	6	Limitation of Certification Suspension of Certification		
16. Date of CMS/MSA Receipt		8	Revocation of Certificate Injunction	Ì	MMDDYY
	1 None	10 11	Civil Monetary Penalty TA & Training For Unsucc	cessful PT	
MMDDYY	2 Termination (23-day) 3 Termination (90-day)	12		Approval	
	rtiste Sanction	13			1
	5 Move Routine Survey Date Forward	rd 14	Enforcement Action		

FORM CMS-562 (1-93)

APR-24-2009 FRI 02:43 PM DAV CHAR EAST

FAX: NO. 70453181.

RM 5129, 01

APR-24	-2009 FRI 02:	43 PM DAV CHAR CHOI			The challeng or sections	10	PRINTED:	04/15/2009
EPARTM	ENT OF HEALTH	AND HUMAN SERVICES			EIVED APR	2 9 2009	OMB NO. (RVEY
ENTERS	FOR MEDICARE	A WILDION AND STREET IN A	1		NETRUCTION		COMPLET	'ED
TEMENT OF C	DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILT	DING			C	- 1
		342627	B. WING		A-10-10-10-10-10-10-10-10-10-10-10-10-10-		04/18	3/2009
			1	STREET	ADDRESS, CITY, ST.	ate, zip gode		
ME OF PRO	OVIDER OR SUPPLIER		1	3204 8	SHARON AMITY			
HARLOT	TE EAST DIALYS	S		CHAI	RLOTTE, NC 28:	ALL AC ACOUNT	CTION	(XS)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	FREF TAG		(EACH CORRECTED COORSEREFEREN			DATE
V 147	REFERENCE	C RR-10 AS ADOPTED BY		147	See	Alfida	À	5/15/09
	Catheters in Ad	ons for Placement of Intravascula ults and Children						
	A. Educate appropriate prevent intrava B. Assess	porker education and training health-care workers regarding the infection control measures to iscular catheter-related infections. Chowledge of and adherence to lodically for all persons who rescular catheters.						
	individual pat the insertion other manife [blood afrear removed to a site.	the catheter sites visually intendent the catheter sites have tenderness site, fever without obvious source stations suggesting local or BSI in infection], the dressing should ballow thorough examination of the	ie					
	1 Hamadight	ous Catheters, Including PICCs, is, and Pulmonary Artery Cathete ediatric Patients.	rs in					
	B. Antib	r and catheter-site care jotic lock solutions: Do not routine tic lock solutions to prevent CRBS elated blood stream infections].	ely 31				,	
	1 f	NDARD is not met as evidenced the facility's policies and procedu				\wedge	,	
	clinical re	cord review, and stan interest an estati falled to change or clean an e	exit site			TILE		(XA) DAT
	l la la la la la la la la la la la la la	'S OR PROVIDER/SUPPLIER REPRESENTA	MVES SIC	SHATURE	1 1	160	/FA	4-24-

Any deficiency statement ending with an esterisk (*) 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 tollowing 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 of survey whether are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

treatment was

pct's and RNs

occasions.

P. 02 PRINTED: 04/15/2009 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/15/2009 COMPLETION 1. An in-service on Central Venous Catheter changes and initiation of Completed on 4-15-09 by the vascular Access Manager with attendance all 2. Teammates will be observed by RN or Facility Administrator to assure 5-15-09 company guidelines are adhered to. Teammates will be observed on 3 3. Bi-weekly meetings between RN's and Facility Administrator will be held to discuss any concerns or issues pertaining to any patient or teammate.

4. Teammates and RN's are instructed to document any event that is a variation from company policy and procedure and/or any Physicians order

5. MD was fully aware of pt's refusal of dressing changes. On several MD visits, MD verbalized to pt, the importance of dressing changes performed in-center by RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 342627 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3204 SHARON AMITY CHARLOTTE, NC 28205 CHARLOTTE EAST DIALYSIS PROVIDER'S PLAN OF CORRECTION JEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID PREFIX TAG DEFICIENCY) TAG V 147 Continued From page 1 V 147

of a patient's central venous catheter dressing 7 of 16 hemodialysis treatments (Patient #1).

The findings include:

Review of the facility's policy "Central Venous Catheter (CVC) Care" (revised on 04/2009) revealed that the purpose of the care was to reduce the risk of infection in the patient and to reduce trauma to the catheter and exit site while minimizing blood loss. The policy review also revealed that cuffed catheters with well-healed exit sites may not require a dressing but still require examination and cleaning of exit site each treatment.

A clinical record review on 04/15/2009 for patient #1 revealed that the 32 year old patient had his first dialysis treatment at the facility 12/30/2004. The review revealed that the patient had "CVC right side fernoral catheter" used for his hemodialysis treatments at the facility. The review of the patient's post treatment flow sheets on the dates of 03/10/2009, 03/26/2009, 03/28/2009, 04/04/2009, 04/07/2009, 04/11/2009 and 04/14/2009 revealed that no staff either changed the patient's CVC dressing or documented cleaning of the patient's dressing after his hemodialysis treatments. No documentation was found in the patient's clinical record where the facility's administration or the patient's physician was made aware of the patient not having his CVC catheter cleaned after each hemodialysis treatment.

Staff interview on 04/15/2009 at 1010 with the facility's administrator revealed that he was not aware of the patient refusing catheter care after the 7 missed changing or cleaning of the exit site.

		TAOM	ΕQ	X NO. 70453181;	Р.	03
APR-24	1-2009 FRI 02:4	4 PM DAV CHAR EAST	I F	th trot to to determ	PRINTED:	04/15/2009
					FORM A OMB NO.	PPROVED 0938-0391
PARTM		AND HUMAN SERVICES & MEDICAID SERVICES		CHONNICTICK	(X3) DATE SU COMPLE	RVEY
	e repriencies	(XI) PROVIDERISUPPLIENCLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		Į.
PLAN OF	CORRECTION	DEMINICATION INCIDENT	A BUILDING			5/2009
		342527				
	OVIDER OR SUPPLIER	And the state of t	STRE	et address, city, state, zip co Magharon amity	-141	1
		.	CH	IARLOTTE, NC 28205		ner
HARLO	ITE EAST DIALYSIS		T ID	PROVIDER'S PLAN OF CO	ORRECTION IN SHOULD BE	COMPLETION DATE
(X4) ID PREFIX	SUMMARY ST LEACH DEFICIENT RECULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	Called a Looke ton your	DAIL
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V 147	Continued From	page 2	V 147		•	
- • • •	The interview als	o revealed that the stati should				
	make the admini	stration aware if the patient the cvc lication and cleaning of the cvc			•	
	catheter exit site	·•				
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	Reference intak	e #NC00054102.				
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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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	the time for reviewing instructions, searching examing the printing include	link
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intringing data needed, and completing and of Financial Management, HCFA, P.O. Box 20004, Daniel		
gestions for 10though D.C. 20503.		
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ject(0838-0583), Washington, D.C. 20503.	
rovider/Supplier Number	Provider/Supplier Name CHARLOTTE EAST DIALYSIS
142627 Type of Survey (select all that apply)	A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanctions/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life Safety Code L CHOW M Other
Extent of Survey (select all that apply)	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

	Please	enter the worklo		each surveyor.	On-Site	dentification number On-Site		Off-Site Report Preparation
erveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	Hours 8am-6pm (F)	Hours 6pm-12am (G)	(H)	Hours (I)
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13.							- Llowes	
14.					Total Ro	O Supervisory Rev	Mem Lioms	0.00

Total SA Supervisory Review Hours....

1.00

Total SA Clerical/Data Entry Hours....

0.50

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

EventID: OB2211

Facility ID: 001554

Page

EPARTMENT OF HEALTH AND HUMAN SERVICES	OMB 0938-0360
ENTERS FOR MEDICARE & MEDICARIO	N/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT
END STAGE NEWAL DIOLICAT	TION - TO BE COMPLETED BY FACILITY 2. Provider Number
	[312000
Name of Facility Payita East	
Ol # Address	navonAnity
Charlotte / 3204 N. SI	Lr County
4. City C	MECK/ENBURG
Char lotte	7. ZIP Code
6. State	2520 S 10. Fiscal Year Ending Date
8. Telephone No.	9. Facsimile No. (2(31/10
1220 (31-15/20	
11. Name/Address/Telephone Number of Authorized Off	Address: (704) 53 (-155)
Name:	CI 1 (COCKETE NC-26205 CDY) 551110
CARLES METUCAL Icheck all	that apply and specify in Hemarks section to a service
2. Expansion to	new location
4. Change of location	Callela Journal
gara. Other (specify)	For Profit U Not for Profit U Pablio
13. Ownership (vz)	(v₃) Yes WNo If Yes, hospital provider number
14. Is this Facility Hospital-Based (check one)	(V4) [[] [] [] []
	(vs) ☐ Yes ☐ No If Yes, SNF provider number
15. Is this Facility SNF-Based (check one)	(V6)
	No. If Yes, name and address of parent organization
.o. Is this facility owned and/or managed by a multi-facility	v organization? (vn Yes No If Yes, name and address of parent organization Address:
Name:	1423 Pacific Ave Tacoma Wastinaton 98401
(VB) DAVITA DIALYSIS	pocify in Remarks section [see item 27])
17. Services Provided: (ve) (check all that apply and se	3. Transplantation 4. Home Training: 5. Home Support: Hemodialysis Hemodialysis
1. Hemodialysis 2. Peritoneal Dialysis	3. Transplantation Hemodialysis Hemodialysis Peritoneal Dialysis Peritoneal Dialysis
18. Is Reuse Practiced?	(V10) Ves No
19. Reuse System (V11) (check all that apply)	1. Manual 2. Settir-Automatos
19. Reuse System (VII) (Check all that angly)	termolin 12 Heat 13 Columnia
20. Germiolde (V12) (check all that apply)	Other (specify) RENALIN
21. Number of Dialysis Patients	Hemodialysis + (V15) Peritoneal Dialysis
$(V13)$ Total Patients = $(V14)$ \underline{Y}	
22. Number of Stations (check all that apply and inc	clude isolation stations under rotal Stations
Total Stations = (V17) Y	/ Hemodialysis + (vis)/
(***)	(V19) Tyes No
23. Does the facility have isolation stations?	is facility patients treated on each shift for full week prior to submission of this form) MONDAY C. TUESDAY D. WEDNESDAY A 1 2 3
24. Total Number of Patients (enter number of dialys	MONDAY C. TUESDAY D. WEDNESDAT D. WEDNESDAT
A. SUNDAY 1 2	3 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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E. THURSDAT	3 4 1 2 3 4
1 2 3 7 7	
25. Total Number of patients followed at home (va	20)Pi
CVI I VIVII	

partment of Health and Human		Comnia	int (SA or RO)	
artment of Health and Human Heare/Medicaid/CLIA Complaint Form Part I - To Be Com	pleted by Component First F	CECEIANIE COMPA	3. Date Com	plaint Received
1. Medicare/Medicaid Facility Nam Identification Number CHARLOT 3204 SE	ie and Address TE EAST DIALYSIS IARON AMITY OTTE, NC 28205		030	609 DYY
4. Receiving Component Acknow State Survey Agy. 1 State Survey Agy.	6A. Source of Com	plaint 1 Resident/Paties 2 Ombudsman 3 Facility Emplo	5 Of	of Complainants let 011
1 Resident Abuse 1 Resident Neglect 2 Resident Rights 3 Resident Rights 4 Patient Domping 5 Environment 6 Care or Services 7 Dictary 8 Misuse of Funds/ Property 10 Proficien Record 11 Falsifica Record 12 Unqual 13 Quality 15 Diagna 16 Frand 16 Frand 17 Falsific	ncy Test fiton of fiton Personnel Control ten Handling		oleted following Substantiated Unsubstantiated/ Unable to Verify	C. Number of Complainants per Allegation 1 0 1 2 3 4 5
8. Action (if multiple actions, indicate earli 1 Investigate within 2 working day 2 Investigate within 10 working day 3 Investigate within 45 working day	ays 6 Other Action (S ays 7 None	pecify)		
4 Investigate during next onsite	se Completed By Component	Investigating Co	emplaint (SA or RO)	
9. Investigated by 1 State Survey Agency 2 RO 3 Other (Specify)	10. Complaint Survey Date 0 4 1 5 0 9 M M D D Y Y	ie	11. Findings (Under 7B	Above)
12. Proposed Actions Taken by SA or RO 1: 0 4 2 Reco 2: 3 Reco 3: 4 POC 5 Fine 6 Den 7 Lice	ial of Payment for New Admissions use Revocation	9 Provisional L 10 Special Mon 11 Directed PO 12 Limitation of 13 Suspension 14 Revocation 15 Injunction 16 Civil Mone	tior 18 State to 19 Sus C 20 Sus C 20 Sus C 21 Nor C 22 Off Certificate 22 Off Certificate 23 Enfantary Penalty	er (Specify) ordenent Action
13. Date of Proposed Action	14. Parties Notified and Dates 1 Facility 2 Complainant 3 Representative 4 Other (Specify)	Party 1.	0 4 1 6 0 9 0 4 2 1 0 9 MMDDYY	Medicaid SA (MSA) (Attach HCFA-2567) M MD DY Y
M MD D Y Y	Completed By Component T	aking Final Close	Out Action (KU/MS/	18. Date of Final Action Sign
Part III - To Be 16. Date of CMS/MSA Receipt M M D D Y Y	17. CMS RO/MSA Action 1 None 2 Termination (23-day) 3 Termination (90-day) 4 Intermediate Sanction 5 Move Routine Survey Date	7 8 9 10 11 12	Suspension of Certification Revocation of Certificate Injunction Civil Monetary Penalty TA & Training For Unsuc Cancellation of Medicare Other (Specify)	M M D D Y Y
		CMS RO		Page 1 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES	OWB 0938-0360
CENTERS FOR MEDICARE & MEDICAID SERVICES	CTIFICATION AND SURVEY AND CERTIFICATION REPORT
END STAGE RENAL DISEASE APPLICATION/NC	OTIFICATION AND SURVEY AND CERTIFICATION REPORT
· · · · · · · · · · · · · · · · · · ·	1 - TO BE COMPLETED BY FACILITY 2. Provider Number
1. Name of Facility Davifa East Charlotte	392627
3 Street Address	
2/4	5. County
4. City Charlotte	MECKIENBURG
6. State	7.ZIP Code 7.8705
NC	9 Facsimile No. 10. Fiscal Year Ending Date
8, Telephone No.	(nou) 531-8122 /2/31
11. Name/Address/Telephone Number of Authorized Official	Address: Telephone No.
Name: 2 2011 N	J. M. Lyon 531-1990
(check all that ap	apply and specify in Remarks section (see item 27)
12. Type of 7 photosists 2. Expansion to new lo	location 3. Change of ownership
☐ 4. Change of location, ☐ 5. Expansion in current	nt location 2 of only
132 7. 00.00 (0)	For Profit Not for Profit Public
13. Ownership (vz)	(V3) Yes No If Yes, hospital provider number
14. Is this Facility Hospital-Based (check one)	(V4)
15. Is this Facility SNF-Based (check one)	(V5) Yes No If Yes, SNF provider number
·	(V6)
to the facility owned and/or managed by a multi-facility organi	nization? (vz) Yes Yoo If Yes, name and address of parent organization Address:
Name:	Address:
(VB)	in the continuing from (77)
(vs) 17. Services Provided: (vs) (check all that apply and specify	normants section uses them 2.17 4. Home Training: 5. Home Support:
1. Hemodialysis 2. Peritoneal Dialysis 3. Trai	Hemodialysis Hemodialysis
18. Is Reuse Practiced?	(V10) Yes No
19. Reuse System (v11) (check all that apply)	1. Manual 2. Semi-Automated 12. Paractic Acid Mixture
1. Formali	III 2. Heat
20. Germicide (Viz) (Sheak all and Apply)	(specify)
21, Number of Dialysis Patients	
- 10 - Hem	nodialysis + (vis)Peritoneal Dialysis
22. Number of Stations (check all that apply and include is	
	modialysis + (viii)Hemodialysis Training
(V16) Total State	(V19) Yes No
23. Does the facility have isolation stations?	(4,0)
24. Total Number of Patients (enter number of dialysis facility	ity patients treated on each shift for full week prior to submission of this form) C. TUESDAY D. WEDNESDAY AY 1 2 3 4
1 2 3 4 1 2	$\frac{3}{4}$
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E, THURSDAY F, FRIDA	3 4 1 2 3 4
	5 14 13 1
8	7
25. Total Number of patients followed at home (vzo)	P

6. Staffing	(vz1) Pegístered Nu	rse'2.	00	vzz) 🗌 Lioensed Praci	tical Nurse	
(list full-time equivalents)	(vzs) Social Worker	·		vz4) 🖾 Dietitian		<u>25</u>
¢.	. (V25) Technicians	1.	00	vze) Others		25
7. Remarks: (Use this space	e for explanatory stateme	nts for Items 1–2	26)	-		
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understand that incorrec	ed in this Application Survitor erroneous statements	s may cause the	ion Report (Pa Request for Ap	rt I) is true and correct oproval to be denled, o	t to the best or facility app	of my belief. I proval to be
understand that incorrect rescinded, under 42 C.F.	t or erroneous statements .R. 405.2100 and 405.21	s may cause the	ion Report (Pa Request for Ap	rt!) is true and correct oproval to be denied, o	Date	proval to be
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