Exhibit H

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

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

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

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

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

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

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Sincerely,
Kay D. Cuaton, RN
Kay D. Cuaton, RN
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

Mr Williams,
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 HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: L76B

Facility ID: 944655

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 342543

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) VANCE COUNTY DIALYSIS
(L4) 854 S BECKFORD DRIVE
(L5) HENDERSON, NC (L6) 27536

4. TYPE OF ACTION 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2000

6. DATE OF SURVEY 07/16/2010 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 09 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) 12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified ~~Beds~~ 43 hemo stations (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1 Acceptable POC
X B Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7 Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A recertification survey and follow-up to the 07/26/2007 complaint concluded on 07/16/2010 with Condition level deficiecies cited in the following areas: 494.150-Responsibilities of the Medical Director; 494.180-Governance. A credible allgation was received on 08/13/2010. A follow-up survey to the 07/16/2010 recertification survey was conducted on 08/30/2010. All previously cited deficiencies have been corrected. The facility is in compliance with all ESRD CFC

17. SURVEYOR SIGNATURE [signature] Date: 08/31/2010 (L19)

18. STATE SURVEY AGENCY APPROVAL [signature] Date: 9/1/010 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above: ___

22. ORIGINAL DATE OF PARTICIPATION 03/15/1989 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: 00 (L30)
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00101 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

RECEIVED AUG 1 3 2010

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on facility policy review, observation and staff interview, the facility direct patient care staff failed to don/wear gloves with direct patient/equipment contact and sanitize hands after glove removal. The findings included: Facility policy 1-05-01, Infection Control For Dialysis Facilities (revision 10/08) revealed staff is required to wear/don gloves when caring for patients or touching the patient equipment at the dialysis station, and required to perform hand hygiene after removal of gloves, after patient and dialysis delivery system contact, between patients, and before touching clean areas. Policy review revealed "Only teammates with clean hands may remove items from clean supply cart". Observation on 7/13/10 at 1130 revealed staff #1 did not wear gloves when she touched the dirty dialysis machine at station #17 where patient #1 had just completed his dialysis treatment. Observation on 7/13/10 at 1135 revealed staff #1 did not remove her dirty gloves or sanitize her hands after removing the needles from patient #1's arm access and prior to retrieval of clean	V 113	V113 1. Survey deficiency results will be reviewed with all teammates 2. Policy # 1-05-01 Infection Control for Dialysis Facilities will be reviewed with all teammates with emphasis on proper hand washing/hygiene and glove usage. 3. All teammates will complete LMS MAN 2002 infection control mandatory training. 4. LMS training records will be audited for compliance and tracked to verify completion by all teammates. 5. Daily homeroom meetings were initiated on July 22 and will be held with the clinical team daily x 1 week, then weekly x 2 months to review infection control practice requirements. 6. Daily infection control audits were initiated on July 22 and will be performed daily x 2 weeks. When compliance is noted, frequency will become weekly x 4 weeks until compliance is noted, then monthly. 7. Infection control audit results will be reviewed at the CQI meeting and a plan implemented and adjusted as needed. 8. Clinical Mgr (CM)will review the job description, role and responsibilities with all hemo nurses and PCTS. 9. All nurses will be inserviced regarding expectations of monitoring staff compliance with infection control policies. 10. The Clinical Mgr will monitor daily for team compliance with infection control policies and compliance with the plan of correction. 11. Infection control audit results will be reviewed by the Governing Body and a plan implemented and adjusted as needed 12. Disciplinary action will result in continued non-compliance with infection control policy and plan.	8/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James D Wiley

TITLE: Administrator

(X6) DATE: 8/12/10

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.

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V 113	Continued From page 1 supplies. Observation on 7/13/10 at 1203 revealed staff #2 did not don gloves (she used the glove as a barrier between the dirty machine and her hand) to touch the dirty dialysis machine at station #13 where patient #2 was dialyzing. Observation revealed after staff #2 discarded the glove she did not sanitize her hands before touching the door knob on the lobby exit door. Observation on 7/13/10 at 1220 revealed staff #2 did not don gloves (she used the glove as a barrier between the dirty machine and her hand) to touch the dirty dialysis machine at station #16 where patient #3 was dialyzing. Observation revealed after staff #2 discarded the glove she did not sanitize her hands after discarding the glove. Observation on 7/14/10 at 1115 revealed staff #3 did not don gloves (she used the glove as a barrier between the dirty machine and her hand) to touch the dirty dialysis machine at station #19 where patient #4 was dialyzing. Observation on 7/16/10 at 0850 revealed staff #5 did not don gloves (she used the glove as a barrier between the dirty machine) or sanitize her hands after addressing the machine alarm on contaminated dialysis machine at station #29 where patient #18 was dialyzing. Interview on 7/16/10 at 0859 with staff #5 revealed she didn't don the glove to address the dialysis machine alarm or sanitize her hands after contaminated equipment contact because she "just didn't think about it".	V 113		

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V 113	Continued From page 2 Interview with the facility Clinical Nurse Manager on 7/14/10 at 1230 revealed she was aware that staff did not follow appropriate standard precautions during direct patient care, but her job duties did not include personnel issues. Interview revealed "the Facility Administrator is responsible for the oversight of the staff".	V 113		
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This STANDARD is not met as evidenced by: Based on facility policy review, observation, and staff interview, the facility staff failed to maintain separate clean and dirty areas and failed to ensure non-disposable tape was not shared between patients.	V 117	V117 1. Policy # 1-05-01 Infection Control for Dialysis Facilities will be reviewed with all ~~teammates with emphasis the importance of~~ maintaining separate clean and dirty areas and that supplies, including but not limited to tape, that are taken into the dialysis station will be disposed of , dedicated for single patient use, or cleaned and disinfected before taken to a common clean area. Non disposable items that cannot be cleaned and disinfected i.e. tape should be dedicated for use on a single patient. s Same as #1-12 above cont pg 4	8/9/10

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V 117	Continued From page 3 The findings included: Facility policy 1-05-01, Infection Control For Dialysis Facilities (revision 10/08) revealed ..."clean areas should be clearly designated for ...storage of...unused supplies and equipment...clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled...items taken into the dialysis station will be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before taken to a common clean area or used on another patient...non disposable items that cannot be cleaned and disinfected (e.g., adhesive tape) will be dedicated for use only on a single patient". Observation on 7/13/10 at 1130 revealed staff #1 did not maintain the clean computer cart when she removed the patient treatment sheet from the top of the contaminated dialysis machine at station #17 (where a patient was dialyzing) to the clean computer cart. Observation on 7/13/10 at 1220 revealed staff #2 did not maintain the clean computer keyboard when she did not sanitize her hands prior to touching the computer keyboard and after working with the patient dialyzing at station #16. Observation on 7/13/10 at 1150 revealed staff #1 did not discard a contaminated roll of tape as required after taking it to dialysis station #17 where a patient was dialyzing. Observation revealed staff #1 used the same contaminated roll of tape for the patient dialyzing also at station #19. Observation on 7/14/10 at 1115 revealed staff #3	V 117	V117 cont. All teammates will complete LMS MAN 2002 infection control mandatory training. LMS training records will be audited for compliance and tracked to verify completion by all teammates. Daily homeroom meetings were initiated on July 22 and will be held with the clinical team daily x 1 week, then weekly x 2 months to review infection control practice requirements. Daily infection control audits were initiated on July 22 and will be performed daily x 2 weeks. When compliance is noted, frequency will become weekly x 4 weeks until compliance is noted, then monthly. Infection control audit results will be reviewed at the CQI meeting and a plan implemented and adjusted as needed. Clinical Mgr (CM) will review the job description, role and responsibilities with all hemo nurses and PCTS. . All nurses will be in-serviced regarding expectations of monitoring staff compliance with infection control policies. The Clinical Mgr will monitor daily for team compliance with infection control policies and compliance with the plan of correction. . Infection control audit results will be reviewed by the Governing Body and a plan implemented and adjusted as needed Disciplinary action will result in continued non-compliance with infection control policy and plan.	8/9/10

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V 117	Continued From page 4 did not maintain a clean computer cart when she placed a contaminated glove on it that she had just used to touch the dialysis machine at station #19, where a patient was dialyzing. Interview with the facility Clinical Nurse Manager on 7/14/10 at 1230 revealed the computers and computer carts are considered clean areas. Interview revealed she was aware that staff did not follow appropriate standard precautions during direct patient care, but her job duties did not include personnel issues. Interview revealed "the Facility Administrator is responsible for the oversight of the staff".	V 117		
V 120	494.30(a)(1)(i) IC-TRANSDUCER PROTECTORS-NOT WETTED/CHANGED Use external venous and arterial pressure transducer filters/protectors for each patient treatment to prevent blood contamination of the dialysis machines' pressure monitors. If the external transducer protector becomes wet, replace immediately and inspect the protector. If fluid is visible on the side of the transducer protector that faces the machine, have qualified personnel open the machine after the treatment is completed and check for contamination. This includes inspection for possible blood contamination of the internal pressure tubing set and pressure sensing port. If contamination has occurred, the machine must be taken out of service and disinfected using either 1:100 dilution of bleach (300-600 mg/L free chlorine) or a commercially available, EPA-registered tuberculocidal germicide before reuse. Change filters/protectors between each patient treatment, and do not reuse them. Internal	V 120		

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V 120	Continued From page 5 transducer filters do not need to be changed routinely between patients. This STANDARD is not met as evidenced by: Based on facility policy review, observation and staff interview, the facility staff failed to change bloody transducer filters to prevent possible cross contamination of blood. The findings included: Review of facility policy 1-03-11, Changing The Transducer Protectors (revised Sept 2008), ..."The external transducer protector will be replaced..."Whenever blood or saline is observed in contact with the patient side of the transducer protector"... Observation on 7/13/10 revealed staff did not replace the bloodied transducer protectors on the patients who were dialyzing at stations #9 and #33 as required. Observation revealed the patient's transducer protectors at stations #9 and #33 were wet with blood at 0903, 0925 and 0957 (54 minutes). Interview with the facility Clinical Nurse Manager on 7/14/10 at 1230 revealed staff should have "changed out" the bloodied transducer protectors as soon as it becomes bloodied. Interview revealed she was aware that staff did not follow appropriate standard precautions during direct patient care, but her job duties did not include personnel issues. Interview revealed "the Facility Administrator is responsible for the oversight of the staff".	V 120	V 120 1. Policy # 1-03-11 Changing Transducer Protectors will be reviewed with all clinical teammates with emphasis on that the external transducer protectors are to be replaced whenever blood or saline is observed in contact with the patient side of the transducer protector. 2. All teammates will complete LMS MAN 2002 infection control mandatory training. 3. LMS training records will be audited for compliance and tracked to verify completion by all teammates. 4. Daily infection control audits which include transducer monitoring, were initiated on July 22 and will be performed daily x 2 weeks. When compliance is noted, frequency will become weekly x 4 weeks until compliance is noted, then monthly. 5. Infection control audit results will be reviewed at the CQI meeting and a plan implemented and adjusted as needed. 6. Clinical Mgr will review the job description, role and responsibilities with all hemo nurses and PCTS. 7. All nurses will be inserviced regarding expectations of monitoring staff compliance with infection control policies including the changing of transducers when needed. 8. The Clinical Mgr will monitor daily for team compliance with infection control policies and compliance with the plan of correction. 9. Infection control audit results will be reviewed by the Governing Body and a plan implemented and adjusted as needed 10. Disciplinary action will result in continued non-compliance with infection control policy and plan.	8/9/10
V 405	494.60(c)(2) PE-COMFORTABLE TEMPERATURE	V 405		

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V 405	Continued From page 6 The dialysis facility must: (i) Maintain a comfortable temperature within the facility; and (ii) Make reasonable accommodations for the patients who are not comfortable at this temperature. This STANDARD is not met as evidenced by: Based on observation, patient interview and staff interview, the facility failed to maintain a comfortable temperature in the treatment area during patient dialysis treatments. The findings included: Observation on 7/15/10 at 0930 revealed 7 of 7 patients dialyzing in the Pod that housed dialysis stations #21-43 were dialyzing and each patient was covered with a blanket. Observation on 7/15/10 at 0930 revealed 7 of 8 patients dialyzing in the Pod that housed dialysis stations #13-20 were dialyzing and each patient was covered with a blanket. Observation on 7/15/10 at 0930 revealed 7 of 8 patients dialyzing in the Pod that housed dialysis stations #1-12 were dialyzing and each patient was covered with a blanket. Observation on 7/15/10 at 0930 revealed 8 of 9 patients dialyzing on the back wall area of the treatment room that housed stations #25-33 were dialyzing and each patient was covered with a blanket. Interview on 7/15/10 at 0940 with patient #15 (one of the patients covered by a blanket during	V 405	V 405 1. Teammates will be informed of the temperature control process, expectation and results of non-compliance with comfortable temperature control. 2. Temperature will be set at 70 degrees on all thermostats. With covered lock boxes. The key will be maintained by the Charge Nurse. 3. Teammates will monitor patients for signs of being cold every shift. 4. Teammates will notify Charge Nurse when patients c/o of being cold. 5. Attempts will be made by the Charge Nurse to make reasonable accommodations for the patients who are not comfortable at this temperature. 6. The Clinical Mgr will monitor daily for team compliance with the plan of correction. FA is responsible for ongoing compliance with POC.	8/6/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 405	Continued From page 7	V 405		

dialysis treatment) revealed the facility is cold "all the time". Interview revealed patient #15 brings a blanket from home each treatment day to cover up with because the treatment room is kept too cold.

Interview on 7/15/10 at 0945 with patient #17 (one of the patients covered by a blanket during dialysis treatment) revealed she covered herself with a blanket because she was too cold. Interview revealed e patient treatment area had been so cold prior to covering herself with a blanket, that her "teeth were chattering".

Interview with the Facility Administrator on 7/15/10 at 1630 revealed there were several thermostats for the patient treatment area and each had been set at different temperatures (62-72 degrees). Interview revealed the facility had no system in place to ensure the patient treatment area was maintained at a comfortable temperature for patients during dialysis treatment.

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V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS	V 407		

Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).

This STANDARD is not met as evidenced by:
Based on facility policy review, observation, staff interview, and hemodialysis treatment sheet review, the facility staff failed to ensure patient access sites were visible to staff during hemodialysis treatments.

The findings included:

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

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V 407	Continued From page 8 Review of facility policy 3-01-07A, Patient Rights, Responsibilities and Facility Rules (revised December 2008), revealed patients are expected to keep their access sites visible at all times during hemodialysis treatment. Observation on 7/13/10 at 0903, 0925 and 0957 revealed staff was not able to see patient #11's AV fistula access at station #33 during dialysis treatment because it was covered by a blanket Observation on 7/13/10 at 0903 and 0925 revealed staff was not able to see patient #9's AV graft access at station # 12 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 0903 revealed staff was not able to see patient #10's AV fistula access at station #14 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 0903 revealed staff was not able to see patient #12's catheter access at station #37 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1130 revealed staff was not able to see patient #5's AV graft access at station #6 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1150 revealed staff was not able to see patient #6's AV fistula access at station #37 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1200 revealed staff was not able to see patient #7's AV graft access	V 407	V 407 1. Clinical Mgr will review the importance of keeping VA sites uncovered with each patient. 1. Policy # 1-04-01 AVF and AVG Vascular Access Care will be reviewed with all teammates, with emphasis placed on VA site monitoring. Acknowledgment of understanding the expectation and result of non-compliance was signed by all clinical teammates. 2. 3. Policy #1-01-09 Against Medical Advise (AMA) was reviewed with emphasis on use for documentation of patient refusal to keep VA sites uncovered during treatment. 4. Access sites will be monitored for visibility throughout dialysis treatment and documented. 5. Teammates will encourage patients to uncover access sites and document. The Charge Nurse will be notified of patient refusals. An AMA will be completed. 6. The Charge Nurse will monitor visibility of access sites every shift for compliance. 7. The Clinical Manager will monitor process daily for compliance with plan. FA is responsible for ongoing compliance with POC.	8/6/10

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

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

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V 407	Continued From page 9 at station #30 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1221 revealed staff was not able to see patient #8's catheter access at station #12 because during dialysis treatment it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #12's AV fistula access at station #5 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #13's catheter access at station #25 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #14's AV fistula access at station #26 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0930 revealed staff was not able to see patient #16's AV graft access 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	V 407		

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V 407	Continued From page 10 revealed no documented evidence of patient education or patients refusal, respectively.	V 407		
V 409	494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of-- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. This STANDARD is not met as evidenced by: Based on facility policy review, facility disaster plan review and staff interview, the facility failed to ensure staff was knowledgeable regarding staff/patient meeting area outside the dialysis building in the event of an emergency evacuation for 1 of 4 staff interviewed (#6). The findings included:	V 409	V409 1. Policy #4-07-01 Disaster, Fire and Business Continuity Emergency Preparedness Guidelines will be reviewed and all teammates will be in-serviced regarding building layout, location of exits and emergency evacuation site. 2. Evacuation location site will be posted at all exit doors. 3. Teammates will be quizzed to determine knowledge of designated emergency evacuation location site. 4. Emergency preparedness drills will be completed with teammates quarterly included emphasis on evacuation location site. 5. Completion of quarterly emergency training and completion of plan of correction will be reviewed at CQI meetings. The plan will be adjusted as needed. 6. Facility Administrator will monitor for compliance with plan.	8/13/10

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

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V 409	Continued From page 11 Review of facility policy, 4-07-01, Disaster, Fire and Business Continuity Emergency Preparedness Guidelines revised 9/09) revealed staff training included where to go if evacuating from the dialysis facility and off-site evacuation destination... Review of the facility's current disaster plan revealed the emergency evacuation off-site destination would be the parking lot of the dialysis facility. Interview on 7/15/10 at 1535 revealed staff did not know where staff/patients would meet outside in the event of an emergency evacuation of the building. Interview revealed she thought the meeting area was behind the building. Interview on 7/16/10 at 0945 with the Facility Administrator revealed the meeting area is in the parking lot located in the front of the building.	V 409		
V 412	494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section. This STANDARD is not met as evidenced by: Based on facility policy review, disaster preparedness plan review, patient interview and staff interview, the facility failed to ensure patients were knowledgeable regarding emergency preparedness procedures for 6 of 6 patients interviewed (#5, 22, 20, 21, 18, 17). The findings included: Review of facility policy, 4-07-01, Disaster, Fire	V 412		

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

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V 412	Continued From page 12 and Business Continuity Emergency Preparedness Guidelines revised 9/09) revealed staff training included where to go if evacuating from the dialysis facility and off-site evacuation destination... Review of the facility's current disaster plan revealed the emergency evacuation off-site destination would be the parking lot of the dialysis facility. Plan review also revealed short-term (disruption of operations less than 72 hours) and long-tern (disruption of operations of greater than 72 hours) disaster plans. Short-tern Disaster Guidelines... -Dialysis treatments will be provided as needed by a back-up facility -Patients will be contacted by person in charge -Designated evacuation location is the parking lot... Long-tern Disaster Guidelines... -Dialysis treatments will be provided as needed by a back-up facility -Patients will be contacted by person in charge -Designated evacuation location is the parking lot... Emergency shelter-local hospital... 1. Interview on 7/12/10 at 1212 with patient #5, who was admitted October, 2009, revealed he did not know where the outside evacuation location was 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. 2. Interview on 7/14/10 at 0920 with patient #22, who was admitted in 3/2008, revealed she did	V 412	V 412 1.Policy #4-07-01 Disaster, Fire and Business Continuity Emergency Preparedness Guidelines will be reviewed and all teammates will be inserviced regarding building layout, location of exits and emergency evacuation site. 1. All patients will be re-educated regarding the emergency evacuation and disaster planning, with emphasis placed on emergency evacuation location site and plan if facility is non-operational. 2. Emergency evacuation location site will be posted at all exit doors. 4. All new and visiting patients will receive emergency and disaster planning education during their admission process 5. Disaster planning pamphlets will be ordered from NW 6 and distributed to all pts. 6. A patient emergency and disaster planning quiz will be created and reviewed with all patients. 1. 7. Medical records will be audited monthly x 3 months for documentation of emergency and disaster planning education, including all current, new and visiting patients. Audits will be completed quarterly thereafter, if compliance is noted. 8. Guest Services contact number will be added to the facility answer machine message to assist patient in the event of a disaster or emergency. 9. Medical record audit results will be reviewed at CQI meeting monthly. A plan will be implemented as needed. 10. FA will monitor process for compliance with plan.	8/13/10

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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. 5. 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	V 412		

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V 412	Continued From page 14 that the network distributes that addresses how patients should prepare for disaster emergencies at home, and patients are educated quarterly regarding emergency evacuation. Interview on 7/16/10 at 1605 with the facility Administrative Assistant (individual responsible for conducting the facility fire drills) revealed she was not sure why patients would indicate a lack of evacuation location knowledge because the facility's evacuation location had to be changed recently due to a facility relocation (4/10). Interview revealed patients had been educated to this change with the exception of the transient patients. Interview also revealed if patients are admitted after the September disaster preparedness education, staff does not educate patients again until the next September meaning new patients may go as long as 12 months without disaster preparedness education.	V 412		
V 413	494.60(d)(3) PE-ER EQUIP ON PREMISES-02, AED, SUCTION Emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, must be on the premises at all times and immediately available. This STANDARD is not met as evidenced by: 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 use at all times. The findings included:	V 413		

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

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V 413	Continued From page 15 Review of the facility policy 01-02-08, Emergency Equipment Checks (revised 12/2008) revealed staff is required to conduct weekly checks on the emergency suction equipment to assure the suction is operational. Review of the weekly emergency equipment checklist log revealed weekly checks were conducted on the emergency suction equipment on 7/6, 7/7 and 7/13/10. Observation on 7/16/10 at 1445 of the emergency equipment cart revealed when the suction machine was turned on, there was no suction. Observation revealed the suction canister top of the suction machine had a long crack in it. Interview on 7/16/10 at 1451 with staff #7, the Registered Nurse who signed the Emergency Equipment Checklist on 7/6 and 7/13/10, revealed she does not check the emergency suction equipment suction ability when she performs the emergency equipment check, just that the "suction machine turns on". Interview on 7/16/10 at 1445 with the Clinical Nurse Manager revealed staff is required during the weekly emergency equipment checks that the suction machine has an adequate amount of suction.	V 413	V 413 1. Policy: 1-02-08 Emergency Equipment Checks will be reviewed with all nurses, with emphasis on proper checking of suction machine to verify suction ability. 2. The suction machine will be checked weekly for verification that an adequate amount of suction is available and documented. 3. The damaged canister top of the suction machine was replaced and extra suction canister tops placed on the crash cart. 1. 4. Emergency equipment checks will be monitored by the Clinical Manager monthly.	8/13/10
V 587	494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and	V 587		

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

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V 587	Continued From page 16 (3) Maintain this information in the patient ' s medical record. This STANDARD is not met as evidenced by: Based on facility policy review, staff interview, and medical record review, the facility failed to retrieve, review and incorporate in the patient's medical record self monitoring records for 1 of 2 (#23) peritoneal dialysis (PD) patients reviewed. The findings included: Review of facility policy 5-09-01, Maintenance and Retention of Patient Medical Records (revised 9/08), revealed the medical record includes treatment flow sheets. Interview on 7/16/10 at 1200 with the PD nurse revealed patients are required to bring their home dialysis flow sheets to facility each monthly clinic visit. Interview revealed the dialysis flow sheets are reviewed by the nurse making sure the patient has followed physician orders related to their dialysis treatment. Interview revealed dialysis flow sheets should be incorporated into the patient's medical record. 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's medical record did not contain home treatment flow sheets from 3/1/10 /10-4/15/10 (first date of in-center hemodialysis).	V 587	V 587 1. Policy #5-01-22 Routine Support Service will be reviewed with the PD nurse, with emphasis placed on the requirement for monthly treatment sheet review by the PD nurse. 2. Letters will be given to all patients stating the importance of bringing treatment sheets into the PD nurse for review and documented. 3. Patients will be given a calendar every month reminding them of the date to bring treatment sheets with them to PD clinic. 4. Reminders will be posted on the chart for the RN to ask the patient for the treatment sheets during clinic days. 5. PD nurse will educate the patient of the importance of treatment sheet review when patients do not bring the sheets as requested and document the patient education in the medical record. 6. Chart audits will be completed on all home patients' medical records for current treatment sheets and documented review of the treatment sheet by the PD RN. 7. 7. The PD nurse will request patients to bring in any missing treatment sheets and document. 8. Medical record PD treatment sheet audit results will be reviewed at the CQI meetings and adjustments to the plan made as needed. 9. On-going refusal to bring treatment sheets for review will become part of the patient's IDT plan of care. 10. The home program manager (HPM) will monitor the process monthly for compliance with the plan.	8/13/10

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

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V 587	Continued From page 17 Interview on 7/16/10 at 1200 with the PD nurse revealed no explanation as to why this patient's home treatment flow sheets were not in the patients medical record.	V 587		
V 589	494.100(c)(1)(i) H-MONITOR HOME ADAPT;HOME VISIT=POC Services include, but are not limited to, the following: (i) Periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel in accordance with the patient's plan of care. This STANDARD is not met as evidenced by: Based on facility policy review, staff interview and medical record review, the facility staff failed to monitor patients home adaptation for 1 of 2 (#23) peritoneal dialysis (PD) patients reviewed. The findings included: Review of facility policy 5-01-23, Peritoneal Dialysis Home Environment Adaptation (revised 9/08), revealed in addition to the initial home assessment visit ..."Additional home visits may be performed as needed to assess the patient's home adaptation". Interview 7/16/10 at 1200 with the PD nurse revealed home visits are conducted on the first patients home treatment after training, annually thereafter and as needed. Interview revealed peritonitis of a PD patient would warrant a home visit to ensure the home environment was conducive for home dialysis.	V 589	V589 1. The Best Demonstrated Practice for home visits, Policy #5-01-23 Peritoneal Dialysis Home Environment Adaptation and Policy #5-01-22 Routine Support Service will be reviewed with all Home RNs by the HPM, with emphasis on the required frequency and criteria for routine home visits, home visits related to peritonitis, change in home environment or when the patient is unable to come in to clinic due to health status. 2. All home patient charts will be reviewed for documented home visits and to determine the need for a home visit. Monthly audits will be performed x3 months, then quarterly if compliance is noted. 3. The home visit chart review results will be reviewed at the CQI meetings monthly and adjustments made to the plan as needed. 4. Patients found meeting the criteria for home visits will be deemed unstable and assessed by the IDT for plan of care, including peritonitis. 5. HPM will monitor the process for compliance with the plan of correction monthly.	8/13/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 589	Continued From page 18	V 589		

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 antibiotics.

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 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

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

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V 589	Continued From page 19 cycler."... Interview on 7/16/10 at 1200 with the PD nurse revealed during the 4/6/10 home visit, patient #23 was given a list of things that needed to be improved in the home. Interview revealed a subsequent home visit was conducted on 4/14/10 and the home conditions had not improved. Review of the medical record revealed the interdisciplinary team determined the patient was not a PD candidate and was discharged from PD on 4/22/10 and admitted tot he facility for hemodialysis.	V 589		
V 626	494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS. This STANDARD is not met as evidenced by: Based on facility policy review, quality improvement Continuous Quality Improvement Program (CQI) documentation review, and staff interview, the facility CQI Committee failed to	V 626		

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V 626	Continued From page 20 identify goals for total infections, adequacy (KT/V), iron saturation (Tsats), hospitalizations and albumin indicators 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. The findings included: Review of facility policies 1-02-01 (hemodialysis) and 5-02-13 (peritoneal dialysis), 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. Policy review revealed mineral metabolism/Renal bone disease (PTH), vascular access, infections, and nutrition (albumin) were indicators that were to be monitored. 1. Review of the CQI documentation from 4/10-6/10 revealed the total number of infections for hemodialysis patients had increased from 1.4% to 4.2% since March 2010. Review of the CQI documentation revealed no infection rate goal had been identified to determine if an action plan was needed. Review of the CQI documentation revealed the goal area for infection rate was left blank. 2. Review of the CQI documentation from 4/10-6/10 revealed hemodialysis patient adequacy >1.2 had decreased from 97% in March to 94.1% in April. Review of the CQI documentation from 4/10-6/10 revealed the area KT/V >1.2 did not have a goal set to determine if	V 626	V 626 1. The Clinical Services Specialist (CSS) and/ or Regional Operations Director (ROD) will attend CQI meetings to insure appropriate review and planning process. 2. CQI meetings will be held monthly with attendance by all QI team members. QI members unable to attend in person, will attend by phone. Documentation of attendance by phone will be noted on the QIFMM signature page. The QI member will sign the form on return to the facility or by fax to document attendance. FA will follow-up to verify all signatures are in place on QIFMM signature page. 3. CQI meeting calendar appointment will be sent to all QI members prior to meeting date to allow adequate scheduling of members to attend. 4. QI team members will take the QIFMM process and documentation training course in LMS, CEC2064 Governing Body, Plan of Care, Quality Improvement and Facility Management Meeting (QIFMM) Review Course, prior to the next meeting. 5. FA will monitor course completion dates of all QI members to assure compliance 6. CM will attend the CQI meeting monthly and present clinical issues and outcomes results to the QI team. 7. A plan of correction will be discussed and implemented by the QI team for appropriate review and documentation of the CQI meeting and documented in the QIFMM form at the next CQI meeting. 8. The CQI meeting documentation, QIFMM form, will include a review of all clinical outcomes results, including but not limited to adequacy, bone mineral management ,anemia, vascular access, established outcome goals, root cause if not meeting goal, action plans, priority, responsible party and follow-up of effectiveness of plans. cont. pg 22	8/13/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

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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 hospitalizations/hospitalization rate goal had been identified to determine if an action plan was needed.	V 626	V626 cont. 9. The CSS will monitor the CQI meeting, QIFMM documentation monthly x 6 months or until compliance is noted. CSS recommendations for process or documentation changes will be presented by the CSS at the following CQI meeting.	8/13/10
	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 4/10-6/10 revealed the albumin of >/= 4.0 for			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 this concern should not be an issue for future meetings given a new facility PD nurse started on 7/1/10.	V 626		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS 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		

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

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V 628	Continued From page 23 This STANDARD is not met as evidenced by: Based on facility policy review, Continuous Quality Improvement Program (CQI) documentation review, adverse occurrence report documentation review, staff interview, and staffing documentation review, the CQI Committee failed to include accurate information regarding AOR occurrences and staff complaints in CQI. The findings included: Review of facility policies 1-02-01 (hemodialysis) and 5-02-13 (peritoneal dialysis), 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. 1. Review of the 6/15/10 CQI meeting minute documentation revealed the "adverse occurrence reporting" (AOR) did not contain accurate information. CQI documentation review revealed the following AORs/month: 1/10=10 AORs; 2/10= 0 AORs; 3/10=17 AORs; 4/10=8 AORs; 5/10=0 AORs. Review of the "Alleged Incidents/AOR Tracking" documentation revealed a difference in the number of adverse occurrences reported. AOR tracking log revealed the following number of AOR reports: 1/10=9; 2/10=7;	V 628	V 628 1. The FA will review the importance and expectation of accurate AOR numbers reported for CQI meeting review and corporate reporting with all nursing and administrative teammates. 2. The nurse will enter AORs as necessary into Snappy as they occur. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. 3. The administrative team will review the AOR numbers for completion and accuracy prior to submission to the QI team and corporate reporting. 4. The QI team will review the AOR numbers for trends, during CQI meeting monthly, determine root cause, implement action plans with responsible party and timelines, evaluate effectiveness of the plans and adjust the plan accordingly as needed. 5. The Governing Body will approve the implementation of facility staffing patterns to maintain and ensure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 7. The FA will ensure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 8. All teammate complaints will be documented by the FA and reported to the QI team monthly at the CQI meetings. A plan of action will be implemented and adjusted as needed. FA is responsible for ongoing compliance with POC.	8/13/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 628	Continued From page 24 3/10=15; 4/10=8; 5/10=12. Interview with the Facility Administrator on 7/16/10 at 0945 revealed no explanation could be provided for why the CQI meeting minutes did not reflect accurate AOR numbers. 2. Interview with 3 staff members who requested anonymity during 7/13-16/10 revealed they had complained verbally to the Facility Administrator regarding the workload being too much with the amount of staff available on particular days. Interview with the Facility Administrator on 7/14/10 at 1125 revealed patient care technicians (PCTs) are scheduled with a 5:1 patient/tech ratio, and the nurses are scheduled with a 13:1 patient to staff ratio if all the scheduled staff work. Interview revealed because a licensed staff had been given vacation for 6 consecutive weeks and a PCT had been on medical leave for "a few months" they had tried to pull together staff from other facilities to help, but this was not always possible. Review of the staffing schedule, assignment sheets and time cards revealed days that PCTs had a 6:1 and nursing staff had 18:1. Review of the "Chronic Direct Patient Care Hrs/Tx"(treatment) from 1/10-5/10 revealed the facility direct patient care staff was under the facility budget (1.80) for 1/10 (1.66), 2/10 (1.71), 3/10 (1.75), and 4/10 (1.78). Review of the 5/10 and 6/10 CQI documentation revealed these complaints were not reflected in	V 628		

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

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V 628	Continued From page 25 the CQI meeting minutes.	V 628		
V 629	494.110(a)(2)(i) QAPI-INDICATOR-ADEQUACY OF DIALYSIS The program must include, but not be limited to, the following: (i) Adequacy of dialysis. 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 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. 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. Review of the 6/15/10 CQI documentation revealed a goal of 3% of hemodialysis patients would have a KT/V of <1.2. Review of the 6/15/10 CQI documentation revealed the 3% goal was not met. CQI documentation review 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	V 629	V629 1. The FA will review the importance and expectation of accurate AOR numbers reported for CQI meeting review and corporate reporting with all nursing and administrative teammates. 2. The nurse will enter AORs as necessary into Snappy as they occur. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. 3. The administrative team will review the AOR numbers for completion and accuracy prior to submission to the QI team and corporate reporting. 4. The QI team will review the AOR numbers for trends, during CQI meeting monthly, determine root cause, implement action plans with responsible party and timelines, evaluate effectiveness of the plans and adjust the plan accordingly as needed. 5. The Governing Body will approve the implementation of facility staffing patterns to maintain and ensure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 7. The FA will ensure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 8. All teammate complaints will be documented by the FA and reported to the QI team monthly at the CQI meetings. A plan of action will be implemented and adjusted as needed. FA is responsible for ongoing compliance with POC.	8/13/10

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

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

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V 629	Continued From page 26 documentation revealed the CQI committee had not determined a root cause for the under performance of the adequacy indicator, or developed/implemented an action plan to try to achieve adequacy goal. 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.	V 629		
V 631	494.110(a)(2)(iii) QAPI-INDICATOR-CKD-MBD The program must include, but not be limited to, the following: (iii) Mineral metabolism and renal bone disease. This STANDARD is not met as evidenced by: Based on facility policy review, quality improvement Continuous Quality Improvement Program (CQI) documentation review, and staff interview, the facility CQI program failed to have a set parathyroid hormone (PTH) goal for peritoneal dialysis (PD) such that under performance could be identified and action plans implemented if needed, and the CQI Committee failed to evaluate the performance of the hemodialysis PTH action plan. 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 631	V631 1. The FA will review the importance and expectation of accurate AOR numbers reported for CQI meeting review and corporate reporting with all nursing and administrative teammates. 2. The nurse will enter AORs as necessary into Snappy as they occur. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. 3. The administrative team will review the AOR numbers for completion and accuracy prior to submission to the QI team and corporate reporting. 4. The QI team will review the AOR numbers for trends, during CQI meeting monthly, determine root cause, implement action plans with responsible party and timelines, evaluate effectiveness of the plans and adjust the plan accordingly as needed. 5. The Governing Body will approve the implementation of facility staffing patterns to maintain and ensure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 7. The FA will ensure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 8. All teammate complaints will be documented by the FA and reported to the QI team monthly at the CQI meetings. A plan of action will be implemented and adjusted as needed. FA is responsible for ongoing compliance with POC.	8/13/10

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

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V 631	Continued From page 27 Review of the 6/15/10 CQI meeting minutes revealed 80% of hemodialysis patients should have a calcium of <9.5. CQI documentation review revealed the calcium goal had not been met for 5/10. Review revealed that only 78.7% of the patients had a calcium of <9.5. CQI documentation revealed no documented evidence that the CQI committee analyzed this under performance to determine if an action plan was needed. 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.	V 631	V632 1. The FA will review the importance and expectation of accurate AOR numbers reported for CQI meeting review and corporate reporting with all nursing and administrative teammates. 2. The nurse will enter AORs as necessary into Snappy as they occur. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. 3. The administrative team will review the AOR numbers for completion and accuracy prior to submission to the QI team and corporate reporting. 4. The QI team will review the AOR numbers for trends, during CQI meeting monthly, determine root cause, implement action plans with responsible party and timelines, evaluate effectiveness of the plans and adjust the plan accordingly as needed. 5. The Governing Body will approve the implementation of facility staffing patterns to maintain and ensure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 7. The FA will ensure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 8. All teammate complaints will be documented by the FA and reported to the QI team monthly at the CQI meetings. A plan of action will be implemented and adjusted as needed. FA is responsible for ongoing compliance with POC.	8/13/10
V 632	494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management. This STANDARD is not met as evidenced by: Based on facility policy review, quality improvement Continuous Quality Improvement Program (CQI) documentation review, and staff interview, the facility CQI Committee failed to failed to determine the root cause for not meeting hemoglobin goal and failed to evaluate the action plan for performance improvement. 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	V 632		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 632	Continued From page 28 plans implemented and tracked for performance improvement and sustainment. Review of the 6/15/10 CQI meeting minutes revealed 65% of hemodialysis patients should have a hemoglobin 10-12. CQI documentation review revealed the hemoglobin goal had not been met from 3/10-5/10. Review revealed the following hemoglobin results: 3/10=59.2% 4/10=54.5% 5/10=56% CQI documentation revealed no documented evidence that the CQI committee analyzed this area to determine the root cause for its under performance. Review of the CQI documentation for 5/19/10 and 6/15/10 revealed a hemoglobin action plan was needed. Review of the hemoglobin action plan for 5/19/10 and 6/15/10 indicated to "Continue using _____ (company name) protocol and reassess next month". CQI documentation revealed the 6/10 action plan was the same as 5/10 with little improvement. CQI documentation review revealed no documented evidence that the CQI committee evaluated the hemoglobin action plan for performance improvement. Review revealed the area "Evaluation of Plan of Correction from Last Meeting" was left blank. 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.	V 632		
V 633	494.110(a)(2)(v) QAPI-INDICATOR-VASCULAR	V 633		

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V 633	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. Review of the 6/19/10 QCI documentation revealed a catheter goal of 18% for hemodialysis patients. Documentation review revealed the facility had not met this goal since 1/10. Documentation revealed the following catheter percentages: 1/10=27.5% 2/10=24.3% 3/10=25.4% 4/10=34.3% 5/10=21.8% CQI documentation revealed no documented evidence that the CQI committee analyzed this	V 633	V633 1. The FA will review the importance and expectation of accurate AOR numbers reported for CQI meeting review and corporate reporting with all nursing and administrative teammates. 2. The nurse will enter AORs as necessary into Snappy as they occur. 3. The administrative team will print the AOR tracking report from Snappy for reporting AOR data to the QI team monthly. 3. The administrative team will review the AOR numbers for completion and accuracy prior to submission to the QI team and corporate reporting. 4. The QI team will review the AOR numbers for trends, during CQI meeting monthly, determine root cause, implement action plans with responsible party and timelines, evaluate effectiveness of the plans and adjust the plan accordingly as needed. 5. The Governing Body will approve the implementation of facility staffing patterns to maintain and ensure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 6. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 7. The FA will ensure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 8. All teammate complaints will be documented by the FA and reported to the QI team monthly at the CQI meetings. A plan of action will be implemented and adjusted as needed, FA is responsible for ongoing compliance with POC.	8/13/10

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V 633	Continued From page 30 indicator to determine the root cause for its under performance. 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.	V 633		
V 710	494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR This CONDITION is not met as evidenced by: Based on facility policy review, continuous quality improvement documentation review, observation, staff interview and patient interview, the Medical Director did not provide oversight regarding patient safety , Continuous Quality Improvement Program and the dialysis process in that: A) Patient access sites were not visible to staff during hemodialysis treatments; ~Cross refer to 494.60 (c)(4) Physical Environment Tag 407 B) Staff was not knowledgeable regarding staff/patient meeting area outside the dialysis building in the event of an emergency evacuation; ~Cross refer to 494.60 (d)(1) Physical Environment Tag V409 C) Patients were not knowledgeable regarding emergency preparedness procedures;	V 710	**V 710** **Medical Director responsibilities** The Governing Body (GB) has assigned a single Medical Director (MD) who will be accountable to the GB for the delivery of care and outcomes in this facility. 1. The Medical Director (MD) roles and responsibilities have been reviewed with the MD. 2. The Medical Director will attend monthly CQI meetings as part of the QI team to review all facilities issues and clinical outcomes, including, but not limited to AORs, vascular access concerns and needs, patient care staffing ratios, staffing education, competence, issues, complaints and needs, patient education, emergency preparedness, safety concerns and quality of care. 3. The Medical Director will monitor the QI process to assure appropriate and complete process of review, trending, documentation and follow -up of facility issues and outcomes results with documented review, goals, root cause if not meeting goal, action plans, priority, responsible party and follow-up of effectiveness of plans. MD and Governing Body are responsible for ongoing compliance with POC.	8/6/10

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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	V 710		

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V 710	Continued From page 32 V629 H) CQI program did not have a set parathyroid hormone (PTH) goal for peritoneal dialysis (PD) such that under performance could be identified and action plans implemented if needed, and did not evaluate the performance of the hemodialysis PTH action plan. ~Cross refer to 494.110 (a)(2)(iii) Quality Assessment and Performance Improvement Tag V631 I)CQI did not determine the root causes for not meeting hemoglobin goal and did not evaluate the action plan for performance improvement. ~Cross refer to 494.110 (a)(2)(iv) Quality Assessment and Performance Improvement Tag V632 J) CQI did not determine roots cause for high central venous catheter rate (CVC) for hemodialysis patients ~Cross refer to 494.110 (a)(2)(v) Quality Assessment and Performance Improvement Tag V633 K) Adequate numbers of direct care staff was not available during patient dialysis treatments; ~Cross refer to 494.180 (b) Governance Tag 757 L) Staff did not conduct assessments for	V 710		

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V 710	Continued From page 33 patients that experienced complications during treatment, perform diabetic foot checks as required; monitor the dialysis process (blood flow rates (BFR), dialysate flow rate (DFR), monitoring intervals during treatment, dry weight calculations, covered access sites), ensure assist patients as needed to the bathroom, obtain and document patient data post dialysis treatment; --Cross refer to 494.180 (b) Governance Tag 758	V 710		
V 711	494.150 MD RESP-MED DIR QUAL/ACCOUNTABLE TO GOV BODY The dialysis facility must have a medical director who meets the qualifications of §494.140(a) to be responsible for the delivery of patient care and outcomes in the facility. The medical director is accountable to the governing body for the quality of medical care provided to patients. This STANDARD is not met as evidenced by: Based on continuous quality improvement (CQI) meeting minutes review, staff interview and physician interview, the facility failed to have a single physician Medical Director responsible for the delivery of care and outcomes in the facility. The findings included: Review of the CQI meeting minutes for 4/10, 5/10 and 6/10 revealed each meeting was attended by 3 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 "shared" the medical director	V 711	V 711 The Governing Body (GB) has assigned a single Medical Director (MD) who will be accountable to the GB for the delivery of care and outcomes in this facility. 1. The Medical Director roles and responsibilities have been reviewed with the MD, and the FA. 2. All Medical Director items will be directed appropriately to the Medical Director. 3. The ROD on behalf of the GB will monitor the process for compliance to ensure appropriate facility reviews by Med Dir per the MD roles and responsibilities.	8/6/10

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

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V 711	Continued From page 34 position. Interview revealed these 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 711		
V 712	494.150(a) MD RESP-QAPI PROGRAM Medical director responsibilities include, but are not limited to, the following: (a) Quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on facility policy review, continuous quality improvement (CQI) documentation review, staff interview and physician interview, the Medical Director failed to ensure oversight of the CQI program such that indicator goals were identified, root cause analyses were conducted, action plans were developed and evaluated as needed, and accurate indicator data was tracked/trended. The findings included: Review of facility policy 5-02-13 (peritoneal dialysis) and 1-02-01 (hemodialysis) 9/08 revealed "The Facility medical Director is responsible for ensuring the execution of the Quality Improvement Program, including implementation, continuing monitoring, development of action plans and program evaluation"...	V 712	V 711 The Governing Body (GB) has assigned a single Medical Director (MD) who will be accountable to the GB for the delivery of care and outcomes in this facility. 1. The Medical Director roles and responsibilities have been reviewed with the MD, and the FA. 2. All Medical Director items will be directed appropriately to the Medical Director. 3. The ROD on behalf of the GB will monitor the process for compliance to ensure appropriate facility reviews by Med Dir per the MD roles and responsibilities.	8/6/10

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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 712		
V 713	494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance.	V 713		

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V 713	Continued From page 36 This STANDARD is not met as evidenced by: Based on facility policy review and staff interview, the medical director failed to ensure staff was knowledgeable regarding staff/patient meeting area outside the dialysis building in the event of an emergency evacuation for 1 of 4 staff interviewed (#XX). The findings included: Review of facility policy, 4-07-01, Disaster, Fire and Business Continuity Emergency Preparedness Guidelines revised 9/09) revealed staff training included where to go if evacuating from the dialysis facility and off-site evacuation destination... Review of the facility's current disaster plan revealed the emergency evacuation off-site destination would be the parking lot of the dialysis facility. Interview on 7/15/10 at 1535 revealed staff #5 did not know where staff/patients would meet outside in the event of an emergency evacuation of the building. Interview revealed she thought the meeting area was behind the building. Interview on 7/16/10 at 0945 with the Facility Administrator revealed the meeting area is in the parking lot located in the front of the building.	V 713	V713 1.Policy #4-07-01 Disaster, Fire and Business Continuity Emergency Preparedness Guidelines will be reviewed and all teammates will be inserviced regarding building layout, location of exits and emergency evacuation site. 1. All patients will be re-educated regarding the emergency evacuation and disaster planning, with emphasis placed on emergency evacuation location site and plan if facility is non-operational. 2. Emergency evacuation location site will be posted at all exit doors. 4. All new and visiting patients will receive emergency and disaster planning education on their first visit. 5. Disaster planning pamphlets will be ordered from NW 6 and distributed to all pts. 6. A patient emergency and disaster planning quiz will be created and reviewed with all patients. 1. 7. Medical records will be audited monthly x 3 months for documentation of emergency and disaster planning education, including all current, new and visiting patients. Audits will be completed quarterly thereafter, if compliance is noted. 8. Guest Services contact number will be added to the facility answer machine message to assist patient in the event of a disaster or emergency. 9. Medical record audit results will be reviewed at CQI meeting monthly. A plan will be implemented as needed. 10. FA will monitor process for compliance with plan.	8/6/10
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all	V 726		

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V 726	Continued From page 37 other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on facility policy review, patient treatment sheet/medical record review and staff interview, the facility failed to ensure the hemodialysis treatment sheets included accurate times that patients were monitored by staff and accurate times of medication administration. The findings included: 1. Review of facility policy 1-03-09, Intradialytic Treatment Monitoring, (9/08) revealed treatment checks should be completed and documented every 30 minutes that included the following: -blood pressure -heart rate -blood flow rate -dialysate flow rate -arterial and venous pressures -fluid removal and/or replacement -vascular access status and line connections -patient status and subjective well-being Review of the patient treatment sheets on 6/22/10 revealed 33 patient dialyzed on 1st shift and 29 patients dialyzed on 2nd shift. Review of the 6/22/10 staffing sheet revealed 5 patient care technicians (PCTs) and 2 nurses provided care on 1st and 2nd shift. Review of the patient treatment sheets on 7/5/10 revealed 36 patient dialyzed on 1st shift and 38 patients dialyzed on 2nd shift. Review of the 7/5/10 staffing sheet revealed 7 PCTs and 3 nurses provided care on 1st and 2nd shift.	V 726	V726 1. The FA will insure adequate staffing/patient ratios to maintain safe dialysis treatments by implementing the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. Adequate staffing plan has been implemented 2. The FA will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 3. The ROD will monitor the process to ensure compliance with the plan of correction for adequate staffing and Clinical Nurse Manager availability. 4. Post-treatment assessments will be completed on all patients by a RN. 5. Clinical Teammates will be in-serviced on Policy #1-03-09 Intradialytic Treatment Monitoring, Policy #1-03-12 Post Treatment Patient Assessment and Policy #1-06-01 Medication Policy with emphasis placed on the requirement for and expectation of documentation of vital signs and machine treatment monitoring, medication documentation and post treatment assessments etc. 6. Policy #1-01-09 Against Medical Advised (AMA) was reviewed with emphasis on documentation of patient refusal for BP checks and patient refusal of keeping their VA site visible for monitoring during treatment. 7. 100% of Treatment sheets will be audited daily for compliance with documentation of out of range BP with assessment of patient by RN; Reason for PRN medication administration and follow-up of effectiveness. 25% of treatment sheets will be audited weekly once compliance is noted for a period determined by the Governing Body. (GB) The GB will continue to provide oversight and make on-going recommendations concerning audit frequency as needed. 8. Treatment sheet audit results will be reviewed with the QI team at the CQI meetings monthly and a plan implemented as needed. cont. pg 39	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 726	Continued From page 38 Review of the patient hemodialysis treatment sheets for 6/22/10 and 7/5/10 revealed the treatment sheet reflected inaccurate vital sign/monitoring entry times for each patient. Treatment sheet review revealed each patient's vital signs were documented as being obtained by the staff every 30 minutes on the 30 minute. Treatment sheet review revealed the appearance that 1 staff member took as many as 6-7 patients vital signs simultaneously. Interview on 7/15/10 at 1245 with the facility Nurse Manager revealed the hemodialysis treatment sheet did not reflect accurate times of when the patient was evaluated/monitored by staff. Interview revealed most staff documented the time the dialysis machine automatically took the patient's vital signs and not the actual time they conducted the evaluation. Interview revealed the dialysis medical record/treatment sheet was not accurate regarding determination of actual monitoring intervals, respectively. 2. Review of the patient treatment sheets on 6/22/10 revealed 33 patient dialyzed on 1st shift and 29 patients dialyzed on 2nd shift. Review of the patient treatment sheets on 7/5/10 revealed 36 patient dialyzed on 1st shift and 38 patients dialyzed on 2nd shift. Review of the patient hemodialysis treatment sheets for 7/12/10 revealed patient dialysis treatment sheets reflected inaccurate times of medication administration. Treatment sheet review revealed as many as 16 different medications were administered to 7 different patients over a 3 minute time frame (0746-0749).	V 726	V726 cont. 9. Continued non-compliance with plan will result in disciplinary action 10. CNM will monitor the plan for compliance with staffing and documentation of medical records.	8/6/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

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V 726	Continued From page 39 Interview on 7/15/10 at 1415 with the licensed staff responsible for medication administration on 7/12/10 revealed the medication administration times on the 7/12/10 treatment sheets were not correct. Interview revealed medication administration can take approximately 6-15 minutes per patient dependent upon the type and number of medications. Interview revealed the times of medication administration on the patient treatment sheets are not always reflective of the actual administration times. Interview revealed being able to enter the time she gave the med was not always possible because the computer does not allow her to enter information if the PCT staff has not entered their required information upon initiation of the patient's treatment. So, she enters the time that she puts the information in the computer instead of when she actually administers the medications.	V 726		
V 750	494.180 CFC-GOVERNANCE This CONDITION is not met as evidenced by: Based on staff interview, staffing documentation review, staff assignment/time card review, facility policy review, dialysis treatment sheet review, and observation, the the governing body failed to provide oversight to ensure the treatment area was conducive for dialysis treatment, adequate staff was provided during patient treatment, ensure patients were safe and monitored during treatment and patient needs were met in that: A) The temperature of the patient treatment area was cold; ~Cross refer to 494.60 (c)(2) Physical Environment Tag V405	V 750	V 750 1. The survey results were reviewed with the Governing Body and a plan of correction implemented at the time of survey with on-going updates to the plan as needed, during the period of implementation. 2. The Governing Body will meet at least bi-weekly, and more often as needed, to monitor the progress with correction of the deficiencies cited during survey. 3. The FA will report all facility issues, staff and patient needs to the Governing Body in a timely manner, appropriately as needed. 4. The ROD will monitor the Governing Body involvement with the facility and the process for compliance with the plan of correction monthly.	7/16/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 750	Continued From page 40 B) Adequate staffing was not provided during patient care -Cross refer to 494.180 (b) Governance Tag V757 C) Staff was not available to conduct assessments for patients that experienced complications during treatment, perform diabetic foot checks, monitor the dialysis process, ensure patients were assisted to the bathroom, obtain and document patient data post dialysis treatment; -Cross refer to 494.180 (b) Governance Tag V758	V 750		
V 757	494.180(b)(1) GOV-STAFF # & RATIO MEET PT NEEDS The governing body or designated person responsible must ensure that- (1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; This STANDARD is not met as evidenced by: Based on staff interview, staffing documentation review, and staffing assignment/time card review, the governing body failed to have adequate numbers of direct care staff during patient dialysis treatments. The findings included:	V 757	V757 1. The Governing Body will approve the implementation of facility staffing patterns to maintain and insure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 2. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 3. The survey results were reviewed with the Governing Body and a plan of correction implemented at the time of survey with on-going updates to the plan as needed, during the period of implementation. 4. The Governing Body will meet at least weekly, and more often as needed, to monitor the progress with correction of the deficiencies cited during survey. 5. The FA will report all facility issues, staff and patient needs to the Governing Body in a timely manner, appropriately as needed. 6. The ROD will monitor the Governing Body involvement with the facility and the process for compliance with the plan of correction monthly. 7/16/10	7/16/10

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V 757	Continued From page 41 Interview on 7/13/10 at 1145 with the Facility Administrator revealed the facility is normally staffed with a 5:1 patient/staff ratio for PCTs and on Monday/Wednesday/Fridays, a 19:1 patient to RN ratio with a medication nurse and Tuesday/Thursday/Fridays a 16 ½:1 patient to RN ration with one medication nurse. Review of the " Chronic Direct Patient Care Hrs/Tx " documentation from 1/10-5/10 revealed the facility was budgeted for 1.80 hours of direct hands on care per patient treatment. Documentation review revealed the facility staffed under budget from 1/10-4/10. Documentation review revealed the following hours of direct patient care: 1/10-1.66 2/10-1.71 3/10-1.75 4/10-1.78 Interview on 7/14/10 at 1545 with the Facility Administrator revealed the direct hands on care numbers did not reflect accurate direct patient care numbers. Interview revealed the respective numbers also included the Clinical Manager because she was an hourly paid employee and she had administrative duties at times and not directly involved in direct patient care. Review of the 6/22/10 staff assignment/employee time card review revealed there was not adequate numbers of direct patient care staff on 6/22/10. Review of the 6/22/10 staff assignment revealed 2 PCTs " called out " and had not been not replaced. Review revealed there were 5 PCTs, 1 RN and one LPN (medication nurse). Review of 6/22/10 treatment	V 757		

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V 757	Continued From page 42 log revealed 33 patients dialyzed on 1st shift, and 29 patients dialyzed on 2nd shift. Review of the 6/22/10 staff assignment revealed the med nurse and the RN had been given a full PCT assignment as well as their nursing duties. Staff assignment review revealed the Clinical Manager had been given a full RN assignment plus she rounded with the physician each shift. Interview on 7/14/10 at 1155 with the Clinical Manager revealed on 6/22/10 she had been on the staff assignment sheet as one of the direct care nurses, but because she had to make rounds with the physician, she really couldn't take an assignment. Interview revealed she has " administrative duty " rounding with the physician. She stated rounding with the physicians is an " all day task, because they see every patient on each shift and afterwards I have to enter all the order changes " . Interview revealed she does try to help out as much as she can when there is not enough direct care staff, but it is extremely difficult. Interview on 7/14/10 at 1545 with the Facility Administrator revealed the facility recently had an increase in the number of treatment stations from 33 to 43 on 6/28/10. Interview revealed only 38 of the available 43 stations had been utilized for patient treatment. Interview revealed the direct care staff had not been increased to accommodate the increase in patient treatments. Review of the 7/5/10 (after the increase in treatment stations) staff assignment/employee time card review revealed there was not adequate numbers of direct patient care staff on 7/5/10. Review of the 7/5/10 staff assignment revealed 2 PCTs " called out " and had not	V 757		

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

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V 757	Continued From page 43 been not replaced. Review revealed there were 6 PCTs, 2 RNs and one LPN (medication nurse). Review of 7/5/10 treatment log revealed 36 patients dialyzed on 1st shift, and 38 patients dialyzed on 2nd shift. Review of the 7/5/10 staff assignment revealed the med nurse took a full PCT assignment and the 2 RNs split a PCT assignment as well as their nursing duties. Staff assignment review revealed the PCTs had 6.3 patients a piece and the RNs had 19 patients a piece and also were responsible for administering medications as well. Interviews from 7/13/10-7/16/10 with several direct care staff who wished to remain anonymous revealed the work load expectation was too much especially with the added treatment stations. Interview on 7/14/10 at 1155 with the Clinical Manager revealed she was not able to do her administrative duties because she was " on the floor " working as a nurse " all the time ". Interview on 7/14/10 at 1545 with the Facility Administrator revealed there was no pool of extra staff to call in the event of staff " call outs " for 6/22/10 and 7/5/10 because one nurse had been given 6 weeks of consecutive vacation time, and one PCT had been out for months on medical leave.	V 757		
V 758	494.180(b)(1) GOV-RN, MSW, & RD AVAIL TO MEET PT NEEDS 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;	V 758		

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

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V 758	Continued From page 44 This STANDARD is not met as evidenced by: Based on facility policy review, staff interview, dialysis treatment sheet review, and observation, facility staff failed to: 1) conduct assessments for patients that experienced complications during treatment; 2) perform diabetic foot checks as required; 3) monitor the dialysis process (blood flow rates (BFR), dialysate flow rate (DFR), monitoring intervals during treatment, dry weight calculations, covered access sites); 4) ensure patients were assisted to the bathroom as required; 5) obtain and document patient data post dialysis treatment for 34 of 43 patient treatment sheets reviewed and/or observed during dialysis treatment (#28, 4, 31, 32, 26, 39, 24, 37, 30, 19, 38, 43, 40, 9, 41, 42, 36, 34, 35, 33, 11, 9, 10, 12, 5, 6, 7, 8, 13, 14, 16, 25, 27, 29). The findings included: Review of facility policy 1-03-12, Post Treatment Patient Assessment, (9/07) revealed patient care staff obtain and document basic data on each patient post dialysis and compare to pre dialysis findings and any findings that may preclude the discharge of the patient will be reported to the licensed nurse. Review revealed if the patient's condition required intervention the licensed nurse assesses the patient, collects further data and notifies the physician as needed. Policy review revealed a post treatment assessment is conducted to ensure the patient is stable, to determine the patient's discharge status and to evaluate the effectiveness of the treatment plan.	V 758	V 758 1. The Governing Body will approve the implementation of facility staffing patterns to maintain and insure adequate staff to patient ratios, the Immediate Facility Clinical Staffing Plan and the Contingency Plan for Maintaining Safe treatments when short staffed. 2. The Governing Body will insure the Clinical Nurse Manager is available for continued oversight of the facility clinical team and patient needs. 3. The survey results were reviewed with the Governing Body and a plan of correction implemented at the time of survey with on-going updates to the plan as needed, during the period of implementation. 4. The Governing Body will meet at least bi-weekly, and more often as needed, to monitor the progress with correction of the deficiencies cited during survey. 5. Post treatment assessments will be completed on all patients by a RN. 6. Clinical Teammates will be in-serviced on Policy #1-03-09 Intradialytic Treatment Monitoring, Policy #1-03-12 Post Treatment Patient Assessment and Policy #1-06-01 Medication Policy with emphasis placed on the requirement for and expectation of documentation of vital signs and machine treatment monitoring, medication documentation, oxygen administration, and post treatment assessments etc. They will also be re-educated on calculating weight removal and the need to follow physician orders as written for BFR/DFR, foot checks, etc. cont pg 46	

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

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V 758	Continued From page 45 Review of facility policy 1-03-10, Pre/Post Treatment Data Collection, (9/07) revealed patient care staff obtain and document the following information: weight; temperature; blood pressure (BP); cardiac status; respiratory status; peripheral edema; vascular access; mental status; patient subjective statement; ambulatory status; recent hospitalization or outpatient visits. Policy review revealed findings that may preclude the initiation of treatment or discharge of the patient will be reported immediately to the licensed nurse such that an assessment may be conducted. Interview with the Clinical Manager on 7/14/10 at 0945 revealed staff is required to obtain a sitting and standing BP on all ambulatory patients pre and post treatment as part of their data collection/assessment. Review of facility policy 1-03-09, Intradialytic Treatment Monitoring, (9/08) revealed treatment checks should be completed and documented every 30 minutes that included the following: -blood pressure -heart rate -blood flow rate -dialysate flow rate -arterial and venous pressures -fluid removal and/or replacement -vascular access status and line connections -patient status and subjective well-being Review of facility policy 1-03-02, Prescription Verification and Safety Checks, (9/08) revealed blood flow and dialysate flow are included in the information to be checked and verified by staff prior to treatment initiation to ensure the patient receives a safe and effective treatment as	V 758	V758 cont. Policy # 1-04-01 AVF and AVG Vascular Access Care will be reviewed with all teammates, with emphasis placed on VA site monitoring. Acknowledgment of understanding the expectation and result of non-compliance was signed by all clinical teammates. Policy #1-01-09 Against Medical Advised (AMA) was reviewed with emphasis on documentation of patient refusal for BP checks and patient refusal of keeping their VA site visible for monitoring during treatment. 100% of Treatment sheets will be audited daily for compliance with documentation of appropriate dialysis treatment and nursing assessment of patient when complications arise that warrant such assessment. The audit will focus on documentation of post treatment assessment by RN; out of range BP with assessment of patient by RN; Vital sign checks Q 30 min in real time; compliance with physician orders; out of range post treatment weights assessed by RN; Reason for PRN medication administration and follow-up of effectiveness, other complications addressed by RN. 25% of treatment sheets will be audited weekly once compliance is noted for a period determined by the GB. The GB will continue to provide oversight and make on-going recommendations concerning audit frequency as needed. Treatment sheet audit results will be reviewed with the QI team at the CQI meetings monthly and a plan implemented as needed. All unsteady patients or patients designated a fall risk, will be assisted to the patient bathroom. Clinical Mgr will review the importance of keeping VA sites uncovered with each patient. Access sites will be monitored for visibility throughout dialysis treatment and documented. Teammates will encourage patients to uncover access sites and document. The 12 Charge Nurse will be notified of patient refusals. An AMA will be completed. cont pg 47	8/13/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 758	Continued From page 46 prescribed. Review of facility policy 3-01-07A, Patient Rights, Responsibilities and Facility Rules (revised December 2008), revealed patients are expected to keep their access sites visible at all times during hemodialysis treatment. 1. Review of the 7/12/10 dialysis treatment sheet for patient #28 revealed hemodialysis initiated at 1038 . Treatment sheet review revealed a pre-treatment assessment revealed the patient complained about being short of breath. Review of the treatment sheet revealed the patient had a pre-treatment BP of 121/67 but experienced hypotension throughout his treatment. Review revealed this patient had a post treatment BP of 95/30 without documented evidence that a nurse assessed this patient prior to leaving the facility ambulatory. Interview on 7/15/10 at 1545 with the Clinical Manager, revealed she had not been notified by the PCT staff that this patient had an hypotensive episode post treatment. Interview on 7/16/10 at with the PCT #8, the PCT responsible for patient #28 respectively, revealed 7/12/10 was "so busy with so much to do" that she mistakenly documented the patient was ambulatory. Interview revealed this patient is wheelchair bound, and the staff did not inform the nurse that the patient was hypotensive post treatment as required because "there was so much to do". 2. Review of the 7/12/10 dialysis treatment sheet for patient #4 revealed hemodialysis initiated at 1112 with a pre treatment standing BP	V 758	V758 cont. The Charge Nurse will monitor visibility of access sites every shift for compliance. Continued non-compliance with plan will result in disciplinary action , CNM will monitor the plan for compliance.	

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

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V 758	Continued From page 47 of 120/76 and a sitting BP of 118/79. Treatment sheet review revealed the patients treatment discontinued at 1450 with a hypotensive BP (sitting 86/65 and standing 77/36). Treatment sheet review revealed no documented evidence that a nurse assessed this patients hypotension prior to leaving the facility. 3. Review of the 6/22/10 dialysis treatment sheet for patient #31 revealed hemodialysis initiated at 0621 with a sitting BP of 178/91 and a standing BP of 125/68. Review of the treatment sheet revealed the patient experienced hypertension throughout dialysis treatment. Review revealed this patient had a post treatment sitting BP of 203/93 and a standing BP of 214/101 without documented evidence that a nurse assessed this patients hypertension prior to leaving the facility. 4. Review of the 6/22/10 dialysis treatment sheet for patient #32 revealed hemodialysis initiated at 0653 with a sitting BP of 188/104 and a standing BP of 174/98. Review of the treatment sheet revealed the patient experienced hypertension towards the end of treatment. Review revealed this patient had a post treatment sitting BP of 186/140 and a standing BP of 211/150 without documented evidence that a nurse assessed this patient prior to leaving the facility. 5. 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. Treatment sheet review revealed this patients treatment was completed at 0950. Review revealed staff obtained a sitting BP only which was 186/142. Treatment sheet review revealed no documented	V 758		

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

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V 758	Continued From page 48 evidence that the RN assessed this patient's BP needs. 6. Review of the 7/5/10 dialysis treatment sheet for patient #39 revealed hemodialysis initiated at 1225 with a sitting BP of 121/64 and a standing BP of 135/84. Review of the treatment sheet revealed the patient experienced hypertension towards the end of treatment. Review revealed this patient had a post treatment sitting BP of 202/118 and a standing BP of 198/104 without documented evidence that a nurse assessed this patient prior to leaving the facility. 7. Review of the dialysis treatment sheet for 7/5/10 for patient #24 revealed her dialysis treatment initiated at 1155. Treatment sheet review revealed at 1200 the patient indicated she needed oxygen. Review of the treatment sheet revealed no documented evidence that this patient received oxygen or that any licensed staff assessed this patient for any respiratory needs at any time after her request was made and prior to discharge from dialysis treatment. Interview on 7/15/10 at 1545 with the Clinical Manager revealed this occurred on a day when I was rounding with the physician and "we were short staffed. I think she was given O2 but I can't swear to it". 8. Review of the dialysis treatment sheet for 7/5/10 for patient #37 revealed her dialysis treatment initiated at 1217. Treatment sheet review revealed during the pre treatment assessment the patient requested oxygen for shortness of breath. Review of the treatment sheet revealed no documented evidence that this patient received oxygen or that any licensed staff	V 758		

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V 758	Continued From page 49 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 response to the PRN medications. Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff is required to document	V 758		

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V 758	Continued From page 50 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. 11. Review of the treatment sheet for patient #19 revealed a current physician's standing order for monthly foot checks since the patient was diabetic. Review of the dialysis treatment sheet dated on 7/5/10 revealed the patient had been scheduled to get his monthly foot check on 7/5/10. Treatment sheet documentation revealed staff did not conduct the monthly foot check. Treatment sheet review revealed staff documented "missed" as the reason the foot check had not been conducted. 12. Review of the treatment sheet for patient #38 revealed a current physician's standing order for monthly foot checks since the patient was diabetic. Review of the dialysis treatment sheet dated on 7/5/10 revealed the patient had been scheduled to get his monthly foot check on 7/5/10. Treatment sheet documentation revealed staff did not conduct the monthly foot check. Treatment sheet review revealed staff documented "rescheduled" as the reason the foot check had not been conducted. Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff the facility was "short staffed" on 7/5/10 and staff probably either missed or decided to do the foot checks at another time. 13. Review of the treatment sheet dated on 7/5/10 for patient #43 revealed a physician's	V 758		

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

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	342543	A. BUILDING ____ B. WING ____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

(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 758	Continued From page 51 order for a BFR of 4500 cc/minute and a DFR of 700 cc/minute. Treatment sheet review revealed this patient received a BFR of 350 cc/min and a DFR of 600 cc/minute from 1215-1450, her entire dialysis treatment. Record review revealed no documentation as why the BFR had not been provided as ordered. 14. Review of the treatment sheet dated on 6/22/10 for patient #40 revealed a physician's order for a DFR of 600 cc/minute. Treatment sheet review revealed this patient received a DFR of 500 cc/min from 0610-0948, his entire treatment, without documentation as why the DFR had not been provided as ordered. 15. Review of the treatment sheet dated on 6/22/10 for patient #9 revealed a physician's order for a DFR of 700 cc/minute. . Treatment sheet review revealed this patient received a DFR of 600 cc/min from 0635-1049, her entire treatment, without documentation as why the DFR had not been provided as ordered. 16. Review of the treatment sheet dated on 7/5/10 for patient #41 revealed a physician's order for a DFR of 800 cc/minute. Treatment sheet review revealed this patient received a DFR of 600 cc/min from 1140-1530, her entire treatment, without documentation as why the DFR had not been provided as ordered. 17. Review of the treatment sheet dated on 7/5/10 for patient #42 revealed a physician's order for a BFR of 400 cc/minute. Treatment sheet review revealed this patient received a BFR of 350 cc/min from 1231-1400 without documentation as why the BFR had not been provided as ordered.	V 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

(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 758	Continued From page 52 18. Review of the dialysis treatment sheet for 6/22/10 revealed orders for patient #31 to dialyze 240 minutes and to dialyze to a dry weight of 80kg. Treatment sheet review revealed the patient dialyzed the ordered amount of time (244 minutes) but did not get to 80 kg as ordered. Review revealed the patient had a DW of 82.7 kg at the conclusion of her treatment. Treatment sheet review revealed staff removed 2.5 kg of fluid. Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff incorrectly calculated the amount of fluid to be removed for this patient on 6/22/10. Interview revealed this patient should have had 5.6 kg of fluid removed instead of 2.5 kg. 19. Review of the 6/22/10 dialysis treatment sheet for patient #36 revealed this patients treatment initiated at 0630 and concluded at 1055. Treatment sheet review revealed documentation that staff did not monitor this patient every 30 minutes as required. Treatment sheet review revealed this patient went from 0640-0800 (1 hour and 20 minutes) without documented evidence of staff monitoring. 20. Review of the 7/5/10 dialysis treatment sheet for patient #34 revealed this patients treatment initiated at 0711 and concluded at 1044. Treatment sheet review revealed documentation that staff did not monitor this patient every 30 minutes as required. Treatment sheet review revealed this patient went from 0800-0930 (1-1/2 hours) without documented evidence of staff monitoring.	V 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

(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 758	Continued From page 53 21. Review of the 7/5/10 dialysis treatment sheet for patient #35 revealed this patients treatment initiated at 0625 and concluded at 1100. Treatment sheet review revealed documentation that staff did not monitor this patient every 30 minutes as required. Treatment sheet review revealed this patient went from 0623-0730 (1 hour and 5 minutes) without documented evidence of staff monitoring. 22. Review of the 6/22/10 dialysis treatment sheet for patient #33 revealed this patients treatment initiated at 0656 and concluded at 1122. Treatment sheet review revealed documentation that staff did not monitor this patient every 30 minutes as required. Treatment sheet review revealed this patient went from 1003-1103 (1 hour) without documented evidence of staff monitoring. 23. Observation on 7/13/10 at 0903, 0925 and 0957 revealed staff was not able to see patient #11's AV fistula access at station #33 during dialysis treatment because it was covered by a blanket	V 758		
	Observation on 7/13/10 at 0903 and 0925 revealed staff was not able to see patient #9's AV graft access at station # 12 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 0903 revealed staff was not able to see patient #10's AV fistula access at station #14 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 0903 revealed staff was not able to see patient #12's catheter access at station #37 during dialysis treatment because			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ____ B. WING ____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

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V 758	Continued From page 54 it was covered by a blanket. Observation on 7/13/10 at 1130 revealed staff was not able to see patient #5's AV graft access at station #6 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1150 revealed staff was not able to see patient #6's AV fistula access at station #37 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1200 revealed staff was not able to see patient #7's AV graft access at station #30 during dialysis treatment because it was covered by a blanket. Observation on 7/13/10 at 1221 revealed staff was not able to see patient #8's catheter access at station #12 because during dialysis treatment it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #12's AV fistula access at station #5 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #13's catheter access at station #25 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0900 revealed staff was not able to see patient #14's AV fistula access at station #26 during dialysis treatment because it was covered by a blanket. Observation on 7/15/10 at 0930 revealed staff was not able to see patient #16's AV graft access	V 758		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ____ B. WING ____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

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V 758	Continued From page 55 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 bay at the time patient #19 needed assistance to	V 758		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ______ B. WING ______	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

(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 758	Continued From page 56 the bathroom, she didn't assist him because it would have left her bay unattended. 25. Review of the dialysis treatment sheet for 6/22/10 for patient #25 revealed her dialysis treatment initiated at 1230. Review of the pre-treatment nursing assessment revealed the patient ambulated with a walker and indicated that she had a "near miss fall yesterday at home due to weakness in knees". Treatment sheet review revealed this patient's sitting BP post treatment was 147/62. Treatment sheet review revealed the patient left the facility ambulatory, but did not have a standing BP obtained post treatment as required. Interview on 7/15/10 at 1545 with the Clinical Manager revealed staff is required to obtain and document a standing BP on ambulatory patients post dialysis treatment. Interview revealed 6/22/10 was a day the facility had "call out by staff". 26. Review of the dialysis treatment sheet for 6/22/10 for patient #27 revealed his dialysis treatment initiated at 0633. Pre-treatment assessment revealed the patient ambulated to the treatment floor and had no complaints. Treatment sheet review revealed this patients treatment was completed at 1045 and staff did not obtain a standing BP as required. Review revealed no documented evidence that any staff collected the required data post-treatment on 6/22/10. Interview on 7/15/10 at 1545 with the Clinical Manager revealed PCT or licensed staff is required to collect post treatment data on every patient before the patient is discharged from	V 758		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342543	A. BUILDING ____ B. WING ____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

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V 758	Continued From page 57 treatment. Interview revealed the data included temp, respiratory, GI, cardiac, edema, mental, mobility and access information. 27 Review of the dialysis treatment sheet for 6/22/10 for patient #29 revealed his dialysis treatment initiated initiated at 0706. Treatment sheet review revealed no documented evidence that staff obtained post treatment data as required for respiratory, GI, cardiac, edema, mental, mobility and access information. Interview on 7/15/10 at 1545 with the Clinical Manager revealed PCT or licensed staff is required to collect post treatment data on every patient before the patient is discharged from treatment. Interview revealed the data included temp, respiratory, GI, cardiac, edema, mental, mobility and access information.	V 758		

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

sent [illegible] 8/2/10

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 ma[illegible]ing 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 [illegible] 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.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
342543	A. Building B. Wing	7/16/2010

Name of Facility	Street Address, City, State, Zip Code
VANCE COUNTY DIALYSIS	854 S BECKFORD DRIVE 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 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix V0424 Reg. # 405.2161(b)(3) LSC	07/16/2010	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Kay Cruden-Marin	Date: 8-2-10
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/26/2007			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public 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 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 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	Provider/Supplier Name
342653	FRESENIUS MEDICAL CARE MILLBROOK

Type of Survey (select all that apply)

I				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	15401	08/10/2010	08/11/2010	1.00	0.00	17.00	0.50	2.00	2.00
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

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..... 0.00

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

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
342543	VANCE COUNTY DIALYSIS

Type of Survey (select all that apply)

A	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

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.

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1.	15401	07/13/2010	07/16/2010	0.50	0.00	2.00	0.00	1.00	0.75
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

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..... 0.00

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES RECEIVED AUG 0 4 2010 CENTER FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VBSZ12

Facility ID: 944655

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 342543
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) VANCE COUNTY DIALYSIS
(L4) 511 RUIN CREEK RD SUITE 212
(L5) HENDERSON, NC (L6) 27536

4. TYPE OF ACTION: 7 (L8)
1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 09 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) 12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds 43 Stations (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): YES (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A follow-up survey to the 7/26/2007 complaint survey was conducted simultaneously with a recertification survey on 7/13-16, 2010. Tag 0424 has been corrected.

17. SURVEYOR SIGNATURE [signature] Date: 07/20/2010 (L19)

18. STATE SURVEY AGENCY APPROVAL [signature] Date: 8/5/2010 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
342543	A. Building B. Wing	7/16/2010

Name of Facility	Street Address, City, State, Zip Code
VANCE COUNTY DIALYSIS	511 RUIN CREEK RD SUITE 212 HENDERSON, NC 27536

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix V0424 Reg. # 405.2161(b)(3) LSC	07/16/2010	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: [signature]	Date: 7/20/10
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date

Followup to Survey Completed on:
7/26/2007

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public 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 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 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	Provider/Supplier Name
342543	VANCE COUNTY DIALYSIS

Type of Survey (select all that apply)

A	D				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 15401	07/13/2010	07/16/2010	0.50	0.00	2.00	0.00	1.00	0.75
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

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..... 0.00

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

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

RECEIVED J 0 8 2011

PRINTED: 06/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Exhibit I	342587	A. BUILDING ______ B. WING ______	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on review of facility policy and procedures, observation and staff interview, staff failed to follow facility infection control procedure by failing to perform hand hygiene between glove changes and failing to wear gloves while performing residual chemical checks prior to initiation of hemodialysis treatment. Findings included: Review of facility policy "Infection Control for Dialysis Facilities" dated 03/2011 on 6/14/2011 revealed "1. Hand hygiene is to be performed...after removal of gloves, after contamination with blood or other infectious material, after patient and delivery system contact, between patients even if the contact is casual, before touching clean areas such as 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	V 113	**V113** Clinical Teammates (TMs) were in-serviced 6-15-11 in the following: *Policy #1-05-01: Infection Control for Dialysis Facilities.* Verification of attendance at in-service is evidenced by a signature sheet.TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) to remove gloves and wash hands between dirty and clean tasks, 2) to perform hand hygiene whenever gloves are removed, and 3) to wear gloves for all machine contact. The Charge Nurse (CN) is responsible for oversight of infection control practice daily. Instances of non-compliance will be addressed with the TM responsible immediately. The Facility Administrator (FA) or designee will conduct observational infection control audits on random shifts daily for one week, then 3 xs weekly for one month, then weekly for one month, then monthly with regularly scheduled infection control audits.Results of audits will be reviewed 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 POC.	7/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alice M. [illegible], RN	Group Facility Administrator	7/7/

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.

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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.	V 113		
V 132	494.30(a)(1)(i) IC-TRAINING & EDUCATION Infection Control Training and Education 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:	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 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	7/15/11

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V 132	Continued From page 2 Review of facility policy "Infection Control for Dialysis Facilities" dated 03/2011 on 6/14/2011 revealed "16. The expiration date will be checked on all disposable supplies." Observation during tour of the hemodialysis treatment area on 06/14/2011 from 1400-1420 revealed the emergency evacuation cart contained two (2) 17 gauge vascular access needles which had expired 05/2011 and (1) one which had expired 01/2009. Further observation during tour revealed 218 expired light blue-top lab tubes which had expired 10/2010. Interview with the charge nurse on 06/14/2011 at 1420 revealed the emergency cart is routinely checked for expired items. Interview revealed "We must have missed those (vascular access needles)....I don't believe we even use those (light-blue lab tubes) anymore."	V 132		
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or	V 147		

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

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V 147	Continued From page 3 other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This STANDARD is not met as evidenced by: Based on review of facility policy and procedures, observation and staff interview, staff failed to follow facility infection control procedure by failing to perform hand hygiene between dirty and clean procedures involving intravascular catheter devices. Findings included: Review of facility policy "Infection Control for Dialysis Facilities" dated 03/2011 on 6/15/2011 revealed "10. Gloves should be changed when:...When going from a 'dirty' area or task to a 'clean' area or task..." Observation of patient care at station #23 on 06/15/2011 at 1140 revealed Staff #7, a Patient Care Technician (PCT), removed an old intravascular catheter site dressing, cleaned the site, and then applied a clean dressing with same	V 147	V147 Clinical Teammates (TMs) were in-serviced 6-15-11 in the following: *Policy #1-05-01: Infection Control for Dialysis Facilities.* Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) to remove gloves and wash hands between dirty and clean tasks, 2) to perform hand hygiene whenever gloves are removed, and 3) to wear gloves for all machine contact, and 4) perform hand hygiene when moving from a dirty to clean task such as catheter dressing changes. The Charge Nurse (CN) is responsible for oversight of infection control practice daily. Instances of non-compliance will be addressed with the TM responsible immediately. The Facility Administrator (FA) or designee will conduct observational infection control audits on random shifts daily for one week, then 3 xs weekly for one month, then weekly for one month, then monthly with regularly scheduled infection control audits. Results of audits will be reviewed 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 POC.	7/15/11

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V 147	Continued From page 4 gloved hands. Further observation revealed the PCT retrieved a marker from the adjacent computer cart (to write the date and time on the dressing) and then returned the pen to the cart with the same gloved hands. Further observation revealed the PCT, with same gloved hands, hooked the hemodialysis (HD) circuit to the patient's catheter to initiate the HD treatment. Interview with administrative staff on 06/15/2011 at 1300 revealed staff are expected to change gloves and perform hand hygiene between glove changes between dirty and clean procedures. Interview revealed a glove change should have occurred after handling the patient's dirty dressing and before applying the new dressing. Interview revealed Staff #7 failed to follow facility policy by failing to perform hand hygiene between dirty and clean procedures.	V 147		
V 316	494.50(b)(1) MAINTENANCE PER DFU OR 2X/YR;RECORD 7.2.3 Maintenance: per DFU or semiannual/maintenance record Written maintenance procedures and a schedule of preventive maintenance activities designed to minimize equipment malfunctions should be established. In the case of purchased reprocessing equipment or safety equipment, the recommendations of the vendor should be followed unless documented experience supports alternative approaches. If the manufacturer's recommendations are not available, reuse equipment and safety equipment should be inspected on a semiannual basis. 4 Records 4.3 Equipment maintenance record	V 316		

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V 316	Continued From page 5 Records shall be maintained of the dates of preventive maintenance procedures and the results of scheduled testing in order to ensure the proper functioning of reprocessing equipment, environmental-control equipment, safety equipment, or other equipment. 4 Records A place should be provided for the signature or other unique mark of identification of the person ...performing preventative maintenance procedures. This STANDARD is not met as evidenced by: Based on review of manufacturer's preventative maintenance (PM) recommendations, facility PM logs and staff interview, staff failed to ensure PMs were performed timely for the facility's dialyzer reuse processing system. Findings include: Review of the manufacturer's manual for the "Renatron II Dialyzer Reprocessing System" on 6/15/2011 revealed a required inspection of the automated dialyzer reuse processing system must be performed every three months. Review on 6/15/2011 of the PM log for the (2) two Renatron II Dialyzer Reprocessing Systems in use at the facility revealed the last PM performed on both units was 02/28/2011 [two (2) weeks and (4) four days overdue for inspection]. Interview with biomedical staff on 6/15/2011 at 1400 revealed the Renatron units have a required quarterly inspection. Interview revealed	V 316	**V316** Biomedical teammate performed machine maintenance on referenced Renatron Dialyzer reprocessing machine on date of discovery during survey 6/15/11. Biomedical teammate has checked each piece of biomedical equipment in the facility for correct dates and record keeping of maintenance as having been performed. The Area Biomedical Administrator has in-serviced these teammates on this item. The Area Biomedical Supervisor will randomly audit machine preventive maintenance records monthly for 3 months. Results of audits will be reviewed 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 POC. s. The Area Biomedical Supervisor and FA are responsible for compliance with this POC.	7/15/11

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V 316	Continued From page 6 the staff mislabeled the next due date. Interview revealed the required PM was overdue and had not been performed per the manufacturer's recommended every three month interval.	V 316		
V 339	494.50(b)(1) GERM PROCESS=HIGH-LEVEL DISINFECT 11.4.1 Interior (blood/dialysate compartment) 11.4.1.1 Germicidal process: high-level disinfection achieved Chemical germicides or other procedures used for disinfecting of hemodialyzers shall have been shown to accomplish at least high-level disinfection when tested in dialyzers artificially contaminated with appropriate microorganisms. If the germicide has an expiration date from the manufacturer, staff members should be sure that the chemical is not outdated. Some germicides have recommendations for maximum storage time after dilution or activation and before usage. If this is the case, the expiration date of the prepared germicide solution should be marked on the outside of the germicide solution container, and that date should be checked at the beginning of each day, before reprocessing begins. The disinfection process shall not adversely affect the integrity of the dialyzer. Germicides shall be rinsed from the dialyzer to below known toxic levels within a rinse-out period established for the particular germicide (see AAMI 12.4). To prevent injury, staff members shall take care not to mix reactive materials such as sodium hypochlorite and formaldehyde.	V 339		

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V 339	Continued From page 7 This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, observation during tour and staff interview, reuse technician staff failed to ensure disinfection of caps used for reprocessed dialyzers. Findings include: Review of facility policy "Cleaning and Disinfection of Reuse Supplies Policy" dated 03/2007 on 6/15/2011 revealed "4. Dialysate port caps...if used, must be cleaned and disinfected upon receipt and after every reuse procedure...6. Reuse supplies will be cleaned and disinfected with 1% peracetic acid solution for a minimum of 30 minutes..." Observation during tour of the reuse reprocessing area on 6/15/2011 at 0930 revealed a container of disinfectant containing dialysate port caps. Observation revealed some of the dialysate port caps in the container were not fully submerged in the disinfectant. Observation revealed the reuse technician took a reprocessed dialyzer and used two of the caps from the container to cap both of the dialysate delivery ports of the dialyzer. Interview with the reuse technician during the observation revealed the container holding the dialysate port caps with the disinfectant were ready for use. Interview revealed approximately 6-10 of the caps were not fully submerged in the disinfectant. Interview revealed if the dialysate port caps are not fully submerged in the disinfectant, then there is no guarantee the caps have been fully disinfected. Interview revealed	V 339	V339 Reuse clinical teammates were in-serviced on 6/15/11 on Policy: *Cleaning and Disinfection of Reuse Supplies* specifically item #4, dialysate port caps must be cleaned and disinfected upon receipt and after every reuse procedure and that the supplies are to be fully submerged in the disinfectant.. An individual certification has been placed in their file as evidence of this in-service. A new procedure to weight the dialysate port caps to ensure that all caps are fully submerged throughout disinfection was implemented immediately. The use of this system will be audited by the FA or designee at various times weekly for 4 weeks and then monthly will the monthly reuse audits as currently performed. Results of audits will be reviewed 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 the POC	7/15/11

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V 339	Continued From page 8 "All of the caps should be fully submerged before they are ready to reuse."	V 339		
V 402	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Based on facility policy review, observations and staff interview, the facility failed ensure that a fire exit egress was clear and unobstructed for exiting the facility in case of a fire or other emergency. Findings include: Review of facility policy "Fire Safety Preparedness Guidelines" dated 03/2010 on 6/14/2011 revealed "16. Evacuation routes will be...The egress area must remain clear at all times." Observation on 06/14/2011 at 1400 revealed a lighted exit sign over a door located at the rear of the treatment area leading into the biomedical work area. Observation revealed to the left was a lighted exit sign over a door leading to the outside of the clinic. Observation revealed the emergency egress between the treatment area exit door and the exterior exit door was obstructed by pallets of boxes containing supplies. Observation revealed a fire pull station at the rear door, designating an emergency fire	V 402	V402 Teammates were in-serviced on 6-14-11 on Fire Safety Preparedness guidelines as evidenced by entry in the Home Room Meeting minutes by their signature. The egress and fire pull station were blocked by stock that was just delivered, with space for storage at a premium, all teammates were made aware of this policy. The egress was immediately cleared. The FA or designee will perform daily random walk-through of the facility for 2 weeks, weekly for 4 weeks and designate a team member to perform these daily as assigned on the daily assignment sheet. The FA is responsible for compliance with the POC.	7/15/11

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V 402	Continued From page 9 egress. An interview on 06/15/2011 at 0930 with the facility administrator revealed the clinic has limited storage space and the emergency egress becomes cluttered when supplies are delivered. The interview revealed there should be no items blocking a designated fire exit.	V 402		
V 407	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, observations during tour and staff interview, staff failed to ensure access sites were visible during the hemodialysis treatment. Findings include: Review of facility policy "Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care" dated 09/2007 on 06/14/2011 revealed "16. Cannulation sites and blood tubing connections will be verified for accurate, patent and secure connections, and remain visible throughout the treatment." Observation during tour of the treatment area on 06/14/2011 from 1400 through 1415 revealed the vascular access sites for the patients at Station #13, #14 and #20 were covered and not visible while these patients were receiving hemodialysis treatment.	V 407	**V407** Teammates were in-serviced on 6-16-11 on Vascular access care policies related specifically to item number 16, cannulation sites and blood tubing connections will be verified for accurate, paten, and remain visible throughout the treatment. This in-service is documented by staff signature on the in-service sheet. Each patient received the week of 7/4/11 a document outlining the importance of keeping their access uncovered during treatment. For patients that refuse, this will be documented in the medical record will in addition to physician notification. The Charge Nurse is responsible for ensuring compliance with this, any patients and teammates violating will be addressed immediately. FA/designee will audit via observation on random shifts daily x 1 week, 3xs weekly for 2weeks, and then complete random monthly checks to ensure compliance. Results of audits will be reviewed 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 and Charge Nurse are responsible for compliance with the POC.	7/15/11

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	342587	A. BUILDING ____ B. WING ____	06/16/2011

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GOLDSBORO SOUTH DIALYSIS	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 407	Continued From page 10 Interview with the charge nurse on 06/14/2011 at 1415 revealed vascular access sites should remain visible at all times. Interview revealed the vascular access sites for the patients at Station #13, #14 and #20 were covered and not visible during the patient's hemodialysis treatments. Interview revealed staff failed to follow policy by failing to ensure the vascular access sites were uncovered during treatments.	V 407		
V 504	494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: Blood pressure, and fluid management needs. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, treatment records and staff interview, licensed nursing staff failed to perform a post-assessment for two of five hemodialysis patient records reviewed (#9, #8). Findings include: Review of facility policy "Post Treatment Patient Assessment" dated 03/2011 on 6/16/2011 revealed "Purpose: To verify that the patient is stable, to determine the patient's discharge status, and to evaluate the effectiveness of the treatment plan. Policy: 1. The patient care staff will obtain and document basic data on each patient post dialysis and compare to pre dialysis findings...3. If the patient's condition requires	V 504	**V504** TMs were in-serviced 6-16-11 in the following: *Policy #1-03-09: Intradialytic Treatment Monitoring* and *Policy #1-03-11 Post treatment Patient assessment.* Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed ; 1) to monitor and document vital signs at least every 30 minutes, and 2) to complete and document a pre-treatment evaluation prior to the first treatment for all new patients 3) the RN is to complete a post treatment assessment on patients whose pre assessment indicated an abnormality as well as ongoing monitoring by the RN for patients with findings outside of the normal expectations The Charge Nurse (CN) is responsible for oversight of patient monitoring and completion of new patient pre and post treatment assessments per policy. The CN will monitor flowsheets daily to ensure documentation is in place. Instances of non-compliance will be addressed with the TM responsible immediately. The FA or designee will audit treatment flowsheets of 50% for the first two weeks then 50% of treatments sheets 2x week x 4 weeks, then 10% weekly x4, then 10% monthly. Results of audits will be reviewed 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 POC.	8/1/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 504	Continued From page 11 intervention, the licensed nurse assesses the patient and collects any additional data needed." 1. Treatment record review for Patient #9 revealed a 79 year old admitted 01/05/2011 for incenter hemodialysis (HD) treatments three times weekly. Treatment record review for 5/16/2011 revealed a Pre HD assessment at 1110 "Resp(iratory) - SOB (short of breath) upon exertion, rhonchi (abnormal breath sounds)...Other - BP elevated, usually comes down with Tx (treatment)." Review revealed the patient's pre HD blood pressure was 203/92 (normal 120/80). Further review revealed oxygen was initiated at 1112 by the Registered Nurse who performed the pre HD assessment. Further review revealed no reassessment of the interventions or of the patient's condition during or after the HD treatment had ended. Review revealed the patient's post HD blood pressure was 197/81. Interview with nursing administrative staff on 06/16/2011 at 1100 revealed abnormal pre HD assessment findings and any interventions should be reassessed by the licensed nurse. Interview revealed the licensed nurse performing the pre HD assessment and who provided the oxygen intervention failed to follow facility policy by failing to reassess the patient to follow up on the abnormal pre HD assessment findings and by failing to reassess the effectiveness of the oxygen intervention provided. 2. Treatment record review for Patient #8 revealed a 74 year old admitted 04/06/2011 for incenter hemodialysis treatments three times weekly. Treatment record review for 5/19/2011	V 504		

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

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FORM APPROVED
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V 504	Continued From page 12 revealed a Pre HD assessment at 0801 by a licensed nurse. Review revealed a pre HD blood pressure of 205/75. Further review revealed no post HD assessment was performed by staff. Interview with nursing administrative staff on 06/16/2011 at 1100 revealed post HD data should be collected and compared to the pre HD assessment for any changes. Interview revealed staff failed to follow facility policy by failing to collect post HD data prior to the patient being discharged from the facility.	V 504		
V 516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical records and staff interview, staff failed to ensure the comprehensive assessment was completed within 30 days or 13 treatments since the first day of incenter hemodialysis for three of five records reviewed (#9, #7, #8). Findings include: Review of facility policy "Patient Assessment and Plan of Care When Utilizing Duck" dated 12/2010 on 06/15/2011 revealed "4. A comprehensive assessment will be conducted on all new patients within 30 calendar days (or 13 outpatient dialysis	V 516	V516 The Governing Body will ensure the interdisciplinary team (IDT) reviews, updates and implements the plan of care to reflect the services required to address the patient's specific needs identified in the initial assessment required to be completed within 30 days or 13 treatments after admission. The FA will review and in-service the IDT on policy #1-01-07 "Patient Assessment and Plan of Care" with emphasis on the need to review and update and complete the plan of care within the time frame FA/designee will audit 100% of care plans due for the next 3 months, then 10% quarterly to ensure compliance. Results of audits will be reported in QIFMM and addressed as necessary. FA is responsible for ongoing compliance with POC,	7/15/11

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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 [74 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.	V 516		
	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			

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V 516	Continued From page 14 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 #7. 3. Open record review for Patient #8 revealed a 74 year old admitted 04/06/2011 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 5/19/2011(43 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 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 #8.	V 516		
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including,	V 520		

DEPARTMENT OF HEALTH AND HUMAN S[illegible]/ICES
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V 520	Continued From page 15 but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, medical records and staff interview, staff failed to ensure an unstable patient's Plan of Care was updated monthly until stable for one of two unstable patients' care plans reviewed (#10). Findings include: Review of facility policy "Patient Assessment and Plan of Care When Utilizing Duck" dated 12/2010 on 06/15/2011 revealed "7. A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted...At least monthly for unstable patients..." Open record review for patient #10 revealed a 69 year old admitted 02/04/2003 for incenter hemodialysis treatments three times weekly. Review of the patient's annual comprehensive Plan of Care dated 11/19/2009 revealed the patient was "unstable" related to dialysis inadequacy and compliance issues. Further review revealed no follow-up comprehensive assessment was completed until 12/21/2010 (13 months later). Review revealed the updated Plan of Care was reviewed during the interdisciplinary team meeting on 02/21/2011 (two months later)	V 520	**V520** The Governing Body will ensure the interdisciplinary team (IDT) reviews, updates and implements the plan of care to reflect the services required to address the patient's specific needs identified. In any assessment in which the patient is deemed unstable, the patient will be reassessed and care plan meeting performed within 30 days. The FA will review and in-service the IDT on policy #1-01-07 "Patient Assessment and Plan of Care" with emphasis on the need to review and update and complete the plan of care within the time frame The facility will maintain a list of unstable patients to follow monthly to ensure these are completed. FA/designee will audit 100% of care plans due for the next 3 months, then 10% quarterly to ensure compliance. Results of audits will be reported in QIFMM and addressed as necessary. FA is responsible for ongoing compliance with POC.	8/1/11

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V 520	Continued From page 16 and the patient was made "unstable" related to non-compliance issues. Interview with nursing administrative staff on 06/16/2011 at 1115 revealed patients noted to be "unstable" on the plan of care should be reassessed by the interdisciplinary team (IDT) every 30 days and update the plan of care as necessary. Interview revealed Patient #10 was noted to be unstable during the 11/19/2009 IDT comprehensive assessment and plan of care. Interview revealed the IDT failed to reassess the patient every 30 days as per facility policy. Interview further revealed there was not a timely follow-up after the comprehensive assessment was completed 12/21/2010 with the care plan (two months later). Interview revealed there have been administrative oversight issues at the clinic which may have contributed to the lack of follow-up with the timeliness of the comprehensive assessments. Interview revealed the IDT failed to follow facility policy by failing to perform timely reassessments of patients deemed "unstable".	V 520		
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, treatment records and staff interview, staff failed to monitor patients during the hemodialysis (HD) treatment per facility policy for four of five patient records reviewed	V 543		

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V 543	Continued From page 17 (#7, #9, #8, #10). Findings include: Review of facility policy ""Intradialytic Treatment Monitoring" dated 09/2008 on 06/15/2011 revealed "1. Treatment checks should be completed at least every thirty (30) minutes. 2. At a minimum, obtain and document the following: Blood pressure, Heart rate, Blood and dialysate flows, arterial and venous pressures, Fluid removal and/or replacement, Vascular access status and line connections, Patient status and subjective well-being." 1. Open record review on 06/15/2011 for Patient #7 revealed a 53 year old admitted 02/28/2011 for incenter hemodialysis treatments three times weekly. Review revealed on 6/14/2011 staff failed to monitor the patient from 1100-1200 (one hour since last monitoring episode) during the hemodialysis treatment. Review revealed on 6/11/2011 staff failed to monitor the patient from 1132-1230 (58 minutes since last monitoring episode) during the hemodialysis treatment. Review revealed on 5/31/2011 staff failed to monitor the patient from 1230-1330 (one hour since last monitoring episode) during the hemodialysis treatment. Review revealed on 5/21/2011 staff failed to monitor the patient from 1100-1230 (one and a half hours since last monitoring episode) during the hemodialysis treatment. Interview on 06/15/2011 at 1430 with administrative staff revealed patients should be monitored every 30 minutes during the HD treatment. Interview revealed staff failed to follow	V 543	**V543** TMs were in-serviced 6-16-11 in the following: *Policy #1-03-09: Intradialytic Treatment Monitoring* and *Policy #1-03-11 Post treatment Patient assessment*. Verification of attendance at in-service is evidenced by a signature sheet. TMs were instructed to: 1) monitor and document vital signs at least every 30 minutes, and 2) to complete and document a pre-treatment evaluation prior to the first treatment for all new patients. 3) The RN is to complete a post treatment assessment on patients whose pre assessment indicated an abnormality as well as ongoing monitoring by the RN for patients with findings outside of the normal expectations The Charge Nurse (CN) is responsible for oversight of patient monitoring and completion of new patient pre and post treatment assessments per policy. The CN will monitor flowsheets daily to ensure documentation is in place. Instances of non-compliance will be addressed with the TM responsible immediately. The FA or designee will audit treatment flowsheets of 50% for the first two weeks then 50% of treatments sheets 2x week x 4 weeks, then 10% weekly x4, then 10% monthly. Results of audits will be reviewed 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 POC.	8/1/11

DEPARTMENT OF HEALTH AND HUMAN S[illegible]/ICES
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V 543	Continued From page 18 facility policy by failing to monitor Patient #7 every 30 minutes on 06/14/2011, 06/11/2011, 05/31/2011 and 05/21/2011. 2. Open record review on 06/15/2011 for Patient #9 revealed a 79 year old admitted 01/05/2011 for incenter hemodialysis treatments three times weekly. Review revealed on 06/03/2011 staff failed to monitor the patient from 1012-1130 (one hour and 18 minutes since last monitoring episode) during the hemodialysis treatment. Review revealed on 06/01/2011 staff failed to monitor the patient from 1200-1300 (one hour since last monitoring episode) during the hemodialysis treatment. Review revealed on 5/25/2011 staff failed to monitor the patient from 1300-1358 (52 minutes since last monitoring episode) during the hemodialysis treatment. Interview on 06/15/2011 at 1430 with administrative staff revealed patients should be monitored every 30 minutes during the HD treatment. Interview revealed staff failed to follow facility policy by failing to monitor Patient #9 every 30 minutes on 06/03/2011, 06/01/2011 and 05/25/2011. 3. Open record review on 06/15/2011 for Patient #8 revealed a 74 year old admitted 04/06/2011 for incenter hemodialysis treatments three times weekly. Review revealed on 06/07/2011 staff failed to monitor the patient from 0800-0900 (one hour since last monitoring episode) during the hemodialysis treatment. Review revealed on 5/26/2011 staff failed to monitor the patient from 1400-1516 (one hour and 16 minutes since last monitoring episode) during the hemodialysis treatment.	V 543		

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V 543	Continued From page 19 Interview on 06/15/2011 at 1430 with administrative staff revealed patients should be monitored every 30 minutes during the HD treatment. Interview revealed staff failed to follow facility policy by failing to monitor Patient #8 every 30 minutes on 06/07/2011 and 05/26/2011. 4. Open record review on 06/15/2011 for patient #10 revealed a 69 year old admitted 02/04/2003 for incenter hemodialysis treatments three times weekly. Review revealed on 06/04/2011 the patient was on a 1.0K (potassium) dialysate bath and staff failed to monitor the patient from 0930-1026 (56 minutes since last monitoring episode) during the hemodialysis treatment. Interview on 06/15/2011 at 1430 with administrative staff revealed patients should be monitored every 30 minutes during the HD treatment. Interview revealed staff failed to follow facility policy by failing to monitor Patient #10 every 30 minutes on 06/04/2011.	V 543		
V 729	494.170(b)(1) MR-COMPLETE RECORDS PROMPTLY (1) Current medical records and those of discharged patients must be completed promptly. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, closed medical records and staff interview staff failed to ensure the timely completion of a medical record after a patient's discharge from the center for two of three closed patient records reviewed (#4, #6). Findings include:	V 729		

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

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V 729	Continued From page 20 Review of facility policy "Medical Record Maintenance" dated 09/2010 on 5/16/2010 revealed "15. The discharge summary will be documented in the patient's medical record within 30 days after the patient becomes inactive....16. The discharge summary will address the patient's progress and treatment during their inactive status, their prognosis and the disposition of the patient." 1. Closed record review for Patient #4 on 6/16/2011 revealed a 71 year old whose last treatment at the facility was on 11/24/2010. Review of the record document "Discharge Summary," signed by the physician 5/23/2011 (6 months after last treatment), revealed the patient's last treatment at the facility was on 11/24/2010 with a note by the physician "Pt expired @ (hospital) p (after) prolonged hospitalization." Interview with administrative staff on 6/16/2011 at 1245 revealed the patient was discharged from the hospital on 02/28/2011 to a long-term ventilator support facility and was thus technically discharged from the dialysis center on 02/28/2011. Interview revealed the patient later expired at the long-term facility. Interview revealed the completion of the record and discharge summary was almost three months (2 months and 23 days) after the patient was actually discharged from the dialysis center on 02/28/2011. Interview revealed the discharge summary was not completed within 30 days per facility policy. 2. Closed record review for Patient #6 on	V 729	V729 Teammates involved in the discharge process for patients (charge nurses, nurses, administrative personnel) will be in-serviced on facility policy Medical Record Maintenance with focus on the need for a discharge summary to: 1) be documented in the patient's medical record within 30 days after the patient becomes inactive and 2) include the patient's progress and treatment during their inactive status, their prognosis and the disposition of the patient. . These teammates are responsible for compilation of forms required in the medical record for closing charts. These teammates will bring to the attention of the FA monthly any charts due to close and any required paperwork of which the FA will bring to the attention of the Medical Director or patient physician. The FA will then monitor monthly for each month that all closed charts are appropriately documented. The FA is responsible for this POC.	8/16/11

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V 729	Continued From page 21 6/16/2011 revealed a 79 year old who expired 4/12/2011. Review of the record document "Discharge Summary," signed by the physician on 5/23/2011, revealed the patient expired at the local hospital on 4/12/2011. Review revealed the discharge summary was completed 41 days after the patient expired (became inactive at the facility). Interview with administrative staff on 6/16/2011 at 1245 revealed the discharge summary was not completed within 30 days per facility policy.	V 729		

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ME[illegible]CARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID:

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 342587

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) GOLDSBORO SOUTH DIALYSIS
(L4) 1704 WAYNE MEMORIAL DRIVE
(L5) GOLDSBORO, NC (L6) 27530

4. TYPE OF ACTION: 9

1. Initial 2. Re[illegible]
3. Termination 4. CH[illegible]
5. Validation 6. Comp[illegible]
7. On-Site Visit 9. Other
8. Full Survey After Complaint

FISCAL YEAR ENDING DATE (L[illegible]

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 09 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

* Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Add one hemodialysis station to make a total of twenty two (22) stations effective 4/27/2010, per CON Project ID# P-8317-09.

17. SURVEYOR SIGNATURE Date: (L19)

18. STATE SURVEY AGENCY APPROVAL Date: [signature] 5/6/2010 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-151[illegible])
3. Both of the Above

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

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

MEDI[illegible]E/MEDICAID CERTIFICATION AND TRAN[illegible]TAL

ID GE2D11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID 970275

1. MEDICARE/MEDICAID PROVIDER NO (L1) 342587
2. STATE VENDOR OR MEDICAID NO. (L2)
3. NAME AND ADDRESS OF FACILITY
(L3) GOLDSBORO SOUTH DIALYSIS
(L4) 1704 WAYNE MEMORIAL DRIVE
(L5) GOLDSBORO, NC (L6) 27530
4. TYPE OF ACTION 6 (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY (L34)
7. PROVIDER/SUPPLIER CATEGORY 09 (L7)
01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 05 HHA 06 LAB 07 X-Ray 08 OPT/SP 09 ESRD 10 NF 11 IMR 12 RHC 13 PTIP 14 CORF 15 ASC 16 HOSPICE
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other
FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):
10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:
And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 3. 24 Hour RN __ 4. 7-Day RN (Rural SNF) __ 5. Life Safety Code __ 6 Scope of Services Limit __ 7. Medical Director __ 8. Patient Room Size __ 9. Beds/Room
* Code: A1* (L12)
12. Total Facility Beds (L18)
13. Total Certified ~~Beds~~ 21 stations (L17)
14. LTC CERTIFIED BED BREAKDOWN
18 SNF (L37) 18/19 SNF (L38) 19 SNF (L39) ICF (L42) IMR (L43)
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): YES (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A complaint survey was conducted on 3/4/2010. The allegations in the complaint could not be substantiated. However, as a result of the survey, standard level deficiencies were cited (NC00062004).
17. SURVEYOR SIGNATURE [signature] Date: 03/26/2010 (L19)
18. STATE SURVEY AGENCY APPROVAL [signature] Date: 3/30/2010 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)
20. COMPLIANCE WITH CIVIL RIGHTS ACT:
21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 1
22. ORIGINAL DATE OF PARTICIPATION (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
26. TERMINATION ACTION (L30)
VOLUNTARY 00
01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal
INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement
OTHER 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. 00000 (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)
DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

RECEIVED MAR ; 2010

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 510	494.80(a)(7) PA-MSW-PSYCHOSOCIAL NEEDS The patient's comprehensive assessment must include, but is not limited to, the following: (7) Evaluation of psychosocial needs by a social worker. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the interdisciplinary team (IDT) failed to assess psychosocial needs for 1 of 1 (#1) patient reviewed that was deemed unstable. The findings included: Review of facility policy 1-01-07-Hemo Dialysis Patient Assessment and Plan of Care (revised 9/09) revealed the interdisciplinary team ... is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs which will be used to develop the patient's treatment plan and expectations for care. The assessment will include...psychosocial needs as evaluated by a social worker...and assessments will be conducted monthly on unstable patients. Review of the medical record for patient #1 revealed this 33 year old male had been admitted to the facility on 11/07/2005 for hemodialysis for end stage renal disease secondary to diabetes. Review of the medical record revealed this patient had been involuntarily discharged from the dialysis unit on 1/25/10 "effective immediately" due to verbally threatening staff	V 510	V510 The FA will review Policy # 1-01-07 "Patient Assessment and Plan of Care" with the interdisciplinary team (IDT) with emphasis on their responsibility for providing each patient with an individualized comprehensive assessment which will be used to develop the patient's treatment plan and expectations for care. All areas that are required to be addressed in this process, which includes psychosocial needs as evaluated by a social worker, will be discussed with special focus on evaluating patients who have been demonstrating aggressive and disruptive behavior. Policy #1-01-08 "Patient Behavior Agreements, 30 day Discharge, Involuntary Discharge or Involuntary Transfer" will also be reviewed with emphasis on if a patient's behavior is disruptive to the facility, but is non-threatening, a comprehensive assessment will be completed by the IDT in order to identify possible root causes and any potential interventions such as mental health counseling or other applicable referrals. These interventions and subsequent patient response will be documented in the patient's record and evaluated for any further needs. The assessments will be conducted monthly and documented until the patient is no longer deemed unstable or has transferred from the facility. FA/designee will audit records of patient's identified as unstable monthly x 3 then 10% quarterly to ensure compliance. Results of audits will be reported in CQI and addressed as necessary.	4/18/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alice M Hill, RN FA
TITLE: Group Facility Administrator
(X6) DATE: 3/19/10

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ____ B. WING ____	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 510	Continued From page 1 after a patient/staff altercation that occurred on 1/25/10. Interview with the Clinical Manager on 3/4/10 at 1500 revealed this patient had a history of aggressive and disruptive behavior. Interview with staff #1 on 3/4/10 at 1245 revealed this patient had a long history of disruptive behavior but on 1/25/10, the day that the patient threatened the staff, she felt like the patient's behavior was "unpredictable". Interview with staff #2 on 3/4/10 at 1315 revealed that she had seen patient #1 "get smart but never saw him lose his control like he did that day. I felt like he may hurt somebody or even carry out his threats". Review of the medical record revealed the following progress notes: RN progress note on 12/8/08-patient became very angry and irate when asked by staff not to use cell phone in facility due to possible interference with machine circuit boards. Facility Manager progress note on 6/5/09-patient refusing care...demanding a soft drink...using foul language... Facility Administrator progress note on 12/18/09-patient upset because he left his belongings at the facility when he left the premises only to find out upon his return that his belongings had been stolen. He stated "it ain't over-best believe that". RN progress note on 1/22/10-patient requested to	V 510		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 510	Continued From page 2 stop treatment such that he could use the restroom-patient walked past the restroom and lit a cigarette outside the facility. Social Worker progress note on 1/25/10-patient raising voice speaking to RN...refusing to leave facility (treatment completed)...stated "mind your own business"..."I will cut you like I'm going to cut her" (RN)... Review of facility policy 1-01-08, Patient Behavior Agreements, 30 day discharge, Involuntary Discharge or Involuntary Transfer (revision 9/09), revealed "If a patient's behavior is disruptive tot he facility, but is non-threatening, a comprehensive patient assessment will be completed by the interdisciplinary team (IDT) in order to identify any potential action or plan of correction required. The assessment must focus on identifying the root causes of disruptive behavior". Review of medical record revealed that IDT re-assessments occurred monthly from 10/09-12/09 because the patient had been deemed unstable due to his non-compliance to hemodialysis treatments. Review of these re-assessments revealed no documented evidence that the IDT had assessed any psychosocial needs for this patient's aggressive and disruptive behavior. Interview with the Facility Administrator on 3/4/10 at 1510 revealed the IDT had not assessed this patient's aggressive and disruptive behavior.	V 510		
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO	V 520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 342587	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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V 520	Continued From page 3 In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the interdisciplinary team (IDT) failed to re-assess psychosocial needs for 1 of 1 (#1) patient reviewed that was deemed unstable. The findings included: Review of facility policy 1-01-07-Hemo Dialysis Patient Assessment and Plan of Care (revised 9/09) revealed the interdisciplinary team ... is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs which will be used to develop the patient's treatment plan and expectations for care. The assessment will include...psychosocial needs as evaluated by a social worker...and assessments will be conducted monthly on unstable patients. Review of the medical record for patient #1 revealed this 33 year old male had been admitted to the facility on 11/07/2005 for	V 520	V520 The FA will review Policy # 1-01-07 "Patient Assessment and Plan of Care" with the interdisciplinary team (IDT) with emphasis on their responsibility for providing each patient with an individualized comprehensive assessment which will be used to develop the patient's treatment plan and expectations for care. All areas that are required to be addressed in this process, which includes psychosocial needs as evaluated by a social worker, will be discussed with special focus on evaluating patients who have been demonstrating aggressive and disruptive behavior. Policy #1-01-08 "Patient Behavior Agreements, 30 day Discharge, Involuntary Discharge or Involuntary Transfer" will also be reviewed with emphasis on if a patient's behavior is disruptive to the facility, but is non-threatening, a comprehensive assessment will be completed by the IDT in order to identify possible root causes and any potential interventions such as mental health counseling or other applicable referrals. These interventions and subsequent patient response will be documented in the patient's record and evaluated for any further needs. The assessments will be conducted monthly and documented until the patient is no longer deemed unstable or has transferred from the facility. FA/designee will audit records of patient's identified as unstable monthly x 3 then 10% quarterly to ensure compliance. Results of audits will be reported in CQI and addressed as necessary.	4/18/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 4 hemodialysis for end stage renal disease secondary to diabetes. Review of the medical record revealed this patient had been involuntarily discharged from the dialysis unit on 1/25/10 "effective immediately" due to verbally threatening staff after a patient/staff altercation that occurred on 1/25/10. Interview with the Clinical Manager on 3/4/10 at 1500 revealed this patient had a history of aggressive and disruptive behavior. Interview with staff #1 on 3/4/10 at 1245 revealed this patient had a long history of disruptive behavior but on 1/25/10, the day that the patient threatened the staff, she felt like the patient's behavior was "unpredictable". Interview with staff #2 on 3/4/10 at 1315 revealed that she had seen patient #1 "get smart but never saw him lose his control like he did that day. I felt like he may hurt somebody or even carry out his threats". Review of the medical record revealed the following progress notes: RN progress note on 12/8/08-patient became very angry and irate when asked by staff not to use cell phone in facility due to possible interference with machine circuit boards. Facility Manager progress note on 6/5/09-patient refusing care...demanding a soft drink...using foul language... Facility Administrator progress note on	V 520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 5 12/18/09-patient upset because he left his belongings at the facility when he left the premises only to find out upon his return that his belongings had been stolen. He stated "it ain't over-best believe that". RN progress note on 1/22/10-patient requested to stop treatment such that he could use the restroom-patient walked past the restroom and lit a cigarette outside the facility. Social Worker progress note on 1/25/10-patient raising voice speaking to RN...refusing to leave facility (treatment completed)...stated "mind your own business"..."I will cut you like I'm going to cut her" (RN)... Review of facility policy 1-01-08, Patient Behavior Agreements, 30 day discharge, Involuntary Discharge or Involuntary Transfer (revision 9/09), revealed "If a patient's behavior is disruptive tot he facility, but is non-threatening, a comprehensive patient assessment will be completed by the interdisciplinary team (IDT) in order to identify any potential action or plan of correction required. The assessment must focus on identifying the root causes of disruptive behavior". Review of medical record revealed that IDT re-assessments occurred monthly from 10/09-12/09 because the patient had been deemed unstable due to his non-compliance to hemodialysis treatments. Review of these re-assessments revealed no documented evidence that the IDT had assessed any psychosocial needs for this patient's aggressive and disruptive behavior.	V 520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 342587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 6 Interview with the Facility Administrator on 3/4/10 at 1510 revealed the IDT had not assessed this patient's aggressive and disruptive behavior.	V 520		
V 552	494.90(a)(6) POC-P/S COUNSELING/REFERRALS/HRQOL TOOL The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services, to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the interdisciplinary team (IDT) failed to provide psychosocial interventions for 1 of 1 (#1) patient reviewed that displayed aggressive and disruptive behavior. The findings included: Review of facility policy 1-01-07-Hemo Dialysis Patient Assessment and Plan of Care (revised 9/09) revealed the interdisciplinary team ... is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs which will be used to develop the patient's treatment plan and expectations for care. The assessment will include...psychosocial needs as evaluated by a social worker...and assessments will be conducted monthly on unstable patients. Review of the medical record for patient #1 revealed this 33 year old male had been	V 552	V552 The FA will review Policy # 1-01-07 "Patient Assessment and Plan of Care" with the interdisciplinary team (IDT) with emphasis on their responsibility for providing each patient with an individualized comprehensive assessment which will be used to develop the patient's treatment plan and expectations for care. All areas that are required to be addressed in this process, which includes psychosocial needs as evaluated by a social worker, will be discussed with special focus on evaluating patients who have been demonstrating aggressive and disruptive behavior. Policy #1-01-08 "Patient Behavior Agreements, 30 day Discharge, Involuntary Discharge or Involuntary Transfer" will also be reviewed with emphasis on if a patient's behavior is disruptive to the facility, but is non-threatening, a comprehensive assessment will be completed by the IDT in order to identify possible root causes and any potential interventions such as mental health counseling or other applicable referrals. These interventions and subsequent patient response will be documented in the patient's record and evaluated for any further needs. The assessments will be conducted monthly and documented until the patient is no longer deemed unstable or has transferred from the facility. FA/designee will audit records of patient's identified as unstable monthly x 3 then 10% quarterly to ensure compliance. Results of audits will be reported in CQI and addressed as necessary.	4/18/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 552	Continued From page 7 admitted to the facility on 11/07/2005 for hemodialysis for end stage renal disease secondary to diabetes. Review of the medical record revealed this patient had been involuntarily discharged from the dialysis unit on 1/25/10 "effective immediately" due to verbally threatening staff after a patient/staff altercation that occurred on 1/25/10. Interview with the Clinical Manager on 3/4/10 at 1500 revealed this patient had a history of aggressive and disruptive behavior. Interview with staff #1 on 3/4/10 at 1245 revealed this patient had a long history of disruptive behavior but on 1/25/10, the day that the patient threatened the staff, she felt like the patient's behavior was "unpredictable". Interview with staff #2 on 3/4/10 at 1315 revealed that she had seen patient #1 "get smart but never saw him lose his control like he did that day. I felt like he may hurt somebody or even carry out his threats". Review of the medical record revealed the following progress notes: RN progress note on 12/8/08-patient became very angry and irate when asked by staff not to use cell phone in facility due to possible interference with machine circuit boards. Facility Manager progress note on 6/5/09-patient refusing care...demanding a soft drink...using foul language...	V 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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V 552	Continued From page 8 Facility Administrator progress note on 12/18/09-patient upset because he left his belongings at the facility when he left the premises only to find out upon his return that his belongings had been stolen. He stated "it ain't over-best believe that". RN progress note on 1/22/10-patient requested to stop treatment such that he could use the restroom-patient walked past the restroom and lit a cigarette outside the facility. Social Worker progress note on 1/25/10-patient raising voice speaking to RN...refusing to leave facility (treatment completed)...stated "mind your own business"..."I will cut you like I'm going to cut her" (RN)... Review of the Medical record revealed the following Social Worker progress notes: 5/20/09-"Pt's (patient's) psychosocial status remains unchanged at this time"... 7/22/09-"I met with patient to introduce myself as the new social worker"..."Patient stated that no assistance was needed at this time"..."I will continue to monitor, assist with resources, education and counseling as needed"... 9/11/09-"I made contact with patient to assess if any social work related concerns or issues. Patient did not report anything of concern. I will continue to monitor, educate and support as needed". 10/16/09-"I conducted annual psychosocial assessment with patient. Patient was minimally responsive and appeared unwilling to	V 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 552	Continued From page 9 communicate due to not elaborating on answers and keeping his eyes closed"...Patient declined completing the KDQOL" (Kidney Diease Quality of Life) survey... Medical record review revealed no documented evidence that the IDT had addressed this patient's aggressive and disruptive behavior. Review of the 10/09, 11/09 and 12/09 monthly IDT re-assessments revealed the IDT had not assessed this patient's behavior as being a need. Therefore, the IDT had not established interventions such to address this patient aggressive and disruptive behavior. Interview with the Facility Administrator on 3/4/10 at 1510 revealed that the Social Worker had indicated that she never thought to make any type of mental health counseling referrals for this patient. Intake NC00062004 kdc	V 552		

Exhibit J

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

RE: **Medicare Recertification Survey**
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) A description of the correction action(s) and the systems that have been or will be implemented to correct the deficiency.

(b) A description of the monitoring system that has been or will be implemented including the person(s) responsible for the monitoring to assure compliance; and

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

The enclosed CMS form 2567 must contain an **original signature, with the date signed, and returned to me at the above mailing address** **<u>WITHIN 10 WORKING DAYS OF RECEIPT</u>.** 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)

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

MEDICA' MEDICAID CERTIFICATION AND TRANSI 'AL — ID: 1ZU2

PART I - T. BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 970275

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 342587

2. STATE VENDOR OR MEDICAID NO.

3. NAME AND ADDRESS OF FACILITY
(L3) GOLDSBORO SOUTH DIALYSIS
(L4) 1704 WAYNE MEMORIAL DRIVE
(L5) GOLDSBORO, NC (L6) 27530

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 04/09/2009 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 JCAHO
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 09 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP
02 SNF/NF/Dual	06 LAB	10 NF	14 CORF
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) 12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
A recertification survey was conducted on 4/9/2009 with a Condition level deficiency cited for 494.180-V750-Governance along with other standard level citations. A follow-up survey was conducted on 5/22/2009 and all previously cited deficiencies have been corrected.

17. SURVEYOR SIGNATURE [signature] Date: 05/26/2009 (L19)

18. STATE SURVEY AGENCY APPROVAL [signature] Date: 5/27/09 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION 01/22/1997 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00 INVOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00101 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HU[illegible] N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED APR 2 9 2009

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	04/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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V 501	494.80 PATIENT ASSESSMENT 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 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. 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.	V 501		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], RN
TITLE: Facility Administrator
(X6) DATE: 4/27/0[illegible]

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.

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V 501	Continued From page 1 Review revealed no documented evidence that the patient's physician participated in the IDT's assessment as required. Review of the IDT assessment, respectively, revealed there were areas on the assessment that were not completed and left blank. Assessment review revealed the following header areas on the assessment that were incomplete or blank: General information Baseline data Immunizations/Communicable diseases Sleeping Habits Cognitive/Perceptual Sensory Skin Genitourinary Neuromuscular Gastrointestinal Respiratory Vascular Access Cardiovascular Demographics Interview with the Facility Administrator on 4/8/09 at 1615 revealed because of the complexity of the recent changes in the assessment and care plan process, and the staff's lack of understanding the new process, the IDT assessments had not been completed as required. The physician was not available for interview.	V 501	V501 The interdisciplinary team will review and comprehensively assess the patient within the required time frames or unstable event triggering an IDT care conference. Each discipline will clearly denote any findings in the electronic medical record and will complete each provided section of the assessment. The entire IDT assessment will then be printed as a single document and placed in the chart under the tab labeled "care planning". The IDT team will meet within the week after the monthly lab draw to comprehensively and holistically review all patients for stability versus instability and at that time will begin the IDT assessment phase including documentation of all findings prior to the care conference meeting. The rounding physician will assess these patients on rounds in the facility or at a separate appointment and clearly document his findings and his determination of stable or unstable in progress notes or by completing a history and physical examination and documenting those findings. The facility administrator will own this process and will monthly monitor for compliance and results of the findings will be documented and discussed monthly in CQI meeting.	5-9-09
V 520	494.80(d)(2) PATIENT REASSESSMENT [In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be	V 520		

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V 520	Continued From page 2 conducted-] (2) At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the interdisciplinary team (IDT) failed to re-assess a patient after two hospitalizations for 1 of 4 (#2) patients reviewed that had been hospitalized. 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 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 which will be used to develop the patient's treatment plan and expectations for care...The comprehensive assessment will be conducted on all new patients or patients that transfer to the facility within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with the first outpatient dialysis treatment". A comprehensive re-assessment of each patient	V 520	V520 Patients with extended or frequent hospitalizations, marked deterioration in health status, significant change in psychosocial needs, or concurrent poor nutritional status, unmanaged anemia and inadequate dialysis or any other factor contributing to an unstable status will be reassessed by the IDT every 30 days until a determination of stable is met. This includes any patient status post hospital discharge for diagnoses such as medication toxicity. The facility will implement and maintain a process in which upon discharge the administrative assistant ensures that a discharge summary is received prior to the patient's next treatment or the physician is contacted for any updated orders. This will then be given to the RN for review at which point any physician dictated orders will be entered into the order entry system for completion. The patient will then be reviewed at the IDT team meeting prior to care conference to determine if the patient has any needs status post discharge and a comprehensive assessment and care plan will be completed at that time. The facility administrator as a part of this IDT will own this process and monitor monthly as well as quarterly during the review of 10% of the medical records.	5-9-09

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V 520	Continued From page 3 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 her Dilantin monitoring needs. Interview revealed staff enter pertinent staff information into the computer system, which causes the patient to be "flagged" for an IDT assessment. The dietician should take the lead in the assessment process seeking input from the RN and social worker	V 520		

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V 520	Continued From page 4 related to patient needs.	V 520		
V 553	494.90(a)(7)(i) DEVELOPMENT OF PATIENT PLAN OF CARE The interdisciplinary team must identify a plan for the patient's home dialysis or explain why the patient is not a candidate for home dialysis. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review and staff interview, the interdisciplinary team failed to incorporate the reason why patients were not home dialysis candidates in the patient care plan for 6 of 6 (#2, 4, 3, 1, 6, 5) patients reviewed. The findings included: Facility policy 1-01-07, Patient Assessments and Plan of Care (revised 9/08), review revealed the patient care plan will address the patients's modality and will include an explanation regarding why the patient is not a candidate for home dialysis. 1. Medical record review for patient #2 revealed this 62 year old female had been admitted to the facility on 7/10/03 for hemodialysis with a diagnosis of end stage renal disease secondary to hypertension. Record review revealed a current plan of care dated on 10/28/08 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	V 553	V553 Policy #1-01-07 "Patient Assessment and Plan of Care" has been reviewed with the interdisciplinary team (IDT)with emphasis on the need to ensure the assessment addresses home modality therapy options and this is documented accordingly. Going forward until there is a defined area on the care plan the modality teaching and candidacy status will be addressed and documented in the notes area by the nurse with notes from the other IDT members attached. These notes will all be filed in the assessment area of the record. The patient assessment/care plans cited have been updated with the modality candidacy status information. All other current records will be audited for any assessments missing this transplant documentation and these records will be updated by5/9/09 FA/designee will audit records monthly x3 then quarterly to ensure compliance. Results of audits will be reported in CQI meetings and addressed as needed.	5/9/09

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V 553	Continued From page 5 information. 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.	V 553		
	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. 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			

DEPARTMENT OF HEALTH AND HU[illegible] SERVICES
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GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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V 553	Continued From page 6 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. 5. Medical record review for patient #6 revealed this 51 year old patient had been admitted to the facility on 2/4/08 for hemodialysis with a diagnosis of end stage renal disease secondary to focal segmental glomerular sclerosis. Record review revealed a current plan of care dated on 11/18/08 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.	V 553		
	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. 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			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	04/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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V 553	Continued From page 7 staff's lack of understanding the new process, the care plans had not included the required information.	V 553		
V 750	494.180 GOVERNANCE This CONDITION is not met as evidenced by: Based on medical record review, staff interview, facility policy review, observation and facility log review, the Governing Body failed to ensure sufficient management and oversight of the facility was provided in that licensed staff was available to meet patients clinical needs and oversee the dialysis process. The findings included: 1) The facility staff failed to coordinate the care of 1 of 1 (#2) patients reviewed that had been hospitalized for medication toxicity ~Cross refer to Tag V758, example #1 2) The facility staff failed to coordinate the care of 1 of 1 (#4) closed records reviewed that experienced abnormal blood glucose labs ~Cross refer to Tag V758, example #2 3) The facility staff failed to provide the correct dialysate concentrate as ordered by the physician and notify medical staff regarding patients treated on the incorrect dialysate concentrate for 4 of 16 (#7, 8, 9, 10) patients observed during hemodialysis ~Cross refer to Tag V758, examples #3a, 3b, 3c, 3d	V 750	V750 Members of the Governing Body (GB) have reviewed the Statement of Deficiencies (SOD) and formulated the following Plan of Correction (POC). The standards under Condition: Governance (V750) that is not met as well as other standards contains specifics of corrective plans.The focus has been on ensuring the licensed staff meet the patient needs and oversee the dialysis process in areas to include but not be limited to: 1) coordinating care for patients post hospitalization; 2) assessing blood glucose levels on diabetic patients; 3) ensuring patients receive the correct dialysate concentration as ordered; 4) assessing and notifying medical staff of patient hypertensive episodes post dialysis; 5) ensuring meter used for testing are validated and tested as required ; and 6) medications are given as ordered by the physicians. The Governing Body will meet monthly x 3 to ensure compliance with POC. Further compliance to the POC will be reviewed during monthly QA meetings and reported to the Governing Body no less than semi-annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC.	5-9-09

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

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V 750	Continued From page 8 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 ~Cross refer to Tag V758, example #6	V 750		
V 758	494.180(b)(1) ADEQUATE NUMBER OF QUALIFIED/TRAINED STAFF [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	V 758		

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

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V 758	Continued From page 9 staff: 1) coordinated the care of 1 of 1 (#2) patients reviewed that had been hospitalized for medication toxicity; 2) coordinated the care of 1 of 1 (#4) closed records reviewed that experienced abnormal blood glucose labs; 3) provided the correct dialysate concentrate as ordered by the physician and notify medical staff regarding patients treated on the incorrect dialysate concentrate for 4 of 16 (#7, 8, 9, 10) patients observed during hemodialysis; 4) assessed and notified medical staff of patient hypertensive episodes post hemodialysis for 3 of 8 (#11, 12, 6) records reviewed; (5) validated and disinfected 3 of 3 meters used in the process of testing patient dialysate concentrate; 6) administered antibiotics according to physician order for 1 of 3 (#4) records reviewed that had antibiotics administered. The findings included: 1. 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 a diagnosis 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 records 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 upon 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).	V 758	V758 The team has been in-serviced on the increased focus of ensuring the licensed staff meet the patient needs and oversee the dialysis process in areas to include but not be limited to: 1) coordinating care for patients post hospitalization; 2) assessing blood glucose levels on diabetic patients; 3) ensuring patients receive the correct dialysate concentration as ordered; 4) assessing and notifying medical staff of patient hypertensive episodes post dialysis; 5) ensuring meter used for testing are validated and tested as required ; and 6) medications are given as ordered by the physicians. FA/designee will track hospitalized patients and when they are discharged will call the hospital to obtain the discharge summary prior to the next scheduled treatment or the physician will be called for any updated orders needed. This summary will be reviewed for any changes or updates in care by a licensed nurse. The licensed staff has been in-serviced on the need to assess glucose levels monthly on diabetic patients, address as needed, including notifying the physician if needed, and document in progress notes. FA/designee will audit records of diabetic patients monthly x3 then 25% quarterly to ensure compliance. Results of audits will be reported in CQI meetings and addressed as needed. cont pg 11	5-9-09

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

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

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V 758	Continued From page 10 Medical record review revealed no documented evidence that facility staff coordinated with the physician any follow-up regarding the Dilantin toxicity experienced by this patient. Interview with the Facility Administrator on 4/9/09 at 0930 revealed staff had not coordinated this patient's care to ensure her Dilantin levels were being monitored. 2. Medical record review for patient #4 revealed this 37 year old patient had been admitted to the facility on 9/8/06 with a diagnosis of end stage renal disease secondary to hypertension and diabetes. Medical record review revealed this patient's glucose labs had consistently increased since 8/21/08 without documented evidence of adequate staff intervention. Review of the blood glucose lab results were as followed (blood glucose lab reference range 80-120): 8/21/08=176 9/20/08=287 10/8/08=387 11/08=no lab 12/18/08=664 1/22/09=651 2/21/09=980 Review of the psychosocial summary/assessment aspect of the patient care plans dated on 9/23/08 and 10/15/08 revealed "The patient continues to reside at a group home, however, he states they are not feeding him correctly. Patient stated he did not want the social worker to contact group home". Review revealed no documented evidence that staff followed up on this patient's concern that the group home had not been feeding him correctly.	V 758	V758 Teammates have been in-serviced on policy #1-03-08A "Treatment Initiation" with emphasis on the importance of delivering the patient prescription as ordered and the need to verify the correct dialysate concentrates prior to initiation of patient treatment. FA/ designee will audit records for correct dialysate daily x 2 weeks, 3 x weekly x 2, weekly x 3 then random monthly audits to ensure compliance. Results of audits will be reported in CQI and addressed as necessary. The Medical Director reviewed all the acid baths during the CQI meeting after the survey and the number of bath variations available in the clinic has been reduced to four to reduce chance of error and still meet patient needs. Going forward the physician will be notified for an order before there is any bath change for a patient or if the patient is dialyzed on the incorrect dialysate bath. Teammates have been in-serviced on policy # 1-03-12 "Post Treatment Assessment" with emphasis on the importance and need to obtain and document basic data on each patient post dialysis, compare to pre dialysis findings, and report any findings, such as elevated blood pressures, that may preclude discharge to the licensed nurse. If further intervention is needed the nurse then is to assess the patient, collect any additional data needed, notify the physician as needed, and document interventions. FA/designee will audit patient records daily x 1 week, weekly x 2 then complete random monthly audits to ensure compliance. Results of audits will be reported in CQI meetings and addressed as necessary. (cont. pg 12)	5-9-09

PRINTED: 04/22/2009
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER: GOLDSBORO SOUTH DIALYSIS

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

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V 758	Continued From page 11 Medical record review revealed the only documented evidence that staff had addressed this patient's increased blood glucose levels had been patient education provided by the dietician on 11/9/08 and 1/27/09. Review of the physician progress notes from 9/9/08-1/6/09 revealed no documentation that this patient's consistently high blood glucose levels had been addressed by the physician. Medical record review revealed this patient had been hospitalized on 2/25/09 with generalized weakness and hyperglycemia (elevated blood glucose). Review of the hospital discharge summary revealed this patient's blood glucose had been at 998 upon admission. During this hospitalization the patient had an unexpected cardio respiratory arrest and subsequently died at the hospital on 2/28/09. 3a. Hemodialysis treatment sheet review for patient #7 revealed this patient had a current physician's order for a 3 K (potassium) 2 Ca (calcium) dialysate bath. Observation on 4/7/09 at 1050 in the patient treatment area revealed this patient had been dialyzed on a 2 K 2 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 4/7/09 at 1055 with the patient care technician (staff #3) who was caring for patient #7 revealed the patient had been put on the incorrect dialysate bath because the facility ran out of the 3 K dialysate concentrate.	V 758	V758 cont. Teammates have been in-serviced on policy #1-03-02 "Prescription Verification and Safety Checks" and policy 12-13-10A Phoenix Meter Disinfection and Calibration Verification" with emphasis on the need to verify the dialysis prescription and perform safety checks prior to each treatment initiation and that the need for the Phoenix meters to be disinfected and verified with documentation prior to daily use. FA/ designee will audit thePhoenixmeter logs daily x 1 week, weekly x2 then do random monthly audits to ensure compliance. Results of audits will be reported in CQI and addressed as necessary. The licensed teammates have been in-serviced on the need to ensure medications, including antibiotics, are administered as ordered by the physician. A change in the ordering process has been made to ensure medications are available as needed. FA/ designee will audit records weekly x 3 then monthly to ensure compliance. Results of audits will be reported in CQI and addressed as necessary. FA is responsible for ongoing compliance with POC.	5-9-09

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V 758	Continued From page 12 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. 3b. Hemodialysis treatment sheet review for patient #8 revealed this patient had a current physician's order for a 2 K 2.5 Ca dialysate bath. Observation on 4/8/09 at 0910 in the patient treatment area revealed this patient had been dialyzed on a 2 K 2 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 #3) who had been caring for patient #8 revealed the patient had been put on the incorrect dialysate bath because the pressure in the loop that carries the 2 K 2.5 Ca concentrate was very low which caused the conductivity alarm of the hemodialysis machine to sound, so "I changed the concentrate to a 2 K 2 CA for a brief period of time just until the pressure increased. I just forgot to change it back". 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. 3c. Hemodialysis treatment sheet review for patient #9 revealed this patient had a current physician's order for a 2 K 2.5 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 Ca bath.	V 758		

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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V 758	Continued From page 13 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 #4) who had been caring for patient #9 revealed the patient had been put on the incorrect dialysate bath because the pressure in the loop that carries the 2 K 2.5 Ca concentrate was very low which caused the conductivity alarm of the hemodialysis machine to sound, so "I changed the concentrate to a 2 K 2 CA for a brief period of time just until the pressure increased. I just forgot to change it back". 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	V 758		

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V 758	Continued From page 14 dialysis concentrate to the hemodialysis machine. Observation on 4/8/09 at 0925 revealed the Biomedical Technician checked the wall connection for the 2 K 2.5 Ca acid and stated "someone had cut the acid off from the wall which had caused the acid not to feed into the hemodialysis machine. 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. 4a. Medical record review for patient #11 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 4/7=265/97 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".	V 758		

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V 758	Continued From page 15 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 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	V 758		

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

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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". 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.	V 758		
	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			

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

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V 758	Continued From page 17 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". 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. 5. Facility policy 1-03-02, Prescription Verification And Safety Checks, revealed staff will verify the dialysis prescription and perform safety checks prior to each treatment initiation. Interview with Administrative staff on 4/8/09 at 1400 revealed staff use 1 of 3 Phoenix meters to test the conductivity and pH of the concentrate	V 758		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	04/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 758	Continued From page 18 prior to each treatment initiation. Interview also revealed the Phoenix meters are calibrated and disinfected daily which is logged on the Phoenix Meter Log. Facility policy 12-13-10A, Phoenix Meter Disinfection And Calibration Verification, review revealed the Phoenix meters are disinfected and verified prior to daily use. Review of the Phoenix Meter Log revealed directives for staff to calibrate the meters for conductivity and pH prior to first use each day. Log review from 1/1/09-4/8/09 revealed no documented evidence that staff calibrated and disinfected the meters as required on 21 of 82 treatment days. No explanation for the lack of Phoenix meter calibration could be provided during interview with the Facility Administrator on 4/9/09 at 0945. 6) Medical record review for patient #4 revealed this 37 year old patient had been admitted to the facility on 9/8/06 with a diagnosis of end stage renal disease secondary to hypertension and diabetes. Medical record review revealed a physician order dated on 10/23/08 for Cubicin (antibiotic) 500mg IV with hemodialysis treatment for 2 weeks due to Osteomylitis of the left foot. Record review revealed another physician's order dated on 11/13/08 to extend the Cubicin for 6 more weeks (ending 12/27/08). Review of the hemodialysis treatment sheets for this patient revealed the patient did not receive the complete dosage of antibiotic ordered by the physician. Review revealed the antibiotic had been stopped on 11/18/08 (5 1/2 weeks early).	V 758		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	342587	A. BUILDING ______ B. WING ______	04/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO SOUTH DIALYSIS	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 758	Continued From page 19 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.	V 758		

Department of Health and Human Services
Centers for Medicare & Medicaid Servic

OMB NO. 0938-0390

Post-Certification 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.

Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
342587	A. Building B. Wing	5/22/2009

Name of Facility	Street Address, City, State, Zip Code
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27530

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix V0501 Reg. # 494.80 LSC	05/22/2009	ID Prefix V0520 Reg. # 494.80(d)(2) LSC	05/22/2009	ID Prefix V0553 Reg. # 494.90(a)(7)(i) LSC	05/22/2009
ID Prefix V0760 Reg. # 494.180 LSC	05/22/2009	ID Prefix V0758 Reg. # 494.180(b)(1) LSC	05/22/2009	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
		5/22/09	Kay D. Cuaton /cs	5/22/09
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/9/2009

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public 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 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 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	Provider/Supplier Name
342587	GOLDSBORO SOUTH DIALYSIS

Type of Survey (select all that apply): I

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply): A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	15401	04/07/2009	04/09/2009	1.00	1.00	21.25	0.50	6.00	12.00
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
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

Total RO Clerical/Data Entry Hours..... 0.00

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

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

P[illegible] 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 [illegible]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 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 Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
342587	GOLDSBORO SOUTH DIALYSIS

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	15401	05/22/2009	05/22/2009	1.00	0.00	3.50	0.00	2.00	1.00
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

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..... 0.00

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED
OMB NO. 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT - Version 2

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: Goldsboro South Dialysis
2. CCN: 34-2587
3. Street Address: 1704 Wayne Memorial Dr
4. NPI: 1821058900
5. City: Goldsboro
6. County: Wayne
7. Fiscal Year End Date: 12/31
8. State: NC
9. ZIP Code: 27534
10. Administrator's Email Address: alice.hall@davita.com
11. Telephone No.: 919-739-6505
12. Facsimile No.: 919-739-6506
13. Medicare Enrollment (CMS 855A) 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: (V1) (check all that apply. If "Other", 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) ☒ 1. For Profit ☐ 2. Not For Profit ☐ 3. Public

17. Is this Facility Hospital-Owned? (V3) ☐ 1. Yes ☒ 2. No If Yes, hospital CCN (V4):
If yes, is this Facility on the main hospital-campus? (V5) ☐ 1. Yes ☒ 2. No

(V6) Hospital name:

18. Is this Facility SNF-Owned? (V7) ☐ 1. Yes ☒ 2. No If Yes, SNF CCN (V8):

19. Is facility owned and/or managed by a multi-facility organization? (V9) ☐ 1. No ☒ 2. Yes

☒ Owned ☐ Managed

(V10) If Yes, name of parent or managing organization: DaVita Inc

(V11) Address:
601 Hawaii St, El Segundo, CA 90245-4841

20. Current Services: (check all that apply)

(V12) ☒ 1. In-center Hemodialysis (HD) ☐ 2. In-center Peritoneal Dialysis (PD)(CAPD/CCPD)
☐ 3. Home HD Training & Support ☐ 4. Home PD (CAPD/CCPD) Training & Support

21. Requested Services: (check all that apply)

(V13) ☒ 1. In-center HD ☐ 2. In-center PD(CAPD/CCPD)
☐ 3. Home HD Training & Support ☐ 4. Home PD (CAPD/CCPD) Training & Support

22. Do Facility staff provide and/or support dialysis in nursing home(s)?

(V14) ☐ 1. Yes ☒ 2. No If yes, list all nursing homes under "Remarks" *(Item 33)* and answer the next question on Staffing(V15)

(V15) Staffing for dialysis provided by: ☐ 1. DME ☐ 2. Nursing home staff ☐ 3. This facility

(V16) Dialysis type: ☐ 1. HD ☐ 2. PD

23. Number of dialysis patients:

(V17) 73 In-center HD (V18) 0 In-center Nocturnal HD (V19) 0 In-center PD
(V20) 0 Home PD (V21) 0 Daily Home HD (V22) 0 Conventional Home HD

24. Number of dialysis stations including isolation stations (complete all sections that apply):

(V23) 22 Total Stations (V24) 22 In-center Hemodialysis (V NA Home Training Station(s)/Room(s)

FORM CMS-3427 (06/09)

25. How is isolation provided? (V26) ☐ 1. Room ☒ 2. Area ☐ 3. Agreement (Attach copy)

26. If applicable, number of hemodialysis stations designated for isolation: (V27) 1

27. Days of Operation (check all that apply) (V28): ☒ MWF ☒ TTS

Opening Times: (V29) MWF Staff: 0530 (V30) MWF Patients 0600 (V31) TTS Staff 0530 (V32) TTS Patients 0600

28. Is reuse practiced? (V33) ☒ 1. Yes ☐ 2. No

29. Reuse System (V34) ☐ 1. Manual ☒ 2. Semi-Automated ☐ 3. Automated ☐ 4.Centralized/Offsite

30. Staff (List full-time equivalents)

(V35) Registered Nurse	3.	(V36) LPN/LVN	0
(V37) Masters Social Worker	0.8	(V38) Registered Dietitian	0.8
(V39) Patient Care Technician	8	(V40) Others	1

31. State license number (if applicable) (V41): n/a 32. Certificate of Need required? (V42) ☒ Yes ☐ No ☒ NA

33. Remarks (attach additional pages if needed):

Nursing list:

34. The information contained in this Application Survey and Certification Report (Part 1) is true and correct to the best of my knowledge. I understand that incorrect and erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate: Signature of Administrator/Medical Director	Title	Date
Alice M [signature], RN	Group Facility Administrator Medical Director/CEO	6/14/11

PART II. - TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A approved by MAC)? (V43) ☒ Yes ☐ NO

(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) NCC

38. Network Number (V46) VI

I have reviewed this form and it is complete: 39. Surveyor Team Leader Name/Number (Print)	Professional Discipline *(Print)*	40. Survey Exit Date
Doug Stanton	RN, FSL	6/16/11

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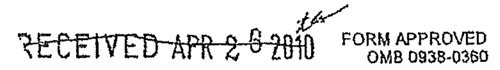
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



FORM APPROVED
OMB 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: ldsboro South Dialysis
2. Provider Number: 3 4 2 5 8 7
3. Street Address: 1704 Wayne Memorial Dr.
4. City: Goldsboro
5. County: Wayne
6. State: North Carolina
7. ZIP Code: 27534-2240
8. Telephone No.: 919-739-6505
9. Facsimile No.: 919-739-6506
10. Fiscal Year Ending Date: 12/31

11. Name/Address/Telephone Number of Authorized Official
Name: Alice Hill, Facility Administrator
Address: 1704 Wayne Memorial Dr. Goldsboro, NC 27534-2240
Telephone No.: 919-739-6505

12. Type of Application/Notification: (v1) *(check all that apply and specify in Remarks section* [see Item 27])
☐ 1. Initial ☐ 2. Expansion to new location ☐ 3. Change of ownership
☐ 4. Change of location ☒ 5. Expansion in current location ☐ 6. Change of services/operations
☒ 7. Other *(specify)* Addition of one Hemodialysis station

13. Ownership (V2) ☒ For Profit ☐ Not for Profit ☐ Public

14. Is this Facility Hospital-Based *(check one)* (v3) ☐ Yes ☒ No *If Yes, hospital provider number* (V4) ☐☐☐☐☐☐

15. Is this Facility SNF-Based *(check one)* (v5) ☐ Yes ☒ No *If Yes, SNF provider number* (v6) ☐☐☐☐☐☐

16. Is this facility owned and/or managed by a multi-facility organization? (v7) ☒ Yes ☐ No *If Yes, name and address of parent organization*
Name: (v8) DaVita Inc. FEIN 51-0354549
Address: 601 Hawaii St. El Segundo, CA 90245-4814

17. Services Provided: (v9) *(check all that apply and specify in Remarks section* (see item 27))
☒ 1. Hemodialysis ☐ 2. Peritoneal Dialysis ☐ 3. Transplantation ☐ 4. Home Training: ___ Hemodialysis ___ Peritoneal Dialysis ☐ 5. Home Support: ___ Hemodialysis ___ Peritoneal Dialysis

18. Is Reuse Practiced? (v10) ☒ Yes ☐ No

19. Reuse System (v11) *(check all that apply)* ☐ 1. Manual ☒ 2. Semi-Automated ☐ 3. Automated

~~20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde~~ ☒ 4. Peracetic Acid Mixture
☐ 5. Other *(specify)* ____

21. Number of Dialysis Patients
(V13) 67 Total Patients = (V14) 67 Hemodialysis + (V15) 0 Peritoneal Dialysis

22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) 22 Total Stations = (V17) 22 Hemodialysis + (V18) 0 Hemodialysis Training

23. Does the facility have isolation stations? **(Included in total station count)** (V19) ☒ Yes ☐ No

24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

A. SUNDAY				B. MONDAY				C. TUESDAY				D. WEDNESDAY			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
0	0	0	0	21	16	0	0	16	14	0	0	21	16	0	0

E. THURSDAY				F. FRIDAY				G. SATURDAY			
1	2	3	4	1	2	3	4	1	2	3	4
16	14	0	0	21	16	0	0	16	14	0	0

25. Total Number of patients followed at home (V20) 0

FORM CMS-3427 (05-97)

26. Staffing *(list full-time equivalents)*				
	(V21) ☐ Registered Nurse	3.00	(V22) ☐ Licensed Practical Nurse	__.__
	(V23) ☒ Social Worker	0.50	(V24) ☒ Dietitian	0.50
	(V25) ☒ Technicians	7.00	(V26) ☒ Others	1.00

Remarks: *(Use this space for explanatory statements for Items 1-26)*

28. The information contained in this Application Survey and Certification Report (Part 1) is true and correct to the best of my belief. I understand that incorrect or erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R.405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date
[signature]	L+C Manager	4/26/2010

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number (if *the facility has a provider number*) 3 4 2 5 8 7

30. Network Number (V27) V 1

31. State Region (V28) IV

32. State County Code (V29)

33. Type of Survey (V30) *(checkall that apply)* ☐ Initial ☐ Complaint ☐ Recertification ☑ Other

34. Survey Protocol (V31)*(check all that apply)* ☐ Basic ☐ Initial ☐ Supplemental ☑ Combination

35. Surveyor Name/Number *(print)*	Professional Discipline *(print)*
Izzie Conley	RN

36. Date of Survey [signature] 4/27/2010

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0360. The time required to complete this information collection is 2.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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

FORM APPROVED
OMB 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: Goldsboro South Dialysis

2. Provider Number: 3 4 2 5 8 7

3. Street Address: 1704 Wayne Memorial Dr.

4. City: Goldsboro

5. County: Wayne

6. State: North Carolina

7. ZIP Code: 27534-2240

8. Telephone No.: 919-739-6505

9. Facsimile No.: 919-739-6506

10. Fiscal Year Ending Date: 12/31

11. Name/Address/Telephone Number of Authorized Official
Name: Alice Hill
Address: 1704B Wayne Memorial Dr. Goldsboro, NC 27534
Telephone No. 919-739-6505

12. Type of Application/Notification: (v1) *(check all that apply and specify in Remarks section [see item 27])*
- ☐ 1. Initial
- ☐ 2. Expansion to new location
- ☐ 3. Change of ownership
- ☐ 4. Change of location
- ☐ 5. Expansion in current location
- ☐ 6. Change of services/operations
- ☒ 7. Other *(specify)* survey inspection Complaint

13. Ownership (V2): ☒ For Profit ☐ Not for Profit ☐ Public

14. Is this Facility Hospital-Based *(check one)* (v3) ☐ Yes ☒ No *If Yes, hospital provider number* (V4) ☐☐☐☐☐☐

15. Is this Facility SNF-Based *(check one)* (v5) ☐ Yes ☒ No *If Yes, SNF provider number* (V6) ☐☐☐☐☐☐

16. Is this facility owned and/or managed by a multi-facility organization? (v7) ☒ Yes ☐ No *If Yes, name and address of parent organization*
Name: (V8) DaVita Inc.
Address: 601 Hawaii St. El Segundo, CA 90245-4814
FEIN 51-0354549

17. Services Provided: (v9) *(check all that apply and specify in Remarks section (see item 27))*
- ☑ 1. Hemodialysis
- ☐ 2. Peritoneal Dialysis
- ☐ 3. Transplantation
- ☐ 4. Home Training: ___ Hemodialysis ___ Peritoneal Dialysis
- ☐ 5. Home Support: ___ Hemodialysis ___ Peritoneal Dialysis

18. Is Reuse Practiced? (V10) ☑ Yes ☐ No

19. Reuse System (v11) *(check all that apply)* ☐ 1. Manual ☑ 2. Semi-Automated ☐ 3. Automated

~~20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde ☑ 4. Peracetic Acid Mixture~~
☐ 5. Other *(specify)* ______

21. Number of Dialysis Patients
(V13) 67 Total Patients = (V14) 67 Hemodialysis + (V15) Ø Peritoneal Dialysis

22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) 21 Total Stations = (V17) 21 Hemodialysis + (V18) ___ Hemodialysis Training

23. Does the facility have isolation stations? (Included in total station count) (V19) ☑ Yes ☐ No

24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

A. SUNDAY				B. MONDAY				C. TUESDAY				D. WEDNESDAY			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
0	6	0	0	21	15	0	0	16	12	0	0	21	15		

E. THURSDAY				F. FRIDAY				G. SATURDAY			
1	2	3	4	1	2	3	4	1	2	3	4
16	14	0	0								

25. Total Number of patients followed at home (V20) Ø

FORM CMS-3427 (05-97)

26. Staffing	(V21) ☐ Registered Nurse	3.0	(V22) ☐ Licensed Practical Nurse	0.00
(list full-time equivalents)	(V23) ☐ Social Worker	0.08	(V24) ☐ Dietitian	0.08
	(V25) ☐ Technicians	6.00	(V26) ☐ Others	2.00

27. Remarks: *(Use this space for explanatory statements for Items 1-26)*

(V26) Other - Administrative Assistant
Inventory Control

28. The information contained in this Application Survey and Certification Report (Part 1) is true and correct to the best of my belief. I understand that incorrect or erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R.405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date
[signature]	Group Facility Administrator	3/4/10

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number (if *the facility has a provider number*) 3 4 2 5 8 7

30. Network Number (V27) 0 1

31. State Region (V28) NC

32. State County Code (V29) NCE

33. Type of Survey (V30) *(checkall that apply)* ☐ Initial ☒ Complaint ☐ Recertification ☐ Other

34. Survey Protocol (V31) *(check all that apply)* ☒ Basic ☐ Initial ☐ Supplemental ☐ Combination

35. Surveyor Name/Number *(print)*	Professional Discipline *(print)*
[signature] 15401	RN

36. Date of Survey
3/4/2010

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0360. The time required to complete this information collection is 2.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Department of Health and Human Services
Medicare/Medicaid/CLIA Complaint Form

Control Number: GE2D11 (NC00062004)

Part I - To Be Completed by Component First Receiving Complaint (SA or RO)

1. Medicare/Medicaid Identification Number: 342587

Facility Name and Address:
GOLDSBORO SOUTH DIALYSIS
1704 WAYNE MEMORIAL DRIVE
GOLDSBORO, NC 27530

3. Date Complaint Received: 012810 (MM DD YY)

4. Receiving Component: 1
1 State Survey Agy. 2 RO

5. Date Acknowledged: 020410 (MM DD YY)

6A. Source of Complaint
1: 1
2:
3:

1 Resident/Patient Family
2 Ombudsman
3 Facility Employee/Ex-Employ
4 Anonymous
5 Other

6B. Total Number of Complainants: 02

7. Allegations

	7.A. Category	7.B. Findings	7.C. Number of Complainants per Allegation
1	03	02	02
2	01	02	02
3			
4			
5			

7.A. Category:
1 Resident Abuse
2 Resident Neglect
3 Resident Rights
4 Patient Dumping
5 Environment
6 Care or Services
7 Dietary
8 Misuse of Funds/Property
9 Certification/Unauthorized Testing
10 Proficiency Test
11 Falsification of Records / Reports
12 Unqualified Personnel
13 Quality Control
14 Specimen Handling
15 Diagnostic Erroneous Test Results
16 Fraud/False Billing
17 Fatality/Transfusion Fatality
18 Other (Specify)
19 Life Safety Code
20 State Monitoring

7.B. Findings (To be completed following investigation)
01 Substantiated
02 Unsubstantiated/Unable to Verify

8. Action (if multiple actions, indicate earliest action): 3
1 Investigate within 2 working days
2 Investigate within 10 working days
3 Investigate within 45 working days
4 Investigate during next onsite
5 Referral (Specify)
6 Other Action (Specify)
7 None

Part II - To Be Completed By Component Investigating Complaint (SA or RO)

9. Investigated by: 1
1 State Survey Agency
2 RO
3 Other (Specify)

10. Complaint Survey Date: 030410 (M MDD YY)

11. Findings (Under 7B Above): unsubstantiated

12. Proposed Actions Taken by SA or RO
1: 04
2:
3:

1 Recommend Termination (23-day)
2 Recommend Termination (90-day)
3 Recommend Intermediate Sanction
4 POC (No Sanction)
5 Fine
6 Denial of Payment for New Admissions
7 License Revocation
8 Receivership
9 Provisional License
10 Special Monitor
11 Directed POC
12 Limitation of Certificate
13 Suspension of Certificate
14 Revocation of Certificate
15 Injunction
16 Civil Monetary Penalty
17 TA & Training for Unsuccessful PT
18 State Onsite Monitoring
19 Suspension of Part of Medicare Payments
20 Suspension of All Medicare Payments
21 None
22 Other (Specify)
23 Enforcement Action

13. Date of Proposed Action: 030410 (M MDD Y Y)

14. Parties Notified and Dates
1 Facility
2 Complainant
3 Representative
4 Other (Specify)

	Party	Date
1.	1	031510
2	2	031710
3.		

15. Date Forwarded to CMS RO or Medicaid SA (MSA) (Attach HCFA-2567): (MMD DY Y)

Part III - To Be Completed By Component Taking Final Close-Out Action (RO/MSA)

16. Date of CMS/MSA Receipt: (MMDDYY)

17. CMS RO/MSA Action:
1 None
2 Termination (23-day)
3 Termination (90-day)
4 Intermediate Sanction
5 Move Routine Survey Date Forward
6 Limitation of Certificate
7 Suspension of Certification
8 Revocation of Certificate
9 Injunction
10 Civil Monetary Penalty
11 TA & Training For Unsuccessful PT
12 Cancellation of Medicare Approval
13 Other (Specify)
14 Enforcement Action

18. Date of Final Action Sign-off: (MMDDYY)

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public 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 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 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	Provider/Supplier Name
342587	GOLDSBORO 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
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply): A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	15401	03/04/2010	03/04/2010	1.00	0.00	5.00	0.00	2.00	3.00
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

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..... 0.00

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

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

FORM APPROVED
OMB 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility: Goldsboro South Dialysis

2. Provider Number: 342587

3. Street Address: 1704 Wayne Memorial Drive

4. City: Goldsboro

5. County: Wayne

6. State: NC

7. ZIP Code: 27534

8. Telephone No.: 919-739-6505

9. Facsimile No.: 919-739-6506

10. Fiscal Year Ending Date: 12/31

11. Name/Address/Telephone Number of Authorized Official
Name: Alice Hill
Address: 1704 Wayne Memorial Dr Goldsboro, NC 27534
Telephone No.: 919-739-6505

12. Type of Application/Notification: (V1) *(check all that apply and specify in Remarks section* [see item 27])
- ☐ 1. Initial
- ☐ 2. Expansion to new location
- ☐ 3. Change of ownership
- ☐ 4. Change of location
- ☐ 5. Expansion in current location
- ☐ 6. Change of services/operations
- ☒ 7. Other *(specify)* recertification

13. Ownership (V2): ☒ For Profit ☐ Not for Profit ☐ Public

14. Is this Facility Hospital-Based *(check one)* (V3) ☐ Yes ☒ No *If Yes, hospital provider number* (V4) ______

15. Is this Facility SNF-Based *(check one)* (V5) ☐ Yes ☒ No *If Yes, SNF provider number* (V6) ______

16. Is this facility owned and/or managed by a multi-facility organization? (V7) ☒ Yes ☐ No *If Yes, name and address of parent organization*
Name: (V8) DaVita Inc
Address: 601 Hawaii St El Segundo, CA 90245-4814

17. Services Provided: (V9) *(check all that apply and specify in Remarks section* [see item 27])
- ☒ 1. Hemodialysis
- ☐ 2. Peritoneal Dialysis
- ☐ 3. Transplantation
- ☐ 4. Home Training: ___ Hemodialysis ___ Peritoneal Dialysis
- ☐ 5. Home Support: ___ Hemodialysis ___ Peritoneal Dialysis

18. Is Reuse Practiced? (V10) ☒ Yes ☐ No

19. Reuse System (V11) *(check all that apply)* ☐ 1. Manual ☒ 2. Semi-Automated ☒ 3. Automated

20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde ☒ 4. Peracetic Acid Mixture ☐ 5. Other *(specify)* ______

21. Number of Dialysis Patients
(V13) 67 Total Patients = (V14) 67 Hemodialysis + (V15) 0 Peritoneal Dialysis

22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) 21 Total Stations = (V17) 21 Hemodialysis + (V18) 0 Hemodialysis Training

23. Does the facility have isolation stations? (V19) ☒ Yes ☐ No

24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

Day	1	2	3	4
A. SUNDAY	0	0	0	0
B. MONDAY	21	22	0	0
C. TUESDAY	16	7	0	0
D. WEDNESDAY	21	22	0	0
E. THURSDAY	16	7	0	0
F. FRIDAY	21	22	0	0
G. SATURDAY	16	7	0	0

25. Total Number of patients followed at home (V20) 0

26. Staffing (list full-time equivalents)

(V21)	Registered Nurse	4.	(V22)	Licensed Practical Nurse	1.
(V23)	Social Worker	.25	(V24)	Dietitian	.25
(V25)	Technicians	9.	(V26)	Others	2.

27. Remarks: *(Use this space for explanatory statements for Items 1–26)*

28. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my belief. I understand that incorrect or erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date
[signature], RN	FACILITY ADMINISTRATOR	4/7/09

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number *(if the facility has a provider number)* 342587

30. Network Number (V27) VI

31. State Region (V28) NC

32. State County Code (V29) NCE

33. Type of Survey (V30) *(check all that apply)* Initial Complaint (Recertification) Other

34. Survey Protocol (V31) *(check all that apply)* (Basic) Initial Supplemental Combination

35. Surveyor Name/Number *(print)* [signature] 15401

Professional Discipline *(print)* RN

36. Date of Survey

4/9/09

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0360. The time required to complete this information collection is 2.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

- 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			✓

*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).

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

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

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?

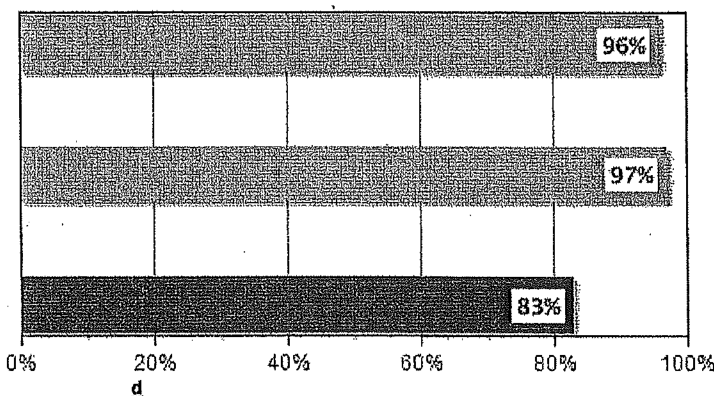
- This graph shows the percentage of patients at each facility who had enough wastes removed from their blood during dialysis, or who had a URR of 65 or more.
- Higher percentages mean that more patients at the facility had a URR of 65 or more.
- On the graphs, longer bars are better.

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?

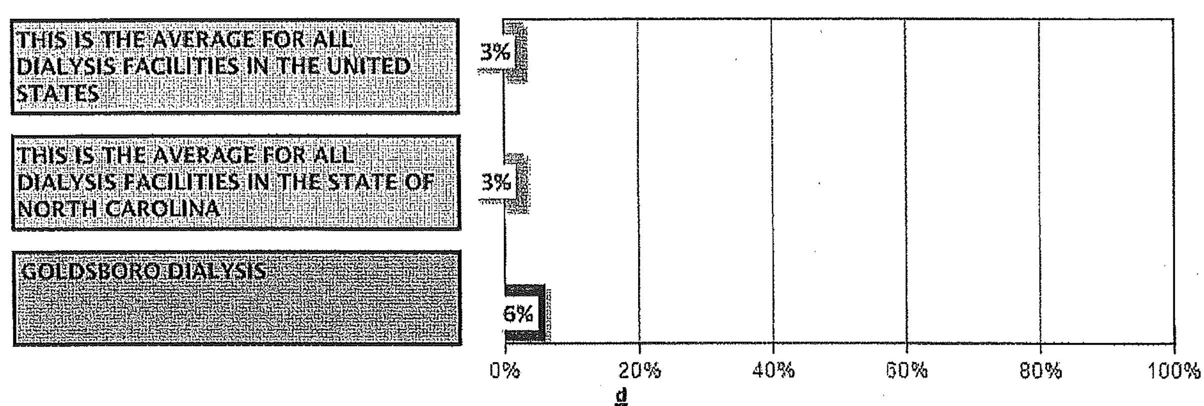
- Generally, patients with kidney failure don't live as long as patients with normal kidneys.
- Many factors affect how long a dialysis patient lives. Some of these factors are under the control of the patient (like not skipping treatments), and some of these factors are under the control of the facility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

What Does This Table Show?

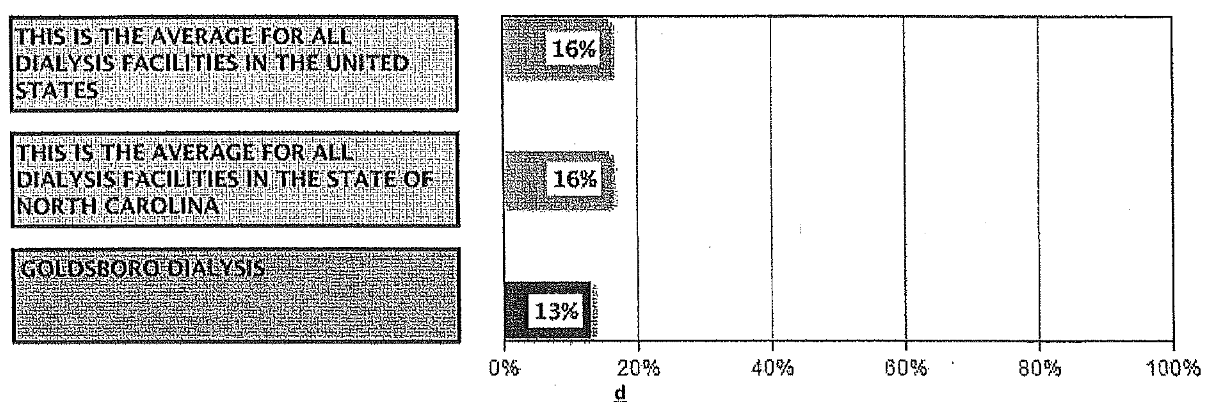
- This information is in categories called Better than Expected (live longer than expected), As Expected, or Worse than Expected (don't live as long as expected).
- This information lets you compare patient survival at the facilities you selected. Use this information when you talk to your doctor or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

Why is Anemia Important to You?	What Do These Graphs Show?
• 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.	• 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.

Exhibit K

Return To Previous Page

Dialysis Facility Compare

Compare Quality Measures

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

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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.)