

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152535		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2012	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE NEPHROLOGY LAPORTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MONROE ST LA PORTE, IN 46350			
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V0000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: June 4, 5, and 6, 2012</p> <p>Facility #: 008894</p> <p>Medicaid Vendor #: 20032320D</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 8, 2012</p>			V0000			

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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V0119	<p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p> <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, interview, and policy review, the facility failed to ensure a common supply cart was not used for supplies during dialysis initialization and disconnection in 2 of 4 observations with the potential to affect all 15 patients.</p> <p>Findings:</p> <p>1. On June 4, 2012, at 1:50 PM, this surveyor observed the dialysis floor for the second time. A 3 foot tall stainless steel wheeled tray was being used for supplies to initiate treatment and to discontinue treatment. There is 1 tray per 4 chairs and there are 8 current chairs. The supplies are gathered from the main supply cabinet across the room, placed on the stainless steel tray, and brought to the patient. They clean the tray with bleach solution. The tray is shared among 4 patients on treatment at the same time. They did have a chux beneath the</p>	V0119	<p>V119 The stainless steel wheeled trays will be removed from the clinic by July 6, 2012. All dialysis chairs that do not have side trays will be removed prior to this date and replaced with chairs that have side trays; thus, eliminating the need for the wheeled steel trays. Until July 6 th , chux will be used as a barrier to the clean supplies. Clinic Manager responsible for monitoring daily.</p> <p>The Director of Operations will verify on July 7 th that the trays have been removed from the treatment area.</p>	07/06/2012			

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	<p>supplies. The surveyor observed station # 7 Patient # 1 and station # 5 Patient # 2 for removal from dialysis.</p> <p>2. On June 6, 2012, at 11:30 AM, observation of the whole unit identified chux were not being used beneath the supplies on the silver tray as patients waited for initiation of dialysis.</p> <p>3. On June 6, 2012, at 11:40 AM, the Clinical Manager, Employee A, indicated the trays are carryovers from before and the staff and patients are comfortable with them but could see how cross contamination could occur.</p> <p>4. On June 6, 2012, at 11:35 AM, the Director of Operations, Employee B, indicated cross contamination could occur with 1 tray to 4 patients especially with the lack of chux on the tray protecting the supplies.</p> <p>5. A policy titled "Cleaning the Dialysis Station Between Patient Treatments", FMS-CS-IC-II-155-110 C, 10-OCT-2008, states, "3. Clean and disinfect the dialysis station or treatment area (chair bed, table,) after each patient treatment with 1:100 bleach solution."</p>						

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V0222	<p>494.40(a) ACID BULK STORAGE TANKS-SAFETY CONTROLS 5.4 Concentrate preparation 5.4.3 Bulk storage tanks (acid concentrate): safety controls Procedures should be in place to control the transfer of the acid concentrate from the delivery container to the storage tank to prevent the inadvertent mixing of different concentrate formulations. If possible, the tank and associated plumbing should form an integral system to prevent contamination of the acid concentrate. The storage tanks and inlet and outlet connections, if remote from the tank, should be secure and labeled clearly.</p> <p>Based on observation and interview, the facility failed to have procedures in place to prevent the inadvertent mixing of the 2K and 3K acid centrally delivered to large storage tanks in 1 of 1 water distribution systems observed with the potential to effect all 15 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> On June 4, 2012, at 3:20 PM, the surveyor observed two large storage tanks for acid. One was identified as 2K and one identified as 3K. On June 4, 2012, at 3:20 PM, the Bio medical technician, Employee C, indicated she transfers acid from large drums into the tanks. She indicated there is not a cross check system to make sure 	V0222	<p>V222 Pursuant to the Conditions and Coverage and interpretive guidelines for safety controls on the acid bulk storage, the procedure as adopted by FMC Nephrology LaPorte's Governing Body below has historically been followed:</p> <p>At the time of delivery, verify that the concentrate received has the appropriate contents and match the packing slip and concentrate drum label.</p> <p>Verify the concentrate containers to be transferred by comparing the chemical composition on the manufacturers label to the correct chemical composition labeling affixed to the concentrate acid holding tank.</p> <p>Verify that manufacturer containers (55-gallon drums) are</p>	06/15/2012	

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	<p>the correct acid is going into the correct tank. This is something she does when needed with her other duties. When asked for a policy, she indicated there is not a policy for filling bulk storage tanks.</p> <p>3. On June 6, 2012, at 12:00 PM, the Director of Operations, Employee B, presented an undated Procedure for filling the bulk acid tanks. The procedure did not contain a cross check system.</p>		<p>sealed with the appropriate wrapper. Ensure that the container caps have not be removed or tampered with.</p> <p>For a cross check, the holding tanks have permanent chemical composition labels affixed to each acid storage tank and are color coded for a second verifying identification process with 2k (RED tape) or 3k (ORANGE tape). The 2k red acid fill port is affixed to the side of the 2k acid storage tank for a direct hook up. The 3k orange acid fill port is affixed to the side of the 3k acid storage tank for a direct hook up. This assures that the acid that has been verified in the 55 gallon drum is getting transferred into the correct acid storage tank.</p> <p>All bio-medical technician staff are trained on these procedures. Bio-medical technicians will check and verify that the acid drum getting transferred into the correctly labeled storage tank matches up with all above stated criteria before transferring.</p>		

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V0681	<p>494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.</p> <p>Based on personnel record and procedure review and interview, the facility failed to ensure all staff were current in their competencies for 2 of 8 staff files reviewed (D and E) with the potential to affect all 15 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Personnel record D, date of hire (DOH) 11/15/2004, registered dietitian, failed to evidence the 2012 Mandatory In-services were completed. The mandatory inservices for 2011 were completed prior to June 2011 and the 2012 ones needed to be completed before 6/1. Personnel record E, DOH 5/14/2003, social worker, failed to evidence the 2012 Mandatory In-services were completed. The mandatory inservices for 2011 were 	V0681	<p>V681 Personnel record D, registered dietitian and Personnel record E, social worker have completed the annual OSHA exams on June 12, 2012 and Clinic Manager has filed in their personnel records.</p> <p>Clinic Manager will audit the personnel records quarterly and initiate a process to in-service all staff within 2 – 4 weeks prior to expiration dates to be in compliance with competency standards. Clinic Manager will discuss audit findings and in-service plans with the IDT in monthly QAI meetings.</p>	06/12/2012			

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	<p>completed prior to June 2011 and the 2012 ones needed to be completed before 6/1.</p> <p>3. A procedure for Fresenius Medical Care OSHA/DOT Safety In-Service Annual Log (Required) revised 12/15/11 states, "For all FMCNA employees on an Annual basis."</p> <p>4. On June 6, 2012, at 11:10 AM, the Clinical Manager, Employee A, indicated the mandatory in-services were not done. This facility was not their home facility, and the in-services would be done in their home facility.</p>				