

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152648	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2014
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NAME OF PROVIDER OR SUPPLIER FORT WAYNE WEST DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 4916 ILLINOIS RD STE 118 FORT WAYNE, IN 46804
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V000000	<p>This was a federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: December 3, 4, 5, and 8, 2014.</p> <p>Facility #: 012606</p> <p>Medicaid Vendor #: 201044760</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 10, 2014</p>	V000000		
V000116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>patients. Based on observation, policy review, and interview, the facility failed to ensure all staff followed infection control policies for cleaning equipment before use for 1 of 13 observations, creating the potential to affect all the facility's 58 patients. (#14)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During observation on 12/4/14 at 10:20 AM, employee G removed the Phoenix meter and thermometer from the dirty sink area across from stations 5 and 6, checked the conductivity at station 5, checked the temperature of patient #14, and returned the Phoenix meter and thermometer to the dirty area. Employee G failed to clean the Phoenix meter and thermometer prior to use. 2. During interview on 12/4/14 at 11:51 AM, employee B indicated equipment should be cleaned prior to use and returned to designated areas. 3. During interview on 12/4/14 at 11:51 AM, employee A indicated dirty areas are for dirty equipment and clean areas are for clean equipment. 4. The facility's policy titled "Infection Control for Dialysis Facilities," # 	V000116	<p>Facility Administrator (FA) educated Employee G regarding surveyor findings for observed actions and reviewed Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities on 12/4/2014. Education documented on One-on-One Meeting Form.</p> <p>All direct care staff were educated by FA on 12/4/2014 and 12/5/2014 reviewing Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities. TMs educated that items taken to dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before returning to clean area or used on another patient. Dirty supplies must not be placed in areas designated for clean items only. TMs must disinfect thermometers by wiping outer casing with 1:100 bleach solution after each patient use, and prior to returning thermometer to clean area; Phoenix Meters must be disinfected with 1:100 bleach solution after each patient use and prior to returning to clean area. Teammates signed clinical in-service form.</p> <p>Infection Control Manager or designee will complete Infection Control Audits bi-monthly x 2 months, then monthly. All results will be reviewed with Medical Director during Facility Health Meeting, minutes will reflect.</p>	01/08/2015

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V000119	<p>1-05-01, revised September, 2014, states, "25. Non-disposable items, such as stethoscopes, are not to be shared unless disinfected between patients. ... 33. If electronic thermometers and/or blood glucose meters are used, measures will be taken to prevent cross contamination between patients. For example, the thermometer should not be placed on potentially contaminated equipment such as the dialysis delivery system. If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before returning to clean area or using on another patient. ... 42. Items taken into the dialysis station will be disposed of, ... or cleaned and disinfected before taken to a common clean area or used on another patient. 43. Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment."</p> <p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p>		FA is responsible for compliance with plan of correction	

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	<p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure staff followed personal protective equipment (PPE) policies for 1 of 13 observations, creating the potential to affect all the facility's 58 patients. (employee L)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During observation on 12/4/14 at 10:50 AM, employee L escorted the patient from station # 1 out into the lobby. Employee L failed to remove shield, gloves, and gown prior to leaving treatment area. Upon return to treatment area, employee L failed to change gown and shield and proceeded to connect dialysis lines at station # 2. 2. During observation on 12/4/14 at 10:50 AM, sign inside treatment room door states "Remove these [points to gown and gloves] and always do this [picture of washing hands]." 	V000119	<p>FA educated Employee G regarding surveyor findings for observed actions and reviewed Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities on 12/4/2014. Education documented on One-on-One Meeting Form.</p> <p>On 12/5/2014 storage cabinet was placed inside the treatment room at the entrance from the lobby which is stocked with new disposable lab coats to facilitate changing PPE when necessary at that location.</p> <p>All direct care staff were educated by FA on 12/4/2014 and 12/5/2014 reviewing Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing PPE must be removed prior to leaving the treatment area. PPE is not to be worn in non-treatment areas. Teammates signed clinical in-service form.</p> <p>Infection Control Manager or designee will complete Infection Control Audits bi-monthly x 2 months, then monthly. All results will be reviewed with Medical Director during Facility Health</p>	01/08/2015

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V000408	<p>3. During interview on 12/4/14 at 11:50 AM, employee A indicated staff have to remove PPE prior to exiting treatment area and don a new gown and wash hands or use sanitizer upon re-entering treatment area.</p> <p>4. During interview on 12/5/14 at 12:55 PM, employee A indicated they spoke with employee L on 12/4 and was told employee L left the PPE on due to the patient was not stable enough to walk to the lobby alone and they wanted to be sure they were safe. Employee A indicated the employee still should have changed gown upon re-entering the treatment area.</p> <p>5. The facility's policy titled "Infection Control for Dialysis Facilities," # 1-05-01, revised September, 2014, states, "16. ... PPE is to be removed prior to leaving the treatment area. PPE is not to be worn in non-treatment areas."</p> <p>494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to,</p>		<p>Meeting, minutes will reflect.</p> <p>FA is responsible for compliance with plan of correction</p>	

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	<p>fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on observation, policy review, and interview, the facility failed to ensure supplies in the evacuation kit were not expired for 1 of 1 observation, creating the potential to affect all the facility's 58 patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During observation on 12/4/14 at 10:55 AM, the evacuation kit was noted to contain 2 hemodialysis fistula needle sets with the expiration dates Dec 2013 and Feb 2014. 2. During interview on 12/4/14 at 11:35 AM, employee C indicated the evacuation kit is checked monthly by one of the other nurses for expired supplies. 3. The facility's policy titled "Emergency Equipment Checks," # 1-02-08, revised March, 2011, states, "2. The following equipment checks will be performed by a licensed nurse teammate to verify the designated equipment is available and functional: ... Monthly: Evacuation kit is complete and supplies have not expired." 	V000408	Expired fistula needles immediately removed and replaced with unexpired fistula needles. Governing Body met on 12/4/2014 and approved revised Emergency Evacuation Kit Checklist to separately identify each needle size and require each size needle to be separately verified as unexpired. FA educated RN responsible for verifying contents of evacuation kit regarding expired supplies on 12/4/2014. Education documented on One-on-One Meeting Form. All RNs will be educated by FA by 1/8/2015 reviewing Policy & Procedure #01-02-08 Emergency Equipment Checks. RNs educated following equipment checks must be performed by a licensed nurse, staff must verify designated equipment is available and functional: Weekly: Oxygen supply is adequate with at least 1 tank on or next to crash cart, airways are available, suction is operational, AED is operational and pads are compatible with device, ambu bag operational, emergency cart is clean, operational, and supplies have not expired, TMs must conduct and document monthly checks on evacuation kits to ensure kits is complete and supplies have not expired. Attendance of in-service	01/08/2015			

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			will be evidenced by teammate's signature on the clinical in-service form. Audits of the Evacuation Kit will be completed by a licensed nurse teammate using the revised Emergency Evacuation Kit Checklist monthly. FA or designee will verify findings monthly documenting by initials on each item. All results with be reviewed with Medical Director during Facility Health Meeting, minutes will reflect. FA is responsible for compliance with plan of correction		