

# 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, Interim Division Director http://www.ncdhhs.gov/dhsr

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

August 2, 2010

VIA E-MAIL

Mr. James Williams, Facility Administrator Vance County Dialysis 854 S. Beckford Drive Henderson, NC 27536

RE:

Medicare Recertification Survey CMS Certification Number (CCN): 342543

Dear Mr. Williams:

Thank you for the cooperation and courtesy extended during my recent visit to your facility July 13-16, 2010 for the purpose of conducting a recertification survey as well as a follow up to the 7/26/2007 complaint survey. As a result of this survey, it was determined that this facility was not in compliance with two (2) of Medicare's Conditions of Coverage:

494.150 Responsibilities of the Medical Director (V710) 494.180 Governance (V750)

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 Coverage. We are unable to recertify your facility in the Medicare program. For this reason, deficiencies affecting the Condition of Coverage 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 90 days from the last date surveyed.

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

Mr. James Williams
August 2, 2010
Page Two

(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 <u>original</u> 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.

Sincerely,

Kay D. Cuaton, RN

Kay D. Cuaton, RN

Acute and Home Care Licensure & Certification Section

Enclosures: CMS-2567 (w/patient list), 2567B



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

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Mr. James Williams August 2, 2010 Page Two

(c) The date by which all correction actions will be completed and in place. This date must be included on the CMS Form 2567.

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Sincerely,

Kay D. Cuaton, RN

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Acute and Home Care Licensure & Certification Section

Enclosures: CMS-2567 (w/patient list), 2567B

#### Cuaton, Kay

From:

Cuaton, Kay

Sent:

Monday, August 02, 2010 7:52 PM

To:

james.williams@davita.com

Cc:

donna.zook@davita.com; Cuaton, Kay; Blue, Nakunda

Attachments: vance county sod.pdf; Vance County patient list.doc; Vance County CONDITION.RTF

Attached is the CMS form 2567, Statement of deficiencies for the recertification survey conducted July 13-16, 2010 along with the patient identifier list and cover letter. During my visit I also conducted a follow-up to the 7/26/2007 complaint survey. CMS form 2567B form is also attached. Please call as directed in the cover letter if you have any questions. I am requesting that you send me an e-mail such that I am certain that you indeed have received this information.

Regrds

Kay Cuaton-Maier

DEPARTMENT OF HEALT	TH AND HUI	3ERVICES		m****	CENTE		CARE & MI	EDICAID SER	VICES
V NA	MEDIC.	ZE/MEDICAID TO BE COMPLI	CERTIFICA	TION AP	UPVEV.	ACENCY		ID: L76B Facility ID <sup>19</sup>	944655
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(L9) 01/01/2000	·	Ol Hospital	05 HHA	09 ESRD	13 PTTP		g. ren surv	ey After Complaint	
·	16/2010 (L34)	02 SNF/NF/Dual	06 LAB	10 NF	14 CORF		FISCAL YEAR	ENDING DATE:	(L35)
8. ACCREDITATION STATUS:	(L10)	03 SNK/NF/Distinct	67 X-Ray	11 IMR	15 ASC 16 HOSPI	œ	12/3		• •
0 Unaccredited 1 TIC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HUST	CE	, m, J	,	
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14 LTC CERTIFIED BED BREAK	DOWN			,	15. FACILITY	MEETS	• .		
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A recertification survey and the 494.150-Responsibilities of the survey and the survey are survey are survey and the survey are survey and the survey are survey are survey are survey and the survey are survey are survey and the survey are s	L. Madiant Divanta	→ A0A 120_Governa:	nce & aredible	aligation v	vas teceived or	1 48/13/2010. 7	( IOHOW-DD SUI)	SEA OF THE HAVE THE	m) o
recertification survey was co	nducted on 08/30/2	010. All previously	cited deficienci	es have bee	en corrected. 7	he facility is in	compliance wi	th all ESRD CFC	,,,
SURVEYOR SIGNATURE		Date.			18. STATE S	URVEY AGEN	CY APPROVAL	Date	
	./)	01	an (n.). (2030		$\Lambda$	()	OH.1	h 10	
Bay Dile	eceten-	Maies	08/31/2010	(L19)	<u> </u>	- CW	·	<i>b</i> 16 .	(L20
<u> </u>	ART II - TO BE	COMPLETED	BY HCFA R	EGIONA	L OFFICE	OR SINGLĚ	STATE AGE	ENCY	
19. DETERMINATION OF ELIC			MPLIANCE WIT		21. 1	. Statement of Fig	nancial Solvency (	HCFA-2572)	
		RIG	GHTS ACT:	•		. Ownership/Con . Both of the Abo		osure Stint (HCFA-1	513)
X 1. Facility is Eligible 2. Facility is not El					_	. 2001 01 210 1 100			
Z. Factory is not to	(1.2)	) .				•	,		
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OF PARTICIPATION 03/15/1989	BEOINN	ING DATE	12/12/11/0 12	//IL	01-Merger,			05-Fail to Meet He	alth Salety
	(141)		(L25)		02-Dissatisf	action W/ Reimb	irsement	06-Fail to Meet Ag	reement
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25. LTC EXTENSION DATE:		nsion of Admissions:	•		04-Other Re	ason for Withdray	/al	07-Provider Status	Change
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	(L32)			(L33)	DETERM	A MOITAMIN	PPROVAL		

RECEIVED AUG 1 3 2010

PRINTED: 08/02/2010 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES  ) PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI			COMPLETED	
		342543	B. WING			07/16/2010	
	OVIDER OR SUPPLIER			511	T ADDRESS, CITY, STATE, ZIP COD RUIN CREEK RD SUITE 212 NDERSON, NC 27536		<u> </u>
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE C HE APPROPRIATE	(X5) COMPLETION DATE
V 113	This STANDARD Based on facility postaff interview, the failed to don/wear patient/equipment after glove removative is required to wear patients or touchidalysis station, a hygiene after removative is resulted to wear patients or touchidalysis station, a hygiene after removative is required to wear patients or touchidalysis delivery stations.	oves when caring for the the patient's equipment at the fif must remove gloves and en each patient or station.  It is not met as evidenced by: oblicy review, observation and facility direct patient care staff gloves with direct contact and sanitize hands all.  Ided:  5-01, Infection Control For (revision 10/08) revealed staff r/don gloves when caring for the patient equipment at the not required to perform hand towal of gloves, after patient and system contact, between	V	113	vita  1. Survey deficiency result with all teammates 2. Policy # 1-05-01 Infection Dialysis Facilities will be revite ammates with emphasis on washing/hygiene and glove to a survey of the survey of	ion Control for riewed with all proper hand isage, inplete LMS MAN actory training, will be audited for erify completion by ings were initiated on the clinical team in x 2 months to review quirements. It audits were initiated formed daily x 2 weeks. If frequency will until compliance is essults will be reviewed lan implemented and review the job insibilities with all hemoviced regarding	8/9/10 !
	patients, and beforeview revealed hands may remo cart".  Observation on did not wear gloudialysis machine had just completed to the completed by the completed	Only teammates with clean ve items from clean supply  7/13/10 at 1130 revealed staff #1 ves when she touched the dirty at station #17 where patient #1 ted his dialysis treatment.  7/13/10 at 1135 revealed staff #1 ther dirty gloves or sanitize her oving the needles from patient is and prior to retrieval of clean			expectations of monitoring infection control policies.  10. The Clinical Mgr will compliance with infection compliance with the plan  11. Infection control audit by the Governing Body at and adjusted as needed  12. Disciplinary action w non-compliance with infeplan.	monitor daily for team a control policies and of correction. It results will be reviewed and a plan implemented ill result in continued	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the salegual os provide sumident profession to the penetus, (coe inspectable). Accept for introng notices, see inclings and plans of correction are disclosable 14 days following the date 1st 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 ise 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 Obsoleta

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID:L76B11

Facility ID: 944655

If continuation sheet Page 1 of 58

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		NSTRUCTION .	(X3) DATE SURVEY  COMPLETED		
		342543	B. WIN	IG		07/1	6/2010	
1	OVIDER OR SUPPLIER OUNTY DIALYSIS			511 RL	ODRESS, CITY, STATE, ZIP CODE NN CREEK RD SUITE 212 ERSON, NC 27536			
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V 113	Continued From page supplies.	ge 1	\	/ 113				
	did not don gloves barrier between the to touch the dirty di where patient #2 w revealed after staff did not sanitize her door knob on the lo Observation on 7/2 did not don gloves barrier between the to touch the dirty of where patient #3 v revealed after staff did not sanitize her glove.  Observation on 7/2 did not don gloves barrier between the glove.	(3/10 at 1220 revealed staff #2 (she used the glove as a e dirty machine and her hand) lialysis machine at station #16 vas dialyzing. Observation if #2 discarded the glove she or hands after discarding the  14/10 at 1115 revealed staff #3 is (she used the glove as a ine dirty machine and her hand) dialysis machine at station #19						
	did not don glove barrier between the hands after addressed die where patient #1 Interview on 7/11 revealed she did dialysis machine	6/10 at 0859 with staff #5 In't don the glove to address the alarm or sanitize her hands and equipment contact because						

CENTERS FOR MEDICARE & MEDICAID GETVICES STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	COMPLETED		
		342543	B. WING		07/16/20	010
	OVIDER OR SUPPLIER		511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536		
(X4) ID PREFIX TAG	SUMMARY S'	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID : PREFIX   TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(XS) . OMPLETION DATE
	on 7/14/10 at 1230 staff did not follow a precautions during duties did not includ Interview revealed responsible for the 494.30(a)(1)(i) IC-C AREA;NO COMMO Clean areas should preparation, handle and unused supplies should be clearly series where used handled. Do not he	cility Clinical Nurse Manager revealed she was aware that appropriate standard direct patient care, but her job de personnel issues. "the Facility Administrator is oversight of the staff".  CLEAN/DIRTY;MED PREP	V 113			
	When multiple do (including vials completed individual patient area away from dominated in the separately to each dose medication.)  Do not use completed in the separated in th	se medication vials are used ontaining diluents), prepare doses in a clean (centralized) lialysis stations and deliver the patient. Do not carry multiple vials from station to station.  In medication carts to deliver attents. If trays are used to ons to individual patients, they		V117  1. Policy # 1-05-01 Infection Co Dialysis Facilities will be review teammates with emphasis the im maintaining separate clean and c and that supplies, including but tape, that are taken into the dialy will be disposed of, dedicated f patient use, or cleaned and disin	red with all  portance of  lirty areas  not limited to  ysis station  or single	8/9/10
	This STANDARI Based on facility staff interview, t	between patients.  D is not met as evidenced by:  y policy review, observation, and the facility staff failed to maintain and dirty areas and failed to cosable tape was not shared ts.		taken to a common clean area. I disposable items that cannot be disinfected i.e. tape should be d use on a single patient. s Same above cont pg 4	Non cleaned and edicated for	· · · · · · · · · · · · · · · · · · ·

TATEMENT OF DEFICIENCIES  ) PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342543	B. WING			07/16/2010	
	OVIDER OR SUPPLIER		-	511	ET ADDRESS, CITY, STATE, ZIP COI RUIN CREEK RD SUITE 212 NDERSON, NC 27536	DE	
(X4) ID PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX (EACH DEFICIENCY OF LSC DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTIO) TAG CROSS-REFERENCED TO THE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
TAG V 117	Continued From pay The findings include Facility policy 1-05- Dialysis Facilities (r"clean areas shoustorage ofunuse equipmentclean a separated from cor supplies and equip taken into the dialy dedicated for use of cleaned and disinf common clean are patientnon dispondered and disinf be dedicated for use Observation on 7/ did not maintain the she removed the the top of the con station #17 (wher clean computer of Observation on 7/ did not maintain when she did not touching the con working with the Observation on did not discard a required after ta	ge 3 de: D1, Infection Control For evision 10/08) revealed ald be clearly designated for ed supplies and areas should be clearly staminated areas where used ment are handleditems sis station will be disposed of, only on a single patient, or ected before taken to a a or used on another sable items that cannot be ected (e.g., adhesive tape) will se only on a single patient".  13/10 at 1130 revealed staff #1 ne clean computer cart when patient treatment sheet from taminated dialysis machine at e a patient was dialyzing) to the	V	117	V117 cont.  All teammates will compared infection control mand LMS training records with compliance and tracked to vall teammates.  Daily homeroom meeting July 22 and will be held with daily x 1 week, then weekly review infection control part on July 22 and will be perfected weeks. When compliance is will become weekly x 4 were compliance is noted, then recompliance is noted, then recompliance is noted, then recompliance is noted. Clinical Mgr (CM)will revides an eded.  Clinical Mgr (CM)will revides and PCTS.  All nurses will be in-serve expectations of monitoring with infection control political mgr will mit compliance with infection control audit results in the clinical mgr will mit compliance with the plan Infection control audit results by the Governing Body as implemented and adjusted and plan.	polete LMS MAN latory training. Ill be audited for rerify completion by gs were initiated on the clinical team / x 2 months to actice requirements. audits were initiated formed daily x 2 s noted, frequency seks until monthly. ults will be reviewed tolan implemented and riew the job consibilities with all riced regarding g staff compliance icies. control policies and of correction. sults will be reviewed and a-plan d as needed result in continued	8/9/10
	revealed staff # roll of tape for the #19.	t used the same contaminated ne patient dialyzing also at station			; ; ;		, , ,
	Observation on	7/14/10 at 1115 revealed staff #3					<u> </u>

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
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PLAN OF	CORRECTION	1	A. BUILDING		
		342543	B. WING		07/16/2010
		1 342040	Terpes	TADDRESS, CITY, STATE, ZIP CODE	
NAME OF PRO	OVIDER OR SUPPLIER	•		RUIN CREEK RD SUITE 212	
ハッかいた しょ	DUNTY DIALYSIS		L	IDERSON, NC 27536	
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V-117	Continued From pa	ye 4	;		:
	did not maintain a c	clean computer cart when she	1 1		į į
	placed a contamina	ated glove on it that she had			•
	just used to touch the state of	he dialysis machine at station			
	#19, where a patie	III was dialyzing.	1		ļ .
	Intendent with the	acility Clinical Nurse Manager			
	interview with the i	revealed the computers and	1		1
	computer carts are	e considered clean areas.			:
}	Interview revealed	d she was aware that statt did			1
	not follow appropr	iate standard precautions	<u>'</u>		:
	during direct natio	nt care, but her job duties did			1
	i not include nersor	anel issues. Interview revealed			į
	"the Facility Admir	nistrator is responsible for the	ļ	•	1
	l oversight of the st	laff":	1/400	1 1	
V 12	n ! 404 30(a)(1)(i) IC	-TRANSDUCER	V 120	1	
, ,,,	PROTECTORS-	NOT WETTED/CHANGED	1		
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	Use external ven	ous and arterial pressure	1	1	
	transducer filters	/protectors for each patient		!	
	i treatment to prev	vent blood contamination of the	1	:	
	dialysis machine	s' pressure monitors.	į	i I	•
	1	and year protector becomes Wet	1	ş	<b>i</b>
	If the external tra	ansducer protector becomes wet, ately and inspect the protector. If	•		
	replace immedia	the side of the transducer	1		<b>!</b>
	fluid is visible of	ces the machine; have qualified	i		
	: protector that ta	the machine after the treatment	i		
	: personnei open	d check for contamination. This		İ	
	is completed an	tion for possible blood		<u> </u>	
	anitamination (	of the internal pressure tubing set			İ
	and pressure se	ensing port, if contamination has			į
l l	occurred the m	nachine must be taken out of			ļ
	annica and dis	infected using either 1:100			1
	dilution of bleat	ch (300-600 mg/L free chlorine) or		1	
	a commercially	available, EPA-registered			
- 1	tuberculocidal	germicide before reuse.	Į		ì
	1		ļ		i t
	Change filters/	protectors between each patient		· 1	
1	treatment, and	do not reuse them. Internal		T. L. LOFF	If continuation sheet Page 5

CENTERS FOR MEDICARE & MEDICARD DESCRIPTION OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING			
		342543	B. WING		07/16	/2010
	OVIDER OR SUPPLIER		. 5	EET ADDRESS, CITY, STATE, ZIP CODE 11 RUIN CREEK RD SUITE 212 IENDERSON, NC 27536	•	,
VANCEC				PROVIDER'S PLAN OF CORRE	стюн	(X5) .
(X4) ID PREFIX TAG	1 CANDESCRIPTION	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
1400	Continued From pag	70.5	V 120	V 120		
V 120	transducer filters do routinely between pour routinely between pour routinely between pour routinely between pour routinely between pour routinely pour rout	not need to be changed atients.  s not met as evidenced by: blicy review, observation and facility staff failed to change filters to prevent possible an of blood.		1. Policy # 1-03-11 Changing Transprotectors will be reviewed with a teammates with emphasis on that transducer protectors are to be repwhenever blood or saline is observentact with the patient side of the protector.  2. All teammates will complete L 2002 infection control mandatory  3. LMS training records will for compliance and tracked to ve completion by all teammates.  4. Daily infection control au include transducer monitoring, won July 22 and will be performed weeks. When compliance is note will become weekly x 4 weeks to compliance is noted, then montform the substraction control audit results reviewed at the CQI meeting an implemented and adjusted as noted. Clinical Mgr will review the description, role and responsible hemo nurses and PCTS.  7. All nurses will be inserviced.	Il clinical he external laced yed in transducer  MS MAN training.  I be audited rify  dits which yere initiated didaily x 2 ed, frequency antil ally. will be d a plan heded. job lities with all	8/9/10
	Interview with the on 7/14/10 at 12 "changed out" the as soon as it be revealed she wappropriate star patient care, but the personnel issue.	ne facility Clinical Nurse Manager 230 revealed staff should have ne bloodled transducer protectors comes bloodled. Interview ras aware that staff did not follow indard precautions during direct at her job duties did not include es. Interview revealed "the strator is responsible for the e staff". E-COMFORTABLE		expectations of monitoring stat with infection control policies changing of transducers when 8. The Clinical Mgr will monit team compliance with infectio policies and compliance with in correction. 9. Infection control audit resul reviewed by the Governing Be implemented and adjusted as 10. Disciplinary action will re continued non-compliance wi control policy and plan.	including the needed. For daily for neontrol the plan of the will be ody and a plan needed stult in the infection	ion sheet Page 6 0

CENTERS FOR MEDICARE & ME		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE DING .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342543	B. WIN		4	07/16/2010	
	OVIDER OR SUPPLIER			511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
V 405	Continued From pag	ge 6	V	405;		1	i
	facility; and	must: rtable temperature within the e accommodations for the of comfortable at this		3. 40 30 30 30 30 30 30 30 30 30 30 30 30 30			and the same of th
	Based on observat	s not met as evidenced by: ion, patient interview and staff ty failed to maintain a rature in the treatment area vsis treatments.			Ų 465		
	The findings include	led:	1		•		: .
	patients dialyzing	15/10 at 0930 revealed 7 of 7 in the Pod that housed dialysis ere dialyzing and each patient a blanket.			1. Teammates will be informed of temperature control process, exper results of non-compliance with contemperature control.  2. Temperature will be set at 70 do thermostats. With covered lock be	etation and mfortable egrees on all	8/6/10
	natients dialyzing	/15/10 at 0930 revealed 7 of 8 in the Pod that housed dialysis vere dialyzing and each patient a blanket.			will be maintained by the Charge 3. Teammates will monitor patien being cold every shift. 4. Teammates will notify Charge patients c/o of being cold.	Nurse. ts for signs of Nurse when	0,00,10
	natients dialyzino	/15/10 at 0930 revealed 7 of 8 g in the Pod that housed dialysis ere diatyzing and each patlent n a blanket.			5. Attempts will be made by the t make reasonable accommodation patients who are not comfortable temperature. 6. The Clinical Mgr will monitor	s for the at this daily for team	
	patients dialyzin	7/15/10 at 0930 revealed 8 of 9 g on the back wall area of the that housed stations #25-33 were ich patient was covered with a			compliance with the plan of com- responsible for ongoing complian	nce with POC.	+
	Interview on 7/1	5/10 at 0940 with patient #15 ents covered by a blanket during					o sheet Page 1

STATEMENT D	FOR MEDICARE & F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
TPLANTO!		342543	B. WING		07/16/2010
	OVIDER OR SUPPLIER	<u> </u>	511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536	
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
	Continued From page	ne 7	V 405		
V 403	dialysis treatment) r "all the time". Inten	revealed the facility is cold view revealed patient #15 m home each treatment day cause the treatment room is			
	(one of the patients dialysis treatment) with a blanket because Interview revealed been so cold prior blanket, that her "t lnterview with the	O at 0945 with patient #17 s covered by a blanket during revealed she covered herself ause she was too cold. e patient treatment area had to covering herself with a eeth were chattering".  Facility Administrator on evealed there were several e patient treatment area and			
V 48	each had been se (62-72 degrees). had no system in treatment area we temperature for p	at at different temperatures Interview revealed the facility place to ensure the patient as maintained at a comfortable atients during dialysis HD PTS IN VIEW DURING	V 40		
	hemodialysis tree (video surveilland requirement).  This STANDARI Based on facility	in view of staff during atment to ensure patient safety, ce will not meet this  D is not met as evidenced by: policy review, observation, staff emodialysis treatment sheet			
	. review, the facili	ty staff failed to ensure patient re visible to staff during			
	The findings inc	duded:			

CENTERS FOR MEDICARE & MEDICARD SERVICES  (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
) PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING				
		342543	B. WING		07/16	/2010	
	OVIDER OR SUPPLIER		511	ET ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536			
	CIRRIADV S	TATEMENT OF DEFICIENCIES	l ID :	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI	CTION OULD BE	(X5) COMPLETION	
(X4) ID PREFIX TAG	ILVOR DEBICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE	
V/ 407	Continued From page	ne 8	V 407				
V 407	•	•		V 407			
ļ	Review of facility po	blicy 3-01-07A, Patient					
	Rights, Responsibil	ities and Facility Rules 2008), revealed patients are		Clinical Mgr will review the im	portance of	<u> </u>	
	(revised December	neir access sites visible at all	1	keening VA sites uncovered with	each patient.	į į	
	times during hemor	dialysis treatment.		1 Policy # 1-04-01 AVF and AV	3 Vascular	8/6/10	
	•			Access Care will be reviewed wit	h ail	!	
	Observation on 7/1	3/10 at 0903, 0925 and 0957		teammates, with emphasis placed monitoring. Acknowledgment of	OH VA SHE	į	
	revealed staff was	not able to see patient #11's		understanding the expectation and	d result of	•	
	AV fistula access a	at station #33 during dialysis a it was covered by a blanket		non-compliance was signed by al	l clinical .	1	
	i treatment because	if Mas covered by a presured	i	i teammates.		l .	
	Observation on 7/	13/10 at 0903 and 0925	4	2.3. Policy #1-01-09 Against Mo	edical Advise		
	revealed staff was	not able to see patient #98 AV	•	(AMA) was reviewed with emph for documentation of patient refu	iasis on use		
	I amoff access at sta	ation # 12 during dialysis		VA sites uncovered during treats	nent	İ	
	treatment becaus	e it was covered by a blanket.	ļ	4. Access sites will be monitored	l for visibility	. !	
	;			throughout dialysis treatment an	đ	1	
	Observation on 7.	/13/10 at 0903 revealed staff	1	documented.		•	
1	was not able to s	ee patient #10's AV fistula	1	5. Teammates will encourage pe uncover access sites and docum	itients to		
	access at station	#14 during dialysis treatment	;	charge Nurse will be notified o	f natient	1	
\	because it was c	overed by a blanket.		refusals. An AMA will be comp	leted.	•	
	Ot wation on 7	7/13/10 at 0903 revealed staff	1	6. The Charge Nurse will monit	or visibility of	•	
	Upservation of a	see patient #12's catheter access	- 1	access sites every shift for com	pliance.	•	
	was not able to c	iring dialysis treatment because	i	7 The Clinical Manager will m	onitor process	Ì	
	it was covered b	y a blanket.		daily for compliance with plan.	PA IS		
	1			responsible for ongoing compli	ance with		
1	Observation on	7/13/10 at 1130 revealed staff		POC.		1	
	wor not able to	see patient #5's AV graft access				!	
	at station #6 dui	ring dialysis treatment because it	1			!	
1	was covered by	a blanket.					
		7/13/10 at 1150 revealed staff				1	
	Observation on	see patient #6's AV fistula access	ļ			1	
	was not able to	luring dialysis treatment because	į			1	
	it was covered	by a blanket.		į		1	
	•			<b>i</b>		, :	
	Observation or	7/13/10 at 1200 revealed staff	;			† *	
	· was not able to	see patient #7's AV graft access		<u> </u>		on sheet Page 9 o	

CENTERS FOR MEDICARE & MEDICAID SERVICES				OIMB NO. 0350-0						
			(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	JLTI	PLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
PLAN (	OF CO	DEFICIENCIES DRRECTION	IDENTIFICATION NUMBER:	A. BUIL	_DIN	G		35,,,,		
			342543	B. WIN				07/	16/2010	
NAME OF	PROV	/IDER OR SUPPLIER			ST	REET	ADDRESS, CITY, STATE, ZIP CODE			
		INTY DIALYSIS					OUIN CREEK RD SUITE 212 DERSON, NC 27536			
VANCE	COL			7		7	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
(X4) II PREFI TAG	x :	CACH DESICIENT	TATEMENT OF DEFICIENCIES  DY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	•	FACH CORRECTIVE ACTION		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION DATE	
1	07 '	Continued From pag	ne 9	. V	/ 40	7				
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Ο <i>1</i>	of station 430 drain.	g dialysis treatment because	i		i				
	1	it was covered by a	blanket.	1		•				
	ì	Observation on 7/1:	3/10 at 1221 revealed staff			•			:	
		was not able to see	patient #8's catheter access	i		:				
	. !	at station #12 beca	use during dialysis treatment	ì		;				
	. ;	it was covered by a	i blanket.	2		'				
		ot offen an 7/1	5/10 at 0900 revealed staff	:		:				
		Opservation on 171	e patient #12's AV fistula	ļ						
		access at station #	5 during dialysis treatment	į		:				
		because it was co	vered by a blanket.			1				
		Observation on 7/	15/10 at 0900 revealed staff			ì				
		was not able to se	e patient #13's catheter access	Ì		Í			1	
1		at station #25 duri	ing dialysis treatment because			1				
-		it was covered by	a blanket.							
ı		Observation on 7	/15/10 at 0900 revealed staff			İ	·			
		was not able to se	ee patient #14's AV fistula						1	
		access at station	#26 during dialysis treatment						ì	
		because it was co	overed by a blanket.							
		i	MEIAD at 0030 revealed staff							
-		Observation on /	7/15/10 at 0930 revealed staff see patient #16's AV graft access	- }					i.	
		was not able to s	ring dialysis treatment because		,		1			
		it was covered by	y a blanket.	1			1			
- 1							;		•	
		Interview with th	e facility Clinical Nurse Manager	!			i			
1		on 7/14/10 at 12	30 revealed patient's access				1		;	
l		sites should be	visible to staff throughout the	!			:		1	
1		patients dialysis	treatment. Interview revealed efuse to keep their access visible				•		i  -	
		i snould pallent in	it, staff should educate the patient	į						
		on the dangers	of their access site not being	1						
		visible and doci	ument the education and the	i						
		patients refusal	on the dialysis treatment sheet.	į			<u> </u>			
		1								
		Review of the p	patient dialysis treatment sheets				<u> </u>	<u> </u>	tion about Page 10 of	

CENTERS FOR MEDICARE & MEDICARD SERVICES  (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
TEMENT OF C	DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM LETTE				
		342543	B, WING		07/16/	2010			
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536						
VANCE CO	OUNTY DIALYSIS			PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION			
(X4) ID PREFIX TAG	TAOU DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APPROXIMATION OF THE APPROXIMATIO	DATE				
1107	C. Frued Crom na	10 10	V 407		1				
V 407	Continued From pay	ented evidence of patient							
	Levesies up apprint	s refusal, respectively.		∨409					
V 409	494 60(d)(1) PE-EF	RPREP	V 409	1. Policy #4-07-01 Disaster, Fire and	Business				
V 403	STAFF-INITIAL/AN	NUAL/INFORM PTS		Continuity Emergency					
	1	•		Preparedness Guidelines will be revi	iewed and				
	The dialysis facility	must provide appropriate		all teammates will be in-serviced rep building layout, location of exits and	garumg 1	İ			
	training and orients	e staff. Staff training must be		emergency evacuation site.		8/13/10			
	provided and evalu	ated at least annually and		2. Evacuation location site will be p	osted at all	0/13/10			
	include the following	na:	* :	exit doors.  3. Teammates will be quizzed to de	termine				
	(1) Encuring that st	aff can demonstrate a	<u> </u>	knowledge of designated emergence	y				
	knowledge of eme	rgency procedures, including	1	evacuation location site.					
	informing patients (A) What to do;	OI-	1	' A Emergency preparedness drills v	vill be				
}	(R) Where to do. i	ncluding instructions for	i	completed with teammates quarter emphasis on evacuation location si	te.				
1	occasions when t	ne geographic area of the		5 Completion of quarterly emerge	ncy training	;			
	dialycic facility mi	ist be evacuated;	ļ	and completion of plan of correction	on will be				
	(C) Whom to con	cact if an emergency occurs is not in the dialysis facility. This		reviewed at CQI meetings. The pl	an will be				
	while the patient	on must include an alternate	1	adjusted as needed.  6. Facility Administrator will mon	itor for				
	omorgancy phon	e number for the facility for		compliance with plan.					
	instances when t	he dialysis facility is unable to	į.						
1	roceive phone ca	ills due to an emergency							
1	situation (unless	the facility has the ability to	A Comment			1			
	forward calls to	working phone number under conditions); and		-					
	(D) How to disco	nnect themselves from the							
	dialysis machine	if an emergency occurs.							
	i					1			
	This STANDAR	D is not met as evidenced by: y policy review, facility disaster	,			1			
	ninn rovigu and	staff interview, the facility falled			•				
	1 to annura ctaff	was knowledgeable regarding				į			
	· late#Instignt me	etion area outside the dialysis		1		<u> </u>			
	i building in the t	event of an emergency evacuation	.	•		;			
	for 1 of 4 staff interviewed (#6).			<b>1</b>	· ·				
	The findings in	cluded:	!			*			
1	THE INTERIOR								

TEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURV COMPLETER	
) PLAN OF (	CORRECTION		A. BUILDING B. WING		07/16	/2040
		342543		700000	1 0//10	12010
•	OVIDER OR SUPPLIER		511 R	ADDRESS, CITY, STATE, ZIP CODE LUIN CREEK RD SUITE 212 DERSON, NC 27536		
VANCE CO	UNTY DIALYSIS		<del></del>	PROVIDER'S PLAN OF CORRI	-CTION	(X5)
(X4) ID PREFIX TAG	ICACH DEFICIEN	TATEMENT OF DEFICIENCIES  DY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION DATE
V 409	Continued From page	ne 11	V 409	•	;	,
V 409	Review of facility po and Business Conti Preparedness Guid	licy, 4-07-01, Disaster, Fire				
	i revealed the emerc	ty's current disaster plan gency evacuation off-site be the parking lot of the				
	not know where st in the event of an building. Interview	10 at 1535 revealed staff did aff/patients would meet outside emergency evacuation of the v revealed she thought the behind the building.				
V 4	Administrator reverse parking lot locate 12   494.60(d)(2) PE-	NED provide appropriate orientation	V 412			
	specified in para	atients, including the areas graphs (d)(1)(l) of this section.  Is not met as evidenced by:		1	,	:
	Based on facility preparedness pl staff interview, ti patients were kn	policy review, disaster an review, patient interview and ne facility failed to ensure nowledgeable regarding paredness procedures for 6 of 6 wed (#5, 22, 20, 21, 18, 17).				
	The findings inc					
1	Review of facili	ty policy, 4-07-01, Disaster, Fire				

TEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPLETED	
, PLAN OF C	CORRECTION	IDENTIFICATION OF THE PROPERTY	A, BUIL				
		342543	B. WIN			07/16/2	2010
	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
					RUIN CREEK RD SUITE 212		
VANCE CO	UNTY DIALYSIS			HE	NDERSON, NC 27536	-original i	(XS)
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE	HOULD BE	COMPLETION
(X4) ID PREFIX	" " A OU DEELCIEN	CY MUST BE PRECEDED BY FULL	PREF		CROSS-REFERENCED TO THE AP	PROPRIATE '	OKIE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	"	Ì	DEFICIENCY)		
				412		ļ	
V 412		ge 12	1	412			
	and Business Conti	nuity Emergency					
	Drongradness Guid	lelines revised 9/09) revealed					
	! ataff training include	ed where to go it evacuating	Ì		V 412		
	from the dialysis fa	cility and off-site evacuation	1				
	destination		ļ		1.Policy #4-07-01 Disaster, Fire as	nd Business	
• •			Ì		Continuity Emergency		,
	Review of the facili	ity's current disaster plan	1		Preparedness Guidelines will be re	eviewed sud	•
	' revealed the emen	dency evacuation off-site			all teammates will be inserviced re	egarung	,
	destination would be the parking lot of the		:		building layout, location of exits	anu	
	dialusis facility Pl	an review also revealed			emergency evacuation site.  1. All patients will be re-educated	regarding	;
	- short-term (disrupt	tion of operations less than 12	l		the emergency evacuation and dis	saster	ı
ļ	hours) and long-te	ern (disruption of operations of	:		planning, with emphasis placed o	n emergency	
	greater than 72 ho	ours) disaster plans:			evacuation location site and plan	if facility is	:
	i		i		non-operational.		
	Short-tern Disaste	er Guidelines			2. Emergency evacuation location	n site will be	8/13/10
1	-Dialysis treatmer	nts will be provided as needed	ì		nocted at all exit doors.		
	by a back-up faci	lity	•		A All new and visiting patients	will receive	; !
	-Patients will be o	contacted by person in charge	7		emergency and disaster planning	g education	Ì
1	Designated evar	cuation location is the parking	ì		during their admission process	121 To a malacon of	:
	i lot		1		5. Disaster planning pamphlets	Will be ordered	! !
}		- 41 15	İ		from NW 6 and distributed to al	u pis, coter planning	i.
	Long-tern Disast	er Guidelines			6. A patient emergency and dis quiz will be created and reviewe	ed with all	:
ļ	-Dialysis treatme	ents will be provided as needed	.			Ca film an	;
1	by a back-up fac	cility	İ		patients. 1. 7. Medical records will be au	dited monthly x	
Į.	-Patients will be	contacted by person in charge	1		3 months for documentation of	emergency and	1
	-Designated eve	acuation location is the parking	- T		dispeter planning education, inc	cluding all	1
	lot	the smithal			new and visiting patier	ats, Audits will	
	Emergency she	Iter-local hospital	Ì		be completed quarterly thereaf	ter, if compliance	
	1	7/40/40 of 1010 with nation! #5	1		is noted		
	1. Interview on	7/12/10 at 1212 with patient #5,			9 Guest Services contact num	ber will be added	i
	<ul> <li>who was admitt</li> </ul>	ted October, 2009, revealed he	1		to the facility answer machine	message to assist	}
	ı did not know wi	here the outside evacuation	1		nationt in the event of a disaste	er or emergency.	
	location was in	the event the facility had to be			9. Medical record audit results	Will be reviewed	
1	evacuated, and	he did not know what to do in the			at CQI meeting monthly. A pl	an will de	,
	event of a natu	iral disaster and the facility was	•		implemented as needed.	a- compliance	
	not operational	<b>l.</b>	ŧ		10. FA will monitor process f	or computance	
	į	THE AMERICAN THE PROPERTY HOSPITAL HOSP	1		with plan.		:
1	2. Interview of	n 7/14/10 at 0920 with patient #22,	:		· •		
	who was admi	tted in 3/2008, revealed she did	i				wheet Bana 1

PRINTED: 08/02/2010 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 ATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING O PLAN OF CORRECTION 07/16/2010 B. WING 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536 VANCE COUNTY DIALYSIS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE (X4) ID TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG V 412 V 412 Continued From page 13 not know where the outside evacuation location was in the event the facility had to be evacuated. 3. Interview on 7/14/10 at 0926 with patient #20, who was admitted December, 2009, revealed she did not know where the outside evacuation location was in the event the facility had to be evacuated, and she did not know what to do in the event of a natural disaster and the facility was not operational. 4. Interview on 7/14/10 at 0942 with patient #21, who was admitted in 2006, revealed she did not know where the outside evacuation location was in the event the facility had to be evacuated, and she did not know what to do in the event of a natural disaster and the facility was not operational. Interview on 7/15/10 at 0940 with patient #18, who was admitted approximately a year ago, revealed he did not know where the outside evacuation location was "for this building" in the event the facility had to be evacuated, and he did not know what to do in the event of a natural disaster and the facility was not operational. 6. Interview on 7/15/10 at 0945 with patient #17, a transient patient dialyzing at the facility while vacationing at the lake with family, revealed 7/15/10 was her second treatment at the facility "this week" and she did not know where the outside emergency evacuation location was in the event the facility had to be evacuated.

Interview with the Facility Administrator on 7/15/10 at 0945 revealed the facility provides patients every September with a "Hurricane Planning & Safety for Dialysis Patients" booklet

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use at all times.

The findings included:

Based on facility policy review, Emergency Equipment Checklist log review, observation and staff interview, the facility staff failed to ensure the emergency equipment was ready to

TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
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V 413	revealed staff is received the checks on the emergency equipment of the week checklist log reveal conducted on the conducted on the conducted on 7/6, 7/7 and 7/1.  Observation on 7/1 emergency equipment of the conducted on the	y policy 01-02-08, ent Checks (revised 12/2008) quired to conduct weekly rgency suction equipment to is operational. dy emergency equipment led weekly checks were emergency suction equipment	V 413i	V 413 1. Policy: 1-02-08 Emergency E Checks will be reviewed with al with emphasis on proper checki machine to verify suction ability 2. The suction machine will be weekly for verification that an a amount of suction is available a documented. 3. The damaged canister top of machine was replaced and extra canister tops placed on the cras 1. 4. Emergency equipment ch monitored by the Clinical Man	Il nurses, ng of suction y. checked adequate and the suction a suction checart. ecks will be	8/13/10	
	Registered Nurse Equipment Check revealed she doe suction equipment performs the emo	110 at 1451 with staff #7, the who signed the Emergency dist on 7/6 and 7/13/10, s not check the emergency at suction ability when she ergency equipment check, just machine turns on.					
V	Nurse Manager the weekly emer suction machine		V 5	37			
	(2) Retrieve and	I review complete self-monitoring information from self-care designated caregiver(s) at least					

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CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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V 58 <b>7</b>	Continued From pa	nge 16 formation in the patient 's	V 587			
	This STANDARD Based on facility p and medical record retrieve, review an medical record sel (#23) peritoneal d The findings included Review of facility and Retention of l (revised 9/08), record includes treatment Interview on 7/16 revealed patients home dialysis floodinic visit. Interview sheets are review the patient has for	policy 5-09-01, Maintenance Patient Medical Records vealed the medical record at flow sheets.  /10 at 1200 with the PD nurse are required to bring their w sheets to facility each monthly riew revealed the dialysis flow yed by the nurse making sure followed physician orders related reatment. Interview revealed ets should be incorporated into		1. Policy #5-01-22 Routine Support S will be reviewed with the PD nurse, v emphasis placed on the requirement f monthly treatment sheet review by th nurse.  2. Letters will be given to all patients the importance of bringing treatment into the PD nurse for review and doc 3. Patients will be given a calendar emonth reminding them of the date to treatment sheets with them to PD clit 4. Reminders will be posted on the c the RN to ask the patient for the treasheets during clinic days.  5. PD nurse will educate the patient importance of treatment sheet review patients do not bring the sheets as reand document the patient education medical record.  6. Chart audits will be completed or patients' medical records for current sheets and documented review of the treatment sheet by the PD RN.	stating sheets sumented. very bring nic. hart for tment very when equested in the all home treatment is	8/13/10
	revealed this 44 renal disease se admitted to the review revealed from PD and ini 4/22/10 due to the review revealed	edical record for patient #23 year old female with end stage econdary to lupus had been facility in 2008 for PD. Record this patient had been discharged tiated in-center hemodialysis on recurrent peritonitis. Record If the patient's medical record did ne treatment flow sheets from		7. 7. The PD nurse will request patibring in any missing treatment shee document.  8. Medical record PD treatment shee results will be reviewed at the CQI and adjustments to the plan made a 9. On-going refusal to bring treatment for review will become part of the IDT plan of care.  10. The home program manager (I monitor the process monthly for continuous patients)	eet audit meetings s needed. ent sheets patient's	

hemodialysis).

3/1/10 /10-4/15/10 (first date of in-center

with the plan.

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	T	u moi e ce	ONSTRUCTION	(X3) DATE SURV	<b>≘</b> Υ .
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V 587	Continued From page	ge 17	1	587			
!	Intonview on 7/16/11	at 1200 with the PD nurse	į	•		ı	
,	toyaglad no evolant	ation as to why this patient's	} :	į		;	l
	home treatment flo	w sheets were not in the	1	ė.			1
	patients medical re	cord.	1				l
11500	• '	MONITOR HOME	,	V 589 į			
V 589	ADAPT;HOME VIS	IT=POC	i	1			
1	ADAPT HOME VIO	11,-100	ļ	;			
	Condess include h	out are not limited to, the	İ	i	•		
	following:	the state of the s					;
	(i) Portodic monito	ring of the patient's home					!
į.	(i) renous monde	ng visits to the patient's home		1	11500		
}	by facility personn	el in accordance with the			V589 1. The Best Demonstrated Practice	for home	1
1	patient's plan of ca	ara			visits, Policy #5-01-23 Peritoneal I	Dialysis Home	
	patient's plan of or	310.		İ	Environment Adaptation and Polic	y #5-01-22	
j			1	İ	Routine Support Service will be re	viewed with	
<b>\</b>	1		. [	Ì	all Home RNs by the HPM, with e	mphasis on	
•	•	-	1	1	the required frequency and criteria	for routine	8/13/10
	This STANDARD	is not met as evidenced by:	į		home visits, home visits related to	peritonitis,	
1	This or Airpard	policy review, staff interview		į	change in home environment or W	hen the patient	1
1	; paseu on racinty	rd review, the facility staff failed	i		is unable to come in to clinic due t	o health status.	
1	dilu ilicultat reco	ts home adaptation for 1 of 2	i		2. All home patient charts will be	reviewed for	1
ļ	(#33) positonesi r	dialysis (PD) patients reviewed.		1 1	documented home visits and to de	termine the	<u></u>
	(#20) peritoriear	month and the second	į	:	need for a home visit. Monthly au	aits Will De	,
1	! i The findings incl	ided:	i		performed x3 months, then quarte	itiA ii	-
	the minnings mon	<del>yı m. m. −</del>	:		compliance is noted.  3. The home visit chart review re-	nite will he	;
	- Beview of facility	policy 5-01-23, Peritoneal	ļ		reviewed at the CQI meetings mo	nthly and	
1	Dialysis Home F	nvironment Adaptation (revised			adjustments made to the plan as r	eeded.	
	i gins) revealed i	n addition to the Initial home	į t		4. Patients found meeting the cri	teria for home	•
ļ	acceptement visit	"Additional home visits may	į		vieite will be deemed unstable an	d assessed by	
1	he nertomed as	needed to assess the patient's	1		the IDT for plan of care, including	g peritonitis.	
1	home adaptation	n <sup>a</sup> -	İ		5. HPM will monitor the process	for compliance	3
1	i ilome acaptato	·• •			with the plan of correction month	nly.	•
	Intention 7/16/1	0 at 1200 with the PD nurse					!
	revealed home	visits are conducted on the first	١		1		1
1	nationts home t	reatment after training, annually	1			•	
1	thorostor and s	as needed. Interview revealed	1				1
ł	nertenitie of a	PD patient would warrant a home			,		
	visit to opeure t	he home environment was	ł	•			!
	conducive for h	nome dialvsis.	1				
1	I COMMUNITY OF THE	fortime descript man.			A		

Continued From page 18

antibiotics.

STATEMENT OF DEFICIENCIES

VD PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

VANCE COUNTY DIALYSIS

(X4) ID

PREFIX

TAG

V 589

(X1) PROVIDER/SUPPLIER/CLIA

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

Review of the medical record for patient #23 revealed this 44 year old female with end stage renal disease secondary to lupus had been admitted to the facility in 2008 for PD. Record review revealed this patient had been discharged from PD and initiated in-center hemodialysis on 4/22/10 due to recurrent peritonitis. Record review revealed the patient was hospitalized on 10/15/2009, 3/29/10 and 4/22/10 for peritonitis. Record review revealed in addition to these hospitalizations, the patient was also diagnosed with peritonitis on 3/5/10 and was treated with

Medical record review revealed PD staff did not conduct a home visit to assess this patients home adaptation with her initial diagnosis of peritoneal on 10/15/2009 and each subsequent infection 3/5/10 and 3/29/10 until 4/6/10. Record

REGULATORY OR LSC IDENTIFYING INFORMATION)

IDENTIFICATION NUMBER:

342543

PRINTED: 08/02/2010 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A BUILDING B. WING 07/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION IEACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) V 589

review revealed prior to the 4/6/10 home visit, the last time staff conducted a home visit was on 10/10/08. Medical record review revealed PD staff conducted a home visit on 4/16/10 (after her 3rd peritonitis episode). Review of the 4/16/10 PD nurse progress note revealed "As a result of this (peritonitis) I did a home visit (conducted on 4/6/10). Her current living conditions are a huge concern. Front door wide open with no screen to prevent insects from flying in. I didn't notice any pets but there was a distinct animal urine smell permeating the house, Bugs/Ants crawling on the kitchen counter. Her bedroom had expired supplies. Spider webs in several corners even some on some of the expired boxes. The boxes also had possible insect feces, roaches crawling on the walls. I saw two ants crawl across her

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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V 589 !	Continued From pa	ge 19	V 589		•	
i	cycler."	•	. i			1
1		, , , , , , , , , , , , , , , , , , ,				1 .
1	Interview on 7/16/1	0 at 1200 with the PD nurse				
į	revealed during the	4/6/10 home visit, patient t of things that needed to be				
1	#23 was given a ils	me. Interview revealed a				i
1	improved in the no	visit was conducted on 4/14/10	1 .			;
į	and the home con	ditions had not improved.				!
•	and the nome con					1
,	Review of the med	lical record revealed the		1		į
	Interdisciplinary te	am determined the patient was				İ
	not a PD candidat	e and was discharged from PD				
,	on 4/22/10 and ac	mitted tot he facility for			,	
ļ	hemodialysis.					'
V 626	494,110 QAPI-CC	VERS SCOPE	V 626	); {		i
1	SERV/EFFECTIV	E/IDT INVOL	1			1
	i v to in familie	ly must develop, implement,				•
i .	! The dialysis lacil	aluate an effective, data-driven,		1		. 1
	. Wallifall, and exc	ent and performance	•	į		
	improvement nro	gram with participation by the	i İ			1
	professional mer	nbers of the interdisciplinary		•		i
	team The progra	am must reflect the complexity	} !	†		· i
	of the dialysis far	cility's organization and services		-		
	i (including those	services provided under		1		; :
	errannement), a	nd must focus on indicators	1	1		<u>i</u>
1	related to improv	red health outcomes and the	1			:
	prevention and r	eduction of medical errors. The	į	•		1
	dialysis facility n	nust maintain and demonstrate	i ]	,		-
	evidence of its	uality improvement and				1
		provement program for review by	Ì			1
	CMS.		<u> </u>			
			1			i
	This STANDAR	D is not met as evidenced by:				
	Barad on facilit	v policy review, quality		· <b>(</b>		Į.
	improvement C	ontinuous Quality Improvement				
	Program (COI)	documentation review, and starr				•
1	interview, the f	acility CQI Committee failed to	•		<del></del>	

STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE BURV COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING			1
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V 626	identify goals for tot (KT/V), iron saturati and albumin indicat performance could implemented as nee peritoneal nurse (Pimeetings as required The findings included Review of facility pand 5-02-13 (peritor Quality Improvement analyzed and trackwill be reviewed, replans Implemented improvement and revealed mineral redisease (PTH), valuatition (albumin) be monitored.	al infections, adequacy on (Tsats), hospitalizations ors such that areas of under be identified and action plans eded, and failed to enure the D) attended the CQI monthly ed.  ed:  clicies 1-02-01 (hemodialysis) oneal dialysis), Continuous ont Program (revised 9/08), dicators would be measured, ed. Areas under performing oot causes identified, action of and tracked for performance sustainment. Policy review metabolism/Renal bone scular access, infections, and were indicators that were to	V 626	V 626  1. The Clinical Services Specialist or Regional Operations Director (R attend CQI meetings to insure approved and planning process.  2. CQI meetings will be held montattendance by all QI team members unable to attend in person by phone. Documentation of attend phone will be noted on the QIFMM page. The QI member will sign the return to the facility or by fax to disattendance. FA will follow-up to signatures are in place on QIFMM page.  3. CQI meeting calendar appoints sent to all QI members prior to me allow adequate scheduling of mer attend.  4. QI team members will take the process and documentation trainin LMS, CEC2064 Governing Body Quality Improvement and Facility Meeting (QIFMM) Review Counnext meeting.  5. FA will monitor course complial QI members to assure complial QI members to assure complial QI members to assure compliance.	oD) will opriate the with with s. QI n, will attend dance by M signature to form on occument overify all signature ment will be setting date to onbers to so QIFMM ong course in the prior to the setting dates of ance ong monthly	8/13/10
	for hemodialysis r	d the total number of infections patients had increased from	.	and present clinical issues and or to the QI team.		
	CQl documentation goal had been ide plan was needed documentation relinfection rate was 2. Review of the 4/10-6/10 reveals adequacy >1.2 h March to 94.1% documentation fi	ce March 2010. Review of the con revealed no infection rate entified to determine if an action. Review of the CQI evealed the goal area for left blank.  CQI documentation from ed hemodialysis patient ad decreased from 97% in in April. Review of the CQI com 4/10-6/10 revealed the area of have a goal set to determine if		7. A plan of correction will be di implemented by the Ql team for review and documentation of the and documented in the QIFMM next CQI meeting.  8. The CQI meeting documentat form, will include a review of al outcomes results, including but adequacy, bone mineral manage vascular access, established out root cause if not meeting goal, a priority, responsible party and feffectiveness of plans. cont. pg	appropriate c CQI meeting form at the  ion, QIFMM I clinical not limited to ment ,anemia, come goals, action plans, ollow-up of	

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-F  V 626 Continued From page 21  an action plan was needed. Review of the CQI documentation revealed the goal area for KT/V  >1.2 was left blank.  3. Review of the CQI documentation from changes will	N (X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  VANCE COUNTY DIALYSIS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 626 Continued From page 21 an action plan was needed. Review of the CQI documentation revealed the goal area for KT/V >1.2 was left blank.  3. Review of the CQI documentation from 4/10-6/10 revealed the percentage of hemodialysis patients with an iron saturation (Tsats) >20 had decreased from 77.9% in March to 68.8% in April to 64.9% in May. Review of the CQI documentation revealed no goal had been identified for the percentage of patients with an iron saturation (Tsats) >1.2 to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for iron saturation (Tsats) >1.2 to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for iron saturation (Tsats) >1.2 was left blank.  4. Review of the CQI documentation from 4/10-6/10 revealed number of patient hospitalizations/hospitalization rate for hemodialysis patients increased from 7.7% in March to 13.9% in April to 12% in May 2010. Review of the CQI documentation revealed no	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 626 Continued From page 21  an action plan was needed. Review of the CQI documentation revealed the goal area for KT/V > 1.2 was left blank.  3. Review of the CQI documentation from 4/10-6/10 revealed the percentage of hemodialysis patients with an iron saturation (Tsats) > 20 had decreased from 77.9% in March to 68.8% in April to 64.9% in May. Review of the CQI documentation revealed no goal had been identified for the percentage of patients with an iron saturation (Tsats) > 1.2 to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for iron saturation (Tsats) > 1.2 was left blank.  4. Review of the CQI documentation from 4/10-6/10 revealed number of patient hospitalizations/hospitalization rate for hemodialysis patients increased from 7.7% in March to 13.9% in April to 12% in May 2010.  Review of the CQI documentation revealed no	RD SUITE 212
an action plan was needed. Review of the CQI documentation revealed the goal area for KT/V >1.2 was left blank.  3. Review of the CQI documentation from 4/10-6/10 revealed the percentage of hemodialysis patients with an iron saturation (Tsats) >20 had decreased from 77,9% in March to 68.8% in April to 64.9% in May. Review of the CQI documentation revealed no goal had been identified for the percentage of patients with an iron saturation (Tsats) >1.2 to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for iron saturation (Tsats) >1.2 was left blank.  4. Review of the CQI documentation from 4/10-6/10 revealed number of patient hospitalizations/hospitalization rate for hemodialysis patients increased from 7.7% in March to 13.9% in April to 12% in May 2010. Review of the CQI documentation revealed no	OVIDER'S PLAN OF CORRECTION (XS) I CORRECTIVE ACTION SHOULD BE COMPLETION REFERENCED TO THE APPROPRIATE DEFICIENCY)
4/10-6/10 revealed number of patient hospitalizations/hospitalization rate for hemodialysis patients increased from 7.7% in March to 13.9% in April to 12% in May 2010. Review of the CQI documentation revealed no	will monitor the CQI meeting, secumentation monthly x 6 months or liance is noted, CSS dations for process or documentation ill be presented by the CSS at the CQI meeting.
been identified to determine if an action plan was needed.	
5. Review of the CQI documentation from 4/10-6/10 revealed the percentage of peritoneal patients with an iron saturation (TSats) >20 had decreased from 100% in April to 71.4% in May. Review of the CQI documentation revealed no goal had been identified for the percentage of patients with an iron saturation (TSats) >1.2 to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for iron saturation (TSats) >1.2 was left blank.  6. Review of the CQI documentation from	

PRINTED: 08/02/2010 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 STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 07/16/2010 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 VANCE COUNTY DIALYSIS HENDERSON, NC 27536 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 626 V 626 | Continued From page 22 peritoneal dialysis patients had decreased from 50% in April to 42.9% in May 2010. Review of the CQI documentation revealed no goal for albumin >/= 4.0 had been identified to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for albumin >/= 4.0 was left blank. 7. Review of facility policy 5-02-13, Continuous Quality Improvement Program (9/08), revealed the PD nurse was required to attend monthly CQI meetings. Review of the 4/10, 5/10 and 6/10 CQI meeting minutes revealed the nurse responsible for the PD program had not attended these meetings as required. Interview on 7/16/10 at 0945 with the Facility Administrator revealed up until "a few months ago" the CQI program had lacked information, consistency, and documentation. Interview revealed the nurse responsible for the PD program from 4/10-6/10 was responsible for multiple facilities, and could not always attend the monthly meetings. Interview also revealed

V 628

494.110(a)(2)

on 7/1/10.

QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS

this concern should not be an issue for future meetings given a new facility PD nurse started

The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves.

V 628 . ·

Facility ID: 944655

If continuation sheet Page 23 of 58

	FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURV	
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1	A BUILDING		ĺ
		0.40542	B, WING _		07/16	2010
		. 342543		TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PRO	OVIDER OR SUPPLIER		[3]	511 RUIN CREEK RD SUITE 212	•	
VANCE CC	DUNTY DIALYSIS			HENDERSON, NC 27536		
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRRECTION 1	(X5) .
(X4) ID	WALL DESIGNEN	WINDST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE	DATE
PREFIX TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		·
			V 6:	20	:	
V 628	Continued From page	ge 23	V 6.	V 628		
	This STANDARD is	s not met as evidenced by:	i	1. The FA will review the impo	rtonce and	:
1	Based on facility po	licy review, Continuous	ļ	expectation of accurate AOR m	umbers reported	
	Quality improvemen	nt Program (CQI)	1	for CQI meeting review and co	morate reporting	i
	documentation revi	ew, adverse occurrence		with all nursing and administra	tive teammates.	
1	report documentation	on review, staff interview, and	Ì	2. The nurse will enter AORs a	s necessary into	1 .
1	staffing documents	tion review, the CUI	1	Snappy as they occur.	I Hooding A	
1	Committee falled to	include accurate information		3. The administrative team wil	I print the AOR	
	rogarding AOR OCC	currences and staff complaints	Į.	tracking report from Snappy for	or reporting AOR	8/13/10
	in CQI.		1	data to the QI team monthly.	v robornes	9113110
	in our			3. The administrative team wil	Il review the	
· l	The findings include	ed.	1	AOR numbers for completion	and accuracy	
į.	I he lindings includ	150.		prior to submission to the QI t	eam and	
		policies 1-02-01 (hemodialysis)	1	corporate reporting.		
Ì	Review of facility	dialucie) Continuous	i	4. The QI team will review th	e AOR numbers	1
	and 5-02-13 (pent	oneal dialysis), Continuous	Ì	for trends, during CQI meeting	g monthly.	•
	: Quality Improvem	ent Program (revised 9/08),	1	determine root cause, implem	ent action plans	1
٠.	revealed quality in	ndicators would be measured,	. :	with responsible party and tir	nelines, evaluate	1
	analyzed and trac	ked. Areas under performing	1 .	effectiveness of the plans and	adjust the plan	1
	will be reviewed,	root causes identified, action	į	accordingly as needed.	,	;
1	plans implemente	ed and tracked for performance	Ì	5. The Governing Body will	approve the	1
·	improvement and	sustainment.	ļ	implementation of facility st	affing patterns to	- [
- }			į	maintain and ensure adequat	e staff to patient	1
1	1. Review of the	6/15/10 CQI meeting minute	1	ratios, the Immediate Facility	y Clinical Staffing	
\	documentation re	evealed the "adverse occurrence	!	Plan and the Contingency Pl	an for Maintaining	1
	reporting" (AOR)	did not contain accurate	i	Safe treatments when short s	staffed.	
	information. CQ	I documentation review revealed	}	6. The Governing Body will	insure the Clinical	
	the following AO	Rs/month:		Nurse Manager is available	for continued	<u> </u>
1	1/10=10 AORs;			oversight of the facility clin	ical team and	!
	2/10= 0 AORs;		1	nationt needs		
	3/10=17 AORs;			17 The FA will ensure adequ	uate staffing/patient	
	4/10=8 AORs;	•	1	ratios to maintain safe dialy	sis treatments by .	!
1	5/10=0 AORs.			implementing the Immediat	te Facility Clinical	j
	ł			Staffing Plan and the Conti	ngency Plan for	
	Davious of the "	Alleged Incidents/AOR Tracking"	1	Maintaining Safe treatment	s when short staffed.	i
1	Leview of the	revealed a difference in the	1	R All teammate complaints	s will be documented	
	gocumentation	erse occurrences reported. AOR		by the FA and reported to t	he QI team monthly	
	number of adve	realed the following number of		at the COI meetings. A pla	an of action will be	ļ
	tracking log rev	edica nie longwing names s.		implemented and adjusted	as needed. FA is	1
	AOR reports:			responsible for ongoing co	mpliance with POC.	
	1/10=9;		l (	1		
	2/10=7;		<u> </u>		Mr Margaline	sheet Page 24 of 5

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				(X3) DATE SL	IBAEA
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT A. BUILDING		CONSTRUCTION	07/16/2010	
•		342543	B. WING				
	OVIDER OR SUPPLIER	·		511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212		•
VANCECC	ONT PIACTOR			HE	NDERSON, NC 27536		T MEX
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
V 628	Continued From pag	ge 24	V	628			
	3/10=15;		l	i	·		
	4/10=8;			ì			!
İ	5/10=12.		<b>!</b>	:			:
			•				•
	Interview with the F	acility Administrator on	i	:			
	7/16/10 at 0945 rev	ealed no explanation could					;
	be provided for why	the CQI meeting minutes did	1	•			
,	not reflect accurate	AOR numbers.	!	1			
	ì		Ì	:			•
	2. Interview with 3	staff members who requested	į	•			ŀ
	anonymity during 7	7/13-16/10 revealed they had	ļ	į			
	complained verbal	y to the Facility Administrator	:		•		ĺ
	regarding the work	load being too much with the	j				
.	amount of staff ave	allable on particular days.	i				•
	1	Facility Administrator on	i				1
1	Interview with the	vealed patient care technicians	Ì				•
	(DOTa) are rebadi	uled with a 5:1 patient/tech					i
1	retin and the nurs	ses are scheduled with a 13:1	i				1
	nation to staff rati	o if all the scheduled staff					i
	work Interview re	vealed because a licensed staff		•	·		İ
}	had been given Vi	acation for 6 consecutive weeks	1				1
	and a PCT had be	een on medical leave for "a few					l
1	months" they had	tried to pull together staff from			,		
	other facilities to	nelp, but this was not always			1		!
	possible.						1
-	1		!		•	******	
	Review of the sta	iffing schedule, assignment	!		•		
	sheets and time	cards revealed days that PCTs			•		1
	had a 6:1 and hu	rsing staff had 18:1.	3				•
1	Danish and the NO	hronic Direct Patient Care	. 1				t
	Review of the "C	nt) from 1/10-5/10 revealed the	;		,		1
	: Hrs/ I x (treatment	ient care staff was under the	l <sub>e</sub>				i
	facility offect par	.80) for 1/10 (1.66), 2/10 (1.71),	1		:		1 .
	3/10 (1.75), and	4/10 (1.78).	1		. }		!
	: 3/10 (1./5), and	-110 (1110)	l				!
ĺ	Daview of the F	10 and 6/10 CQI documentation	· •				1
	Teview of these	complaints were not reflected in	l		· • • • • • • • • • • • • • • • • • • •		

PRINTED: 08/02/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>OMB NO. 0938-0</u>391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA *TEMENT OF DEFICIENCIES* COMPLETED IDENTIFICATION NUMBER: A. BUILDING J PLAN OF CORRECTION 07/16/2010 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536 VANCE COUNTY DIALYSIS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 628 V 628 Continued From page 25 the CQI meeting minutes. V629 494.110(a)(2)(i) QAPI-INDICATOR-ADEQUACY V 629 1. The FA will review the importance and expectation of accurate AOR numbers reported OF DIALYSIS for CQI meeting review and corporate reporting with all nursing and administrative teammates. The program must include, but not be limited to, 2. The nurse will enter AORs as necessary into the following: Snappy as they occur. (I) Adequacy of dialysis. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. This STANDARD is not met as evidenced by: 3. The administrative team will review the AOR Based on facility policy review, Continuous numbers for completion and accuracy prior to 8/13/10 Quality Improvement Program (CQI) submission to the QI team and corporate documentation review, and staff interview, the reporting. facility CQI Committee failed to identify areas of 4. The QI team will review the AOR numbers under performance, determine root causes for for trends, during CQI meeting monthly, under performance, implement action plans and determine root cause, implement action plans with responsible party and timelines, evaluate track performance improvement as it related to effectiveness of the plans and adjust the plan adequacy (KT/V) for hemodialysis patients. accordingly as needed. 5. The Governing Body will approve the The findings included: implementation of facility staffing patterns to maintain and ensure adequate staff to patient Review of facility policies 1-02-01, Continuous ratios, the Immediate Facility Clinical Staffing Quality Improvement Program (revised 9/08), Plan and the Contingency Plan for Maintaining revealed quality indicators would be measured, Safe treatments when short staffed, analyzed and tracked. Areas under performing 6. The Governing Body will insure the Clinical will be reviewed, root causes identified, action Nurse Manager is available for continued plans implemented and tracked for performance oversight of the facility clinical team and patient improvement and sustainment. 7. The FA will ensure adequate staffing/patient Review of the 6/15/10 CQI documentation ratios to maintain safe dialysis treatments by revealed a goal of 3% of hemodialysis patients implementing the Immediate Facility Clinical would have a KT/V of <1.2. Review of the Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6/15/10 CQI documentation revealed the 3% 8. All teammate complaints will be documented goal was not met. CQI documentation review by the FA and reported to the QI team monthly

revealed in May there were 5.9% of hemodialysis

patients with a KT/V <1.2. Review revealed CQI

committee documented "Meeting Goal" for KT/V.

Review revealed the facility had not met adequacy goal for 6/10. Review of the CQI at the CQI meetings. A plan of action will be

responsible for ongoing compliance with POC.

implemented and adjusted as needed. FA is

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		342543	B. WING			07/16/2	2010
	OVIDER OR SUPPLIER			511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536		
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V 629	Continued From page documentation reverse not determined a roperformance of the developed/implementation reverse achieve adequacy (interview on 7/16/1 Administrator reverse ago" the CQI program (ago" the CQI program (ago" the CQI) (iii) Consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency, and consistency (iii) Mineral metabolic improvement Consistency (and interview, the facility peritoneal dialysis performance could implemented if metabolic implemented in metabolic implemented in metabolic implemented in metabolic implemented in metabolic implemented in metabolic implemented in metabolic implemented in meta	aled the CQI committee had of cause for the under adequacy indicator, or need an action plan to try to goal.  O at 0945 with the Facility aled up until "a few months am had lacked information, locumentation.  APHINDICATOR-CKD-MBD  include, but not be limited to, plism and renal bone disease.  is not met as evidenced by: policy review, quality tinuous Quality Improvement cumentation review, and staff lity CQI program failed to have thormone (PTH) goal for the identified and action plans are ded, and the CQI Committee the performance of the Haction plan.  Inded:  policies 1-02-01, Continuous nent Program (revised 9/08), indicators would be measured, acked. Areas under performance and tracked for performance and tracked for performance.		629	V631  1. The FA will review the importance expectation of accurate AOR number for CQI meeting review and corporat with all nursing and administrative te 2. The nurse will enter AORs as necessappy as they occur.  3. The administrative team will print tracking report from Snappy for report data to the QI team monthly.  3. The administrative team will revien numbers for completion and accurace submission to the QI team and corporeporting.  4. The QI team will review the AOR trends, during CQI meeting monthly root cause, implement action plans or responsible party and timelines, evaluated effectiveness of the plans and adjust accordingly as needed.  5. The Governing Body will approve implementation of facility staffing maintain and ensure adequate staff ratios, the Immediate Facility Clinical teans and the Contingency Plan for Safe treatments when short staffed.  6. The Governing Body will insure Nurse Manager is available for conversight of the facility clinical teans the facility of the facility clinical teans to maintain safe dialysis treating Plan and the Contingency Maintaining Safe treatments when 8. All teammate complaints will be the CQI meetings. A plan of action implemented and adjusted as need responsible for ongoing compliants.	e reported e reporting e remor	8/13/10

\**\TCCDC	SEOR MEDICARE	MEDICAID SERVICES				UIVIB NO. I	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	JLTIF	LE CONSTRUCTION	(X3) DATE SURVI	
ATEMENT OF ID PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING	G	COMPLETED	
		342543	B. WIN	IG		07/16/	2010
				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AME OF PR	OVIDER OR SUPPLIER				511 RUIN CREEK RD SUITE 212		
VANCE CO	DUNTY DIALYSIS	•			HENDERSON, NC 27536		
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1705							
V 531	Continued From p	age 27	V	63 /	1 V632		
V 001	Continued Front	5/10 CQI meeting minutes			I. The FA will review the impo	rtance and	
	Review of the of it	emodialysis patients should			expectation of accurate AOR m	imbers reponed	
	revealed 80% of f	-o.E. COL documentation			for CQI meeting review and co	rporate reporting	
	have a calcium of	<9.5. CQI documentation			with all nursing and administra	Hye wallinates.	
	review revealed th	ne calcium goal had not been			2. The nurse will enter AORs a	s necessary nac	
	met for 5/10. Rev	riew revealed that only 78.7%	}		Snappy as they occur.	moint the AOR	:
	of the patients ha	d a calcium of <9.5. CQI	1		3. The administrative team will tracking report from Snappy for	r reporting AOR	i
	documentation re	vealed no documented			tracking report from Shappy it	i reporting resid	i
	evidence that the	CQI committee analyzed this			data to the QI team monthly.  3. The administrative team will	I review the	<u> </u>
	under performan	ce to determine if an action plan	•		AOR numbers for completion	and accuracy	8/13/10
	was needed.	•	:		prior to submission to the QI t	earo and	1
	•		i		corporate reporting.	011111 1111111	t ·
	Interview on 7/16	6/10 at 0945 with the Facility	:		4. The QI team will review th	AOR numbers	
	Administrator rev	realed up until "a few months.	1		for trends, during CQI meetin	e monthly.	1
	ago" the CQI pro	gram had lacked information,			determine root cause, implem	ent action plans	
	consistency, an	d documentation.	1			nelines, evaluate	‡
VE	32 494 110(a)(2)(iv	QAPI-INDICATOR-ANEMIA	į	V	osa21 with responsible party and the effectiveness of the plans and	adjust the plan	İ
V 0.	MANAGEMENT				accordingly as needed.		
			! !		5. The Governing Body will	approve the	i
	The program mi	ust include, but not be limited to,	1		implementation of facility sta	ffing patterns to	Ì
	the following:	30( 113.112.)	į		maintain and ensure adequate	staff to patient	;
	(iv) Anemia ma	nagement.	į		ratios the Immediate Facility	Clinical Staffing	i
	. (IV) Anemia ma	augonom .	,*		<ul> <li>Plan and the Contingency Pl</li> </ul>	an for Maintaining	- !
l	,		1		Safe treatments when short s	taffed.	ì
	TEL DEALINAD	D is not met as evidenced by:	- 1		6. The Governing Body will	insure the Clinical	1
	Inis STANDAP	y policy review, quality	1		Nurse Manager is available	for continued	1
	Rased ou racili	continuous Quality Improvement			oversight of the facility clin	cal team and	
1	Improvement	documentation review, and staff		****	natient needs.		
	Program (CQI)	acility CQI Committee failed to	Ì		7. The FA will ensure adequ	iate staffing/patient	1
	interview, the f	nine the root cause for not			ratios to maintain safe dialy	sis treatments by	
	failed to deterr	globin goal and failed to evaluate			implementing the Immediat	e Facility Clinical	
	meeting hemo	giodii goal and laned to overdet			Staffing Plan and the Conti	ngency Plan for	\ !
1	the action plan	for performance improvement.	ļ		Maintaining Safe treatment	when short statted	. · ·
	1	to the sta			8. All teammate complaints	Will be documented	. !
	The findings in	ncinaea:			by the FA and reported to t	ne Qi team monthiy	:
1		w. 4 00 04 Continuous			at the CQI meetings. A pla	n of action will be	4
1	Review of fact	lity policies 1-02-01, Continuous	į		implemented and adjusted	as needed. TA IS	i
Ì	' Quality Impro	vement Program (revised 9/08),	i		responsible for ongoing co	mphance with FOC	• !
	Isun halcavar '	ity indicators would be measured,			) T		ì
1	bns bezwiene i	tracked. Areas under performing	; :				ţ
Į.	will be review	ed, root causes identified, action	}			<del> </del>	nhaot Daga 2

STATEMENT OF DEFICIENCIES  1D PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	342543 B. WING				07/16/2010			
	OVIDER OR SUPPLIER		511 R	STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE		
	Continued From page	70.28	V 632			İ		
V 632	plans implemented improvement and si	and tracked for performance				•		
	revealed 65% of he have a hemoglobin review revealed the been met from 3/10 following hemoglob 3/10=59.2% 4/10=56% CQI documentation evidence that the	10 CQI meeting minutes emodialysis patients should 10-12. CQI documentation he hemoglobin goal had not 0-5/10. Review revealed the coin results:						
	and 6/15/10 rever was needed. Rev plan for 5/19/10 a "Continue using _ and reassess ne							
	was the same as CQI documentat documented evid evaluated the he	ion revealed the 6/10 action plan 5/10 with little improvement. ion review revealed no dence that the CQI committee emoglobin action plan for provement. Review revealed the n of Plan of Correction from Last ft blank.						
	Administrator re ago" the CQI pr	6/10 at 0945 with the Facility exealed up until "a few months ogram had lacked information, and documentation.  () QAPI-INDICATOR-VASCULAR	V 63	3				

TATEMENT OF DEFICIENCIES  10 PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A BUILDING		(X3) DATE SURVEY COMPLETED	
	342543		B. WING		07/16/2010		
NAME OF PR	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		7,2010	
				11 RUIN CREEK RD SUITE 212			
VANCE CO	DUNTY DIALYSIS		· F	ENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
V 633	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  ACCESS  The program must include, but not be limited to, the following: (v) Vascular access.  This STANDARD is not met as evidenced by: Based on facility policy review, Continuous Quality Improvement Program (CQI) documentation review, and staff interview, the facility CQI Committee failed to determine the root cause for high-central venous catheter rate. (CVC) for hemodialysis patients.  The findings included:  Review of facility policies 1-02-01, Continuous Quality Improvement Program (revised 9/08), revealed quality indicators would be measured, analyzed and tracked. Areas under performing will be reviewed, root causes identified, action plans implemented and tracked for performance improvement and sustainment.		V 633	1	nce and nces and nces reported rate reporting reammates. ncessary into note the AOR norting AOR view the accuracy and DR numbers onthly, action plans nes, evaluate nest the plan ove the g patterns to ff to patient mical Staffing or Maintaining dd. re the Clinical		
	patients. Docume facility had not me	er goal of 18% for hemodialysis ntation review revealed the t this goal since 1/10. vealed the following catheter		7. The FA will ensure adequate s ratios to maintain safe dialysis trimplementing the Immediate Fac Staffing Plan and the Contingenc Maintaining Safe treatments whe 8. All teammate complaints will by the FA and reported to the QI at the CQI meetings. A plan of a implemented and adjusted as near responsible for ongoing compliants.	eatments by illity Clinical by Plan for an short staffed, be documented team monthly action will be eded, FA is		
		on revealed no documented					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A BUILD		COMPLETED
		342543	B. WING		07/16/2010
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212	
VANCE CO	DUNTY DIALYSIS			HENDERSON, NC 27536	
(X4) ID PREFIX TAG	IFACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY	N SHOULD BE COMPLETION DATE .
V 633	Continued From page	ge 30	VE	33	
	indicator to determine performance.	ne the root cause for its under	1		
V 710	Administrator revea ago" the CQI progra consistency, and d	PONSIBILITIES OF THE	V	710	
	Based on facility p quality improveme observation, staff i the Medical Direct regarding patients	is not met as evidenced by:  olicy review, continuous  nt documentation review,  nterview and patient interview,  or did not provide oversight  safety, Continuous Quality  gram and the dialysis process		Wedical Director responsib The Governing Body (GB) h Medical Director (MD) who to the GB for the delivery of in this facility.  1. The Medical Director (M responsibilities have been re 2. The Medical Director will	as assigned a single will be accountable care and outcomes  D) roles and 8/6/10 viewed with the MD.
	during hemodialys	94.60 (c)(4) Physical		meetings as part of the QI te facilities issues and clinical but not limited to AORs, va- concerns and needs, patient staffing education, compete complaints and needs, patie	am to review all outcomes, including, scular access care staffing ratios, nce, issues,
	B) Staff was not lest staff/patient meet building in the every evacuation;  -Cross refer to 4 Environment Tag	enowledgeable regarding ling area outside the diatysis ent of an emergency 94.60 (d)(1) Physical		emergency preparedness, sa quality of care.  3. The Medical Director will process to assure appropriate process of review, trending follow -up of facility issue results with documented recause if not meeting goal, a responsible party and follow of plans. MD and Governity responsible for ongoing co	If monitor the QI te and complete , documentation and s and outcomes view, goals, root action plans, priority, w-up of effectiveness ng Body are

PRINTED: 08/02/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: **,D PLAN OF CORRECTION** A BUILDING B, WING 07/16/2010 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 VANCE COUNTY DIALYSIS HENDERSON, NC 27536 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAĠ DEFICIENCY V 710 V 710 Continued From page 31 -Cross refer to 494.60 (d)(2) Physical Environment Tag V412 D) Staff did not ensure the emergency equipment was ready to use at all times; -Cross refer to 494.60 (D) (3) Physical **Environment Tag V413** E) Continuous Quality Improvement Program (CQI) failed to identify facility outcome goals such that areas of under performance could be identified and action plans implemented as needed, and failed to enure the peritoneal nurse (PD) attended the CQI monthly meetings as required; ~Cross refer to 494.110 Quality Assessment and Performance Improvement Tag V626 F) CQI did not include accurate information regarding AOR occurrences and staff complaints; ~Cross refer to 494.110 (a)(2) Quality Assessment and Performance Improvement Tag V628

G) CQI did not identify areas of under performance, determine root causes for under performance, implement action plans and track performance improvement as it related to adequacy (KT/V) for hemodialysis patients;

-Cross refer to 494.110 (a)(2)(i) Quality
Assessment and Performance Improvement Tag

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	
		342543	B. WIN	G		07/16/2010	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(XS) , COMPLETION DATE
V 710	Continued From pag	e 32	V	710			
	hormone (PTH) goal such that under perf			em come and an employment play it as			
	Cross refer to 494. Assessment and Pe	110 (a)(2)(iii) Quality rformance Improvement Tag			· <del>·</del>		1
	, meeting hemoglobii	nine the root causes for not n goal and did not evaluate performance improvement.	1	to the second se			
		.110 (a)(2)(iv) Quality erformance Improvement Tag	-	:			***
	central venous cath	rmine roots cause for high neter rate (CVC) for					
		o4.110 (a)(2)(v) Quality erformance Improvement Tag					
		ers of direct care staff was not tient dialysis treatments;	;	**************************************			
	~Cross refer to 49	4.180 (b) Governance Tag 757	:	*		•	;
	L) Staff did not co	nduct assessments for		;			•

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NO PLAN UP	CORRECTION	BENTA IONTION NOMBER	A, BUILI	OING			
		342543	B. WING	3		07/16/2010	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID ;	SUMMARY ST	FATEMENT OF DEFICIENCIES		,	PROVIDER'S PLAN OF CORRECTION	PRRECTION ; (	
PREFIX ,	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	× i_	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
V 710	Continued From pag	je 33	· V	710	•	:	
	patients that experie	nced complications during			•		
		diabetic foot checks as	;	į			•
		e dialysis process (blood flow		į			:
	rates (BFR), dialysa		i	į			
		during treatment, dry weight	į	1			
	calculations, covere	d access sites), ensure assist	;	i			•
	· patients as needed	to the bathroom, obtain and	-	:			-
	document patient di	ata post dialysis treatment;	!	:			Ī
	-Cross refer to 494	.180 (b) Governance Tag 758	: i	÷			
V 711	494.150 MD RESP-	MED DIR .	\ \ \ \	711			i
	QUALIACCOUNTA	BLE TO GOV BODY		i	(		
					V 711		ĺ
		must have a medical director		1	The Governing Body (GB) has assigned		015110
		lifications of §494.140(a) to be			single Medical Director (MD) who will		8/6/10
		delivery of patient care and		Į	accountable to the GB for the delivery	of care	!
		cility. The medical director is			and outcomes in this facility.		
		governing body for the quality			the seed of the second of the second		1
	of medical care pro	vided to patients.	!		1. The Medical Director roles and	I. 41. a	1
			İ	Ì	responsibilities have been reviewed wit MD, and the FA.	n the	!
	•		!		2. All Medical Director items will be d	irected	1
	· 1		;		appropriately to the Medical Director.	.,, 00.00	i
		ls not met as evidenced by:	1		3. The ROD on behalf of the GB will n	nonitor	•
		us quality improvement (CQI)	. }	٠,	the process for compliance to ensure		•
		eview, staff interview and	1	•	, appropriate facility reviews by Med Di	r per the	1
ļ	: physician interview	, the facility failed to have a edical Director responsible for			MD roles and responsibilities.		·
	the delivery of care	e and outcomes in the facility.	;		i		i i
	The findings include	ied:	:		i		
			i				1
		meeting minutes for 4/10,	İ				į.
	5/10 and 6/10 reve	ealed each meeting was					
		erent physicians that signed as	-				!
	the facility Medica	I Director.		_			1
	Interview on 7/13/	10 at 1130 with the Facility		-			;
		ealed the facility has 3	1		}		-
		hared" the medical director					1.

TATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X1) PROVIDER/SUPPLIER/CLIA  (DENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
ı		342543	B. WING		07/16	/2010	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	SUMMARY S'	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATÉ	
	attend the continuous meetings as the factor rotating basis.  Phone interview with 1607 revealed the restanded by the "Month". Interview of shared Medical Diagrams of the factor restands of the factor restands of the factor restands of the factor restands of the factor restands of the factor restands of the factor restands of the factor restands of the factor review, staff intervities of the CQI programs identified, root can action plans were needed, and accut tracked/trended.  The findings including including the factor of the	revealed these physicians as quality improvement ility's Medical Director on a the physician #1 on 7/16/10 at monthly CQI meeting is edical Director serving that also revealed the facility has rector duties for years". SP-QAPI PROGRAM sponsibilities include, but are following: ment and performance ram.  Is not met as evidenced by: solicy review, continuous ent (CQI) documentation view and physician interview, tor failed to ensure oversight of such that indicator goals were use analyses were conducted, developed and evaluated as mate indicator data was	V 711	V 711 The Governing Body (GB) has a single Medical Director (MD) waccountable to the GB for the de and outcomes in this facility.  1. The Medical Director roles a responsibilities have been reviem MD, and the FA.  2. All Medical Director items with directed appropriately to the Modirector.  3. The ROD on behalf of the Government of the process for compliance to appropriate facility reviews by the MD roles and responsibilities.	who will be alivery of care and wed with the will be addical and B will monitor ansure Med Dir per	8/6/10	
	implementation,	continuing monitoring, action plans and program					

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 ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: D PLAN OF CORRECTION A. BUILDING B. WING 07/16/2010 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 VANCE COUNTY DIALYSIS HENDERSON, NC 27536 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 712 V 712 Continued From page 35 Review of the 4/10-6/10 CQI documentation revealed a lack of program oversight. Review of the CQI documentation revealed indicators that did not include required goals (used to determine under performance), indicators that did not meet goal that were not identified as under performing such that a root cause analysis could be conducted, areas identified as under performing in which root cause analyses were not conducted, action plans that had not been tracked or evaluated for effectiveness, and indicators that tracked/trended inaccurate AOR data. Review of the CQI meeting minutes for 4/10, 5/10 and 6/10 revealed each monthly meeting was attended by different physicians that signed as the facility Medical Director. Interview on 7/13/10 at 1130 with the Facility Administrator revealed the facility has 3 physicians that "share" the medical director position. Interview revealed these 3 physicians attend the continuous quality improvement ! meetings as the facility's Medical Director on a rotating basis. Phone interview with physician #1 on 7/16/10 at 1607 revealed the monthly CQI meeting is attended by the "Medical Director serving that month". Interview also revealed the facility has "shared Medical Director duties for years". V 713 V 713 | 494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM

not limited to, the following:

Medical director responsibilities include, but are

(b) Staff education, training, and performance.

PRINTED: 08/02/2010

STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A BUILDING		(X3) DATE SURVEY COMPLETED	
		342543	B, WIN	IG		07/16/2010	
	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE . 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		• .	JD PPOVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
1	Continued From pag	e 36 not met as evidenced by:	V	713	<i>V</i> 412		:
	Based on facility poli interview, the medica staff was knowledge meeting area outside event of an emerger staff interviewed (#X The findings include Review of facility po and Business Contin Preparedness Guide staff training include from the dialysis facility revealed the emerg destination would be dialysis facility.  Interview on 7/15/11 did not know where	cy review and staff al director failed to ensure able regarding staff/patient the dialysis building in the cy evacuation for 1 of 4 X). d: d: licy, 4-07-01, Disaster, Fire			1. Policy #4-07-01 Disaster, Fire and E Continuity Emergency Preparedness Guidelines will be review all teammates will be inserviced regarbuilding layout, location of exits and emergency evacuation site.  1. All patients will be re-educated referency evacuation and disaster planning, with emphasis placed on emergency evacuation location site and plan if fanon-operational.  2. Emergency evacuation location site posted at all exit doors.  4. All new and visiting patients will be emergency and disaster planning education first visit.  5. Disaster planning pamphlets will be from NW 6 and distributed to all pts.  6. A patient emergency and disaster quiz will be created and reviewed with patients.  1. 7. Medical records will be audited 3 months for documentation of emergency including the state of the sum of	wed and ding egarding r eergency cility is e will be receive cation on e ordered planning th all monthly x gency and g all	8/6/10
	of the building. Inte	rview revealed she thought as behind the building.			current, new and visiting patients. At be completed quarterly thereafter, if is noted.		
V 726	Administrator revea parking lot located 494.170 MR-COMF ACCESSIBLE The dialysis facility	O at 0945 with the Facility aled the meeting area is in the in the front of the building. PLETE, ACCURATE, must maintain complete,	AND ADDRESS OF THE PERSON OF T	V 726	8. Guest Services contact number wito the facility answer machine messa patient in the event of a disaster or er 9. Medical record audit results will bat CQI meeting monthly. A plan will implemented as needed.  10. FA will monitor process for comwith plan.	ge to assist mergency, be reviewed I be	
	including home pat dialysis supplies at	ssible records on all patients, ients who elect to receive nd equipment from a supplier er of ESRD services and all		,			

#### DÉPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2010 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	LTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
D PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL			COMPLETED		
		342543	B. WING	3		07/16	/2010	
NAME OF PRO	OVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212					
VANCE CO	DUNTY DIALYSIS	:			ENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPE DEFICIENCY)	ULD BE !	(X5) COMPLETION DATE	
V 726	Continued From pa	ge 37	<del>)</del> V	726			l I	
V 120			1	,	1. The FA will insure adequate staffi	ng/patient	:	
	other home dialysis	patients whose care is under	į		ratios to maintain safe dialysis treatm	ents by	i	
	the supervision of the	ne tacility.	•	į	implementing the Immediate Facility	Clinical	:	
					Staffing Plan and the Contingency P	ian for	1	
	This STANDARD i	s not met as evidenced by:			Maintaining Safe treatments when sh	ort staffed.	1	
	Based on facility po	olicy review, patient treatment			Adequate staffing plan has been imp	lemented	1	
	sheet/medical reco	rd review and staff interview,	!		2. The FA will insure the Clinical N	irse	ì	
	the facility failed to	ensure the hemodialysis	:		Manager is available for continued of	versight of	1	
	treatment sheets in	ncluded accurate times that	1		the facility clinical team and patient	needs.		
	patients were mon	itored by staff and accurate	1		3. The ROD will monitor the proces	s to ensure	· ·	
	times of medication	n administration.	1		compliance with the plan of correcti	on for	1	
	Infloor Street				adequate staffing and Clinical Nurse	: Manager	1	
	The findings include	ted:	1		availability.		-	
	The monge more	***			4. Post-treatment assessments will b	e completed		
	d Davinus of facili	ty policy 1-03-09, Intradialytic			on all patients by a RN.			
	1. Review of lacin	ring, (9/08) revealed treatment			5. Clinical Teammates will be in-se		1	
	reatment Monito	mig, (9700) revealed irealment			Policy #1-03-09 Intradialytic Treats	nent	Ì	
	checks should be	completed and documented	1		Monitoring, Policy #1-03-12 Post T	reatment		
		that included the following:	ĺ		Patient Assessment and Policy #1-0	16-01	ì	
	-blood pressure		;	•	Medication Policy with emphasis p	laced on the		
	-heart rate		ļ		requirement for and expectation of			
	-blood flow rate	•	;		documentation of vital signs and m	achine	•	
	-dialysate flow rat	te	;		treatment monitoring, medication of		:	
'	-arterial and veno	ous pressures			and post treatment assessments etc			
1	-fluid removal and	d/or replacement	į		6. Policy #1-01-09 Against Medica	d Advised	1	
1	-vascular access	status and line connections			(AMA) was reviewed with emphas	sis on	:	
	-patient status an	d subjective well-being	. ! .		documentation of patient refusal for	or BP checks	;	
<del> </del>	F				and patient refusal of keeping their	VA site		
-	Review of the na	tient treatment sheets on	, ,		visible for monitoring during treat	ment.	į	
	: 6/22/10 revealed	33 patient dialyzed on 1st shift	j		7. 100% of Treatment sheets will b	be audited .	ļ	
	and 20 nationte	dialyzed on 2nd shift. Review of			daily for compliance with docume	ntation of	1	
	the 6/00/10 stoff	ing sheet revealed 5 patient care	1		out of range BP with assessment of	r patient by		
	ine vikel to stati	(s) and 2 nurses provided care			RN; Reason for PRN medication a	idministration	ļ	
	rechnicians (PC)	shift	i		and follow-up of effectiveness. 25	% of treatment	į	
	on 1st and 2nd s	HIL.	-		sheets will be audited weekly once	e compliance is	1	
	i	# 4 house and about an 7/E/40	Į		noted for a period determined by	ne Governing	į	
	Review of the pa	atient treatment sheets on 7/5/10			Body. (GB) The GB will continue	to provide		
1	revealed 36 pati	ent dialyzed on 1st shift and 38	1 .		oversight and make on-going reco	mmendations		
	patients dialyzed	d on 2nd shift. Review of the	1		concerning audit frequency as nee	oted.	1 .	
1	7/5/10 staffing sheet revealed 7 PCTs an				8. Treatment sheet audit results w	ill be reviewed		
1	nurses provided	care on 1st and 2nd shift.			with the QI team at the CQI meet			
}			i		and a plan implemented as neede	d. cont. pg 39		

Facility ID: 944655

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342543	B, WING		07/1	6/2010
	OVIDER OR SUPPLIER		STR 5	<u>.</u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	sheets for 6/22/10 a treatment sheet refl sign/monitoring enti Treatment sheet re vital signs were dod by the staff every 3 Treatment sheet re that 1 staff member vital signs simultan Interview on 7/15/1 Nurse Manager re treatment sheet did when the patient w staff. Interview rev the time the dialys the patient's vital s they conducted the revealed the dialys sheet was not acc of actual monitorin  2. Review of the	nt hemodialysis freatment and 7/5/10 revealed the ected inaccurate vital ry times for each patient. View revealed each patient's sumented as being obtained 0 minutes on the 30 minute. View revealed the appearance of took as many as 6-7 patients ecusly.  D at 1245 with the facility realed the hemodialysis of not reflect accurate times of the realed most staff documented is machine automatically took igns and not the actual time explanation. Interview is medical record/treatment urate regarding determination and intervals, respectively.	V 726	V726 cont.  9. Continued non-compliance we result in disciplinary action 10. CNM will monitor the plan f with staffing and documentation records.	or compliance	8/6/10
	and 29 patients di	33 patient dialyzed on 1st shift. alyzed on 2nd shift. ient treatment sheets on 7/5/10	: : : :			;
	revealed 36 patients dialyzed Review of the patients for 7/12/10 treatment sheets medication admirreview revealed a medications were	nt dialyzed on 1st shift and 38				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
		342543	B. WING		07/16/2010	
	OVIDER OR SUPPLIER		STREE 511 HEI			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
V 726	Continued From page	ge 39	V 726			
V 75	Interview on 7/15/10 staff responsible for 7/12/10 revealed the times on the 7/12/11 correct. Interview madministration can a minutes per patient number of medication treatment sheets at actual administratic being able to enter was not always pos does not allow her staff has not entered upon initiation of the enters the time that the computer instellading administers the medical staff has not entered upon the staff has not entered	at 1415 with the licensed medication administration on a medication administration of treatment sheets were not evealed medication ake approximately 6-15 dependent upon the type and ons. Interview revealed the administration on the patient of the ontimes. Interview revealed the times interview revealed the time she gave the med asible because the computer to enter information if the PCT and their required information in the patient's treatment. So, she the puts the information in ad of when she actually edications.	V 750	V 750	red with the	
	Based on staff inte	is not met as evidenced by: erview, staffing documentation nment/time card review, facility ysis treatment sheet review,		Governing Body and a plan of co implemented at the time of surve updates to the plan as needed, du of implementation.	rrection y with on-going ring the period	7/16/10
	and observation, to provide oversight was conducive for staff was provided ensure patients with treatment and pate A) The temperatures was cold;	he the governing body failed to to ensure the treatment area dialysis treatment, adequate during patient treatment, ere safe and monitored during ient needs were met in that: re of the patient treatment area		2. The Governing Body will mee weekly, and more often as neede progress with correction of the d during survey. 3. The FA will report all facility patient needs to the Governing E manner, appropriately as needed 4. The ROD will monitor the Go involvement with the facility and compliance with the plan of corr	d, to monitor the efficiencies cited issues, staff and tody in a timely everning Body die process for	1
	-Cross refer to 4!	94.60 (c)(2) Physical V405				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

ATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  07/16/2010		
	,	342543	B. WING				
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	JEACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
V 750 į	Continued From pag	ge 40	V 750	•			
	patient care	g was not provided during .180 (b) Governance Tag					
V 757	complications during foot checks, monitor patients were assisted and document patients treatment;  -Cross refer to 49: V7.58	ailable to conduct: attents that experienced up treatment, perform diabetic of the dialysis process, ensure sted to the bathroom, obtain ent data post dialysis 4.180 (b) Governance Tag	V 75	V757  1. The Governing Body will approve implementation of facility staffing paramaintain and insure adequate staff to ratios, the Immediate Pacility Clinical Plan and the Contingency Plan for M Safe treatments when short staffed.  2. The Governing Body will insure the Nurse Manager is available for conting oversight of the facility clinical team needs.  3. The survey results were reviewed Governing Body and a plan of correspond to the facility clinical team of the facility clinica	patient a) Staffing laintaining the Clinical inued a and patient with the	7/16/10	
	responsible must	dy or designated person ensure that- number of qualified personnel ever patients are undergoing		implemented at the time of survey we updates to the plan as needed, during of implementation.  4. The Governing Body will meet a	vith on-going g the period at least		
	dialysis so that the appropriate to the meets the needs  This STANDARD Based on staff in review, and staffing review, the goveloped to the appropriate that the staff in the s	e patient/staff ratio is level of dialysis care given and of patients;  is not met as evidenced by: terview, staffing documentation ng assignment/time card ming body failed to have		weekly, and more often as needed, the progress with correction of the cited during survey.  5. The FA will report all facility is and patient needs to the Governing timely manner, appropriately as needs. The ROD will monitor the Governivolvement with the facility and the compliance with the plan of correct 7/16/10	deficiencies sues, staff Body in a eded. ming Body he process for		
	The findings incl	uded:	i	•			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391			
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M(	JLTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
'D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING		COMPLETE	יט	
			B, WIN	æ				
-		342543	D. VVIIV			07/11	6/2010	
NAME OF PRO	OVIDER OR SUPPLIER							
				511 F	RUIN CREEK RD SUITE 212			
VANCE CC	OUNTY DIALYSIS			HEN	IDERSON, NC 27536			
(X4).ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID.	1	PROVIDER'S PLAN OF CORRE		(X5) COMPLETION	
PREFIX		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP		DATE	
TAG :	REGULATORT	OR LSC IDENTIFTING INCOMMENTAL	1 1/10	, ;	DEFICIENCY)		•	
		44	1 7	757:				
V /5/ ;	Continued From p	age 41	: V	757			!	
		do at dade with the Caritte	:	! ; ;		•	•	
		10 at 1145 with the Facility	į				<b>!</b>	
	Administrator reve	ealed the facility is normally patient/staff ratio for PCTs and	•	;			:	
		esday/Fridays, a 19:1 patient to	:	1				
		edication nurse and	:	;				
		y/Fridays a 16 ½:1 patient to		:	•		1	
		e medication nurse.	;		•		•	
•	1	o modioanem name	<u> </u>					
	Review of the "C	Chronic Direct Patient Care		1			1	
	Hrs/Tx " docume	ntation from 1/10-5/10 revealed	į	Ì		•	1	
	the facility was bu	dgeted for 1.80 hours of direct					į.	
	hands on care pe	r patient treatment.		[		•		
	Documentation re	eview revealed the facility		1			1	
	staffed under but	iget from 1/10-4/10.		-				
	1	eview revealed the following	l		·			
	hours of direct pa	atient care:		. [				
	1/10-1.66	•		į			İ	
	2/10-1.71		i	1			:	
	3/10-1.75		:	į.			,	
	4/10-1.78	•	1	!				
	Interview on 7/4	1/10 at 1545 with the Facility	ŧ					
		vealed the direct hands on care	ı				!	
	numbers did not	reflect accurate direct patient	1	.3			i	
		nterview revealed the respective					<u>i</u>	
		cluded the Clinical Manager	i	i				
		s an hourly paid employee and	1.	į				
		strative duties at times and not	<b>†</b> .	1		•	;	
		in direct patient care.	,	į				
			1	1			i	
	Review of the 6/		İ	•		•	i i	
		ployee time card review revealed		•	•		!	
		dequate numbers of direct patient		1			1	
		22/10. Review of the 6/22/10					1	
		t revealed 2 PCTs " called out "	1					
		en not replaced. Review revealed	1			•	1	
		CTs, 1 RN and one LPN		. '				
1	(medication nur	se). Review of 6/22/10 treatment					1	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342543 ·	B, WIN	1G	·	07/1	5/2010
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	TX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COM HE APPROPRIATE	
V 757	and 29 patients dialy the 6/22/10 staff ass nurse and the RN has assignment as well a assignment review in had been given a full rounded with the physician assignment care nurses, but becrounds with the physician. She staff physicians is an "a every patient on each to enter all the order revealed she does to can when there is in but it is extremely distributed.	ants dialyzed on 1st shift, zed on 2nd shift. Review of ignment revealed the med ad been given a full PCT as their nursing duties. Staff evealed the Clinical Manager I RN assignment plus she vician each shift.  at 1155 with the Clinical no 6/22/10 she had been on sheet as one of the direct cause she had to make siciain, she really couldn't take erview revealed she has "I rounding with the ed rounding with the lid day task, because they see the shift and afterwards I have rechanges". Interview ry to help out as much as she of enough direct care staff,	V	757			
	from 33 to 43 on 6/2 only 38 of the availar utilized for patient to the direct care staff accommodate the like the direct care staff accommodate the like th	umber of treatment stations 28/10. Interview revealed able 43 stations had been reatment. Interview revealed had not been increased to increase in patient treatments.  0 (after the increase in staff assignment/employee vealed there was not					-
	7/5/10. Review of I	of direct patient care staff on the 7/5/10 staff assignment called out " and had not	!				1

ATEMENT OF DEFICIENCIES  OD PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (XZ) MI A. BUII		NSTRUCTION	COMPLET	
i		342543	B. WIN	G		0711	16/2010
]	OVIDER OR SUPPLIER	342540		STREET AI \$11 RUI HENDI			
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	I ID PREF	-1X	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(XS) COMPLETION DATE
V 757	been not replaced. 6 PCTs, 2 RNs and Review of 7/5/10 tre patients dialyzed of dialyzed on 2nd shi assignment reveale PCT assignment as wel assignment review patients a piece and piece and also wel administering med Interviews from 7/ direct care staff when an on ymous reveale	Review revealed there were one LPN (medication nurse). eatment log revealed 36 in 1st shift, and 38 patients ift. Review of the 7/5/10 staff ed the med nurse took a full and the 2 RNs split a PCT is as their nursing duties. Staff revealed the PCTs had 6.3 ind the RNs had 19 patients a re responsible for ications as well.  13/10-7/16/10 with several the work load expectation becially with the added		757			
V	Manager revealed administrative dustributed in floor "working as Interview on 7/14 Administrator reveateff to call in the 6/22/10 and 7/5/given 6 weeks of one PCT had be leave.	/10 at 1155 with the Clinical d she was not able to do her ties because she was " on the s a nurse " all the time ".  //10 at 1545 with the Facility realed there was no pool of extrate event of staff " call outs " for 10 because one riurse had been f consecutive vacation time, and en out for months on medical OV-RN, MSW, & RD AVAIL TO DS		V 758			
	responsible mu The registered	pody or designated person st ensure that- nurse, social worker and dietitian s interdisciplinary team are et patient clinical needs;			· .		

* "ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDÉR/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		342543	B. WIN	G		07/16/	2010
	DVIDER OR SUPPLIER			511	ET ADDRESS, CITY, STATE, ZIP CODE I RUIN CREEK RD SUITE 212 :NDERSON, NC 27536		
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
V 758	Confinued From pag	ge 44	V	758	V 758	;	
	Based on facility por dialysis treatment significant facility staff failed to patients that experiment; 2) performequired; 3) monitoring interval calculations, cover patients were assisted required; 5) obtain post dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment sheets reduring dialysis treatment.	policy 1-03-12, Post Treatment			1. The Governing Body will approve implementation of facility staffing promaintain and insure adequate staff tratios, the Immediate Facility Clinic Plan and the Contingency Plan for Safe treatments when short staffed.  2. The Governing Body will insure Nurse Manager is available for contoversight of the facility clinical teat needs.  3. The survey results were reviewed Governing Body and a plan of contimplemented at the time of survey updates to the plan as needed, during implementation.  4. The Governing Body will meet weekly, and more often as needed the progress with correction of the cited during survey.  5. Post treatment assessments will on all patients by a RN.  6. Clinical Teammates will be in-Policy #1-03-09 Intradialytic Tree Monitoring, Policy #1-03-12 Post Patient Assessment and Policy #1 Medication Policy with emphasis	opatient to opatient cal Staffing Maintaining the Clinical tinued m and patient d with the ection with on-going ng the period at least bito monitor deficiencies be completed serviced on atment Treatment -06-01 placed on the	
·	staff obtain and department post dialy findings and any discharge of the licensed nurse. condition require assesses the parameters of the post revealed a post conducted to endetermine the parameters of the post	cent. (9/07) revealed patient care cocument basic data on each sis and compare to pre dialysis findings that may preclude the patient will be reported to the Review revealed if the patient's dintervention the licensed nurse tient, collects further data and ician as needed. Policy review treatment assessment is sure the patient is stable, to eatient's discharge status and to ectiveness of the treatment plan.			requirement for and expectation of documentation of vital signs and treatment monitoring, medication documentation, oxygen administ treatment assessments etc. They educated on calculating weight reducated to follow physician orders a BFR/DFR, foot checks, etc. cont pg 46	machine  ration, and post will also be re- emoval and the	

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED	
		342543	B, WING		07/16/	/2010
	OVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COD	Ė	
NAME OF PR	OVIDER OR SUFFLIER			1 RUIN CREEK RD SUITE 212		
VANCE CO	DUNTY DIALYSIS	•	- н	ENDERSON, NC 27536		
	CINNIADV C	TATEMENT OF DEFICIENCIES .	. ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIVE		COMPLETION DATE
TAG	REGULATORY DI	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY		
	<u> </u>		1			
V 758	Continued From pa	ge 45	V 758	V758 cont. Policy # 1-04-01	AVF and AVG	
		olicy 1-03-10, Pre/Post		Vascular Access Care will be	reviewed with an	
ĺ	Treatment Data Co	llection, (9/07) revealed	•	teammates, with emphasis pla		
1	noticet core staff of	otain and document the	•	monitoring. Acknowledgmen		
	following information	n: weight; temperature; blood	1	the expectation and result of a signed by all clinical teamma		
}	DESCRIPTION OF THE PROPERTY OF	fiac status; respiratory status;	:	Policy #1-01-09 Against Me		! !
1	pressure (or ), care	vascular access; mental	į	(AMA) was reviewed with er	nohasis on	<b>:</b>
1	etature patient cubi	ective statement; ambulatory	į	documentation of patient refu	isal for BP checks	<b>i</b>
	atotuci recent hoer	sitalization or outpatient visits.	;	and patient refusal of keeping	their VA site visible	; t
	Status, recent nos	aled findings that may	;	for monitoring during treatm	ent.	<b>i</b>
	Policy leview rever	ion of treatment or discharge		100% of Treatment sheets will be audited daily		1
	preciode the initial	e reported immediately to the	1	for compliance with documentation of appropriate		
1	of the patient will b	th that an assessment may be		dialysis treatment and nursing assessment of patient when complications arise that warrant such		8/13/10
1	3	in that all assessment may be				
	conducted.	•		assessment. The audit will for	ocus on	
	i all all all all all all all all all al	Clinical Managar on 7/14/10 at		documentation of post treatm	nent assessment by	
	Interview with the	Clinical Manager on 7/14/10 at	1	RN; out of range BP with as	sessment of patient by	
1	0945 revealed sta	ff is required to obtain a sitting	ļ	RN; Vital sign checks Q 30	min in real time;	:
	and standing BP	on all ambulatory patients pre		compliance with physician of	orders; out of range	•
		t as part of their data	1	post treatment weights asses	sed by RN; Reason	i
	, collection/assessr	nent.	į	for PRN medication admini	stration and follow-up	
		y and no transfer its	1.	of effectiveness, other comp	olications addressed by	,
İ	Review of facility	policy 1-03-09, Intradialytic		RN. 25% of treatment sheet	s will be audited	
	Treatment Monito	ring, (9/08) revealed treatment		weekly once compliance is		1
	checks should be	completed and documented	Í	determined by the GB. The	CE CONTINUE TO	:
		that included the following:		provide oversight and make recommendations concerning	on-going or audit frequency se	:
l	-blood pressure		1	needed.	ing addit inequency as	•
	-heart rate			Treatment sheet audit resu	its will be reviewed	·
	-blood flow rate	<b>1</b> _	1	with the QI team at the CQ		i t
	-dialysate flow ra		ì	a plan implemented as need	led.	į
	-arterial and vend	ous pressures	ì	All unsteady patients or pa	itients designated a fall	ŧ
	-fluid removal an	d/or replacement	j.	risk, will be assisted to the	patient bathroom.	İ
	-vascular access	status and line connections		Clinical Mgr will review t	he importance of	į
ļ	-patient status at	nd subjective well-being		keeping VA sites uncovere	d with each patient.	i
		K 4 DO DO Description		Access sites will be moni	tored for visibility	1
	Review of facility	policy 1-03-02, Prescription		throughout dialysis treatme	ent and documented.	!
: [	Verification and	Safety Checks, (9/08) revealed		Teammates will encourage	patients to uncover	
1	blood flow and d	ialysate flow are included in the		access sites and document	The 12 Charge Nurse	1
	information to be	checked and verified by staff	ì	will be notified of patient		:
]	prior to treatmer	t initiation to ensure the patient		be completed. cont pg 47		i
1	*	and affective treatment as	ł	;		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING  (X3) DATE SURVEY COMPLETED				
	•	342543	B. WIN	G		07/16	/2010
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
V 758	prescribed.  Review of facility por Rights, Responsibil (revised December	dicy 3-01-07A, Patient ities and Facility Rules 2008), revealed patients are deir access sites visible at all	V	758	V758 cont.  The Charge Nurse will monitor visi access sites every shift for complian Continued non-compliance with plin disciplinary action  CNM will monitor the plan for continued monitor the plan for continued to the plan fo	ce. an will result	
	sheet for patient #2 initiated at 1038. revealed a pre-treathe patient compilar breath. Review of the patient had a experienced hypot treatment. Review post treatment BP	12/10 dialysis treatment 8 revealed hemodialysis Freatment sheet review Itment assessment revealed It includes the treatment sheet revealed It includes the treatment BP of 121/67 but It includes the patient had a It includes the patient had a It includes the patient of the prior It is assessed this patient prior It it is ambulatory.		-			
	Manager, reveale	10 at 1545 with the Clinical d she had not been notified by this patient had an ode post treatment.		**			:
	responsible for pa 7/12/10 was "so i she mistakenly d ambulatory. Inte wheelchair bound the nurse that the	1/10 at with the PCT #8, the PCT atient #28 respectively, revealed busy with so much to do" that bocumented the patient was rview revealed this patient is d, and the staff did not inform a patient was hypotensive post uired because "there was so				-	
	sheet for patient	e 7/12/10 dialysis treatment #4 revealed hemodialysis with a pre treatment standing BP	1			• •	

'ATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE S COMPLI		
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
÷		342543	B. WING		07	/16/2010	
	OVIDER OR SUPPLIER		51	ET ADDRESS, CITY, STATE, ZIP CODE 1 RUIN CREEK RD SUITE 212 ENDERSON, NC 27536			
77,1102		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5) COMPLETION	
(X4) ID PREFIX TAG	IEVON DEEICIEM	DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE	
V 758	Continued From pag	je 47	V 758	•		:	
	of 120/76 and a sitti	ng BP of 118/79. Treatment		•			
	sheet review reveal	ed the patients treatment	;	•			
	discontinued at 145	0 with a hypotensive BP				i	
	(sitting 86/65 and st	anding 77/36). Treatment		· • •		!	
	sheet review reveal	ed no documented evidence	•			•	
	that a nurse assess	ed this patients hypotension	1	<u>[</u>			
	prior to leaving the	facility.	 	* · · · · · · · · · · · · · · · · · · ·			
Ì	a David-waftha 6	/22/10 dialysis treatment					
	3. Review of the of	31 revealed hemodialysis	1				
	initiated at 0621 with a sitting BP of 178/91 and a		}				
-	etanding RP of 125	5/68. Review of the treatment				1	
	sheet revealed the	patient experienced	•	Į.		:	
	hypertension throu	ighout dialysis treatment.				į	
	Review revealed t	his patient had a post	1	1 1			
	treatment sitting B	P of 203/93 and a standing BP					
	of 214/101 without	t documented evidence that a	1	1			
	: nurse assessed th	is patients hypertension prior to	•	1		1	
1	leaving the facility	•	t 1			I.	
	•	and the second short	: i	:			
	4. Review of the 6	3/22/10 dialysis treatment sheet	;	1		;	
1	for patient #32 rev	vealed hemodialysis initiated at	i	7		;	
	0653 with a sitting	BP of 188/104 and a standing eview of the treatment sheet				i	
	BP 01 1/4/90, Re	ent experienced hypertension	i			:	
	Levesien me han	of treatment. Review revealed		<u> </u>	· · · · · · · · · · · · · · · · · · ·	<u> </u>	
	this nationt had a	post treatment sitting BP of	1			i	
1	186/140 and a st	anding BP of 211/150 without	!	1		i	
	: documented evid	lence that a nurse assessed this	:	1		İ	
	patient prior to le	aving the facility:					
	r Dandau File	dialysis treatment sheet for				!	
	5. Keview of the	nt #26 revealed her dialysis					
	6/22/10 for paule	ed at 0618 with a hypertensive					
	treatment Bi	of 203/134. Treatment sheet				į	
	pre-ireaunem or	this patients treatment was	i e	1			
	completed at 00	50. Review revealed staff	}	i,			
	obtained a sittin	g BP only which was 186/142.					
1	Trootment shee	t review revealed no documented					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	S FOR MEDICARE & F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	LDING		30.00	
		342543	B. WIN	IG		07/1	6/2010
	OVIDER OR SUPPLIER			511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212		
VANCE CO	DUNTY DIALYSIS		-1	HE	NDERSON, NC 27536	eticki -	(X5)
(X4) ID PREFIX TAG	FACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	₹X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
V 758	Continued From pag	ne 48	V	758			
		N assessed this patient's BP		1			:
	6. Review of the 7/	5/10 dialysis treatment sheet	:	i			j
	for patient #39 reve	aled hemodialysis initiated at	į	i			;
	1225 with a sitting	BP of 121/64 and a standing		;			
	BP of 135/84. Revi	ew of the treatment sheet t experienced hypertension	. '	i			
	i towards the end of	treatment. Review revealed	1	:	•		
	this patient had a p	ost treatment sitting BP of		1			•
	202/11B and a star	ding BP of 198/104 without	;	:			÷
	documented evider	nce that a nurse assessed this	•	i ;			
-	patient prior to leav	ring the facility.	1	:		•	•
	7/5/10 for patient #	ialysis treatment sheet for 24 revealed her dialysis at 1155. Treatment sheet	And the second second				
	review revealed at needed oxygen. I revealed no docur	.1200 the patient indicated she Review of the treatment sheet nented evidence that this					
	patient received o	xygen or that any licensed staff	į				!
	assessed this pati	ent for any respiratory needs at request was made and prior to					ļ
	any time after ner discharge from di	lequest was made and prior to					:
	1		;				1
	: Interview on 7/15	110 at 1545 with the Clinical I this occurred on a day when I	<del></del>				
	was rounding with short staffed. I the	n the physician and "we were link she was given O2 but I can't	; ;				
ļ.	swear to it".						•
	7/5/10 for patient	dialysis treatment sheet for #37 revealed her dialysis d at 1217. Treatment sheet	1				
	review revealed	during the pre treatment	1		i		
	assessment the	patient requested oxygen for	:				
	shortness of bre	ath. Review of the treatment	i				1
	, sheet revealed r	o documented evidence that this oxygen or that any licensed staff	;		İ		

#### PRINTED: 08/02/2010 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 ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ID PLAN OF CORRECTION A. BUILDING 07/16/2010 B. WING 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536 VANCE COUNTY DIALYSIS (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 758 Continued From page 49 V 758 assessed this patient for any respiratory needs at any time after her request was made and prior to discharge from dialysis treatment. 9. Review of the dialysis treatment sheet for 6/22/10 for patient #26 revealed her dialysis treatment initiated at 0618 with a hypertensive pre-treatment BP of 203/134. Review of the pre-treatment nursing assessment revealed the patient requested acetaminophen. Treatment sheet review revealed 625 mg of acetaminophen (analgesic) was administered at 0631 and 25mg of diphenhydramine (antihistamine) was administered at 0632. Treatment sheet review revealed no documented evidence that the nurse assessed the patient's response to the PRN medications. Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff is required to document the patient's response to any PRN medication administered. Interview revealed she administered the PRN medications and because of staffing on 6/22/10, she did not get back to the patient to assess the patient as required due to the work load. 10. Review of the dialysis treatment sheet for 6/22/10 for patient #30 revealed her dialysis treatment initiated at 0610 with a pre-treatment request for diphenhydramine for itching.

Treatment sheet review revealed the patient received 25mg of diphenhydramine at 0637. Treatment sheet review revealed no documented evidence that the nurse assessed the patient's

Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff is required to document

response to the PRN medications.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SUI COMPLET	
		342543	B. WING		07/1	6/2010
	OVIDER OR SUPPLIER		511	T ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536		•
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V 758	administered. Intended administered the PF of staffing on 6/22/1 patient to assess the the work load.  11. Review of the the #19 revealed a cumfor monthly foot chediabetic. Review of dated on 7/5/10 revealed to get him 7/5/10. Treatment revealed staff did nother check. Treatment	se to any PRN medication view revealed she RN medications and because 0, she did not get back to the e patient as required due to  reatment sheet for patient rent physician's standing order ecks since the patient was the dialysis treatment sheet vealed the patient had been is monthly foot check on sheet documentation not conduct the monthly foot sheet review revealed staff ed" as the reason the foot	V 758			
	revealed a current monthly foot check diabetic. Review o dated on 7/5/10 rescheduled to get h 7/5/10. Treatment revealed staff did check. Treatment documented "rescheck had not bee linterview on 7/15/10 Manager revealed staffed" on 7/5/10	physician's standing order for as since the patient was fithe dialysis treatment sheet vealed the patient had been is monthly foot check on a sheet documentation not conduct the monthly foot sheet review revealed staff sheduled" as the reason the foot en conducted.  10 at 1545 with the Clinical at staff the facility was "short and staff probably either it to do the foot checks at				
		treatment sheet dated on #43 revealed a physician's				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	1	# 71DI E CC	NSTRUCTION	(X3) DATE SU	RVEY
TEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUIL			COMPLET	ED
		342543	B. WIN			07/1	6/2010
NAME OF PRO	OVIDER OR SUPPLIER	·		511 RI	ADDRESS, CITY, STATE, ZIP CODE JIN CREEK RD SUITE 212		,
VANCE CO	OUNTY DIALYSIS			HEND	DERSON, NC 27536	TCTION	(X5)
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V 758	Continued From pa	ne 51	V	758			
V 756	Conunced From pa	4500 cc/minute and a DFR of	İ	1			
	order for a BFR 01	atment sheet review revealed	1	!			
	700 cc/minute. The	d a BFR of 350 cc/min and a		1			
	this patient receive	ute from 1215-1450, her entire	1	i	•		ì
	DFK of boo commit	Record review revealed no		:			
	degraphetion as	why the BFR had not been		t			
İ	, provided as ordere	ed.	į	;	,		:
	provided as orders		·	4			•
	i 14 Review of the	treatment sheet dated on	1	i			ļ
	sizziin for natient	#40 revealed a physician's		:			•
	order for a DFR of	600 cc/minute. Treatment		į.	•		2
	cheef review reve	aled this patient received a	!	į		, .	:
	DER of 500 cc/mil	n from 0610-0948, his entire		•			ļ
	treatment, without	t documentation as why the	1	;			į .
	DFR had not bee	n provided as ordered.	i -	1			
•	:		-	;			<b>!</b> ·
	15. Review of the	e treatment sheet dated on	ļ	! i			!
	6/22/10 for patier	nt #9 revealed a physician's		. '!	·		1
1	order for a DFR	of 700 cc/minute Treatment		1			I
	sheet review revi	ealed this patient received a	1	1			
}	DFR of 600 cc/m	in from 0635-1049, her entire	1	ļ			
	treatment, withou	it documentation as why the	ļ	ļ		<b>Y</b>	
	DFR had not be	en provided as ordered.			· · · · · · · · · · · · · · · · · · ·		
	10 0	ne treatment sheet dated on	1	,			
	16. Review of the	t #41 revealed a physician's	<u></u>			<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>	<u> </u>
	//b/10 for patien	of 800 cc/minute. Treatment	ļ			-	. 1
	order for a DFR	realed this patient received a	1.		** * *		1
	Sheet tenew ter	nin from 1140-1530, her entire	į				;
	trantment with	out documentation as why the	i				1
	: DER had not be	een provided as ordered.	į,		i		
	•		ı		•		
	17. Review of	the treatment sheet dated on	1		¥		t .
1	7/5/10 for patie	nt #42 revealed a physician's			1		1 ,
	! order for a BFF	of 400 cc/minute. Treatment			i .		•
	sheet review re	evealed this patient received a	!	•			!
	BER of 350 cci	min from 1231-1400 without			1		
1	documentation	as why the BFR had not been	1		;		:
	provided as or	dered.	1		<u> </u>		

'ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO DING	(X3) DATE SURVEY COMPLETED			
2.20.01.		. 10510	B. WING			07/16	6/2010
	OVIDER OR SUPPLIER	342543		511 RU	ODRESS, CITY, STATE, ZIP CODE IIN CREEK RD SUITE 212 ERSON, NC 27536		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  OF THE PRECEDED BY FULL  OF THE PRESENT OF THE OPEN AT THE	ID PREFI	× !	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	1		DEFICIENCY)		<u>+</u>
V 758	Continued From pag	ge 52	V	758			
	6/22/10 revealed or 240 minutes and to 80kg. Treatment sl patient dialyzed the minutes) but did no Review revealed the at the conclusion of sheet review revealfuid.  Interview on 7/15/1/ Manager revealed amount of fluid to 8/22/10. Interview	lalysis treatment sheet for ders for patient #31 to dialyze dialyze to a dry weight of neet review revealed the cordered amount of time (244 t get to 80 kg as ordered. The patient had a DW of 82.7 kg if her treatment. Treatment led staff removed 2.5 kg of the treatment of the correctly calculated the per removed for this patient on the prevealed this patient should if fluid removed instead of 2.5					
	sheet for patient # treatment initiated 1055. Treatment documentation th	: 6/22/10 dialysis treatment /36 revealed this patients /3 at 0630 and concluded at sheet review revealed at staff did not monitor this minutes as required. Treatment caled this patient went from		1			
	20. Review of the sheet for patient treatment initiate 1044. Treatment documentation to patient every 30 sheet review rev	ar and 20 minutes) without tence of staff monitoring.  e 7/5/10 dialysis treatment #34 revealed this patients at at 0711 and concluded at at staff did not monitor this minutes as required. Treatment realed this patient went from 2 hours) without documented f monitoring.					

TATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
	342543	B. WING		07/	16/2010
NAME OF PROVIDER OR SUPPLIER VANCE COUNTY DIALYSIS		511 R	ADDRESS, CITY, STATE, ZIP CODE UIN CREEK RD SUITE 212 DERSON, NC 27536		
EACH DEFI	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
sheet for patient treatment initiate 1100. Treatment documentation patient every 30 sheet review re 0623-0730 (1 h documented ev 22. Review of sheet for patient treatment initia 1122. Treatment documentation patient every 3 sheet review re 1003-1103 (1 h evidence of streatment open sheet for patient every 3 sheet review re 1003-1103 (1 h evidence of streatment open sheet review re 1003-1103	the 7/5/10 dialysis treatment #35 revealed this patients and at 0625 and concluded at that sheet review revealed that staff did not monitor this minutes as required. Treatment realed this patient went from our and 5 minutes) without dence of staff monitoring.  The 6/22/10 dialysis treatment th #33 revealed this patients and at 0656 and concluded at and sheet review revealed that staff did not monitor this dominutes as required. Treatment revealed this patient went from four) without documented aff monitoring.  The form on 7/13/10 at 0903, 0925 and staff was not able to see patient a access at station #33 during the form of	V 758			
revealed staff graft access a treatment bed Observation of was not able access at sta	n 7/13/10 at 0903 and 0925 was not able to see patient #9's AV t station # 12 during dialysis ause it was covered by a blanket. on 7/13/10 at 0903 revealed staff to see patient #10's AV fistula dion #14 during dialysis treatment as covered by a blanket.				
was not able	on 7/13/10 at 0903 revealed staff to see patient #12's catheter access during dialysis treatment because	!			1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURV COMPLETED	
		342543	B. WING		07/16/	2010
	OVIDER OR SUPPLIER		511	ET ADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 NDERSON, NC 27536		
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V 758	Continued From pag it was covered by a l		V 758		:	
	was not able to see	/10 at 1130 revealed staff patient #5's AV graft access dialysis treatment because it anket.			: : : : : : : : : : : : : : : : : : : :	
	was not able to see	8/10 at 1150 revealed staff patient #6's AV fistula access g dialysis treatment because blanket,				
	was not able to see	3/10 at 1200 revealed staff patient #7's AV graft access g dialysis treatment because blanket.				
	was not able to see	3/10 at 1221 revealed staff e patient #8's catheter access use during dialysis treatment a blanket.				
	was not able to see	5/10 at 0900 revealed staff e patient #12's AV fistula 5 during dialysis treatment vered by a blanket.				
	was not able to se	15/10 at 0900 revealed staff e patient #13's catheter access ng dialysis treatment because a blanket.				
	was not able to se	15/10 at 0900 revealed staff se patient #14's AV fistula #26 during dialysis treatment vered by a blanket.				
		15/10 at 0930 revealed staff ee patient #16's AV graft access				

#### 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 TEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING "ND PLAN OF CORRECTION R WNG 07/16/2010 342543 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536 VANCE COUNTY DIALYSIS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG V 758 Continued From page 55 V 758 at station #19 during dialysis treatment because it was covered by a blanket. Interview with the facility Clinical Nurse Manager on 7/14/10 at 1230 revealed patient's access sites should be visible to staff throughout the patients dialysis treatment. Interview revealed should patient refuse to keep their access visible during treatment, staff should educate the patient on the dangers of their access site not being visible and document the education and the patients refusal on the dialysis treatment sheet. Review of the patient dialysis treatment sheets revealed no documented evidence of patient education or patients refusal, respectively. 24. Medical record review revealed patient #19 had a history of falls and had been assessed by licensed staff on 1/10/10 as a high risk for falls. Record review revealed a current patient plan of care that directed staff to assist this patient to the bathroom as needed. Observation in the patient treatment area on 7/14/10 at 0955 revealed patient #19, a 73 year old male, was walking unassisted to the bathroom. Observation revealed patient #19 had an unsteady gait and was walking such that each of his steps stopped abruptly on the balls of his feet causing his posture to bend forward. Interview on 7/14/10 at 1115 with staff #7, who

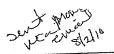
was responsible for patient #19 on 7/14/10, revealed she had been told earlier that morning by administrative staff to not leave any bay unattended by staff at any time. Interview revealed because she was the only staff in her

PRINTED: 08/02/2010

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342543	B, WING		07/16/2010	
	OVIDER OR SUPPLIER		511 8	FADDRESS, CITY, STATE, ZIP CODE RUIN CREEK RD SUITE 212 IDERSON, NC 27536		
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V 758	the bathroom, she d would have left her	idn't assist him because it by unattended.  Italysis treatment sheet for 125 revealed her dialysis 1230. Review of the 1230 gassessment revealed the 124 with a walker and indicated 125 restances. Treatment sheet 125 patient's sitting BP post 126. Treatment shee	V 758			
	document a standi post dialysis treatn 6/22/10 was a day staff".	ng BP on ambulatory patients nent. Interview revealed the facility had "call out by			· ·	
	6/22/10 for patient treatment initiated	dialysis treatment sheet for #27 revealed his dialysis at 0633. Pre-treatment	• • • • • • • • • • • • • • • • • • • •			
	the treatment floo Treatment sheet r treatment was con not obtain a stand revealed no docu collected the requ 6/22/10.	aled the patient ambulated to rand had no complaints. eview revealed this patients impleted at 1045 and staff did ling BP as required. Review mented evidence that any staff lired data post-treatment on 1/10 at 1545 with the Clinical d PCT or licensed staff is				
,	required to collect	t post treatment data on every patient is discharged from		1 · · · · · · · · · · · · · · · · · · ·		!

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DATE SU COMPLE		
		342543	B. WING		. 07/	16/2010	
	DVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536				
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	Continued From page treatment. Interview temp, respiratory, G mobility and access	v revealed the data included St, cardiac, edema, mental,	V 758			:	
	6/22/10 for patient; treatment initiated sheet review revea that staff obtained required for respira mental, mobility an Interview on 7/15/1 Manager revealed required to collect patient before the treatment. Intervie	lialysis treatment sheet for #29 revealed his dialysis initiated at 0706. Treatment led no documented evidence post treatment data as atory, GI, cardiac, edema, and access information.  10 at 1545 with the Clinical PCT or licensed staff is post treatment data on every patient is discharged from lew revealed the data included GI, cardiac, edema, mental, as information.					
,							

#### Department of Health and Human Servi Centers for Medicare & Medicaid Servi.



Form Approved OMB NO. 0938-0390

#### Post-Certification Revisit Report

ublic reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and harmonic in an an accompleting 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. 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.

leowon Project (0938-0390), Washington, D.C. 20	503.		(Y3) Date of Revisit
(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing		7/16/2010
342543		Street Address, City, State, Zip Code	
Name of Facility		854 S BECKFORD DRIVE	
VANCE COUNTY DIALYSIS		HENDERSON, NC 27536	The stee provinces
		1 1 to ch	you those deficiencies previously

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported 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 regulation control to the support and requirement on the survey report form).

		11.67	(Y4) Item	· (Y5)	Date	(Y4) II	tem	(Y5)	Date
Item		(Y5) Date  Correction  Completed			Correction Completed		ID Prefix		Correction Completed
ID Prefix	-	07/16/2010	ID Prefix		-		Reg. #		-
	405.2161(b)(3)		LSC		- -		LSC		Correction
ID Prefix		Correction Completed	ID Prefix		Correction Completed	1	ID Prefix		Completed
Reg.#			Reg.#				Reg.#		
LSU		Correction Completed	ID Prefix		Correction	Į.	ID Prefix		Correction Completes
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Review CMS R	ved By	Reviewed By	Date:	Signature	of Surveyor	*	Vilno a C		Dater
	vup to Survey C	ompleted on: 6/2007		Check for any Uncorrected Page 1 of 1	I Deficienci	d Deficie es (CMS	encies. Was a St -2567) Sent to th		YES NO

## SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

ubl. porting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering unintaining 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, actually suggestions 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 actually project (0838-0583), Washington, D.C. 20503.	ig and
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Provider/Supplier Number 342653	Provider/Supplier Name FRESENIUS MEDICAL CARE MILLBROOK	
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.

Surveyor ID Number (A)	First Datë 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)
1. 15401	08/10/2010	08/11/2010	1.00	0.00	17.00	0,50	2.00	2.00
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14.			<u>.  </u>			Supervisory Revie	J. Jane	0.00

Total SA Supervisory Review Hours .....

0.50

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.50

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

Facility ID: 041024

0.00

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

## SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

.*		including time for muleswing instructions, searching existing data sources, gathering and
ıldı	worting burden for this collection of information is estimated to average	to 10 minutes per response, including time for reviewing instructions, scarching existing data sources, gathering and
ainta	ining data needed, and completing and reviewing the collection of inton	the 10 minutes per response, including time for recovering instances are response, including this burden estimate or any other aspect of this collection of information, mation. Send comments regarding this burden estimate or any other aspect of this collection of information, mation, Send comments and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork lent, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the December and Paperwork lent, Paper
abadi	ing engestions for reducing the burden, to Office of Financial Manageria	sii, nora i.o. zonave
eduč	tion Project(0838-0583), Washington, D.C. 20503.	

Provider/Supplier Number 342543	Provider/Supplier Name VANCE COUNTY DIALYSIS					
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	<ul><li>E Initial Certification</li><li>F Inspection of Care</li><li>G Validation</li><li>H Life Safety Code</li></ul>	I J K L	Recertification Sanctions/Hearing State License 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	ng 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 12am-8am (E)	On-Site Hours sam-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (1)
1. 15401	07/13/2010	07/16/2010	0.50	0.00	2.00	0.00	1.00	0.75
2.						<u> </u>	<u> </u>	
3.		<u> </u>	<u></u>					
4.								
5								
6.								<del>                                     </del>
7.							1.	
8.								
9.				_			,	
10.		_	_					
11.								_
12.							<del></del>	
13.						<del>.</del> ].		
14.					Total BO	Supervisory Revi	Hours	0.00

Total SA Supervisory Review Hours .....

0.50

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.50

EventID: VBSZ12

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

Facility ID: 944655

0.00

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

PEPARTMENT OF HEALTH AI	ED HUI	SERVICES K	CERTIFICA	TION AN	dentei – Ok medi d transmittal	CARE & WO	ID: VBSZ12	
ZXXA	PART I - T	O BE COMPLI	TED BY TE	E STATE	SURVEY AGENCY		Facility ID: 944655	****
MEDICAREMEDICAID PROVIDER NO. (I.1' 342543 LS VENDOR OR MEDICAID NO. (L2)	٠. ا	3. NAME AND AD (L3) VANCE COU (L4) 511 RUIN CR (L5) HENDERSOI	nty dialysi reek RD sut	ß.	(LG) 27536	4. TYPE OF  1. Initial 3. Terminal 5. Validatio 7. On-Site V	6. Complaint	·
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ership (1.34)	7. PROVIDER/SUI 01 Hospital 02 SNE/NE/Dazi	PPLIER CATEGO 05 HHA 06 LAB	ORY 69 ESRO 10 NF	09 (L7) 13 FTP 14 CORF	& Full Sur-	vey After Complaint	
5. DATE OF SURVEY  S. ACCREDITATION STATUS:  0 Unaccredited 1 TIC 2 AOA 3 Other	(L10)	03 SNE/NF/District 04 SNE	07 X-R25 08 OPT/SP	11 IMR. 12 P.BC	15 ASC 16 HOSPICE	FISCAL YEAR	R ENDING DATE: (L35)	<del></del>
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Buds 13. Total Certified Bads-	(L18) (L17)	Complianc1. A		ram	And/Or Approved Waivers Cf  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural St  5. Life Safety Code  * Code: A*	6. Scc 7. Me	ope of Services Limit dical Director ient Room Size	
STATIONS  14. LTC CERTIFIED BED BREAKDOWN	19 SNF	ICF	IMR	,	.5. FACILITY MEETS	YES (I	.15)	•
18 SNF 18/19 SNF (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI A follow-up survey to the 7/26/2007 17. SURVEYOR SIGNATURE	complaint sur	Date:	simultaneously: : : : : :	with a recesti	18. STATE SURVEY AGEN	CY APPROVAL	Date:	(L.20)
PART  19. DETERMINATION OF ELIGIBLE  X 1. Facility is Eligible to Part  2. Facility is not Eligible	TY .	20. CC RJ	BY HCFA NOMPLIANCE WIGHTS ACT:		21. 1. Statement of Fi 2. Ownership/Cor 3. Both of the Ab	nancial Solvency ( atrol Interest Disck		
22. ORIGINAL DATE	23. LTC AGR	EEMENT	_24. LTC AGRE	EEMENT	26. TERMINATION ACT		(L30)	
OF PARTICIPATION	BEGINN	ING DATE	ENDING I	DATE	VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimb	00	INVOLUNTARY  05-Fail to Meet Health/Safety  06-Fail to Meet Agreement	
(L24) 25. LTC EXTENSION DATE: (L27)	A. Susper	ATIVE SANCTIONS asion of Admissions; ad Suspension Date;	(L25) S (L44)		03-Risk of Involuntary Termin 04-Other Reason for Withdray	ation	OTHER 07-Provider Status Change 00-Active	
			(L45)					<del></del>
28. TERMINATION DATE:	,	29. INTERMEDIA 00000	ARY/CARRIER N		30. REMARKS			
at BO Browning OB 31 II 1620	(L28)	32. DETERMINA	TION OF APPRO	(L31) TAL DATE	_			
31. RO RECEIPT OF CMS-1539	(L32)	of the per over the state, but remail \$4 h		(L33)	DETERMINATION .	APPROVAL		

Post-Certification	marriate	Danart
Post-Certification	Revisii	Kebou

blic reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and aintaining 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 studies as suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, NED 21207; and to the Office of Management and Budget, Paperwork and Project (0938-0390), Washington, D.C. 20503.

(Y3) Date of Revisit (Y2) Multiple Construction Provider / Supplier / CLIA / (1Y) 7/16/2010 A. Building Identification Number B. Wing 342543 Street Address, City, State, Zip Code Name of Facility 511 RUIN CREEK RD SUITE 212 VANCE COUNTY DIALYSIS HENDERSON, NC 27536

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously eported 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 definition 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 contribution of the contributio equirement on the survey report form).

	(Y5) Date (	(4) Item	(Y5) Date	(Y4) Item	(Y5) Date
4) Item	Correction		Correction		Correction
	Completed		Completed	ID D. S.	Completed
ID Prefix V0424	07/16/2010	ID Prefix		ID Prefix	,
Reg. # 405.2161(b)(3	A .	Reg.#	•	Reg. #	the same of the sa
LSC		LSC		LSC	
	Correction		Correction		Correction
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LSC		LSC		LSC	
	O		Correction		Correction
	Correction		Completed	1	Completed
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Reg.#		1 -		LS	C
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ID Prefix		ID Prefix	)		1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-
Reg.#		Reg. #	· · · · · · · · · · · · · · · · · · ·	Reg	
LSC		LSC _		L	SC
Reviewed By	Reviewed By	Date:	Signature of Surveyor	.10	Date:
-			For Class	w-Ma	les 1/1/20/16
tate Agency	Reviewed By	Date:	Signature of Surveyor:	Ą	Datel
keviewed By CMS RO	Transferrence and		F		
Followup to Survey	Completed on:		Check for any Uncorrected	Deficiencies. V	Vas a Summary of
	/26/2007		Uncorrected Deficiencie	s (CMS-2567) Se	ent to the Facility? YES NO

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Tuble 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 naintaining 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 negestions 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 Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 342543	Provider/Supplier Name VANCE COUNTY DIALYSIS							
Type of Survey (select all that apply)	C L'amentarian		I K L	Recertification Sanctions/Hearing State License CHOW				
Extent of Survey (select all that apply)	A Routine/Standard Survey (all provided Bextended Survey (HHA or Long To C Partial Extended Survey (HHA)  D Other Survey	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA)						

#### 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 Höürs 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 15401	07/13/2010	07/16/2010	0.50	0.00	2.00	0.00	1.00	0.75
2,								
3.				<u> </u>				
4.							<u> </u>	
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6.						<del> </del>		
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12.								
13.					<del> </del>			
14.					Total DO S	upervisory Revi	w Hours	0.00

Total SA Supervisory Review Hours.....

0.50

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

Page

FORM CMS-670 (12-91)

EventiD: VBSZ12

Facility ID: 944655

RVICES NRECEIVED J 08 2011 PRINTED: 06/30/2011 DEPARTMENT OF HEALTH AND HUMAN FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLÍA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING Ethibit 06/16/2011 342587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1704 WAYNE MEMORIAL DRIVE GOLDSBORO SOUTH DIALYSIS **GOLDSBORO, NC 27530** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 113 494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE V113 Wear disposable gloves when caring for the Clinical Teammates (TMs) were in-serviced patient or touching the patient's equipment at the 6-15-11 in the following: Policy #1-05-01: dialysis station. Staff must remove gloves and Infection Control for Dialysis Facilities. wash hands between each patient or station. 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, This STANDARD is not met as evidenced by: the following: 1) to remove gloves and wash 7/15/11 hands between dirty and clean tasks, 2) to Based on review of facility policy and procedures, observation and staff interview, staff perform hand hygiene whenever gloves are failed to follow facility infection control procedure removed, and 3) to wear gloves for all machine contact. The Charge Nurse (CN) is responsible by failing to perform hand hygiene between glove for oversight of infection control practice daily. changes and failing to wear gloves while Instances of non-compliance will be addressed performing residual chemical checks prior to with the TM responsible immediately. The initiation of hemodialysis treatment. Facility Administrator (FA) or designee will conduct observational infection control audits Findings included: on random shifts daily for one week, then 3 xs weekly for one month, then weekly for one Review of facility policy "Infection Control for month, then monthly with regularly scheduled Dialysis Facilities" dated 03/2011 on 6/14/2011 infection control audits. Results of audits will be revealed "1. Hand hygiene is to be reviewed with the Medical Director during the performed...after removal of gloves, after monthly QIFMM and continued frequency of contamination with blood or other infectious audits determined by the team with supporting documentation included in the meeting minutes. material, after patient and delivery system contact, between patients even if the contact is The FA is responsible for compliance with this casual, before touching clean areas such as POC. supplies...9. Gloves should be worn when: potential for exposure to blood, dialysate..." Observation on 06/15/2011 from 0930-0945 revealed Staff #7, a Patient Care Technician (PCT), cannulated a patient's dialysis access with a needle at station #20 and used same gloved hands to acquire another tourniquet from a clean bin. Further observation revealed the same PCT left Station #20, went to the adjacent patient LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

Facility ID: 970275

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN: (VICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B. WING 06/16/2011 342587

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE

GOLDSBORO SOUTH DIALYSIS			GOLDSBORO, NC 27530					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V 113	Continued From page 1 station, and changed the contaminated gloves with no hand hygiene between glove changes. Further observation revealed Staff #6, a PCT, was performing a residual check for disinfectant at station #20 without wearing gloves. Further observation revealed Staff #7 initiated the treatment at Station #20 with ungloved hands and then began typing at the computer stand without performing hand hygiene.  Interview with administrative staff on 06/15/2011 at 1030 revealed staff are expected to perform hand hygiene between glove changes and before touching a clean area or the computer cart. Interview revealed Staff #7 failed to follow facility policy by failing to perform hand hygiene between a glove change where gloves were contaminated. Further interview revealed Staff #6 failed to follow facility policy by failing to wear gloves while performing a residual check. 494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education		113 V 132	V132 Clinical teammates were in-serviced on 6-15-11 in the following Policy #1-05-01: Infection Control for Dialysis Facilities. Verification of in-service is evidenced by a signature sheet. Specifically item listed in policy as #16: The expiration date will be checked on all disposable supplies. The CN is responsible for monthly	7/15/11			
	Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.  This STANDARD is not met as evidenced by: Based on observations during tour and staff interview staff failed to ensure expired supplies were not available for patient use.  Findings include:			checks of supplies within the emergency evacuation kit and has been educated on removing each item to check for any expired items at the times of these checks. The Lab Manager is responsible for monthly checks of all lab supplies for expiration date, she will at that time discard any items not within date and a new process for rotation of lab stock supplies monthly with new additions has been implemented. All facility supplies were inventoried and checked on 6-16-11. The Facility Administrator or designee will perform monthly checks behind the charge nurse for 3 months. The FA is responsible for compliance with this POC				

PRINTED: 06/30/2011

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

STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCE IN IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	DING	CONSTRUCTION	COMPLE	
		342587	B. WING				6/2011
	ROVIDER OR SUPPLIER BORO SOUTH DIALY	sis		1704	ADDRESS, CITY, STATE, ZIP CO WAYNE MEMORIAL DRIVE DSBORO, NC 27530	DE :	
(X4) ID PREFIX TAG	(EACH-DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
V 132	Dialysis Facilities"	oolicy "Infection Control for dated 03/2011 on 6/14/2011 expiration date will be checked	V 1	32	:		
	treatment area or revealed the eme contained two (2) needles which ha which had expire during tour revea	ig tour of the hemodialysis 106/14/2011 from 1400-1420 regency evacuation cart 17 gauge vascular access d expired 05/2011 and (1) one d 01/2009. Further observation led 218 expired light blue-top and expired 10/2010.					
V 14	1420 revealed the checked for expiration "We must have repeated by meedles) I don't (light-blue lab tule 494.30(a)(2) IC-EDUCATION-CARecommendation			147			
	I. Health care wo A. Educate heal appropriate infe intravascular ca B. Assess know guidelines perio manage intrava II. Surveillance A. Monitor the co patients. If patie	orker education and training the-care workers regarding the ction control measures to prevent theter-related infections. ledge of and adherence to dically for all persons who scular catheters.	-		)		

PRINTED: 06/30/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN S VICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING . B. WING 06/16/2011 342587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1704 WAYNE MEMORIAL DRIVE **GOLDSBORO SOUTH DIALYSIS** GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE . SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG TAG **DEFICIENCY**) V 147 Continued From page 3 V 147 other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Clinical Teammates (TMs) were in-serviced Adult and Pediatric Patients. 6-15-11 in the following: Policy #I-05-01: Infection Control for Dialysis Facilities. VI. Catheter and catheter-site care Verification of attendance at in-service is B. Antibiotic lock solutions: Do not routinely use evidenced by a signature sheet. TMs were antibiotic lock solutions to prevent CRBSI instructed using surveyor observations as [catheter related blood stream infections]. 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, and 3) to wear gloves for all machine 7/15/11 contact, and 4) perform hand hygiene when This STANDARD is not met as evidenced by: moving from a dirty to clean task such as Based on review of facility policy and catheter dressing changes. The Charge Nurse procedures, observation and staff interview, staff (CN) is responsible for oversight of infection failed to follow facility infection control procedure control practice daily. Instances of nonby failing to perform hand hygiene between dirty compliance will be addressed with the TM and clean procedures involving intravascular Facility immediately. The responsible catheter devices. Administrator (FA) or designee will conduct observational infection control audits on random shifts daily for one week, then 3 xs weekly for Findings included: one month, then weekly for one month, then Review of facility policy "Infection Control for monthly with regularly scheduled infection Dialysis Facilities" dated 03/2011 on 6/15/2011 control audits. Results of audits will be reviewed

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

a 'clean' area or task..."

revealed "10. Gloves should be changed

Care Technician (PCT), removed an old

when:...When going from a 'dirty' area or task to

Observation of patient care at station #23 on 06/15/2011 at 1140 revealed Staff #7, a Patient

intravascular catheter site dressing, cleaned the site, and then applied a clean dressing with same

Event ID: MMFY11

Facility ID: 970275

POC.

with the Medical Director during the monthly

QIFMM and continued frequency of audits determined by the team with supporting

documentation included in the meeting minutes. The FA is responsible for compliance with this

If continuation sheet Page 4 of 22

TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		342587	B. WING		06/16	/2011	
	OVIDER OR SUPPLIER	SIS	170	ET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE			
GOLDSD				PROVIDER'S PLAN OF CORRE	CTION	· (VE)	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(%5) COMPLETION DATE	
V 147	Continued From p	age 4 rther observation revealed the	V 147				
· •	PCT retrieved a macomputer cart (to dressing) and the with the same do	narker from the adjacent write the date and time on the n returned the pen to the cart yed hands. Further observation					
	hooked the hemo patient's catheter	, with same gloved hands, dialysis (HD) circuit to the to initiate the HD treatment.  ministrative staff on 06/15/2011		· .			
	at 1300 revealed gloves and perfor changes between	staff are expected to change m hand hygiene between glove i dirty and clean procedures. d a glove change should have			. •		
	occurred after had dressing and befunderview revealed	ndling the patient's dirty ore applying the new dressing. It describes the staff #7 failed to follow facility operform hand hygiene					
V 316	between dirty an	d clean procedures. INTENANCE PÉR DFU OR	V 316	3		·	
	7.2.3 Maintenan semiannual/mai Written mainten	ntenance record ance procedures and a schedule					
	minimize equiprestablished. In the reprocessing equipment of the r	hintenance activities designed to nent malfunctions should be he case of purchased juipment or safety equipment, the ns of the vendor should be	•		•		
	followed unless alternative appr	ns of the vention should be documented experience support oaches. If the manufacturer's ns are not available, reuse safety equipment should be	s				
	inspected on a	semiannual basis. maintenance record		)	•		

DEPARTMENT OF HEALTH AND HUMAN \$ .VICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SUR COMPLETI	
	,	342587	B. WING		06/16	2011
	ROVIDER OR SUPPLIER		170	ET ADDRESS, CITY, STATE, ZIP ( 44 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530	CODE	
(X4) ID PREF!X	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
TAG	NEOVE TO STATE OF THE STATE OF			DEFICIENCE		
V 316	preventive mainter results of schedul	maintained of the dates of mance procedures and the ed testing in order to ensure the g of reprocessing equipment, ntrol equipment, safety	V 316			
	other unique manperforming pre procedures.  This STANDARI Based on review maintenance (Plogs and staff in PMs were performed in the performance of the maintenanc	e provided for the signature or k of identification of the person ventative maintenance  D is not met as evidenced by: v of manufacturer's preventative M) recommendations, facility PM rerview, staff failed to ensure med timely for the facility's rocessing system.		maintenance on referenced reprocessing machine on data survey 6/15/11. Biomed checked each piece of biomorphic facility for correct date of maintenance as having Area Biomedical Administ these teammates on the Biomedical Supervisor machine preventive mainter for 3 months. Results of a with the Medical Director OIFMM and continued	te of discovery during ical teammate has medical equipment in a and record keeping been performed. The trator has in-serviced is item. The Area will randomly audit mance records monthly udits will be reviewed a during the monthly frequency of audits	
	6/15/2011 rever automated dialy must be perform Review on 6/15 two Renatron II in use at the fall performed on to weeks and (4)	aled a required inspection of the right and a required inspection of the right and every three months.  6/2011 of the PM log for the (2)  1 Dialyzer Reprocessing Systems cility revealed the last PM both units was 02/28/2011 [two (2) four days overdue for inspection]	)	determined by the ter documentation included in The FA is responsible for POC. s. The Area Biomedical S responsible for compliance	the meeting minutes compliance with this Supervisor and FA are	

DEPARTMENT OF HEALTH AND HUMAN \ .VICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	COMPLET	
		342587	B. WIŃ			06/16	/2011
	ORO SOUTH DIALY	SIS		1704	T ADDRESS, CITY, STATE, ZIP CODE WAYNE MEMORIAL DRIVE LDSBORO, NC 27530		
(X4) ID PREFIX TAG	<b>ゲ A CU りたごりにおり</b>	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
V 316	revealed the required not been performed to the performer recommended ev 494.50(b)(1) GEF DISINFECT  11.4.1 Interior (bl 11.4.1.1 Germical disinfection achies Chemical germic for disinfecting of shown to accomplish to accomplish to accomplish the germical with the germical is a the chemical is a the chemical is a the chemical is a three recommentations after dilution of the pulside of the perison of the pulside of the chemical is a three perison of the pulside of the chemical is a three perison of the pulside of the perison of the pulside of the perison of the pulside of the perison of the pulside of the perison of the pulside of the perison of the pulside of the perison of the pulside of the perison o	ed the next due date. Interview ired PM was overdue and had ed per the manufacturer's ery three month interval. RM PROCESS=HIGH-LEVEL.  cood/dialysate compartment) dal process: high-level eved ides or other procedures used if hemodialyzers shall have been plish at least high-level in tested in dialyzers artificially the appropriate microorganisms. The has an expiration date from the caff members should be sure that not outdated. Some germicides in dations for maximum storage in or activation and before usage, the expiration date of the cide solution should be marked of the germicide solution.	V	339		\	
	container, and to beginning of ear begins.  The disinfection affect the integration in the context of the particular prevent injury, to mix reactive	hat date should be checked at the checked at the checked at the checked at the checked at the checked at the checked at the checked at the checked at the process shall not adversely fitty of the dialyzer. Germicides from the dialyzer to below known in a rinse-out period established ar germicide (see AAMI 12.4). To staff members shall take care not materials such as sodium and formaldehyde.			;		
1							

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SUI	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING			
		342587	B. WIN	IG		06/16	/2011
	ROVIDER OR SUPPLIER		and desired the second second	17	EET ADDRESS, CITY, STATE, ZIP COD 04 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27530	Œ	ب
COLPOD			~~~~ <del>~~</del>		PROVIDER'S PLAN OF COR	PECTION	(X5)
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V 339	Continued From	page 7	٧	339	· ·		
	This STANDARE	is not met as evidenced by:			V339		
	Based on review	v of facility policies and			Reuse clinical teammates were	in-serviced on	
	procedures, obsi	ervation during tour and staff			6/15/11 on Policy: Cleaning and	Disinfection of	
	interview, reuse	technician staff failed to ensure			Reuse Supplies specifically iten	n #4, dialysate	
1	disinfection of ca	ips used for reprocessed		:	port caps must be cleaned and d	lisinfected upon	
	dialyzers.				receipt and after every reuse pro	cedure and that	-
					the supplies are to be fully su disinfectant. An individual of	omerged in the	
	Findings include				been placed in their file as evid	lence of this in-	7/15/11
		Y BOY ing and	1		service. A new procedure to wei	ght the dialysate	1113/11
	Review of facility	y policy "Cleaning and			port caps to ensure that all	caps are fully	
	Disintection of h	Reuse Supplies Policy" dated 5/2011 revealed "4. Dialysate port	1		submerged throughout dis	infection was	
	03/2007 on 6/15	nust be cleaned and disinfected			implemented immediately. The	e use of this	
	capsii useu, ii	d after every reuse procedure6.			system will be audited by the F.	A or designee at	
	Dougo supplies	will be cleaned and disinfected		,	various times weekly for 4	weeks and then	
1	with 1% nerace	tic acid solution for a minimum of			monthly will the monthly recurrently performed. Results of	euse auous as	
	30 minutes"		-		reviewed with the Medical Dir	rector during the	1
	OS Militara				monthly QIFMM and continu	ed frequency of	
1	Observation du	ring tour of the reuse			audits determined by the team	with supporting	
	reprocessing a	rea on 6/15/2011 at 0930 revealed	i		documentation included in the	meeting minutes.	
	a container of o	lisinfectant containing dialysate	١.		The FA is responsible for con	apliance with the	}
	nort caps. Obs	servation revealed some of the			POC		
	dialysate port of	aps in the container were not fully	<i>!</i>	٠.			
	submerged in t	he disinfectant. Observation	-				
	revealed the re	euse technician took a reprocesse	<u> </u>				
	dialyzer and us	sed two of the caps from the					
1	container to ca	p both of the dialysate delivery					
	ports of the dia	nyzor.					
	Intorvious with	the reuse technician during the					
Ì	obconstion re	vealed the container holding the					
1	dialysate nort	caps with the disinfectant were					
1	ready for use.	Interview revealed approximately	,				
	6-10 of the ca	ps were not fully submerged in the	•				
1	disinfectant.	nterview revealed if the dialysate	1				
	port cans are	not fully submerged in the	l				'
	disinfectant, the	hen there is no guarantee the cap	<b>s</b>				
	have been ful	ly disinfected. Interview revealed	1				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SUI COMPLET	
		342587	B. WIN	G		06/16	/2011
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(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
V 339 V 402	they are ready to 494.60(a)	ould be fully submerged before		339 402			
	furnished must be	hich dialysis services are e constructed and maintained to r of the patients, the staff and the		-			
	Based on facility staff interview, the exit egress was	is not met as evidenced by: policy review, observations and the facility failed ensure that a fire clear and unobstructed for y in case of a fire or other		-	V402 Teammates were in-serviced on 6 Safety Preparedness guidelines a	s evidenced by	7/15/11
	Preparedness G	: y policy "Fire Safety suidelines" dated 03/2010 on sled "16. Evacuation routes will area must remain clear at all		•	entry in the Home Room Meeti their signature. The egress and it were blocked by stock that was with space for storage at a teammates were made aware of egress was immediately cleare designee will perform daily	fire pull station just delivered, premium, all this policy. The d. The FA or	
	times."  Observation on lighted exit sign the treatment a work area. Observation of the control	06/14/2011 at 1400 revealed a over a door located at the rear of rea leading into the biomedical servation revealed to the left was gn over a door leading to the linic. Observation revealed the less between the treatment area he exterior exit door was reallets of boxes containing ervation revealed a fire pull station revealed a fire pull station revealed an emergency fire			through of the facility for 2 weel weeks and designate a team mer these daily as assigned on the d sheet. The FA is responsible with the POC.	ks, weekly for 4 inber to perform aily assignment	

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

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUR COMPLETE	
•		342587	B. WIN	IG		06/16/	2011
	ROVIDER OR SUPPLIER ORO SOUTH DIALY			1704	T ADDRESS, CITY, STATE, ZIP CODE 4 WAYNE MEMORIAL DRIVE LDSBORO, NC 27530		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE
V 402	egress.  An interview on 0 facility administra limited storage specomes cluttere. The interview rev blocking a design 494.60(c)(4) PETREATMENTS  Patients must be hemodialysis trea (video surveilland requirement).  This STANDARD Based on review procedures, obsinterview, staff favisible during the Findings included.	6/15/2011 at 0930 with the tor revealed the clinic has pace and the emergency egress of when supplies are delivered. ealed there should be no items pated fire exit.  HD PTS IN VIEW DURING  in view of staff during atment to ensure patient safety, be will not meet this  D is not met as evidenced by:  To of facility policies and ervations during tour and staff ailed to ensure access sites were a hemodialysis treatment.		407	V407 Teammates were in-serviced on Vascular access care policies related to item number 16, cannulation sit tubing connections will be verified paten, and remain visible thriteatment. This in-service is do staff signature on the in-service patient received the week of 7/4/1 outlining the importance of keepin uncovered during treatment. For refuse, this will be documented in record will in addition to physicia. The Charge Nurse is responsible compliance with this, any teammates violating will be immediately. FA/designee will	d specifically les and blood for accurate, oughout the cumented by sheet. Each I a document g their access patients that in the medical in notification. for ensuring patients and e addressed	7/15/11
	(AVF) and Arter Access Care" drevealed "16. Connections will and secure conthroughout the Observation du 06/14/2011 fror vascular acces #13. #14 and #	y policy "Arteriovenous Fistula iovenous Graft (AVG) Vascular ated 09/2007 on 06/14/2011 annulation sites and blood tubing be verified for accurate, patent nections, and remain visible treatment."  In the patient area on 1400 through 1415 revealed the sites for the patients at Station 20 were covered and not visible ients were receiving hemodialysis	•		observation on random shifts da  3xs weekly for 2weeks, and trandom monthly checks to ensur  Results of audits will be revie  Medical Director during the mo  and continued frequency of aud by the team with supporting included in the meeting minutes  Charge Nurse are responsible from the POC.	hen complete to compliance, wed with the nthly QIFMM its determined documentation to The FA and	

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

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
•		342587	B. WING		06/16/	2011	
	ROVIDER OR SUPPLIER	And the state of t	STREET ADDRESS, CITY, STATE, ZIP CODE  1704 WAYNE MEMORIAL DRIVE  GOLDSBORO, NC 27530				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE ALL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
V 407	Continued From (	page 10	V 407			and the second section of the second	
V 504	1415 revealed varemain visible at vascular access #13, #14 and #20 during the patien Interview reveale failing to ensure uncovered during	-ASSESS B/P, FLUID	V 504	signs at least every 30 min	tic Treatment I Post treatment of attendance at nature sheet. TMs and document vital utes, and 2) to		
	include, but is no	mprehensive assessment must of limited to, the following: and fluid management needs.		complete and document evaluation prior to the first treat patients 3) the RN is to complete assessment on patients whose indicated an abnormality as monitoring by the RN for patie outside of the normal expectat	tment for all new e a post treatment pre assessment well as ongoing ents with findings tions The Charge	8/1/11	
	Based on revie procedures, tre- interview, licens	D is not met as evidenced by: w of facility policies and atment records and staff sed nursing staff failed to perform ment for two of five hemodialysis.		Nurse (CN) is responsible for or monitoring and completion of n post treatment assessments per will monitor flowsheets of documentation is in place. I compliance will be addresse	ew patient pre and r policy. The CN laily to ensur- enstances of non- ed with the TN		
	patient records Findings includ Review of facili Assessment" d revealed "Purp stable, to deter status, and to e treatment plan will obtain and patient post die	reviewed (#9, #8).		responsible immediately. The Faudit treatment flowsheets of two weeks then 50% of treatmex 4 weeks, then 10% week monthly. Results of audits will the Medical Director during the and continued frequency of authe team with supporting docuin the meeting minutes. The Facompliance with this POC.	50% for the first sheets 2x weetly x4, then 10% to reviewed with a monthly QIFMM dits determined to mentation includes	tt kkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkkk	

DEPARTMENT OF HEALTH AND HUMAN \$ ...VICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	E CONSTRUCTION	COMPLETE	
		342587	B. WIN	1G		06/16/	2011
NAME OF PROVIDER OR SUPPLIER  GOLDSBORO SOUTH DIALYSIS				170	ET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE .	(X5) COMPLETION DATE
V 504	intervention, the li- patient and collect	censed nurse assesses the is any additional data needed."	٧	504			
	revealed a 79 year incenter hemodial times weekly. Tre 5/16/2011 revealed 1110 "Resp(irator exertion, rhonchi	rd review for Patient #9 ir old admitted 01/05/2011 for lysis (HD) treatments three eatment record review for ed a Pre HD assessment at ry) - SOB (short of breath) upon (abnormal breath BP elevated, usually comes			•		
	down with Tx (tre patient's pre HD (normal 120/80). was initiated at 1 who performed the review revealed interventions or or after the HD trees.	atment)." Review revealed the blood pressure was 203/92 Further review revealed oxygen 112 by the Registered Nurse he pre HD assessment. Further no reassessment of the patient's condition during reatment had ended. Review tent's post HD blood pressure					
	was 197/81.  Interview with no	ursing administrative staff on 100 revealed abnormal pre HD		٠.			
	should be reass Interview reveal the pre HD asse oxygen interven by failing to reas the abnormal pr	lings and any interventions essed by the licensed nurse. ed the licensed nurse performing essment and who provided the tion failed to follow facility policy seess the patient to follow up on the HD assessment findings and best the effectiveness of the atton provided.		,			
	revealed a 74 y	cord review for Patient #8 ear old admitted 04/06/2011 for lialysis treatments three times nent record review for 5/19/2011					

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

STATEMENT (	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		E CONSTRUCTION	(X3) DATE SUI COMPLET	
		342587	B. WIN	iĠ		06/16	/2011
	ROVIDER OR SUPPLIER ORO SOUTH DIALY	sis		170	ET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
(X4) ID PREFIX TAG	CAPH DEDOIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
V 504	revealed a Pre HI licensed nurse. F pressure of 205/7 post HD assessm Interview with nur 06/16/2011 at 11 should be collect assessment for a staff failed to follo collect post HD of discharged from 494.80(b)(1) PA- DAYS/13 TX  An initial compre conducted on all admissions to a of 30 calendar delicenses.	D assessment at 0801 by a Review revealed a pre HD blood 5. Further review revealed no sent was performed by staff.  The sing administrative staff on 100 revealed post HD data and compared to the pre HD in the pr		504	V516  The Governing Body will ensure the interdisciplinary team (IDT) review and implements the plan of care to services required to address the parameters of the parameters of the parameters.	vs, updates reflect the tient's ial	7/15/11
	Based on revie	D is not met as evidenced by: w of facility policies and dical records and staff interview, sure the comprehensive		•	assessment required to be completed days or 13 treatments after admissional will review and in-service the IDT #1-01-07 "Patient Assessment and Care" with emphasis on the need to	ed within 30 ion. The FA on policy Plan of o review and	
	assessment wa	is completed within 30 days or 13 e the first day of incenter or three of five records reviewed			update and complete the plan of complete the time frame  FA/designee will audit 100% of complete the next 3 months, then 10% of complete compliance. Results of au reported in QIFMM and addresse necessary. FA is responsible for compliance with POC,	are plans due quarterly to dits will be d as	
	Plan of Care W on 06/15/2011	ity policy "Patient Assessment an /hen Utilizing Duck" dated 12/201 revealed "4. A comprehensive ill be conducted on all new patien ndar days (or 13 outpatient dialysi	ts				

DEPARTMENT OF HEALTH AND HUMAN S. /ICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING 06/16/2011 342587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1704 WAYNE MEMORIAL DRIVE **GOLDSBORO SOUTH DIALYSIS** GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION (X5) . SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 516 Continued From page 13 sessions for hemodialysis) beginning with the first outpatient dialysis treatment..." 1. Open record review for Patient #9 revealed a 79 year old admitted 01/05/2011 for incenter hemodialysis (HD) treatments three times weekly. Review of the patient's "IDT (interdisciplinary team) Assessment and Plan of Care Report" revealed the initial comprehensive admission assessment was completed 3/20/2011 174 days or 18 hemodialysis (HD) treatments since admission]. Interview with nursing administrative staff on 06/16/2011 at 1100 revealed the IDT Assessment and Plan of Care Report is the computerized version of the patient's initial comprehensive admission assessment. Interview revealed the assessment should be completed within 30 calendar days or 13 dialysis treatments from the patient's admission to the center. Interview revealed staff failed to complete the admission assessment timely for Patient #9. 2. Open record review for Patient #7 revealed a 53 year old admitted 02/28/2011 for incenter hemodialysis treatments three times weekly. Review of the patient's "IDT Assessment and Plan of Care Report" revealed the initial comprehensive admission assessment was completed 04/14/2011 (47 days or 16 HD treatments since admission).

Interview with nursing administrative staff on 06/16/2011 at 1100 revealed the IDT Assessment and Plan of Care Report is the computerized version of the patient's initial

PRINTED: 06/30/2011

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF COMPLETE	
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V 516	Interview revealed completed within treatments from center. Interview complete the addresser #7.  3. Open record r	admission assessment.  ed the assessment should be a 30 calendar days or 13 dialysis the patient's admission to the v revealed staff failed to mission assessment timely for review for Patient #8 revealed a	V 516			
	hemodialysis tre Review of the pa Plan of Care Re comprehensive	itted 04/06/2011 for incenter atments three times weekly. attent's "IDT Assessment and port" revealed the initial admission assessment was 2011(43 days or 16 HD admission).				
	06/16/2011 at 1 Assessment and computerized vice comprehensive Interview reveal completed within	ursing administrative staff on 100 revealed the IDT de Plan of Care Report is the ersion of the patient's initial admission assessment, led the assessment should be n 30 calendar days or 13 dialysis the patient's admission to the				
V 520	center. Intervie complete the ad Patient #8. 9 494.80(d)(2) PA	w revealed staff failed to discount for the discount failed to discount for discount for discount for discount for discount for discount for discount for discount for discount for discount for discount for discount failed in the discount for discount for discount failed in the discount failed in t	V 520			
	paragraphs (a) a comprehensi	with the standards specified in (1) through (a)(13) of this section, ve reassessment of each patient of the plan of care must be		1		
	At least month	y for unstable patients including,		,		

DEPARTMENT OF HEALTH AND HUMAN S. /ICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	COMPLETE	
		342587	B. WING			06/16/	2011
	ROVIDER OR SUPPLIER ORO SOUTH DIALY	SIS		1704	FADDRESS, CITY, STATE, ZIP CODE WAYNE MEMORIAL DRIVE DSBORO, NC 27530		
(X4) ID PREFIX TAG	CEACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
V 520	but not limited to, (i) Extended or fre (ii) Marked deterion (iii) Significant char (iv) Concurrent po	age 15 patients with the following: quent hospitalizations; pration in health status; ange in psychosocial needs; or por nutritional status, nia and inadequate dialysis.	<b>V</b> 5	520			
	Based on review procedures, med staff failed to ens Care was update two unstable pat Findings include  Review of facility Plan of Care Whon 06/15/2011 re-assessment of the plan of care	y policy "Patient Assessment and en Utilizing Duck" dated 12/2010 evealed "7. A comprehensive of each patient and a revision in will be conductedAt least			The Governing Body will ensure the interdisciplinary team (IDT) review and implements the plan of care to services required to address the particular specific needs identified. In any as which the patient is deemed unstable patient will be reassessed and care meeting performed within 30 days will review and in-service the IDT #1-01-07 "Patient Assessment and Care" with emphasis on the need to update and complete the plan of citime frame. The facility will main	vs, updates reflect the tient's ssessment in ole, the plan The FA on policy Plan of to review and are within the ntain a list of	8/1/11
	year old admitted hemodialysis tree. Review of the partient was "undereview revealed assessment was months later).	riew for patient #10 revealed a 69 at 02/04/2003 for incenter eatments three times weekly. atient's annual comprehensive stable" related to dialysis 1 compliance issues. Further 1 no follow-up comprehensive as completed until 12/21/2010 (13) Review revealed the updated Plaviewed during the interdisciplinary on 02/21/2011 (two months later)	n		unstable patients to follow monthing these are completed. FA/designee 100% of care plans due for the nethen 10% quarterly to ensure completed and addressed as necessary. FA is for ongoing compliance with PO	y to ensure will audit xt 3 months, pliance. in QIFMM s responsible	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENT!FICATION NUMBER:	1	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	sis		1704	TADDRESS, CITY, STATE, ZIP CODE WAYNE MEMORIAL DRIVE LDSBORO, NC 27530			
(X4) ID PREFIX • TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
V 520	Interview with nur 06/16/2011 at 11 "unstable" on the reassessed by the every 30 days an necessary. Internoted to be unstated to be unstated to be unstated to be unstated to be unstated to the unstated patient every 30 Interview further follow-up after the was completed (two months lated have been admit clinic which may follow-up with the comprehensive the IDT failed to perform timely referred "unstalled".	as made "unstable" related to ssues.  rsing administrative staff on 15 revealed patients noted to be plan of care should be e interdisciplinary team (IDT) ad update the plan of care as view revealed Patient #10 was able during the 11/19/2009 IDT assessment and plan of care. Ed the IDT failed to reassess the days as per facility policy. revealed there was not a timely recomprehensive assessment 12/21/2010 with the care plan er). Interview revealed there inistrative oversight issues at the retimeliness of the assessments. Interview revealed follow facility policy by failing to reassessments of patients		520 V 543				
	The plan of care to, the following (1) Dose of dial must provide the manage the pa  This STANDAF Based on revie procedures, tre interview, staff the hemodialys	e must address, but not be limited	i		ş.			

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN UI	CORRECTION		A. BUILDING			
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	ROVIDER OR SUPPLIER	olo.	17	EET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE	·	
GOLDSB	ORO SOUTH DIALY	515	G	OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ION SHOULD BE HE APPROPRIATE	
V 543	Continued From p (#7, #9, #8, #10).	page 17	V 543			
	Findings include: Review of facility Monitoring" dated revealed "1. Trea completed at leas At a minimum, of following: Blood dialysate flows, a Fluid removal an access status an status and subje  1. Open record r #7 revealed a 53 for incenter hem weekly. Review failed to monitor hour since last r hemodialysis tre 6/11/2011 staff 1132-1230 (58)	eview on 06/15/2011 for Patient 3 year old admitted 02/28/2011 odialysis treatments three times revealed on 6/14/2011 staff the patient from 1100-1200 (one nonitoring episode) during the eatment. Review revealed on failed to monitor the patient from minutes since last monitoring		TMs were in-serviced 6-16-11 in the Policy #1-03-09: Intradialytic Monitoring and Policy #1-03-11 Po. Patient assessment. Verification of a in-service is evidenced by a signature were instructed to: 1) monitor and do signs at least every 30 minutes, complete and document a pevaluation prior to the first treatmen patients. 3) The RN is to comptreatment assessment on patients assessment indicated an abnormality ongoing monitoring by the RN for findings outside of the normal experiment complete in the patient monitoring and complete patient monitoring and complete patient pre and post treatment assessment documentation is in place. non-compliance will be addressed responsible immediately. The FA will audit treatment flowsheets of first two weeks then 50% of treatment week x 4 weeks, then 10% weekly	Treatment st treatment ttendance at e sheet. TMs cument vital and 2) to ore-treatment t for all new olete a post whose pre y as well as patients with ectations The for oversight stion of new essments per heets daily to Instances of with the TM or designee 50% for the ents sheets 2x	8/1/11
	Review reveale monitor the patisince last monit hemodialysis to 5/21/2011 staff 1100-1230 (one monitoring epistreatment.  Interview on 06 administrative monitored even	the hemodialysis treatment. d on 5/31/2011 staff failed to ent from 1230-1330 (one hour oring episode) during the eatment. Review revealed on failed to monitor the patient from e and a half hours since last ode) during the hemodialysis 6/15/2011 at 1430 with staff revealed patients should be ry 30 minutes during the HD erview revealed staff failed to folice		monthly. Results of audits will be the Medical Director during the mo and continued frequency of audits the team with supporting document in the meeting minutes. The FA is a compliance with this POC.	reviewed with nthly QIFMM determined by ation included	

DEPARTMENT OF HEALTH AND HUMAN S<sub>1</sub> /ICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		342587	B. WIN	IG		06/16/2011		
	ROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530					
(X4) ID PREFIX TAG	WACH DECICIES	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
V 543	facility policy by	failing to monitor Patient #7 s on 06/14/2011, 06/11/2011,	V	543				
	#9 revealed a 7 for incenter hem weekly. Review failed to monitor hour and 18 min enisode) during	review on 06/15/2011 for Patient 9 year old admitted 01/05/2011 nodialysis treatments three times revealed on 06/03/2011 staff the patient from 1012-1130 (one nutes since last monitoring the hemodialysis treatment.						
	Review reveals monitor the pat since last moni hemodialysis tr 5/25/2011 staff 1300-1358 (52	d on 06/01/2011 staff failed to lent from 1200-1300 (one hour toring episode) during the eatment. Review revealed on failed to monitor the patient from minutes since last monitoring the hemodialysis treatment.						
	administrative monitored eve treatment. Into	6/15/2011 at 1430 with staff revealed patients should be ry 30 minutes during the HD erview revealed staff failed to follow failing to monitor Patient #9 tes on 06/03/2011, 06/01/2011 ar	·	• • • • • •				
	3. Open recor #8 revealed a for incenter he weekly. Revi- failed to moni hour since las hemodialysis 5/26/2011 sta 1400-1516 (c	d review on 06/15/2011 for Patier 74 year old admitted 04/06/2011 emodialysis treatments three time ew revealed on 06/07/2011 staff tor the patient from 0800-0900 (ost monitoring episode) during the treatment. Review revealed on aff failed to monitor the patient from hour and 16 minutes since lassisode) during the hemodialysis	nt s ne					

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

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		ECONSTRUCTION	COMPLETE	
		342587	B. WIN	G		06/16/2	2011
	ROVIDER OR SUPPLIER  ORO SOUTH DIALYS	sis		170	ET ADDRESS, CITY, STATE, ZIP CODE 4 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
V 543	Continued From p	age 19	V	543			
	administrative staff monitored every 3 treatment. Interviendacility policy by facevery 30 minutes  4. Open record re #10 revealed a 69 for incenter hemo weekly. Review repatient was on a and staff failed to 0930-1026 (56 m.)	frevealed patients should be 0 minutes during the HD ew revealed staff failed to follow alling to monitor Patient #8 on 06/07/2011 and 05/26/2011.  In the work of					
V 729	administrative sta monitored every treatment. Interv facility policy by t every 30 minutes	5/2011 at 1430 with aff revealed patients should be 30 minutes during the HD riew revealed staff failed to follow ailing to monitor Patient #10 s on 06/04/2011. R-COMPLETE RECORDS		/ <b>72</b> 9		·	
	(1) Current medi discharged patie	cal records and those of nts must be completed promptly D is not met as evidenced by:		e na haranda aranda aranda aranda '			
	Based on review procedures, clos interview staff far completion of a discharge from the patient records to the patient records to the procedure of the procedur	w of facility policies and seed medical records and staff illed to ensure the timely medical record after a patient's the center for two of three closed reviewed (#4, #6).					
	Findings include	<b>:</b> :					

DEPARTMENT OF HEALTH AND HUMAN \ VICES

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	.**	342587	B. WIN	IG		06/16/2011	
	ROVIDER OR SUPPLIER ORO SOUTH DIALY	sis		17	EET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL.  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
V 729	Review of facility Maintenance" dat revealed "15. The documented in the 30 days after the The discharge suprogress and treastatus, their progratient."  1. Closed record 6/16/2011 reveal treatment at the Review of the resummary," signer months after last patient's last treatent's last t	policy "Medical Record ed 09/2010 on 5/16/2010 discharge summary will be e patient's medical record within patient becomes inactive16. mmary will address the patient's atment during their inactive nosis and the disposition of the review for Patient #4 on ed a 71 year old whose last facility was on 11/24/2010. cord document "Discharge ed by the physician 5/23/2011 (6 treatment), revealed the atment at the facility was on a note by the physician "Pt intal) p (after) prolonged	V	729	V729 Teammates involved in the discharge for patients (charge nurses, nurses, administrative personnel) will be inon facility policy Medical Record Maintenance with focus on the need discharge summary to: 1) be docume the patient's medical record within 3 after the patient becomes inactive an include the patient's progress and treduring their inactive status, their prothe disposition of the patient. These teammates are responsible for compforms required in the medical record closing charts. These teammates with attention of the FA monthly any to close and any required paperword the FA will bring to the attention of Medical Director or patient physicis will then monitor monthly for each all closed charts are appropriately of the FA is responsible for this POC	for a ented in 0 days ad 2) catment ognosis and e cilation of d for charts due k of which the an. The FA month that locumented.	8/16/11
	1245 revealed the hospital on (	dministrative staff on 6/16/2011 a ne patient was discharged from 02/28/2011 to a long-term		· .			,
	ventilator suppo discharged from 02/28/2011. Int expired at the lo revealed the co discharge summonths and 23 actually dischar 02/28/2011. In	rt facility and was thus technically the dialysis center on erview revealed the patient later ong-term facility. Interview mpletion of the record and nary was almost three months (2 days) after the patient was ged from the dialysis center on terview revealed the discharge not completed within 30 days per					
	2. Closed recor	d review for Patient #6 on					

## DEPARTMENT OF HEALTH AND HUMAN \ .VICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		342587	B. WI	1G		06/16	/2011	
	ROVIDER OR SUPPLIER ORO SOUTH DIALY	sis	eng day a dag di dag dag dag dag dag dag dag dag dag dag	170	ET ADDRESS, CITY, STATE, ZIP CODE 14 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
V 729	6/16/2011 reveale 4/12/2011. Revie "Discharge Summ on 5/23/2011, rev. local hospital on 4 discharge summa the patient expired facility).	age 21 d a 79 year old who expired w of the record document eary," signed by the physician ealed the patient expired at the 1/12/2011. Review revealed the ry was completed 41 days after d (became inactive at the		729	,			
	1245 revealed the	e discharge summary was not 30 days per facility policy.						
'								

DEPARTMENT OF HEALTH AN	D IA	N SERVICES			ICARE & MED		
*****	Mb_ (CA	RE/MEDICAID CER	TIFICATION.	AND TRANSMITTAL		ID: - Facility	
	ART I - T			TE SURVEY AGENCY	14 mmm or 15		
I. MEDICARE/MEDICAID PROVIDER NO.	'	3. NAME AND ADDRESS (L3) GOLDSBORO SO	OF FACILITY  OTH DIALYSIS		4. TYPE OF AC	TION: 9	
(L1) 342587 2.STATE VENDOR OR MEDICALD NO.		(L4) 1704 WAYNE ME	VIORIAL DRIVE	:	3. Termination	' 4. CH(	
(L2)		(L5) GOLDSBORO, NO		(L6) 27530	5. Validation 7. On-Site Visi	6. Comp 9. Other	
5. EFFECTIVE DATE CHANGE OF OWNE	RSHIP	7. PROVIDER/SUPPLIEF	CATEGORY	<u>09</u> (L7)		After Complaint	•
(L9)		01 Hospital 05 H	HA 09 ES	RD 13 PTIP	0, 141754,123		-
6. DATE OF SURVEY	(L34)	02 SNF/NF/Dual 06 1	AB 10 NF		I I FISCAL YEAR E	NDING DATE	d.
8. ACCREDITATION STATUS:	(L10)		C-Ray IIIM				
0 Unaccredited 1 TJC		04 SNF 08 (	OPT/SP 12 RH	IC IS HOSPICE	1		4
2 AOA 3 Other						_	
11. LTC PERIOD OF CERTIFICATION		10,THE FACILITY IS CE		And/Or Approved Waivers O	f The Following Req	uirements:	
From (a):		A. In Compliance Wi Program Requirer		2. Technical Personne		of Services Limit	•
To (b):		Compliance Base		3. 24 Hour RN	7. Medic	al Director	•
12. Total Facility Beds	(L18)	1. Acceptal	ole POC	4, 7-Day RN (Rural S			
•				5. Life Safety Code	9. Beds/	коот	
13. Total Certified Beds	(L17)	B. Not in Complianc Requirements an	d/or Applied Waive	rs: * Code:	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		<u> </u>		15. FACILITY MEETS	-		
	19 SNF	ICF	IMR	1861 (e) (1) or 1861 (j) (1):	<i>{</i> 1.15	,	
18 SNF 18/19 SNF	17 3/11		•				
(L37) (L38)	(L39)	(LA2)	(L43)				
16. STATE SURVEY AGENCY REMARK	S (IF APPLI	CABLE SHOW LTC CANC	ELLATION DATE)				
Add one hemodialysis station to mak	e a total of 1	wenty two (22) stations e	ffective 4/27/2010	, per CON Project ID# P-8317-	09.		
17. SURVEYOR SIGNATURE		Date:		. 18, STATE SURVEY AGEN	ICY APPROVAL	Date:	
					11. 16	Wil	
			(L19		Say 3 ju	2010	(L20)
PART	1 - TO BE	COMPLETED BY I	ICFA REGION	AL OFFICE OR SINGLE	STATE AGEN	ICY	
19. DETERMINATION OF ELIGIBILITY			ANCE WITH CIVIL	21 1 Statement of F		FA-2572)	1
	•	RIGHTS	ACT:	2. Ownership/Co 3. Both of the Alt		ile Man (Tie 178-174)	•
1. Facility is Eligible to Partic	apate				•		
2. Facility is not Eligible	(L21				•		
	3, LTC AGR	3014CNFT - 74-1	TO AGREEMENT	26. TERMINATION ACTI	ON:	(L30)	
		_	NDING DATE	VOLUNTARY	<u>00</u> <u>n</u>	IVOLUNTARY	
OF PARTICIPATION	BEGINN	NG DATE E	MDINO DAIL	01-Merger, Closure		-Fail to Meet Health/	Safety
		,	1 me)	02-Dissatisfaction W/ Reimi	bursement 00	6-Fail to Meet Agreem	nent
(L24)	(LAI)		L25)	03-Risk of Involuntary Termi	nation O	THER	
25. LTC EXTENSION DATE: 2		ATIVE SANCTIONS		04-Other Reason for Withdra		7-Provider Status Cha	ange
	A. Susper	sion of Admissions:	(LA4)	·	0	0-Active	
(L27)	B. Rescin	d Suspension Date:	(211)				
	21, 1,	•	(L45)				
28. TERMINATION DATE:		29. INTERMEDIARY/CA	RRIER NO.	30, REMARKS			
ZO, TERMINATION DATE.		00000					
•	a 205	V00VV ·	ď.	31)			
	(L28)		\D.				
31. RO RECEIPT OF CMS-1539		32. DETERMINATION C	F APPROVAL DAT	TE			
	(I 30)	<i>e</i>	n.	DETERMINATION	APPROVAL		

DEPARTMENT OF HEALTH A	ND HTIMA	N SERVICES	CENTER FOR MED	ICARE & MEDICAID SERVICES
DEPARTMENT OF MEADINA	MEDIC	E/MEDICAID CERTIFICATION AT	ND TRAN. TAL	ID GE2D11
(A)	PART I -	O BE COMPLETED BY THE STAT	E SURVEY AGENCY	Facility II.) 970275
MEDICARE/MEDICAID PROVIDER NO	)	3. NAME AND ADDRESS OF FACILITY		4. TYPE OF ACTION 6 (L8)
(L1) 342587		(L3) GOLDSBORO SOUTH DIALYSIS		1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.	,	(L4) 1704 WAYNE MEMORIAL DRIVE (L5) GOLDSBORO, NC	(L6) 27530	3. Termination 4. CHOW 5. Validation 6. Complaint
(L2)			<u>09</u> (L7)	7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	IERSHIP	7. PROVIDER/SUPPLIER CATEGORY	13 PTIP	8. Full Survey After Complaint
(19)	(L34)	01 Hospital	14 CORF	
DATE OF SURVEY     ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct 07 X-Ray 11 IMR	15 ASC	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS.  0 Unaccredited   TIC	(233)	04 SNF 98 OPT/SP 12 RHC	16 HOSPICE	12/31
2 AOA 3 Other			· .	
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS CERTIFIED AS:		COST PORT OF THE PROPERTY OF T
From (a):		X A, In Compliance With	2. Technical Personnel	f The Following Requirements.    6 Scope of Services Lamii
To (b):	•	Program Requirements Compliance Based On:	3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	(L18)	X 1. Acceptable POC	4. 7-Day RN (Rural SI	
21, 1,			5. Life Safety Code	9, Beds/Room
13. Total Certified Bods Stution	(L17)	B. Not in Compliance with Program Requirements and/or Applied Waivers:	* Code: A1*	(L12)
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF IMR	1861 (e) (1) or 1861 (j) (1):	YES (LIS)
(L37) (L38)	(L39)	(LA2) (LA3)		
A CENTRAL ACENCY DEMAN	DVC (IE APPI I	CABLE SHOW LTC CANCELLATION DATE):		
A complaint survey was conducted were cited (NC00062004).	on 3/4/2010.	The allegations in the complaint could not be	substantiated. However, as a	result of the survey, standard level deficiencies
17. SURVEYOR SIGNATURE		Date:	18, STATE SURVEY AGEN	CY APPROVAL Date.
// SOKYDIOKOKOMIYONA	.0 1			3/30/20
nay Cuarm	Mh	03/26/2010 (Li9)	Chr Ca	(1.20)
PART	II - TO BI	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE	STATE AGENCY
19. DETERMINATION OF ELIGIBILITY	ſΥ	20. COMPLIANCE WITH CIVIL		nancial Solvency (HCFA-2572) htrol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to Par	ticipate	RIGHTS ACT:	3. Both of the Ab	
2. Facility is not Eligible				
	. (1.21	)		
22, ORIGINAL DATE	23. LTC AGR	EEMENT 24. LTC AGREEMENT	26. TERMINATION ACTIO	314 ()411
OF PARTICIPATION	BEGINN	ING DATE ENDING DATE	VOLUNTARY _	00 INVOLUNTARY
	•		01-Merger, Closure	05-Fail to Meet Health/Salety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimb	
25. LTC EXTENSION DATE:	27. ALTERN	ATIVE SANCTIONS	03-Risk of Involuntary Termin 04-Other Reason for Withdray	OTHER
	A. Susper	sion of Admissions:	V4-Other Reason for Williams	07-Provider Status Change 00-Active
(L27)	B Parcin	(I.44) d Suspension Date:		00-720470
	D, 163011	(L45)		
20 TERMANATION DATE		29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
28. TERMINATION DATE:		•		
•	(1.25)	00000 · (L31)		
	(L28)	. (631)	_	
31. RO RECEIPT OF CMS-1539		32. DETERMINATION OF APPROVAL DATE		
,	(L32)	(L33)	DETERMINATION A	APPROVAL

#### RECEIVED MAR 3 2010



PRINTED: 03/15/2010 FORM APPROVED OMB NO. 0938-0391

CENTEDO	TOD MEDICADE &	MEDICAID SERVICES			. /	UNID NO.	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF AND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL			COMPLETE	1
*			B, WIN	G		1	
		342587		,		03/04	1/2010
NAME OF PRO	OVIDER OR SUPPLIER		,	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	RO SOUTH DIALYSIS				04 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
Ģ025050			<del>,</del>			TION	· (VE)
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY TOLL		PREF	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROVIDENCY)	ULD BE	(X5) COMPLETION DATE
V 510	494.80(a)(7) PA-MS	SW-PSYCHOSOCIAL NEEDS	v	510			
		-shansing accomment must	` <b> </b>	1			
	ine patient's compl	rehensive assessment must mited to, the following:	.]		V510	10n - 42 1	. 1
	include, but is not if	maco to, are reneways	1	١	The FA will review Policy #1-01-07	ranent	1
	(7) Evaluation of pe	sychosocial needs by a social	1 .		Assessment and Plan of Care" with fi interdisciplinary team (IDT) with em	nhasis on	1
	worker.	Storiogogiat traces of a second			their responsibility for providing each	n patient	
	WOINEI.				with an individualized comprehensiv	e	
]					assessment which will be used to dev	elop the	
					patient's treatment plan and expectati	ions for	1
					care. All areas that are required to be	addressed	1
	This STANDARD	is not met as evidenced by:			in this process, which includes psych	osocial	
	Based on facility p	olicy review, medical record			needs as evaluated by a social worke	r, will be	4/18/10
100	review and staff in	terview, the interdisciplinary			discussed with special focus on eval	uating.	
	team (IDT) failed t	o assess psychosocial needs	ļ		patients who have been demonstration aggressive and disruptive behavior.	ng	
	for 1 of 1 (#1) patie	ent reviewed that was deemed			aggressive and disruptive behavior.		
	unstable. The find	lings included:			Policy #1-01-08 "Patient Behavior A	A preements.	
			}		30 day Discharge, Involuntary Disch	narge or	1
	Review of facility	policy 1-01-07-Hemo Dialysis	Į.		Involuntary Transfer" will also be re	psyiewed	
	Patient Assessme	ent and Plan of Care (revised			with emphasis on if a patient's beha	vior is	
	9/09) revealed the	interdisciplinary team is	İ		disruptive to the facility, but is non-	threatening,	ļ
	responsible for pr	oviding each patient with an	1		a comprehensive assessment will be	completed	Į.
	individualized and	comprehensive assessment	1		by the IDT in order to identify poss	ible root	
	documenting his/	her needs which will be used to			causes and any potential intervention	ons such as	
	develop the patie	nt's treatment plan and			mental health counseling or other a	ppiicable	
<u>.</u>	expectations for o	care. The assessment will			referrals. These interventions and s patient response will be documente	absequent	
1 .	includepsychos	ocial needs as evaluated by a			patient's record and evaluated for a	ny further	
	social workerar	nd assessments will be			needs. The assessments will be con	ducted	1
	conducted month	ly on unstable patients.			monthly and documented until the	patient is no	
		died sport for prijant #1			longer deemed unstable or has tran	sferred from	
ŀ	Review of the me	edical record for patient #1	1		the facility.		
	revealed this 33	year old male had been acility on 11/07/2005 for	1				
	admitted to the to	end stage renal disease		•	FA/designee will audit records of	patient's	
	secondary to dia	hotos			identified as unstable monthly x 3	then 10%	
	secondary to dia		· }		quarterly to ensure compliance. R	esuus oi	
	Daylow of the m	edical record revealed this	- 1		audits will be reported in CQI and	numessed as	
	Keylew of the In	n Involuntarily discharged from			necessary.		
	patient nau beet	on 1/25/10 "effective					
,	the dialysis unit	e to verbally threatening staff	ļ				
l	immediately du	e to serbons traceround area					(X6) DATE,

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

FORM CMS-2557(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: GE2D11

Facility ID: 970275

. If continuation sheet Page 1 of 10

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIÉR/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLET			
		342587	B. WIN	G		I .	04/2010	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1704 WAYNE MEMORIAL DRIVE  GOLDSBORO, NC 27530					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TOLE				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
V 510.	after a patient/staff a 1/25/10.	altercation that occurred on linical Manager on 3/4/10 at patient had a history of	V	510	•			
	Interview with staff this patient had a lo	#1 on 3/4/10 at 1245 revealed ing history of disruptive 5/10, the day that the patient f, she felt like the patient's						
	that she had seen	#2 on 3/4/10 at 1315 revealed patient #1 "get smart but never ontrol like he did that day. I t somebody or even carry out						
	Review of the med following progress	ical record revealed the notes:						
	very angry and ira	on 12/8/08-patient became te when asked by staff not to acility due to possible nachine circuit boards.						
	Facility Manager to	progress note on 6/5/09-patient manding a soft drinkusing						
	12/18/09-patient of belongings at the premises only to	ator progress note on upset because he left his facility when he left the find out upon his return that his een stolen. He stated "it ain't that".						
	RN progress note	e on 1/22/10-patient requested to				•		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURV COMPLETED	P	
		342587	B. WING		03/04	ľ
	OVIDER OR SUPPLIER		STREE 170- GO			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
V 510	restroom-patient wa a cigarette outside the Social Worker progr	that he could use the liked past the restroom and lit ne facility.  ess note on 1/25/10-patient	V 510			
	facility (treatment or	ng to RNrefusing to leave ampleted)stated "mind your will cut you like I'm going to				
	Behavior Agreemel Involuntary Dischar (revision 9/09), revi is disruptive tot he a comprehensive p	olicy 1-01-08, Patient onts, 30 day discharge, ge or Involuntary Transfer ealed "If a patient's behavior facility, but is non-threatening, atient assessment will be onterdisciplinary team (IDT) in by potential action or plan of				
	correction required on identifying the rebehavior.	. The assessment must focus oot causes of disruptive				·
	re-assessments of	record revealed that IDT ccurred monthly from use the patient had been	**			
	deemed unstable hemodialysis treat re-assessments re evidence that the	due to his non-compliance to ments. Review of these evealed no documented IDT had assessed any ds for this patient's aggressive				
	at 1510 revealed	Facility Administrator on 3/4/10 the IDT had not assessed this ive and disruptive behavior.				
V 5	20 494.80(d)(2) PA- REASSESSMEN	FREQUENCY T-UNSTABLE Q MO	V 52	0		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				1	0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING			1
			B, WIN	G		02/04	
		342587	D. WING			03/04	/2010
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
				l .	94 WAYNE MEMORIAL DRIVE		
GOLDSBO	RO SOUTH DIALYSIS			GC	OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
14 500	O. B. and Fram por	-0.3	V	520	•		
V 520	1		1			,	
	paragraphs (a)(1) the a comprehensive re and a revision of the conducted-  At least monthly for but not limited to, particle (ii) Extended or freq (iii) Marked deteriors (iii) Significant channel (iv) Concurrent poor unmanaged anemial to the conducted on facility preview and staff in team (IDT) failed to	a and inadequate dialysis.  is not met as evidenced by: blicy review, medical record terview, the interdisciplinary b re-assess psychosocial			The FA will review Policy # 1-01-0 Assessment and Plan of Care" with interdisciplinary team (IDT) with er their responsibility for providing ea with an individualized comprehens assessment which will be used to depatient's treatment plan and expecta care. All areas that are required to learn this process, which includes psynneeds as evaluated by a social world discussed with special focus on evapatients who have been demonstrate aggressive and disruptive behavior.  Policy #1-01-08 "Patient Behavior 30 day Discharge, Involuntary Dis Involuntary Transfer" will also be with emphasis on if a patient's beh disruptive to the facility, but is not a comprehensive assessment will be the IDT in order to identify no	the mphasis on ch patient we evelop the stions for be addressed chosocial cer, will be duating ing  Agreements, charge or reviewed avior is a-threatening, be completed	4/18/10
	needs for 1 of 1 (#	patient reviewed that was     The findings included:			by the IDT in order to identify pos causes and any potential intervent	ions such as	
					mental health counseling or other	applicable	
	Review of facility p	policy 1-01-07-Hemo Dialysis			referrals. These interventions and	subsequent	
	Patient Assessme 9/09) revealed the responsible for pro- individualized and documenting his/f develop the patier expectations for coincludepsychosisocial workeran conducted month	nt and Plan of Care (revised interdisciplinary team is oviding each patient with an comprehensive assessment ner needs which will be used to nit's treatment plan and eare. The assessment will ocial needs as evaluated by a dissessments will be ly on unstable patients.			patient response will be document patient's record and evaluated for needs. The assessments will be comonthly and documented until the longer deemed unstable or has trathe facility.  FA/designee will audit records of identified as unstable monthly a quarterly to ensure compliance, andits will be reported in CQI an necessary.	any further onducted to patient is no insferred from patient's attent's then 10% Results of	
	revealed this 33 y	dical record for patient #1 year old male had been acility on 11/07/2005 for					

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
•		342587	B. WING_		03/04/	/2010
	ROVIDER OR SUPPLIER  ORO SOUTH DIALYSIS		· s	TREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530		
(X4) ID PREFIX TAG	FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
V 520	hemodialysis for end secondary to diabete	i stage renal disease es.	V 52	20		
	patient had been invented the dialysis unit on immediately due to	cal record revealed this voluntarily discharged from 1/25/10 "effective verbally threatening staff altercation that occurred on				
	Interview with the C 1500 revealed this aggressive and dist	linical Manager on 3/4/10 at patient had a history of uptive behavior.				15
	this patient had a lo	#1 on 3/4/10 at 1245 revealed ong history of disruptive 25/10, the day that the patient f, she felt like the patient's redictable".				
	that she had seen	#2 on 3/4/10 at 1315 revealed patient #1 "get smart but never ontrol like he did that day. It somebody or even carry out				-
	Review of the med following progress	lical record revealed the notes:				
	very angry and ira	on 12/8/08-patient became te when asked by staff not to facility due to possible nachine circuit boards.			•	
	Facility Manager prefusing carede fout language	progress note on 6/5/09-patient manding a soft drinkusing				
1	Facility Administra	ator progress note on				

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CON	ISTRUCTION	(X3) DATE SUP COMPLET	ED	
		342587	B. WIN	IG			•	C 4/2010 .	
	ROVIDER OR SUPPLIER DRO SOUTH DIALYSIS			17	04 WA	DRESS, CITY, STATE, ZIP CODE NYNE MEMORIAL DRIVE BORO, NC 27530		··	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	x [		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	ļ.
V 520	12/18/09-patient ups belongings at the fac premises only to find	et because he left his cility when he left the I out upon his return that his n stolen. He stated "it ain't	V	<b>520</b>					
	stop treatment such	n 1/22/10-patient requested to that he could use the lked past the restroom and lit he facility.							
	raising voice speak	ress note on 1/25/10-patient ing to RNrefusing to leave ompleted)stated "mind your vill cut you like I'm going to							
	Behavior Agreemer Involuntary Dischar (revision 9/09), revision starting to the a comprehensive prompleted by the incompleted by the incompleted by the incompleted by the incompleted properties.	olicy 1-01-08, Patient nts, 30 day discharge, ge or Involuntary Transfer ealed "If a patient's behavior facility, but is non-threatening, atient assessment will be nterdisciplinary team (IDT) in y potential action or plan of							
	correction required on identifying the rebehavior.  Review of medical re-assessments of 10/09-12/09 becaudeemed unstable hemodialysis treat re-assessments reevidence that the	The assessment must focus out causes of disruptive record revealed that IDT courred monthly from use the patient had been due to his non-compliance to ments. Review of these evealed no documented IDT had assessed any is for this patient's aggressive				1			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURT	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	*		;
		342587	B. WING		03/04	/2010
	OVIDER OR SUPPLIER ORO SOUTH DIALYSIS		1	EET ADDRESS, CITY, STATE, ZIP CODE 704 WAYNE MEMORIAL DRIVE SOLDSBORO, NC 27530		
GOLDODO				PROVIDER'S PLAN OF CORR	ECTION	(X2)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
V 520	Continued From pag	ge 6	V 520			
V 552	Interview with the Frat 1510 revealed the patient's aggressive 494.90(a)(6) POC-FCOUNSELING/REFT The interdisciplinary necessary monitoris interventions. Thes and referrals for othe patient in achie appropriate psychological astandardized method chosen by the intervals, or more fibasis.  This STANDARD Based on facility preview and staff interventions for 1 displayed aggress.	acility Administrator on 3/4/10 a IDT had not assessed this and disruptive behavior. b/S EERRALS/HRQOL TOOL  y team must provide the ng and social work a include counseling services her social services, to assist wing and sustaining an asocial status as measured by nital and physical assessment social worker, at regular requently on an as-needed  is not met as evidenced by: olicy review, medical record terview, the interdisciplinary o provide psychosocial of 1 (#1) patient reviewed that ive and disruptive behavior.	V 552	V552 The FA will review Policy # 1-01 Assessment and Plan of Care" wi interdisciplinary team (IDT) with their responsibility for providing with an individualized comprehe assessment which will be used to patient's treatment plan and expe care. All areas that are required t addressed in this process, which psychosocial needs as evaluated worker, will be discussed with s on evaluating patients who have demonstrating aggressive and di behavior.  Policy #1-01-08 "Patient Behav Agreements, 30 day Discharge, Discharge or Involuntary Trans: be reviewed with emphasis on i behavior is disruptive to the fac non-threatening, a comprehensi will be completed by the IDT in identify possible root causes an	th the emphasis on each patient naive develop the ctations for the ctations for the ctations for the ctations for the ctations for the ctations for the ctations for the ctations for the ctations for the ctations are ctationally the ctation of the	4/18/10
	Patient Assessme	policy 1-01-07-Hemo Dialysis int and Plan of Care (revised interdisciplinary team is		interventions such as mental he or other applicable referrals. The interventions and subsequent powill be documented in the patie	ese itient response nt's record and	
	responsible for prindividualized and documenting his/l develop the patient expectations for concludepsychos social workerar	oviding each patient with an loviding each patient with an local comprehensive assessment mer needs which will be used to make the care. The assessment will ocial needs as evaluated by a lot assessments will be aly on unstable patients.		evaluated for any further needs assessments will be conducted documented until the patient is deemed unstable or has transfe facility.  FA/designee will audit records identified as unstable monthly quarterly to ensure compliance audits will be reported in CQI	monthly and no longer ared from the of patient's x 3 then 10% a Results of	
		edical record for patient #1		as necessary.	mid munosova	

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	COMPLETE	D
		342587	B, WIN	G		03/04	/2010
	OVIDER OR SUPPLIER O'RO SOUTH DIALYSIS			170	ET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
V 552	Continued From pag admitted to the facili hemodialysis for end secondary to diabete	ty on 11/07/2005 for I stage renal disease	V	552			
	patient had been invented the dialysis unit on immediately due to	cal record revealed this roluntarily discharged from 1/25/10 "effective verbally threatening staff altercation that occurred on					
	Interview with the C 1500 revealed this aggressive and disr	linical Manager on 3/4/10 at patient had a history of uptive behavior.				;	*** *** *******************************
	this patient had a lo	#1 on 3/4/10 at 1245 revealed ong history of disruptive 5/10, the day that the patient f, she felt like the patient's redictable".					
	that she had seen saw him lose his co felt like he may hur	#2 on 3/4/10 at 1315 revealed patient #1 "get smart but never ontrol like he did that day. I t somebody or even carry out		•			
	following progress  RN progress note very angry and ira use cell phone in f	lical record revealed the notes:  on 12/8/08-patient became te when asked by staff not to acility due to possible nachine circuit boards.					
	Facility Manager prefusing careder foul language	progress note on 6/5/09-patient manding a soft drinkusing		•			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURV		
7410 1 0 117 07		342587	A. BUILDING  B. WING		03/04/	1	
•	OVIDER OR SUPPLIER ORO SOUTH DIALYSIS	342301	17	EET ADDRESS, CITY, STATE, ZIP CODE 104 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27530		2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
V 552	belongings at the factories only to find	r progress note on set because he left his cility when he left the d out upon his return that his n stolen. He stated "it ain't	V 552		·	·	
	stop treatment such	n 1/22/10-patient requested to that he could use the liked past the restroom and lit he facility.		1			
	raising voice speak	ress note on 1/25/10-patient ing to RNrefusing to leave ompleted)stated "mind your vill cut you like I'm going to					•
		cal record revealed the orker progress notes:					
	5/20/09-"Pt's (patie remains unchange	nt's) psychosocial status d at this time"					
	the new social wor assistance was ne continue to monito	patient to introduce myself as ker""Patient stated that no eded at this time""I will r, assist with resources, nseling as needed"					
	any social work rel Patient did not rep	ontact with patient to assess if lated concerns or issues, ort anything of concern. I will or, educate and support as					
	assessment with p	cted annual psychosocial patient. Patient was minimally opeared unwilling to					

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

STATEMENT OF AND PLAN OF	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 342587	A, BUII	LDING	E CONSTRUCTION	COMPLET	, , , ,
	OVIDER OR SUPPLIER ORO SOUTH DIALYSIS			1	EET ADDRESS, CITY, STATE, ZIP CODE 704 WAYNE MEMORIAL DRIVE COLDSBORO, NC 27530		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
V 552	and keeping his eye- completing the KDQ of Life) survey Medical record revie	not elaborating on answers sclosed"Patient declined OL" (Kidney Diease Quality ew revealed no documented T had addressed this	-	, 552 552			
	patient's aggressive Review of the 10/09 IDT re-assessments assessed this patie need. Therefore, the	and disruptive behavior.  11/09 and 12/09 monthly  revealed the IDT had not nt's behavior as being a e IDT had not established o address this patient					
	at 1510 revealed the indicated that she n	acility Administrator on 3/4/10 at the Social Worker had sever thought to make any th counseling referrals for this					
	Intake NC0006200 kdc	4				·	
				•		•	
				•		•	
		. •	٠.				



### 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

April 21, 2009

Ms. Alice Hill, FA Goldsboro South Dialysis 1704 Wayne Memorial Drive Goldsboro, NC 27534

Medicare Recertification Survey RE:

CMS Certification Number (CCN): 342587

Dear Ms. Hill:

Thank you for the cooperation and courtesy extended during my recent visit to your facility April 7-9, 2009, for the purpose of conducting a recertification survey. As a result of this survey, it was determined that this facility was not in compliance with one (1) of Medicare's Conditions of Coverage:

#### 494.180 Governance (V750)

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 Coverage. We are unable to recertify your facility in the Medicare program. For this reason, deficiencies affecting the Condition of Coverage 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 90 days from the last date surveyed.

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 description of the correction action(s) and the systems that have been or will be (a) implemented to correct the deficiency.
- A description of the monitoring system that has been or will be implemented including the (b) person(s) responsible for the monitoring to assure compliance; and



Ms. Alice Hill April 21, 2009 Page Two

(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 RECEPT. 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.

Sincerely,

Kay D. Cuaton, RN

Kay D. Cuaton, RN Acute and Home Care Licensure & Certification Section

Enclosures: CMS-2567 (w/patient list)

MEDICA	MEDICAID CERTIFICATION AND TRANSP	TAL
PARTI-T.	BE COMPLETED BY THE STATE SURVEY AV	ENCY

ID: 1ZU2

	r.	AKI I-)	U BE CUMPLE	ELEUDIII	LE SIAL	E BURYEX AGENCY		radily 11. 370213	,
I. MEDICAREMEDICATO PRO (L1) 342587	OVIDER NO.		3. NAME AND AD (L3) GOLDSBORG				4. TYPE OF AC	CTION: 2 (L8)  2. Recordificat	4.C
2.STATE VENDOR OR MEDI	CAID NO.		(L4) 1704 WAYNE	E MEMORIAL	DRIVE		3. Termination		ion
		•	(L5) COLDSBOR	D, NC		(L6) 27530	5. Validation 7. On-Site Vic	6. Complaint	•
5. EFFECTIVE DATE CHANG	GE OF OWNE	RSHIP	7. PROVIDER/SUI	PPLIER CATEGO	ORY	<u>09</u> (L7)			
(L9)			01 Hospital	OS EULA	09 ESRD	13 PTIP	8. Etti survey	After Complaint	
6. DATE OF SURVEY	04/09/2009	(L34)	'02 SNF/NF/Dual	OS LAB	10 NF	14 CORF	FISCAL YEAR I	ATTER OF	.35)
8. ACCREDITATION STATE	is:	_(L10)	03 SINF/INF/Distinct	07 X-Ray	11 IMR	15 ASC		award Daren (L	99)
	JCAHO Other		04 SNF	08 OPT/SP	12 RHC	16 Hospice	12/31		
11. LTC PERIOD OF CERTIFIC			10.THE FACILITY	IS CERTIFIED	ÀS:				***************************************
From (a):			A. In Complian	acc With		And/Or Approved Waivers Of	The Following Requ	ircments;	
			Program Re	equirements		2. Technical Personnel	6. Scope	of Services Limit	
To (b):			1	E Based On:		3. 24 Hour RN	7. Medic		
12. Total Facility Beds		(L18)		cceptable POC		4. 7-Day RN (Rural S) 5. Life Safety Code	NF) 8. Patient 9. Beds/		
13. Total Certified Beds		(L17)	X B. Not in Com Requirement	pliance with Progr ents and/or Applic	ram ed Waivers;	*Code: B*	(L12)		
14. LTC CERTIFIED BED BR	FAKDOWN		<del></del>	·		15. FACILITY MEETS		-	
			TOTE:	Th. 470		· 1861 (e) (1) or 1861 (j) (1):	(£15)	,	
18 SNF 18/1	9 SNF	. 19 SNF	ICF	IMR		1001 (5) (1) 01 1001 (1) (1).		•	
(L37) (	L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGEN	CY REMARK	S (IF APPL	ICABLE SHOW LTC	CANCELLATIO	ON DATE):		-		
A recertification unruev w	as conducted	on 4/9/200	9 with a Condition le	evel deficiency c	ited for 494	.180-V750-Governance along	with other standard	level citations. A fo	llow-pp
survey was conducted on	5/22/2009 an	d all previo	usly cited deficiencie	s have been con	rected				N
17. SURVEYOR SIGNATU	RE 1		Date:		1	18. STATE SURVEY AGEN	CY APPROVAL	Date:	
Kay Cu	afor	N	h	05/26/2009	(L19)	ax Con	X .5/8	7/05	(L20
	PART II	- TO BE	COMPLETED	BY HCFA R		L OFFICE OR SINGLI	STATE AGE	4CY	
19. DETERMINATION OF	ELIGIBILITY			MPLIANCE WI	TH CIVIL	21. 1. Statement of Fi			
X 1. Facility is El	igible to Particip	iato	RIC	HTS ACT:		3. Both of the Abo	trol Interest Disclosur ove :	e Simi (HCFA-1513)	
2. Facility is no	ot Eligible	(L21)	)						
<u> </u>					····	T			
22. ORIGINAL DATE	23	LTC AGR		24. LTC AGRE		26. TERMINATION ACTI		(L30)	
OF PARTICIPATION		BEGINNI	NG DATE	ENDING D	ATE	- Inconstitutions		VOLUNTARY	
01/22/1997						01-Merger, Closure 02-Dissatisfaction W/ Reimbr		-Fail to Meet Health/Saf	
(L24)		(LA1)		(L25)		03-Risk of Involuntary Termin		Fail to Meet Agreemen	ı
25. LTC EXTENSION DA	TE: 27	ALTERN.	ATIVE SANCTIONS			04-Other Reason for Withdraw	. <u>Ω</u>	THER	
		A. Suspen	sion of Admissions:			CTORING ROUSCAL JOS CHARACTER	-	I-Provider Status Chang I-Active	ţe.
	(L27)	D Bannin	i Suspension Date:	(L44)			V'	-70140	
	•	, is, account	i Bushamin Daw.	(LA5)					
						20 DELEADES			
28. TERMINATION DATI	B:		29. INTERMEDIA	RY/CARRIER NO	o.	30. REMARKS		•	
			00101				•		
,		(L28)			(L31)				
31. RO RECEIPT OF CMS-	1539		32. DETERMINAT	ION OF APPRO	VALDATE				•
		(L32)			(L33)	DETERMINATION A	PPROVAL		
							~ <del></del>		

### DEPARTMENT OF HEALTH AND HUI I SERVICES RECEIV

RECEIVEL APR 2 9 2009

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES		TEOETTEO TITE O EGGO	OWR NO. 0938-038
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	B. Wi	NG	04/09/2009
NAME OF PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	

GOLDSBORO SOUTH DIALYSIS

STREET ADDRESS, CITY, STATE, ZIP COD 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 501	494.80 PATIENT ASSESSMENT	У 501		
	The facility's interdisciplinary team consists of, at a minimum, the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient's treatment plan and expectations for care.			
	This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the physician did not participate in the interdisciplinary team's (IDT) assessment and the IDT assessment for 1 of 6 (#3) patients reviewed was incomplete. The findings included:			
	Review of facility policy 1-01-07, Dialysis Patient Assessment and Plan of Care (revised 12/08) revealed the interdisciplinary team consisting of			
-1	the registered nurse, physician treating the patient, social worker, dietician and patient or patient representative is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs.	1		
	Medical record review for patient #3 revealed this patient had been admitted to the facility for hemodialysis on 12/12/07. Record review revealed the current IDT assessment had been completed on 12/11/08 by the nurse, 1/4/09 by the dietician and 11/12/08 by the social worker.			

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPAININ	ALIAI OL LICHELLI	A MEDICAN SERVICES				OMB NO. 0	938-0391
		& MEDICAID SERVICES	(X37 P81	ILTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETE	
ITATEMENT C IND PLAN OF	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	A. BUILDING			ED .
		342587	B, WIN	G		04/09/	2009
		0.4524.1	<u>.,                                    </u>	CTDEE	T ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER	•		1704	WAYNE MEMORIAL DRIVE		ľ
GOLDSBI	DRO SOUTH DIALY	SIS		GO	LOSBORO, NC 27530		
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V 501	Continued From p	ana 1	٧	501	V501		
V 50 I	Commentation	no documented evidence that	Ì		<b>V</b> 501	ļ	
	the patient's physical assessment as re	cian participated in the IDTs			The interdisciplinary team will re comprehensively assess the patie: required time frames or unstable	nt within the event	
	revealed there we that were not com Assessment revidareas on the assiblank: General informations data				triggering an IDT care conference discipline will clearly denote any the electronic medical record and each provided section of the assessment will then single document and placed in the tab labeled "care planning". will meet within the week after the draw to comprehensively and he	é. Each indings in dwill complete sesment. The be printed as a ne chart under The IDT team the monthly lab olistically	5-9-09
	Sleeping Habits Cognitive/Percel Sensory	ommunicable diseases			review all patients for stability vinstability and at that time will tassessment phase including docall findings prior to the care commeeting. The rounding physicia	negin the IDT umentation of of the ference unwill assess	
	Skin Genitourinary Neuromuscular Gastrointestinal Respiratory Vascular Acces Cardiovascular				these patients on rounds in the separate appointment and clear findings and his determination unstable in progress notes or by history and physical examination documenting those findings. Tadministrator will own this promonthly monitor for compliant	facility or at a ly document his of stable or y completing a on and he facility ocess and will	
	Demographics				the findings will be documented	ed and discusse	d
	Interview with the	ne Facility Administrator on 4/8/0	9		monthly in CQI meeting.		
	recent changes	d because of the complexity of the in the assessment and care plants and care plants and care plants and care plants and care plants and another that are plants and not be equired.	n ie				
V 5	The physician 20 494.80(d)(2) P	was not available for interview. ATIENT REASSESSMENT		V 52	OC		
	paragraphs (a	e with the standards specified in )(1) through (a)(13) of this sectio live reassessment of each patier of the plan of care must be	n, d				
	   Audional   1882 (1972)	/aralona Ohsolete Event ID:1	ZU211	-	Facility ID: 970275	if continuation	sheet Page 2 of

PRINTED: 04/22/2009 FORM APPROVED

DEPARTI	VENT OF HEALTH	AND HUMAN SERVICES				OMB NO. DE	38-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA			LAZOT KWI N	TREC	ONSTRUCTION	(X3) DATE SURVEY	
TATEMENT ( ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDENSUPPLIENCEIX IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		. 342587	B. WING			04/09/2	2009
	ROVIDER OR SUPPLIER		.	STREET 1704 V	ADDRESS, CITY, STATE, ZIP CODE WAYNE MEMORIAL DRIVE		
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(X4) ID PREFIX TAG	(ぜんたは ひがだけ)だい	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFO TAG	۲	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY)	OULD BE	COMPLETION DATE
V 520	including, but not following: (i) Extended or fr (ii) Marked deteri (iii) Significant ch (iv) Concurrent p	rage 2  Ily for unstable patients  Ilmited to, patients with the  equent hospitalizations;  oration in health status;  ange in psychosocial needs; or  oor nutritional status,  mia and inadequate dialysis.	V 5	20			
	Based on facility review and staff team (IDT) faile hospitalizations that had been h included: Review of facility Assessment ar revealed "the in	D is not met as evidenced by:  y policy review, medical record interview, the interdisciplinary d to re-assess a patient after two for 1 of 4 (#2) patients reviewed ospitalized. The findings  ty policy 1-01-07, Dialysis Patient of Plan of Care (revised 12/08) interdisciplinary team consisting of nurse, physician treating the			Patients with extended or frequent hospitalizations, marked deterior health status, significant change psychosocial needs, or concurrent nutritional status, unmanaged an inadequate dialysis or any other contributing to an unstable staturessessed by the IDT every 30 determination of stable is met. I any patient status post hospital diagnoses such as medication to facility will implement and mai in which upon discharge the advantagement and received prior to the patient's nor the physician is contacted for orders. This will then be given	ation in in troor emia and factor s will be days until a his includes discharge for exicity. The ntain a process ministrative te summary is ext treatment or any updated to the RN for	5-9-09
	patient, social of patient represe each patient we comprehensive needs which we treatment plant comprehensive all new patient facility within 3 dialysis session the first outpatient.	worker, dietician and patient or intative is responsible for providing assessment documenting his/he assessment documenting his/he and expectations for careThe assessment will be conducted or patients that transfer to the calendar days (or 13 outpatient) one for hemodialysis) beginning we re-assessment of each patient	er s on t	·	review at which point any phys orders will be entered into the system for completion. The parties be reviewed at the IDT team in care conference to determine it any needs status post discharge comprehensive assessment and be completed at that time. The administrator as a part of this this process and monitor month quarterly during the review of medical records.	cician dictated order entry tient will then aceting prior to f the patient has a and a care plan will facility IDT will own thy as well as	S

#### DEPARTMENT OF HEALTH AND HU. I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

04/09/2009

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

342587

B. WING

NAME OF PROVIDER OR SUPPLIER

#### **GOLDSBORO SOUTH DIALYSIS**

STREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 520	Continued From page 3	V 520		
	and a revision in the plan of care will be conducted monthly for unstable patient including, but not limited to, patients with extended or frequent hospitalizations and marked deterioration in health status.			
	Medical record review for patient #2 revealed this 62 year old female had been admitted to the facility on 7/10/03 for hemodialysis. Record review revealed diagnoses of end stage renal disease secondary to hypertension and diabetes and a seizure disorder of which the patient had been prescribed Dilantin (anticonvulsant) "50mg Tablet Suspension 150 mg TID" (three times a day).			
;	Review of the medical record revealed this patient had been hospitalized on 10/13/08-10/21/08 and again on 12/6/08-12/14/08 for Dilantin toxicity. Review revealed the patient's Dilantin level on the 10/13/08 hospital admission had been 38.8 mg/ml, and on the 12/6/08 hospital admission it had been 43.8 mg/ml (lab therapeutic reference range is between 10-20 mg/ml).			
	Medical record review revealed no documented			
	evidence that the IDT assessed this patient after the 10/13/08 and 12/6/08 hospital admissions for Dilantin monitoring needs.			
	Interview with the Facility Administrator on 4/9/09 at 0930 revealed the IDT should have assessed this patient upon hospital discharges to determine the Dilantin monitoring needs. Interview reveale staff enter pertinent staff information into the computer system, which causes the patient to be	ed .		
	"flagged" for an IDT assessment. The dietician should take the lead in the assessment process seeking input from the RN and social worker		Facility ID: 970275 If continuation	

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•	FORM AF OMB NO. 0	
CENTER	FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	UĻTIPLE	CONSTRUCTION	(X3) DATE SUR'	VEY
statement ( and plan of	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		LDING		COMPLESE	:0
•		342587	B. Wil	10		04/09/	2009
NAME OF PR	OVIDER OR SUPPLIER	,		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
	ORO SOUTH DIALY:	RIS	,		4 Wayne memorial drive Oldsboro, NC 27530		
GULDAD				1 90	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC		(EACH CORRECTIVE ACTION SIK CROSS-REFERENCED TO THE APP DEFICIENCY)	)ŲLD BE	COMPLETION DATE
V 520	Continued From p	age 4	٧	520			
	related to patient i	needs.					Į
V 553	494.90(a)(7)(i) DE PLAN OF CARE	VELOPMENT OF PATIENT	٧	553		ı	,
		it it it is a street fact		1	V553	1	
1	The interdisciplina	ary tearn must identify a plan for e dialysis or explain why the		}	Policy #1-01-07 "Patient Assessm of Care" has been reviewed with t	ent and Plan	
	natient is not a ca	indidate for home dialysis.			interdisciplinary team (IDT) with	emphasis on	
	parent to not a 44				the need to ensure the assessment	addresses	Z 10 10 0
				•	home modality therapy options ar documented accordingly. Going f	id this is	5/9/09
		to the man and an analysis of his			there is a defined area on the care	plan the	
	This STANDAKL	is not met as evidenced by: policy review, medical record			modality teaching and candidacy	status will	
	Factors and staff	interview the interdisciplinary			be addressed and documented in	the notes	
	team failed to int	corporate the reason why papents	;		area by the nurse with notes from IDT members attached. These no	the other	1.
	were not home of	lialysis candidates in the patient			be filed in the assessment area of	the record.	`
}	care plan for 6 o	f 6 (#2, 4, 3, 1, 6, 5) patients			The natient assessment/care plan	s cited have	
1	reviewed. The f	indings included;			been undated with the modality	candidacy	
		na na Delient Accessments and			status information, All other cur	rent records	
İ	Facility policy T	-01-07, Patient Assessments and vised 9/08), review revealed the			will be audited for any assessme this transplant documentation an	nd these	
	nationt care niel	n will address the ballenis's			records will be updated by 5/9/09	9 FA/designee	
	iw has viishoo	ll include an explanation regardin	9		will audit records monthly x3 th	en quarterly	
	why the patient	is not a candidate for home			to ensure compliance. Results o	f audits Will	
	dialysis.				be reported in CQI meetings and needed.	1 addtessen as	
	s sault-lanon	rd review for patient #2 revealed			needed.		
	this 62 year old	female had been admitted to the					-
	Eacility on 7/10/	03 for hemodialysis with a	- 1				
	diagnosis of en	d stage renal disease secondary	Į		ļ		1
	to hypertension	n. Record review revealed a	1		`		
	current plan of	care dated on 10/28/08 that did	.				
·	not include an patient was no	explanation regarding why this tale home dialysis candidate.					
	•	the Facility Administrator on 4/8/0	9				
1.	of 1615 reveal	ed because of the complexity of t	nel	,			
İ	i recent change	s in the care plan process and in	e				
	staffs lack of	understanding the new process,					
	the care plans	had not included the required					

## DEPARTMENT OF HEALTH AND HUI SERVICES

PRINTED: 04/22/2009 FORM APPROVED

DEPARTMENT OF TIERE				OMB NO. 0938-039
CENTERS FOR MEDICARI	E & MEDICAID SERVICES			T T T T T T T T T T T T T T T T T T T
	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1, ,		COMPLETED
AND PLAN OF CORRECTION		A. BUI	LDING	
•	1		10	
	342587	B. Wil	NG	04/09/2009
			STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	•		1	
			1704 WAYNE MEMORIAL DRIVE	*
GOLDSBORO SOUTH DIALY	SIS		GOLDSBORO, NC 27530	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 553	Continued From page 5 information.	V 553		
	2. Medical record review for patient #4 revealed this 37 year old patient had been admitted to the facility on 9/8/06 for hemodialysis with a diagnosis of end stage renal disease secondary to hypertension and diabetes. Record review revealed a current plan of care dated on 10/15/08 that did not include an explanation regarding why this patient was not a home dialysis candidate.	,		
	Interview with the Facility Administrator on 4/8/09 at 1615 revealed because of the complexity of the recent changes in the care plan process and the staff's lack of understanding the new process, the care plans had not included the required information.			
,	3. Medical record review for patient #3 revealed this 64 year old patient had been admitted to the facility on 12/12/07 with diagnoses of end stage renal disease secondary to diabetes. Record review revealed a current plan of care dated on 12/12/08 that did not include an explanation regarding why this patient was not a home dialysis candidate.			·
	Interview with the Facility Administrator on 4/8/09 at 1615 revealed because of the complexity of the recent changes in the care plan process and the staff's lack of understanding the new process, the care plans had not included the required information.	e		
	4. Medical record review for patient #1 revealed this 57 year old patient had been admitted to the facility on 2/14/08 for hemodialysis with a diagnosis of end stage renal disease secondary to hypertension and diabetes. Record review			

	DEPART	MENT OF HEALTH	AND HU; 1 SERVICES & MEDICAID SERVICES				FORM A	04/22/2009 APPROVED 0938-0391
5	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SU COMPLE	
			342587	B. WIN	IG		04/09	9/2009
_		ROVIDER OR SUPPLIER ORO SOUTH DIALYS	SIS		17	ET ADDRESS, CITY, STATE, ZIP CODE 04 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27530		
	(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
THE PARTY NAMED IN COLUMN TWO IS NOT THE PARTY N	V 553	that did not include this patient was no Interview with the at 1615 revealed to recent changes in staff's lack of und- the care plans had information.	plan of care dated on 12/12/08 e an explanation regarding why of a home dialysis candidate.  Facility Administrator on 4/8/09 because of the complexity of the the care plan process and the erstanding the new process, d not included the required	·V	553			
		this 51 year old particularly on 2/4/08 to fend stage rena segmental glome revealed a currer that did not include this patient was researched.	I review for patient #6 revealed atient had been admitted to the for hemodialysis with a diagnosis al disease secondary to focal rular sclerosis. Record review at plan of care dated on 11/18/08 de an explanation regarding why not a home dialysis candidate.					
		at 1615 revealed	e Facility Administrator on 4/8/09 because of the complexity of the	e '			•	i.

6. Medical record review for patient #5 revealed this 57 year old patient had been admitted to the facility on 1/10/09 with a diagnosis of end stage renal disease secondary to diabetes. Record review revealed a current plan of care dated on 2/16/09 that did not include an explanation regarding why this patient was not a home dialysis candidate.

recent changes in the care plan process and the staff's lack of understanding the new process, the care plans had not included the required

Interview with the Facility Administrator on 4/8/09 at 1615 revealed because of the complexity of the recent changes in the care plan process and the

information.

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DEPARTA	NENT OF REALTE	I AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO. 09	
TATEMENT	OF DEPICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		CONSTRUCTION	COMPLETE	
		342587	B. WIN			04/09/	2009
	OVIDER OR SUPPLIER			1704	I ADDRESS, CITY, STATE, ZIF CODE WAYNE MEMORIAL DRIVE		
GOLDSBO	ORO SOUTH DIALY			GOI	DSBORO, NC 27530	errori	(X5)
(X4) ID PREFIX TAG	/m / // !! The City in the little in the lit	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL LISC: IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REPERENCED TO THE API DEFICIENCY)	OULD BE	DATE
V 553	Continued From	page 7	٧	553		:	1
V 750	staffe lack of und	iers anding the new process, d not included the required	V	750	¥750		
	Based on medic facility policy rev review, the Gov sufficient manage facility was provious available to medical oversee the dial included:  1) The facility so the facility of 1 of 1 (#4)	N is not met as evidenced by: al record review, staff interview, lew, observation and facility log erning Body failed to ensure gement and oversight of the ided in that licensed staff was et patients clinical needs and lysis process. The findings  taff failed to coordinate the care of medication toxicity  Tag V758, example #1  staff failed to coordinate the care losed records reviewed that boormal blood glucose labs	1		Members of the Governing Boo reviewed the Statement of Defic (SOD) and formulated the follow Correction (POC). The standard Condition: Governance (V750) as well as other standards contain of corrective plans. The focus he ensuring the licensed staff meet needs and oversee the dialysis areas to include but not be limit coordinating care for patients phospitalization; 2) assessing ble levels on diabetic patients; 3) epatients receive the correct dial concentration as ordered; 4) as notifying medical staff of patie episodes post dialysis; 5) ensur for testing are validated and te required; and 6) medications ordered by the physicians. The Governing Body will meet to ensure compliance with PO compliance to the POC will be during monthly QA meetings.	iencies wing Plan of dis under that is not met ins specifics is been on the patient process in ted to: 1) ost pod glucose insuring tysate sessing and ont hypertensive ring meter used sted as are given as at monthly x 3 C. Further the reviewed	5-9-09
	3) The facility dialysate cond and notify me on the incorre (#7, 8, 9, 10) hemodialysis	o Tag V758, example #2 staff failed to provide the correct centrate as ordered by the physici dical staff regarding patients treat of dialysate concentrate for 4 of 1 patients observed during	an ed 6		the Governing Body no less the annually. The Facility admin representing the GB will be rensuring implementation and compliance with this POC.	nan semi- istrator (FA) esponsible for	

# DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

TATEMENT	OF DEFICIENCIES
	F CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

342587

04/09/2009

NAME OF PROVIDER OR SUPPLIER

#### GOLDSBORO SOUTH DIALYSIS

STREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
V 750	Continued From page 8	V 750		
	4) The facility staff failed to assess and notify medical staff of patient hypertensive episodes post hemodialysis for 3 of 8 (#11, 12, 6) records reviewed			
•	~Cross refer to Tag V758, examples #4a, 4b, 4c			
	5) The facility staff failed to validate and disinfect 3 of 3 meters used in the process of testing patient dialysate concentrate  -Cross refer to Tag V758, example #5			
·	6) The facility staff failed to administer antibiotics according to physician order for 1 of 3 (#4) records reviewed that had antibiotics administered			
V 75	QUALIFIED/TRAINED STAFF	V 758		
	[The governing body or designated person responsible must ensure that-] The registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs;			
	This STANDARD is not met as evidenced by: Based on medical record review, staff interview, observation, facility policy review, and facility log review, a registered nurse was not available to meet patients clinical needs by failing to ensure		•	

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

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROMDER/SUPPLIE/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A BUIL	DING			
·	•	342587			the state of the s	04/09/2009	
HAME OF PROVIDER OR SUPPLIER				170	et address, city, state, zip code 4 wayne memorial drive		
GOLDS	30RO SOUTH DIALY			GO	LDSBORO, NC 27530  PROVIDER'S PLAN OF CORRECT	FION	WE!
(X4) ID PREFIX TAG	FACH DEFICIENC	ATIMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC: IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY)	DULD BE	(X5) COMPLETION DATE
V 758	staff. 1) coordinate patients reviewed medication toxicit 1 (#4) closed record abnormal blood g correct dialysate physician and not patients treated of concentrate for 4 observed during notified medical episodes post he records reviewed of 3 meters used dialysate concernaccording to phy records reviewed administered. T  1. Medical records this 62 year old facility on 7/10/0 review revealed disease second and a seizure distriction toxicial records reviewed administered.	ed the care of 1 of 1 (#2) that had been hospitalized for y, 2) coordinated the care of 1 of ords reviewed that experienced lucose labs; 3) provided the concentrate as ordered by the diffy medical staff regarding on the incorrect dialysate of 16 (#7, 8, 9, 10) patients hemodialysis; 4) assessed and staff of patient hypertensive emodialysis for 3 of 8 (#11, 12, 6) 1; (5) validated and disinfected 3 1 in the process of testing patient drate; 6) administered antibiotics sician order for 1 of 3 (#4) d that had antibiotics he findings included: and review for patient #2 revealed female had been admitted to the findings of end stage renal any to hypertension and diabetes isorder of which the patient had I Dilantin (anticonvulsant) "50mg			V758 The team has been in-serviced on to focus of ensuring the licensed staft patient needs and oversee the dialy in areas to include but not be limit coordinating care for patients post hospitalization; 2) assessing blood levels on diabetic patients; 3) ensureceive the correct dialysate conce ordered; 4) assessing and notifying staff of patient hypertensive episodialysis; 5) ensuring meter used for validated and tested as required; a medications are given as ordered physicians.  FA/designee will track hospitalize and when they are discharged will hospital to obtain the discharges to the next scheduled treatment ophysician will be called for any uneeded. This summary will be reany changes or updates in care benurse.  The licensed staff has been in-seneed to assess glucose levels modiabetic patients, address as need notifying the physician if needed.	f meet the sis process ed to: 1)  glucose ring patients entration as gradical des post or testing are and 6) by the ed patients 1 call the ammary prior reserviewed for y a licensed reviced on the inthly on led, including I, and	
	Tablet Suspens day).  Review of the number patient had been 10/13/08-10/21 for Dilantin toxin Dilantin level unadmission had 12/6/08 hospital	nedical records revealed this en hospitalized on //08 and again on 12/6/08-12/14/0 city. Review revealed the patient pon the 10/13/08 hospital been 38.8 mg/ml, and on the al admission it had been 43.8 rapeutic reference range is	)8 's		document in progress notes. FA audit records of diabetic patients then 25% quarterly to ensure cor Results of audits will be reporter meetings and addressed as neede cont pg 11	monthly x3 mpliance.	

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

DEPARTS	MENT OF HEALTH	AND HUMAN SERVICES				FORM AP	
CENTERS	S FOR MEDICARE	& MEDICAID SERVICES				(X3) DATE SUR	
STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDENSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETE	D		
		342587	B, WING			04/09/	2009
NAME OF BE	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		- 145			704 WAYNE MEMORIAL DRIVE		
GOLDSB	ORO SOUTH DIALYS	SIS .		G	OLDSBORO, NC 27530		
(X4) ID PREFIX TAG	JEACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y M JST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAI	PX.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULID BE .	COMPLETION DATE
	Continued From p Medical record reversidence that facil physician any folic toxicity experience Interview with the at 0930 revealed patient's care to e being monitored.  2. Medical record this 37 year old p facility on 9/8/06 renal disease see diabetes. Medic patient's glucose since 8/21/08 wit adequate staff in glucose lab rest glucose lab rest glucose lab refe 8/21/08=176 9/20/08=287 10/8/08=387 11/08=0 lab 12/18/08=664 1/22/09=651 2/21/09=980  Review of the p and 10/16/08 re reside at a groot are not feeding did not want th bome". Review	age 10  fiew revealed no documented ity staff coordinated with the ow-up regarding the Dilantin ed by this patient.  Facility Administrator on 4/9/09 staff had not coordinated this ensure her Dilantin levels were directly administrator on 4/9/09 staff had not coordinated this ensure her Dilantin levels were directly administrator on 4/9/09 staff had not coordinated this ensure her Dilantin levels were directly administration and exitent had been admitted to the with a diagnosis of end stage condary to hypertension and all record review revealed this labs had consistently increased thout documented evidence of allowed documented evidence of allower as followed (blood rence range 80-120):  Disychosocial summary/assessmented the patient continues to up home, however, he states they him correctly. Patient stated he e social worker to contact group in revealed no documented	v v	758	DEFICIENCY)	on policy with ivering the the need to trates prior FA/ rect kly x 2, audits to tits will be the necessary. If the acid er the survey available in ar to reduce ient needs, be notified ath change alyzed on the do no policy # ment" with need to on each pre dialysis s, such as any preclude. If further then is to dditional data needed, and exignee will week, weekly x ly audits to audits will be	5-9-09
	evidence that s concern that the feeding him co	staff followed up on this patient's ne group home had not been prectly.			thousand, ( and bb )		
	1						
<u> </u>		Trans the st	31044		Fertility ID: 970275	f continuation sh	eet Page 11 of 2

PRINTED: 04/22/2009 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 AND PLAN OF CORRECTION COMPLETED A. BUILDING B WING 04/09/2009 342587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1704 WAYNE MEMORIAL DRIVE GOLDSBORO SOUTH DIALYSIS GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAĞ DEFICIENCY) V 758 V 758 Continued From page 11 V758 cont. Medical record review revealed the only documented evidence that staff had addressed Teammates have been in-serviced on policy this patient's increased blood glucose levels had #1-03-02 "Prescription Verification and Safety Checks" and policy 12-13-10A been patient education provided by the dietician Phoenix Meter Disinfection and Calibration on 11/9/08 and 1/27/09. Verification" with emphasis on the need to verify the dialysis prescription and perform Review of the physician progress notes from safety checks prior to each treatment 9/9/08-1/6/09 revealed no documentation that this initiation and that the need for the Phoenix patient's consistently high blood glucose levels meters to be disinfected and verified with 5-9-09 had been addressed by the physician. documentation prior to daily use. FA/ designee will audit the Phoenixmeter logs Medical record review revealed this patient had daily x 1 week, weekly x2 then do random been hospitalized on 2/25/09 with generalized monthly audits to ensure compliance. weakness and hyperglycemia (elevated blood Results of audits will be reported in CQI and glucose). Review of the hospital discharge addressed as necessary. summary revealed this patient's blood glucose had been at 998 upon admission. During this hospitalization the patient had an unexpected The licensed teammates have been incardio respiratory arrest and subsequently died at serviced on the need to ensure medications, the hospital on 2/28/09. including antibiotics, are administered as ordered by the physician. A change in the 3a. Hemodialysis treatment sheet review for ordering process has been made to ensure patient #7 revealed this patient had a current medications are available as needed. FA/ physician's order for a 3 K (potassium) 2 Ca designee will audit records weekly x 3 then (calcium) dialysate bath. Observation on 4/7/09 monthly to ensure compliance. at 1050 in the patient treatment area revealed this Results of audits will be reported in CQI and patient had been dialyzed on a 2 K 2 Ca bath. addressed as necessary. FA is responsible for ongoing compliance Facility policy 1-03-08A, Treatment Initiation, revealed that staff is required to verify the correct with POC. dialysate concentrates prior to initiation of patient treatment Interview on 4/7/09 at 1055 with the patient care technician (staff #3) who was caring for patient #7

K dialysate concentrate.

revealed the patient had been put on the incorrect dialysate bath because the facility ran out of the 3

# DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		342587	B, WING	·		04/0	9/2009
	ROVIDER OR SUPPLIER		5	1704	T ADDRESS, CITY, STATE, ZIP CODE WAYNE MEMORIAL DRIVE LDSBORO, NC 27530		
(X4) ID PREFIX TAG	(FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
V 758	Interview on 477/0 (staff #2) revealed been notified regron the incorrect of 3b. Hemodialysis patient #8 reveals physician's order Observation on 4 treatment area redialyzed on a 2 k. Facility policy 1-frevealed that stadialysate concerning revealed that stadialysate revealed that stadialysate concerning revealed that stadialysate reveale	9 at 1100 with the charge nurse of this patient's physician had not arding this patient being dialyzed in including this patient being dialyzed in including this patient sheet review for ed this patient had a current for a 2 K 2.5 Ca dialysate bath. 1/8/09 at 0910 in the patient excepted this patient had been	V 7	58			
	technician (staff patient #8 revea the incorrect dia in the loop that was very low whof the hemodial changed the co	709 at 0915 with the patient care #3) who had been caring for led the patient had been put on lysate bath because the pressure carries the 2 K 2.5 Ca concentrate lich caused the conductivity alarmysis machine to sound, so "Incentrate to a 2 K 2 CA for a brief lest until the pressure increased. I					
	just forgot to ch Interview on 4/7 (staff #2) revea been notified re on the incorrect 3c. Hemodialy patient #9 rever physician's ord Observation on	ange it back".  7/09 at 1100 with the charge nurse led this patient's physician had not garding this patient being dialyzed dialysate concentrate.  Sis treatment sheet review for aled this patient had a current er for a 2 K 2.5 Ca dialysate bath a 4/8/09 at 0915 in the patient revealed this patient had been	t   I				

dialyzed on a 2 K 2 Ca bath.

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DEPART	MENT OF HEALTH	AND HU. IN SERVICES				FORM A	04/22/2009 APPROVED 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES					
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AND PLAN OF	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUI	LDING	<b>C.</b>	COMPLE	1EU.
			4				
	•	342587	B. WI	1G		04/09	9/2009
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COI	DE .	
	ana natirit DIAL'VI	eie .			04 WAYNE MEMORIAL DRIVE		
GOLDSB	ORO SOUTH DIALY:	515		G	OLDSBORO, NC 27530		
1 054 15	SHAMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COF	RECTION	(X5) COMPLETION
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		
V 758	Continued From p	age 13	V	758			
		J .					
	Facility policy 1-03	-08A, Treatment Initiation,			•		
1	revealed that staff	is required to verify the correct					
	dialysate concentr	ates prior to initiation of patient	·				
- [	treatment.	accorping to the second		1			
-	u caanone.	•			·		
1	Interview on 4/8/0	9 at 0915 with the patient care					
	technician (staff #	4) who had been caring for					
	nationt #9 reveale	d the patient had been put on					
1	the incorrect dialy	sate bath because the pressure	1				
1	in the loop that ca	arries the 2 K 2.5 Ca concentrate	1			•	
1	was very low which	ch caused the conductivity alarm					
ľ	of the hemodialys	sis machine to sound, so "I					
	changed the cond	centrate to a 2 K 2 CA for a brief	- [				
	neriod of time ins	it until the pressure increased.	1			•	
	just forgot to char	nge it back".				•	
Ι.	I JUST IOI GOT TO CHA	1. 19 12 12 12 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		1		1

Interview on 4/7/09 at 1100 with the charge nurse (staff #2) revealed this patient's physician had not been notified regarding this patient being dialyzed on the incorrect dialysate concentrate.

3d. Hemodialysis treatment sheet review for patient #10 revealed this patient had a current physician's order for a 2 K 2 Ca dialysate bath. Observation on 4/8/09 at 0915 in the patient treatment area revealed this patient had been dialyzed on a 2 K 2.5 Ca bath.

Facility policy 1-03-08A, Treatment Initiation, revealed that staff is required to verify the correct dialysate concentrates prior to initiation of patient treatment.

Interview on 4/8/09 at 0915 with the patient care technician (staff #10) who had been caring for patient #10 revealed the patient had been put on the incorrect dialysate bath because there were feed problems when she connected the correct

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,-	DEPARTI	MENT OF HEALTH	AND HUI SERVICES & MEDICAID SERVICES					04/22/2009 APPROVED 0938-0391
S	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		•	342587	B. WII	1G		04/09	9/2009
		ROVIDER OR SUPPLIER ORO SOUTH DIALYS	sis		17	EET ADDRESS, CITY, STATE, ZIP CODE 704 WAYNE MEMORIAL DRIVE FOLDSBORO, NC 27530		
-	(X4) ID PREFIX TAG	. (FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	V 758	Observation on 4/8 Biomedical Techniconnection for the "someone had cut had caused the achemodialysis machinerview on 4/7/0 (staff #2) revealed	e to the hemodialysis machine.  3/09 at 0925 revealed the ician checked the wall  2 K 2.5 Ca acid and stated the acid off from the wall which cid not to feed into the hine.  9 at 1100 with the charge nurse this patient's physician had not		758		·	
•		on the incorrect d  4a. Medical recorrevealed a medic stage renal disea	arding this patient being dialyzed ialysate concentrate.  rd review for patient #11 al history that included end se and hypertension. Record his 38 year old male dialyzed 3					

revealed a medical history that included end stage renal disease and hypertension. Record review revealed this 38 year old male dialyzed 3 times a week for 4 hours. Hemodialysis treatment sheet review revealed this patient had an elevated blood pressure after hemodialysis treatment on 3/28/09, 4/4/09 and 4/7/09. Hemodialysis treatment sheet review revealed the following post treatment blood pressures: 3/28=257/99 4/4=212/79

Facility policy 1-03-12, Post Treatment Patient Assessment (9/07) revealed "The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. Findings that preclude the discharge of the patient will be reported to the licensed nurse. If the patient's condition requires intervention, the licensed nurse assess the patient and collects any additional data needed. The licensed nurse notifies the physician as needed of changes in patient status".

Facility ID: 970275

If continuation sheet Page 15 of 20

4/7=265/97

#### 1 SERVICES DEPARTMENT OF HEALTH AND HUI

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DEPARTMENT OF TICARE				OMB NO.	0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LDING	(X3) DATE SI COMPLE	
	342587	B. WII	NG	. 04/0	9/2009
NAME OF PROVIDER OR SUPPLIER GOLDSBORO SOUTH DIALY			STREET ADDRESS, CITY, STATE, ZIP C 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530	CODE	
OUR MADY CT	ATEMENT OF DEFICIENCIES	מו	PROVIDER'S FLAN OF C	ORRECTION	(X5)

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
V 758	Continued From page 15	. V 758		
	Medical record review revealed no documented evidence that the patient care staff alerted the licensed staff of the elevated blood pressures, that a post treatment nursing assessment had been conducted or that the licensed staff contacted the patients physician regarding the elevated blood pressures, respectively.			
	Interview on 4/78/09 with patient care technicians revealed they do not always document if they notify the nurse regarding an elevated blood pressure post treatment.			
	Interview on 4/8/09 with the licensed staff (staff #2, #11, #12) revealed they do not always get a chance to assess the patient prior to the patient leaving due to productivity issues and being busy with other responsibilities.			
	4b. Medical record review for patient #12 revealed a medical history that included end stage renal disease and hypertension. Record review revealed this 30 year old male dialyzed 3 times a week for 4.45 hours. Hemodialysis treatment sheet review revealed this patient had			
	an elevated blood pressure after hemodialysis treatment on 3/31/09, 4/4/09 and 4/7/09. Hemodialysis treatment sheet review revealed the following post treatment blood pressures: 3/31=168/135 4/4=201/110 4/7=177/112	е		
	Facility policy 1-03-12, Post Treatment Patient Assessment (9/07) revealed "The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings. Findings that preclude the discharge of			

# DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2009 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF	DEFICIE	ENCIES
AND PLAN	OF C	ORRECT	TION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

342587

B. WING

04/09/2009

NAME OF PROVIDER OR SUPPLIER

#### GOLDSBORO SOUTH DIALYSIS

STREET ADDRESS, CITY, STATE, ZIP CODE 1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
V 758	Continued From page 16 the patient will be reported to the licensed nurse. If the patient's condition requires intervention, the licensed nurse assess the patient and collects any additional data needed. The licensed nurse notifies the physician as needed of changes in patient status".	V 758		
	Medical record review revealed no documented evidence that the patient care staff alerted the licensed staff of the elevated blood pressures, that a post treatment nursing assessment had been conducted or that the licensed staff contacted the patients physician regarding the elevated blood pressures; respectively.			
	Interview on 4/78/09 with patient care technicians revealed they do not always document if they notify the nurse regarding an elevated blood pressure post treatment.		·	
,	Interview on 4/8/09 with the licensed staff (staff #2, 11, 12) revealed they do not always get a chance to assess the patient prior to the patient leaving treatment due to productivity issues and being busy with other responsibilities.			
	4c. Medical record review for patient #6 revealed a medical history that included end stage renal disease and hypertension. Record review revealed this 51 year old male dialyzed 3 times a week for 3.30 hours. Hemodialysis treatment sheet review revealed this patient had an elevated blood pressure after hemodialysis treatment on 4/3/09 and 4/6/09. Hemodialysis			
	treatment sheet review revealed the following post treatment blood pressures: 4/3=203/114 4/6=247/141			

PRINTED: 04/22/2009

DEPART	MENT OF HEALTH	AND HUI I SERVICES				FORM A OMB NO. (	PPROVED
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL	E CONSTRUCTION	(X3) DATE SUI	RVĖY
,		342587		1G		04/09	/2009
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
		210	٠		04 WAYNE MEMORIAL DRIVE		
GOLDSB	ORO SOUTH DIALYS	SIS		GC	OLDSBORO, NC 27530		
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V 758	Continued From pa	age 17	V	758			
V /58	Facility policy 1-03 Assessment (9/07 staff will obtain and patient post dialysifindings. Findings the patient will be if the patient's conlicensed nurse as any additional dat notifies the physic patient status".  Medical record revidence that the licensed staff of that a post treatmost contacted the patient status of the contacted the patient status.	1-12, Post Treatment Patient 1) revealed "The patient care 2d document basic data on each 2d sand compare to pre dialysis 2d that preclude the discharge of 2d reported to the licensed nurse 2d dition requires intervention, the 2d sess the patient and collects 2d needed. The licensed nurse 2dian as needed of changes in 2dian as needed of changes in 2dian as needed no documented 2dian as revealed no documented 2dian as revealed no documented 2dian as revealed no documented 2dian as revealed staff 2dian as respectively.	V	736			
	revealed they do notify the nurse r pressure post tre	/09 with patient care technicians not always document if they egarding an elevated blood atment.  09 with the licensed staff (staff					
	#2, 11, 12) revea	aled they do not always get a s the patient prior to the patient roductivity issues and being busy					
	And Safety Ched dialysis prescrip	1-03-02, Prescription Verification cks, revealed staff will verify the tion and perform safety checks atment initiation.					
	Interview with A	dministrative staff on 4/8/09 at taff use 1 of 3 Phoenix meters to			, ·		

test the conductivity and pH of the concentrate

DEPART	MENT OF HEALTH	AND HUI 1 SERVICES					0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		342587	B. WII			04/09/2009	
NAME OF PI	ROVIDER OR SUPPLIER	1		1	EET ADDRESS, CITY, STATE, ZIP CODE		
GOLDSB	ORO SOUTH DIALY	SIS		1	OLDSBORO, NC 27530	•	
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V 758	Continued From page	age 18	V	758		•	
	prior to each treatr	nent initiation. Interview also nix meters are calibrated and hich is logged on the Phoenix					·
	Disinfection And C	3-10A, Phoenix Meter Calibration Verification, review enix meters are disinfected and ally use.					
	directives for staff conductivity and p Log review from documented evid	penix Meter Log revealed  for to calibrate the meters for  bH prior to first use each day.  1/1/09-4/8/09 revealed no  ence that staff calibrated and  eters as required on 21 of 82					
	calibration could	or the lack of Phoenix meter be provided during interview with nistrator on 4/9/09 at 0945.					
	this 37 year old p facility on 9/8/06 renal disease se	d review for patient #4 revealed patient had been admitted to the with a diagnosis of end stage condary to hypertension and		٠,		•	
	diabetes. Medic physician order of (antibiotic) 500m for 2 weeks due Record review of dated on 11/13/0 more weeks (en hemodialysis tre revealed the pat dosage of antibi Review revealed	al record review revealed a dated on 10/23/08 for Cubicin in g IV with hemodialysis treatment to Osteomylitis of the left foot. evealed another physician's orde 08 to extend the Cubicin for 6 ding 12/27/08). Review of the eatment sheets for this patient tient did not receive the complete otic ordered by the physician. It is antibiotic had been stopped 1/2 weeks early).	r				

#### DEPARTMENT OF HEALTH AND HU. **1 SERVICES** FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 04/09/2009 342587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1704 WAYNE MEMORIAL DRIVE **GOLDSBORO SOUTH DIALYSIS** GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 758 Continued From page 19 . V 758 Interview with the Facility Administrator on 4/8/09 at 1545 revealed no explanation could be given for why the patient had not received the amount of Cubicin as ordered by the physician. However, she indicated that the process for ordering this medication had changed around the same time and that may have caused some confusion with the dosages provided to the patient.

PRINTED: 04/22/2009

on Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining 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 suggestions 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 Reduction Project (0938-0390), Washington, D.C. 20503.

	Supplier / CLIA / ion Number	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/22/2009
Name of Facility		<u> </u>	Street Address, City, State, Zip Code	
	O SOUTH DIALYSIS		1704 WAYNE MEMORIAL DRIV GOLDSBORO, NC 27530	/E

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported 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 requirement on the survey report form).

Y4) Item		(Y5) Date (Y	4) Item	<b>(Y</b> 5	) Date (	Y4) Item	(Y5)	Date
ID Prefix	V0501 494.80	Correction Completed 05/22/2009	ID Prefix V0  Reg. # 494		Correction Completed 05/22/2009	ID Prefix Reg. # ,	V0553 t94.90(a)(7)(i)	Correction Completed 05/22/2009
ID Prefix Reg. #		Correction	(D Prefix Vi Reg. # 494 LSC		Correction Completed 05/22/2009	!D Prefix Reg. #		
ID Prefix Reg. #	£		ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correctior Complete
ID Prefit Reg. :	x	Correction Completed	ID Prefix Reg. #		Correction	ID Prefix Reg. # LSC	And the second s	Correctio
ID Pref Reg. LS	· · · · · · · · · · · · · · · · · · ·	Correction Completed	ID Prefix _ Reg. # LSC _		Correction Completed	ID Prefix		
State Ag	ed By	Reviewed By	Date: 5/22/09 Date:	Signature of Signature of	). Cuat	in/a		ate: 5/22/09 Date:
Follow	up to Survey Com			Check for any Uncorrected	Uncorrected D Deficiencies (	eficiencies. Was CMS-2567) Sent		YES NO

### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

		information Cand comments regarding this Diffeet	reviewing instructions, searching existing data sources, gathering and a estimate or any other aspect of this collection of information, 11207; or to the Office of Management and Budget, Paperwork
eductio	on Project(0838-0583), Washington, D.C. 20503.	·	•

Provider/Supplier Number 342587	Provider/Supplier I GOLDSBORO S	Name OUTH DIALYSIS			
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	<ul><li>E Initial Certification</li><li>F Inspection of Care</li><li>G Validation</li><li>H Life Safety Code</li></ul>	I I K L	Recertification Sanctions/Hearing State License 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	ng 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	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 6piii-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 15401	04/07/2009	04/09/2009	1.00	1.00	21,25	0.50	6.00	12.00
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6.								
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10.								
11.							<del></del>	
12.								_
13.								
14.								

Total SA Supervisory Review Hours....

1.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.50

EventID: 1ZU211

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

0.00

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

Facility ID: 970275

Page

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

pe of Survey (select all I D )  ctent of Survey (select A )  A   Survey or ID Number (A)	all that apply)	B Dum C Fede D Follo M Other A Routin B Extend C Partial D Other  c enter the worklo  Last Date Departed	plaint Investigation of the control	on F G H vey (all provides A or Long Term ey (HHA) M AND WOR	Initial Certification Inspection of Care Validation Life Safety Code	J K L	Recertification Sanctions/Hearing State License CHOW  aber.  Travel Hours	Off-Site Report Preparation Hours
I D	Please Fust Date Anived	B Dum C Fede D Follo M Other A Routin B Extend C Partial D Other  c enter the worklo  Last Date Departed	aping Investigational Monitoring ow-up Visit or e/Standard Surve ded Survey (HHL Extended Surve Survey  SURVEY TEAD and information for Pre-Survey Preparation	on F G H vey (all provide: A or Long Term ey (HHA)  M AND WORI r each surveyor.  On-Site Hours	Inspection of Care Validation Life Safety Code (rs/suppliers) Care Facility)  KLOAD DATA Use the surveyor's ide  On-Site Hours	J K L On-Site Hours	Sanctions/Hearing State License CHOW	Preparation
A A Surveyor ID Number	Please First Date Anived	B Extend C Partial D Other  center the worklo  Last Date Departed	led Survey (HHL Extended Survey SURVEY TEA) and information for Pre-Survey Preparation	A or Long Term ey (HHA)  M AND WORI r each surveyor.  On-Site Hours	KLOAD DATA  Use the surveyor's ide  On-Site  Hours	On-Site Hours	Travel	Preparation
	First Date Anived	Last Date Departed	ead information fo Pre-Survey Preparation	on-Site	Use the surveyor's ide On-Site Hours	On-Site Hours	Travel	Preparation
	First Date Anived	Last Date Departed	Pre-Survey Preparation	On-Site Hours	On-Site Hours	On-Site Hours	Travel	Preparation
	Date ··· Arrived ··· -	Date Departed	Preparation	Hours	Hours	Hours		Preparation
	(B)	100		1		(0)	( )	1
		(C)	(D)	(E)	(F)	(G)	(H)	(1)
	05/22/2009	05/22/2009	1.00	0.00	3.50	0,00	2.00	1.00
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6.		MATERIAL CONTRACTOR		***************************************				
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Total SA Supervisory	Review Hours.	****	0.50	Annual Control of the	Total RO Sup	ervisory Re	view Hours	0.00

FORM CMS-670 (12-91)

102000

EventiD: 1ZU212

Facility ID: 970275

Page

1

	RT I - APPLICATION - TO BE CO	MPLETED BY FACILITY
1. Name of Facility		2. CCN
Goldsboro South Dialysis		34-2587
3. Street Address		4.NPI
1704 Wayne Memorial Dr		1821058900
5. City	6. County	. 7 Fiscal Year End Date
Goldsboro	Wayne ·	12/31
8. State	9. ZIP Code	10. Administrator's Email Address
NC .	27534	alice.hall@davita.com
11. Telephone No.	12, Facsimile No.	13. Medicare Enrollment (CMS 855A)
919-739-6505	919-739-6506	completed? Yes No NA
14. Facility Administrator Name Alice	Hill	Address: 1704 Wayne Memorial Dr
· ·		
City: Goldsboro	State: NC	Zip Code: 27534 Telephone No: 919-739-6505
15. Type of Application/Notification: (V	<ol> <li>(check all that apply. If "Other",</li> </ol>	specify in Remarks section [Item 33])
1. Initial	2. Recertification	3. Relocation
4. Expansion	5, Change of Ownership	6. Change of services
7. Other (specify)	,	
16. Ownership (V2) X 1. F	or Profit 2. Not For P	rofit 3. Public
17. Is this Facility Hospital-Owned? (V	/3) 1. Yes	2. No If Yes, hospital GCN (V4):
If yes, is this Facility on the main ho	spital-campus? (V5)	2. No
(V6) Hospital name:	- house-A	
18. Is this Facility SNF-Owned? (V7)	1. Yes	2. No If Yes, SNF CCN (VB):
19. Is facility owned and/or managed	by a multi-facility organization? (V9)	1. No 2. Yes
Owned	Managed	Byggend Regions .
(V10) If Yes, name of parent or mana	iging organization: DaVita Inc	
(V11) Address:	•	
601 Hawaii St. El Segundo, CA 90	0245-4841	
	ILthat apply)	2. In-center Peritoneal Dialysis (PD)(CAPD/CCPD)
(V12) 1. In-center Hemodial  3. Home HD Training	•	4. Home PD (CAPD/CCPD) Training & Support
21. Requested Services: (chec	ck all that apply)	2. In-center PD(CAPD/CCPD)
	, ,	h
(V13) X 1. In-center HD	•	A Hama DD (CADD)(CCDD) Training & Support
(V13) X 1. In-center HD 3. Home HD Training	The state of the s	4. Home PD (CAPD/CCPD) Training & Support
(V13) 1. In-center HD 3. Home HD Training 22. Do Facility staff provide and/or s	upport dialysis in nursing home(s)?	
(V13) 1. In-center HD 3. Home HD Training 22. Do Facility staff provide and/or s	upport dialysis in nursing home(s)?	rks" (Item 33) and answer the next question on Staffing(V15)
(V13) 1. In-center HD  3. Home HD Training  22. Do Facility staff provide and/or s  (V14) 1. Yes 22. No if ye	upport dialysis in nursing home(s)? s, list all nursing homes under "Rema	
(V13) 1. In-center HD  3. Home HD Training  22. Do Facility staff provide and/or s	upport dialysis in nursing home(s)? s, list all nursing homes under "Rema	rks" (Item 33) and answer the next question on Staffing(V15)
(V13) 1. In-center HD  3. Home HD Training  22. Do Facility staff provide and/or s  (V14) 1. Yes 2. No If ye  (V15) Staffing for dialysis provide	upport dialysis in nursing home(s)? s, list all nursing homes under "Rema ded by:  1. DME  1. HD	rks" (Item 33) and answer the next question on Staffing(V15)  2. Nursing home staff  2. PD
(V13)  1. In-center HD  3. Home HD Training  22. Do Facility staff provide and/or s  (V14)  1. Yes  2. No if yes  (V15) Staffing for dialysis provid  (V16) Dialysis type:	upport dialysis in nursing home(s)? s, list all nursing homes under "Remained by:  1. DME  1. HD	rks" (Item 33) and answer the next question on Staffing(V15)  2. Nursing home staff  3. This facility

25. How is isolation provided? (V26) 1. Room 26. If applicable, number of hemodialysis stations designated for iso	2. Area 3. Agreement (Attach copy)
27. Days of Operation (check all that apply) (V28):	7,15
Opening Times: (V29) MWF Staff: CY50 (V30) MWF P	atients 060 (V31) TTS Staff 0 0 (V32) TTS Patients
28. Is reuse practiced? (V33) 1. Yes 2. N	
29. Reuse System (V34) 1. Manual 2. S	
30. Staff (List full-time equivalents) (V35) Registered Nurse	
(V37) Masters Social V	Vorker 09 (V38) Registered Dietitian 0.9
(V39) Patient Care Tec	hnician 8 (V40) Others
31. State license number (if applicable) (V41): n/a	32. Certificate of Need required? (V42) Yes No XNA
33. Remarks (attach additional pages if needed):	·
•	
	•
•	
Nursing list:	,
riording 200	
34 The information contained in this Application Survey and Cer	riffication Report (Part 1) is true and correct to the best of my knowledge.
understand that incorrect and erroneous statements may cause tunder 42 C.F.R. 494.1 and 488.604 respectively.	the Request for Approval to be denied, or facility approval to be rescinded,
	Title Date
I have reviewed this form and it is accurate: Signature of Administrator/Medical Director	Group Facility Administration
	10114111
PART II TO BE CO	Medical Director/CEO MPLETED BY STATE AGENCY
35. Medicare Enrollment (CMS 855A approved by MAC)? (V4	
	o) [7]
(Note: approved CMS 855A required prior to certification)	
36. Type of Survey (V44) 1. Initial	2. Recertification 3. Complaint 4. Other
37. State Region (V45)	
38. Network Number (V46)	
I have reviewed this form and it is complete:	Professional Discipline (Print) 40. Survey Exit Date
39. Surveyor Team Leader Name/Number (Print)	1/1/11
Day CAMPUN	1 14, 182 1 6/10/11

### RECEIVED APR 27 2010

DEPARTMENT OF HEALTH AND HUMAN SEF SENTERS FOR MEDICARE & MEDICAID SEF S

+6	/
RECEIVED APR 2 6 2010	FORM APPROVED OMB 0938-0360

	1- TO BE COMPLETED BY FACILITY	
PART 1 - APPEICATION  Name of Facility	2. Provider Number	
Idsboro South Dialysis	3 4 2 5 8 7	
3. Street Address		
1704 Wayne Memorial Dr.	5, County	
4. City	Wayne	
Goldsboro	7. ZIP Code	-
6. State North Carolina	27534-2240	
8, Telephone No.	9. Facsimile No. 1 0. Fiscal Year Ending Date	
919-739-6505	919-739-6506 12/31	_
11. Name/Address/Telephone Number of Authorized Official Name:	Address: Telephone No	
Alice Hill, Facility Administrator	Goldsboro, NC 27534-2240 919-739-6505	
12. Type of Application/Notification: (v1) (check all that a	nt location	
13. Ownership (V2)	X For Profit Not for Profit Public	
14. Is this Facility Hospital-Based (check one)	(v3) ☐ Yes ☒ No If Yes, hospital provider number	,
	. (M)	
15. Is this Facility SNF-Based (check one)	(v5) Yes X No If Yes, SNF provider number	
	· · · · · · · · · · · · · · · · · · ·	<u>.                                    </u>
16. Is this facility owned and/or managed by a multi-facility organi.	zation? (v7) X Yes No If Yes, name and address of parent organization Address: 601 Hawaii St.	
and the second s	FEIN 51-0354549 El Segundo, CA 90245-4814	
v8) DaVita Inc.  17. Services Provided: (v9) (check all that apply and specify i		
18 is Reuse Practiced?	(vio)⊠ Yes ☐ No	
18. Is Reuse Practiced?  19. Reuse System (v11) (check all that apply)	1. Manual 🛛 2. Semi-Automated 🔲 3. Automated	
	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  1. Fermalin  5. Other (s)	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients  (v14) 67 Hemo	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  1. Fermalin  5. Other (s)	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations  2 (v17) 22 Hemo	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations (v17) 22 Hemo  23. Does the facility have isolation stations? (Included in	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients = (v14) 67 Hemo  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations = (v17) 22 Hemo  23. Does the facility have isolation stations? (Included in 24. Total Number of Patients (enter number of dialysis facility pa	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations (v17) 22 Hemo  23. Does the facility have isolation stations? (Included in	1. Manual	4
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients = (v14) 67 Hemo  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations = (v17) 22 Hemo  23. Does the facility have isolation stations? (Included in  24. Total Number of Patients (enter number of dialysis facility paths)  A. SUNDAY B. MONDAY  1 2 3 4 1 2 3  0 0 0 0 21 16 0	1. Manual	4
19. Reuse System (v11) (check all that apply)  20. Germicide (v12) (check all that apply)  21. Number of Dialysis Patients  (v13) 67 Total Patients = (v14) 67 Hemo  22. Number of Stations (check all that apply and include iso  (v16) 22 Total Stations = (v17) 22 Hemo  23. Does the facility have isolation stations? (Included in	1. Manual	
19. Reuse System (v11) (check all that apply)  20. Germicide (V12) (check all that apply)  21. Number of Dialysis Patients  (V13) 67 Total Patients = (V14) 67 Hemo  22. Number of Stations (check all that apply and include iso  (V16) 22 Total Stations = (V17) 22 Hemo  23. Does the facility have isolation stations? (Included in 24. Total Number of Patients (enter number of dialysis facility parts)  A. SUNDAY B. MONDAY  1 2 3 4 1 2 3  0 0 0 0 21 16 0  E. THURSDAY F. FRIDAY	1. Manual	

Staffing	(V21) L	.egistered Nu		-			_icensed.Pr			0.5	ព
t full-time equivalents)	(V23) 🛛	Social Worke	·r	0.5			Dietitian				
	(V25) 🛛	Technicians		7.	0 0	(V26) 🔀	Others	•		_ 1 .	<u> </u>
Remarks: (Use this space	e for explar	natory statem	ents for Items	s 1-26	)						
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understand that incorre rescinded, under 42 C inature of Authorized Official Communication (V27)  ESRD Provider Number (V27)  Network Number (V28)  State Region (V28)  Type of Survey (V30) (C)  Survey Protocol (V31)(C)	ect or errone F.R.405.21  al  er (if the fact  theckall that  check all the	PART II	nts may caus 2180, respect litle  TO BE CO povider numbe	MPL	Manuer Ted BY	32. Statemplaint	AGENCY  De County Co  Rece  Supplesional Discip	ode (vzs)	Date  // 2	2c/.	8 V
understand that incorre rescinded, under 42 Consture of Authorized Official Construction of Authorized Official Construction (V27)  3. ESRD Provider Number (V27)  1. State Region (V28)  3. Type of Survey (V30) (C4)  4. Survey Protocol (V31)(C5)	ect or errone F.R.405.21  al  er (if the fact  theckall that  check all the	PART II	nts may caus 2180, respect litle  TO BE CO povider numbe	MPL	Manuer Ted BY	32. Statemplaint	AGENCY  De County Co  Rece  Supplesional Discip	ode (vzs)	Date  // 2	2c/.	8 V
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FORM CMS-3427 (06-97)

Page 2 of 3

Pega I of 3

FORM CMS-\$427 (66-97)

END STAGE RENAL DISEASE APPLICATION/N	IOTIFICATION AND SURVEY AND C	ERTIFICATION REPORT
PART I - APPLICATION	N - TO BE COMPLETED BY FACILITY	lo P. U. N. H.
Name of Facility		2. Provider Number 3 4 2 5 8 7
Goldsboro South Dialysis		
3. Street Address		
1704 Wayne Memorial Dr. 4. City	5. County	
Goldsboro	Wayne	
6. Siate	7. ZIP Code	
North Carolina	27534-2240	
8. Telephone No.	9. Facsimile No.	1 0. Fiscal Year Ending Date
919-739-6505	919-739-6506	12/31
11. Name/Address/Telephone Number of Authorized Official	Address:	Telephone No. 919-739-6505
Alice Hill		1 Dr. Goldshow, WC
المستوا	apply and specify in Remarks section [see item apply and specify in Remarks section [see item]	(2(j) 6-13-34
1. Initial 2. Expansion to new l		
☐ 4. Change of location ☐ 5. Expansion in curre ☐ 7. Other (specify) survey inspection	nimilaent	
13. Ownership (V2)	▼ For Profit  Not for Profit	☐ Public
14. Is this Facility Hospital-Based (check one)	(v3) Yes X No If Yes, hospital p.	rovider number
14, is this I donly Noophia base (Mark 1997)	· · · · · · · · · · · · · · · · · · ·	(41)
15. Is this Facility SNF-Based (check one)	(v5) Yes No If Yes, SNF prov	ider number
	A STATE OF THE STA	(v6)
16. Is this facility owned and/or managed by a multi-facility organi	ization? (v7) X Yes No If Yes, name and add	ress of parent organization
	Addition: (17) [ 100 [ 1	
Name:	Address:	
Name:	. 607	Hawali St.
(v8) DaVita Inc.	FEIN 51-0354549 ELS	
(/6) DaVita Inc. 17. Services Provided: (v9) (check all that apply and specify	FEIN 51-0354549 ELS in Remarks section (see item 27))	Hawaii St. egundo, CA 90245-4814
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	PART I	TO BE COMPL	ETEQLEY	SIAIEA	GENCY	· · · · · · · · · · · · ·	
29. ESRD Provider Numbe	r (if the facility has a pr	ovider number)			5	H.D.	
30. Network Number (v27)		*****	•				
31. State Region (V28)	Y /			32. State	County Code (v29)	CE	
33. Type of Survey (v30) (cl	neckall that apply)	· 🔲 Initial	Z Coi	mplaint	☐ Recertification	Other	
34. Survey Protocol (V31)(C	heck all that apply)	, Dasic	· 🔲 Init	ial	Supplemental	☐ Comb	ination
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36. Date of Survey				·			
According to the Paperwork number. The valid OMB con per response, including the collection. If you have any c 7500 Security Boulevard, N	trol number for this informations, time to review instructions, omments concerning the a	ation collection of 09 search existing dat ocuracy of the time	938-0360. IT s resources.	e time requir dather the d	ed to complete this into ata needed, and compl	ormation collection lete and review th	e information
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FORM CMS-3427 (06-97)							, 01

Intermediate Sanction

FORM CMS-562 (1-93)

Move Routine Survey Date Forward

CMS RO

Page 1 of 1

Other (Specify) \_

Enforcement Action

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

p•	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
	ining 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
Sty	ming than included, and completing 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
Pm	nect/0838-0583), Washington, D.C. 20503.

•					
Provider/Supplier Number	Provider/Supplier	Name			
342587	GOLDSBORO S	SOUTH DIALYSIS			
Type of Survey (select all that apply)  A	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other A Routine/Standard Survey (all p B Extended Survey (HHA or Lor C Partial Extended Survey (HHA) D Other Survey	ng Term Care Facility)	I J K L	Recertification Sanctions/Hearing State License CHOW	

#### 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	Last Date Departed	Pre-Survey Preparation Hours	On-Site Hours 12am-8am	On-Site Hours	On-Site Hours 6pm-12sm	Travel Hours	Off-Site Report Preparation Hours
	(B)	(C)	(D) .	(E)	(F) <sup>-</sup>	(G)	(H)	(1)
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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.....

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: GE2D11

Facility ID: 970275

Page

1.

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION A	IND SURVEY AND CERTIFICATION REPORT	
Goldsboro South Dialysis	2. Provider Number  SI FI SI SI SI SI	
2 Ctroat Addrops	>	
4. City 5. County		
	-41/1	
	534	
8. Telephone No. 9. Facsimile No.		
44 Name / Address / Talambaga Number of Authorized Official		
Name: Address: 4	704 Wayne Memorial Dr Telephone No.	
Mice Hill	holdshero. NC 27534 919-739-6505	
4. Change of location 5. Expansion is current location	: 5. Change of ownership : 6. Change of services/operations	
7. Other (specify) 12 centification		
and a second second second		
14. Is this Facility Hospital-Based (check one) (vs) Yes	No If Yes, hospital provider number	
	(V4)	
15. Is this Facility SNF-Based (check one) (vs) Yes	None and got door on before the ring	
	(V6)	
^ →		
(60	Signal Share Shift Nature Scounty  Coldsbore Tipe day No. 10, Fiscal Year Ending Date  1704 Wayne Memorial Scounty  Resulting the Scounty  N.C. 3, 7, 7, 19, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10	
	see (fem 27])	
1. Hemodialysis 2. Peritoneal Dialysis 3. Transplantation	4. Home Training: 5. Home Support: Hemodialysis Hemodialysis	
18. Is Reuse Practiced? (Vic	Yes No	
19. Reuse System (v11) (check all that apply) 1. Manual	12. Semi-Automated 12. Automated	
	☐ 3. Gluteraldehyde ☐ 4. Peracetic Acid Mixture	
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22. Number of Stations (check all that apply and include isolation stations under	Total Stations)	
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23. Does the facility have isolation stations?	(VIB) Yes No	
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16 7 6 0 21 22 0 0 16	7 0 0	
25. Total Number of patients followed at home (vzo)		

26. Staffing	(V21) Registere	d Nurse	<u>4</u> .	(V22)	Licensed Practical Nu	irce /
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	(V25) Technicia	ns	9		. Others	2
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10. Network Number (vzz)	I_					
11. State Region (V28)			· · · · · · · · · · · · · · · · · · ·	32. State	County Code (V29)	1/
i3. Type of Survey (V30) (check	call that apply)	Initial	Com	plaint	. (Recertification)	Other
i4. Survey Protocol (V31) (check	all that apply)	Basic	Initia	[	Supplemental	Combination
5. Surveyor Name/Number (p	rint)	1/7/1	n /	Professio	nal Discipline (print)	
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6. Date of Survey				*		
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ollection. If you have any commer	ats concerning the acc	utacy of the tim	lata resources, ga e estimate(s) or s	ither the da suggestions	ta needed, and complete a	nd review the information
500 Security Boulevard, N2-14-2	6, Baltimore, Maryland	121244-1850.			· Free range man routify pro	AND THE ENGINEE,

)RM CMS-3427 (06-97)

 Patient survival lets you know if the patients treated at a certain dialysis facility generally live longer, as long, or not as long as expected. than expected due to a variety of reasons. For example, a facility may specialize in treating patients who are very ill and who may not live long; it does not always mean they are not providing good care.

#### Patient Survival for January 2006 to December 2009\*

	Better Than Expected**	As Expected	Worse Than Expected**
Survival Categories for the 4961 facilities with available data in US	437	3969	555
Survival Categories for the 159 facilities with available data in North Carolina	11	130	18
GOLDSBORO DIALYSIS		en recent programme de la companya d	/

<sup>\*</sup>The most recent data available. If a facility was not open during this period, information will not be available on this Website. (Contact the facility for the most current information).

Many things can affect how long a patient lives. For more detail about this information, please look at the Glossary and Patient Survival Frequently Asked Questions.

Page Last Updated: February 16, 2011

#### **Return To Previous Page**

<sup>\*\*</sup>Statistically better or worse than the "As Expected" survival category. For more detail about this information, please view the Patient Survival Frequently Asked Questions.

Percentage of Medicare patients who had enough wastes removed from their blood during dialysis (Dialysis Adequacy) in 2009

#### Why is Dialysis Adequacy Important to You?

- Patients with kidney failure need to have wastes removed from their blood often. Too much waste in your blood makes you sick. Dialysis is used to remove wastes from your blood.
- It is important for a facility to remove enough wastes from your blood during dialysis to help you feel better.
- A number known as the urea reduction ratio (URR) measures how much urea is removed during dialysis.
- The URR is a way to measure dialysis adequacy. Your URR should be 65 or greater.

#### What Does This Graph Show?

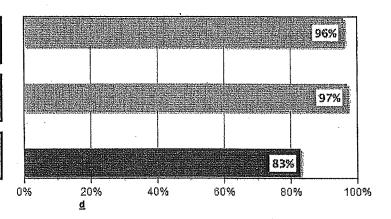
- This graph shows the percentage of patients at each facility who had enough wastes removed from their blood during dialysis, or who had a URR of 65 or more.
- Higher percentages mean that more patients at the facility had a URR of 65 or more.
- · On the graphs, longer bars are better.

Percentage of Medicare patients who had enough wastes removed from their blood during dialysis (Dialysis Adequacy) in 2009

THIS IS THE AVERAGE FOR ALL DIALYSIS FACILITIES IN THE UNITED STATES

THIS IS THE AVERAGE FOR ALL DIALYSIS FACILITIES IN THE STATE OF NORTH CAROLINA

GOLDSBORO DIALYSIS



For more information, please look at the Glossary and Adequacy Questions and Answers.

Patient Survival for January 2006 to December 2009\*

#### Why is Patient Survival Important to You?

- Generally, patients with kidney failure don't live as long as patients with normal kidneys.
- Many factors affect how long a dialysis patient lives. Some of these factors are under the control of the patient (like not skipping treatments), and some of these factors are under the control of the facility (like making sure patients get all the treatments the doctor prescribes).

#### What Does This Table Show?

- This information is in categories called Better than Expected (live longer than expected), As Expected, or Worse than Expected (don't live as long as expected).
- This information lets you compare patient survival at the facilities you selected. Use this information when you talk to your doctor or dialysis facility staff.
- Patient survival at a facility can be worse

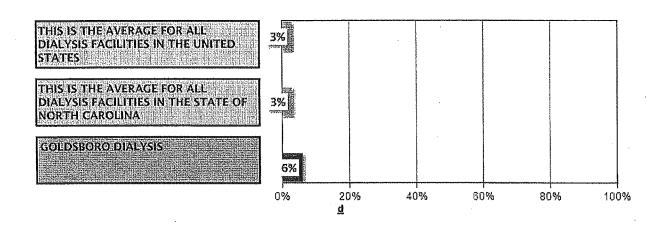
#### Why is Anemia Important to You?

- Most patients with kidney failure have anemia (a low red blood cell count). If you have anemia, you may feel tired or weak. It is important for the facility staff to keep your anemia under control so you feel better.
- A hemoglobin is a blood test that measures anemia. If you are on a drug for anemia like Epogen®, the dialysis facility staff should keep your hemoglobin between 10.0 g/dL and 12.0 g/dL.

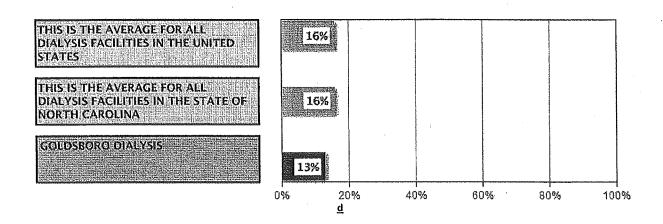
#### What Do These Graphs Show?

- The first graph shows the percent of patients at each facility whose hemoglobin was less than 10.0 g/dL.
   The second graph shows the percent of patients at each facility whose hemoglobin was greater than 12.0 g/dL. Both these graphs show patients whose anemia wasn't controlled.
- Higher percents for each measure mean that the facility had more patients whose anemia wasn't controlled. On the graphs, shorter bars are better.

Graph 1 of 2: Percent of Medicare patients who have an average hemoglobin value less than 10.0 g/dL.



Graph 2 of 2: Percent of Medicare patients who have an average hemoglobin value greater than 12.0 g/dL.



For more detail about this information, please look at the Glossary and Anemia Frequently Asked Questions.

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#### **Return To Previous Page**

### **Dialysis Facility Compare**

#### **Compare Quality Measures**

Quality Measure Results for the selected dialysis facilities within Goldsboro, North Carolina

If your search results show facilities in more than one state, the contact information and the quality measure state averages in the charts and graphs are for the state where the city or ZIP code you entered is located.

State sponsored insurance may not always allow you to choose a dialysis facility outside your state of residence. Please contact the dialysis facility directly if you have questions.

The quality measures are shown in the form of graphs. The displays include National and State averages for each quality measure. To view the graphs for each quality measure, click on one of the links below or show all quality measures by clicking "Show All." Before you look at the Quality Measures for the facilities you selected, please read the following information carefully.

#### What are quality measures?

The quality measures on this website are one way to tell how well facilities care for their patients. You can check on the care given at certain dialysis facilities by comparing their quality measures. The three quality measures on this site are:

- Anemia how many patients at a facility whose anemia (low red blood cell count) wasn't controlled (hemoglobin less than 10.0 g/dL or hemoglobin greater than 12.0 g/dL).
- Hemodialysis Adequacy how many patients at a facility get their blood cleaned enough during dialysis treatments (URR 65% or greater).
- Patient Survival if the patients treated at a facility generally live longer than, as long, or not as long as expected.

#### Why should you look at quality measures?

Dialysis facilities can vary in how well they care for their patients. The three measures listed above help you to know that you are getting good dialysis care. After you look at the quality measures, you can click on the Resources Tab to find out more about good dialysis care.

The care that facilities provide can affect how you feel overall, and how long you survive. Looking at quality measures can:

- help you understand which facilities are providing good care.
- give you information about dialysis facilities to discuss with dialysis staff and your doctor.
- help staff improve how well they care for you and others.

Tips: You can print the quality measures. Feel free to take them with you and ask your doctor or dialysis staff about them.

Read all the information provided with the quality measure carefully. Some facilities may have higher or lower scores because of the types of patients they serve.

Percentage of Medicare patients whose anemia wasn't controlled in 2009. (Wasn't controlled means a hemoglobin less than 10.0 g/dL or a hemoglobin greater than 12.0 g/dL.)