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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152532 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/24/2013 |
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| NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE WABASH VALLEY | STREET ADDRESS, CITY, STATE, ZIP CODE 4001 E WABASH AVE TERRE HAUTE, IN 47803 |
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| (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 |
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| V000000 | <p>This was a CORE ESRD federal recertification survey.</p> <p>Survey Dates: 4-23 and 24-2013</p> <p>Facility #: 008101</p> <p>Medicaid Vendor #: 200470050C</p> <p>Surveyor: Marty Coons, RN, PHNS, Team Leader RN Bridget Boston, RN, PHNS Susan Sparks, RN, PHNS</p> <p>Total Census: 58</p> <p>55-Peritoneal dialysis 3-home hemodialysis</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 29, 2013</p> | V000000 | | |

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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| 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, interview, and review of policies, the facility failed to ensure staff completed hand hygiene in accordance with the facility's own infection control policy and procedure in 1 (employee B) of 1 infection control observations completed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's "Hand Hygiene" policy # FMS-CS-IC-II-155-090A, revision date March 20, 2013 states, "Hands will be ... Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact with patients, Entering and leaving the treatment area, ... Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. After contact with inanimate objects near the patient." On 4/23/13 at 11:20 AM, employee B, a registered nurse, was observed to | V000113 | <p>On May 24, 2013 the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution.</p> <p>The Program Manager is responsible to ensure that all staff members follow "Hand Hygiene" policy to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Program Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A with emphasis placed on glove usage, hand-washing, and hand hygiene using hand sanitizer. Training was completed on April 26, 2013 and an in-service attendance sheet is available in the facility for review.</p> <p>Program Manager held a counseling session for Employee B on April 26, 2013 to discuss</p> | 05/24/2013 | |

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| | <p>collect, from specimens provided by a home Peritoneal Dialysis patient, peritoneal fluid from a specimen cup and urine from a collection container. With gloved hands, employee B collected a sample of each liquid specimen into separate vaccutainers. After collection, he opened the training room door, exited the room, and carried the specimens to the laboratory area. There the employee opened the refrigerator door and placed the specimens inside the refrigerator and then removed his gloves. Without completing hand hygiene, the employee walked to the bleach solution labeled 1:100 bleach, obtained a saturated wipe and returned to the training room, opened the door by way of the handle, entered the room, donned gloves, and then began to cleanse the surfaces. After cleansing the patient chair, table top, and sink countertop, the employee removed his gloves and prepared to leave the room. When asked, the employee indicated there was alcohol foam on the wall and a pump bottle of alcohol gel inside a wall cabinet for completion of hand hygiene. The training room contained a clean sink where hand hygiene could be completed. Observed above the sink were directions for hand hygiene.</p> <p>3. On 4/24/13 at 11 AM, the facility clinic manager indicated the above</p> | | <p>policy violations on April 23rd, 2013 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene.</p> <p>Program Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Program Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Program Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the QAI committee as noted above.</p> | | |

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| | observation was not in compliance with the facility's infection control policy and procedure. | | | |