

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152590	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 1708 CRAGMONT ST MADISON, IN 47250
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V000000	<p>This was a federal ESRD (CORE) recertification survey.</p> <p>Dates of survey: 8/19, 8/20, and 8/21/14</p> <p>Facility #: 004371</p> <p>Medicaid #: 200507780</p> <p>Surveyor: Susan E. Sparks</p> <p>Census 30</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 22, 2014</p>	V000000		
V000113	<p>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.</p> <p>Based on observation and policy review, the facility failed to ensure the staff followed infection control measures and their own policies when touching the keyboards on the 2008T dialysis machine for 1 of 2 observations with the potential to affect all 30 patients.</p>	V000113	<p>The management staff, including the facility's CEO, met on August 26, 2014, and reviewed the summary of deficiencies from the August 19-21, 2014 inspection. After a thorough review of all appropriate policies a POC was developed. The following outlines the plan of correction</p>	09/22/2014

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>Findings:</p> <p>1. On 8/21/14 at 9:10 AM, Employee B was observed working in station 5 without gloves and was touching the data entry component of the machine.</p> <p>2. A policy titled "Personal Protective Equipment", dated 20-Marc-2013, FMC-CS-IC-II-155-080A, states, "Disposable Gloves must be used: ... When touching any part of the dialysis machinery equipment at the dialysis station."</p>		<p>for each deficiency. The Director of Operations will be responsible for coordinating all disciplines to carry out necessary training. V113 494.30(a)(1) IC-Wear Gloves/Hand Hygiene On or before 09/22/14 the Clinical Manager will reeducate all direct patient care staff on the following policy with attention to ensuring disposable gloves are worn when touching any part of the dialysis machine. ·FMS-CS-IC-II-155-080A "Personal Protective Equipment" Policy Clinical Manager (or designee) will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required. The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified deficiencies/ trends will require</p>		

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V000115	<p>494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory.</p> <p>Based on observation and policy review, the facility failed to ensure at least one staff member wore personal protective equipment (PPE) while caring for the patients between initiating and terminating dialysis with the potential for the patients and the staff to acquire an infection for 1 of 2 observations with the potential to affect all 30 patients.</p> <p>Findings:</p>	V000115	<p>initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</p> <p>V115. 494.30(a)(1)(i) IC-IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK On or before 9/22/14 the Clinical Manager will reeducate all direct patient care staff on the following policy: FMS-CS-IC-II-155-180A "Personal Protective Equipment" Policy Education to emphasize: Gloves, fluid resistant gown and full face shield/ or protective eyewear should be worn in area at risk for blood splatter or spill.</p>	09/22/2014

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V000520	<p>1. On 8/21/14 at 9:10 AM, Employee A and Employee B were observed giving care without wearing PPE. Employee A was working in station 10. Employee B was working in station 5. They were on opposite sides of the room.</p> <p>2. PPE were observed hung on hooks at the far end of the dialysis room by the medication preparation room.</p> <p>3. On 8/21/14 at 9:15 AM, Employee B brought a PPE to the surveyor and then immediately put his own on.</p> <p>4. A policy titled "Personal Protective Equipment", dated 20-Marc-2013, FMC-CS-IC-II-155-080A, states, "Patient Care Activities: Designated Patient Care Activities: In area at risk for blood splatter or spill. Gloves, Fluid Resistant Gown, Full Face Shield."</p> <p>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</p>		<p>Clinical Manager or designee will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required. The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.</p>		

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	<p>section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>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.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the interdisciplinary team completed a monthly comprehensive reassessment on an unstable patient when deemed stable in 1 of 4 clinical records reviewed with the potential to effect all 30 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 4, with a plan of care dated 7/2/14, evidenced the patient as being unstable due to an extended hospitalization. The clinical record failed to evidence the interdisciplinary team (IDT) developed and implemented a written and individualized comprehensive assessment on a monthly basis. On 8/21/14 at 11 AM, the Regional 	V000520	<p>V520. 494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO On or before 9/22/14 the Director of Operations will re-educate all members of the Interdisciplinary Team on the following policy: FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care" Policy Education to emphasize: Each patient will be reviewed monthly by the interdisciplinary team for the status of stability to ensure appropriate frequency of reassessment and modification of the Plan of Care. After discussing patient with the team, attending physician will make declaration regarding whether patient is stable or unstable based on criteria specified in the policy. Unstable patients must be reassessed by the</p>	09/22/2014	

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	<p>Manager, Employee C indicated the Interdisciplinary Team had not done a comprehensive assessment. She indicated the Interdisciplinary Team meets, discusses the patient, and determines if their status should moved from unstable to stable. They make the stable determination but don't do new assessments and plans of care. They will work off of the old one.</p> <p>3. A policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care", FMS-CS-IC-I-110-125A, Revised 04-Jul-2012, states, "Unstable patients must be reassessed by the IDT and a new comprehensive assessment and Plan of Care completed monthly until the patient is determined by the IDT to be stable."</p>		<p>Interdisciplinary Team and a new Comprehensive Assessment and Plan of Care completed monthly until the patient is determined by the IDT to be stable. To ensure no reoccurrence of this deficiency, the Clinical Manager will review each completed Comprehensive Interdisciplinary Assessment and Plan of Care prior to filing in the patient record. Clinical Manager will confirm all patients declared unstable are scheduled for monthly Comprehensive Assessment and Plan of Care completed until patient has been declared stable. Additionally, the Clinical Manager will report the findings of the CIA/POC tracking tool to the QAI committee with a summary of any deficiencies found. QAI committee will review and determine further action as necessary to maintain compliance. The QAI minutes document this activity and are available for review at the facility. The Clinical Manager is responsible and the QAI committee monitors for compliance.</p>		