

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000000	<p>This was a Federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: 9-17-14, 9-18-14, and 9-19-14</p> <p>Facility #: 004839</p> <p>Medicaid Vendor #: 200815900A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Census 92</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 25, 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, interview, and review of facility policy, the facility failed to ensure staff had changed gloves and cleansed their hands as identified in facility policy in 6 (#s 2, 6, 8, 9, 12, and 13) of 14 infection control observations completed creating the potential to affect all of the facility's 92 current patients.</p>	V000113	The Governing Body for the facility met on 09/29/2014 to review the Statement of deficiencies and directed the Midwest Group Vice President of Quality to assist the Management team in developing the plan of Correction. The Director of Operations reviewed the following policies "Hand Hygiene Policy"	10/19/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
	<p>(employees C, P, K, N, O, Q)</p> <p>The findings include:</p> <p>1. On 9-18-14 at 11:20 AM, employee C, a licensed practical nurse (LPN), was observed to pick up trash from the chairside table and the floor at station number 11 in preparation to clean the dialysis station. The LPN was observed to place her left hand on the floor while retrieving a piece of trash from under the dialysis chair. After retrieving the trash and placing it in the waste can, the LPN then entered data into the computer using the keyboard on the dialysis machine. The LPN was then observed to proceed to clean the dialysis machine without changing her gloves or cleansing her hands.</p> <p>2. Employee P, a patient care technician (PCT), was observed to prepare to perform central venous catheter (CVC) exit site care and initiate the dialysis treatment on patient number 15 on 9-17-14 at 12:10 PM. The PCT was observed to draw up 10,000 units of heparin into a syringe, retrieve gloves, tape, and the dialysis initiation kit and then don clean gloves without cleansing her hands. The heparin was drawn from a multi-dose vial touched and used by other employees.</p>		<p>FMS-CS-IC-II-155-090A and "Hand Hygiene Procedure" FMS-CS-IC-II-155-090C with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. All current staff will participate in a mandatory in-service by the clinic manager regarding Infection Control Practices the week of 10/06/2014 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that all staff wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. The importance of hand sanitation before and after glove change will be reinforced. The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file. The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>3. Employee K, a PCT, was observed to discontinue the dialysis treatment on patient number 7, with a CVC, on 9-18-14 at 4:45 PM. The PCT was observed to touch the dialysis machine and tubing, access the CVC to draw blood for a laboratory specimen, and start the reinfusion of the extracorporeal circuit. The PCT failed to change her gloves and cleanse her hands after touching the machine and prior to accessing the CVC to draw the blood for the specimen.</p> <p>4. Employee N, a registered nurse (RN), was observed to administer medications to patient number 12 on 9-17-14 at 8:30 AM. The RN prepared the medications at the medication preparation area and proceeded to station number 12. The RN donned clean gloves without cleansing her hands and administered the medication (Hectorol 1 microgram).</p> <p>5. Employee O, a PCT, was observed to initiate the dialysis treatment on patient number 16 on 9-17-14 at 11:35 AM. The PCT was observed to evaluate the access and locate and touch the needle insertion sites. Without changing his gloves and cleansing his hands, the PCT then applied antiseptic to the skin and inserted the needles.</p>		employee including corrective action as appropriate The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>6. Employee Q, an RN, was observed to discontinue the dialysis treatment on patient number 17 on 9-17-14 at 10:00 AM. The RN was observed to retrieve gloves, tape, and gauze from the supply cart and then don clean gloves without cleansing her hands prior to starting the discontinuation process.</p> <p>7. The above-stated observations were discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the employees had not changed their gloves and cleansed their hands in accordance with facility policy.</p> <p>8. The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A states, "Hands Will Be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water . . . Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications. Immediately after removing gloves . . . After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site of the same patient."</p> <p>9. The facility's 1-4-12 "Infection Control Overview" policy number</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>FMS-CS-IC-II-155-060A states, "All infection control policies for patient care are consistent with recommendation of the Centers for Disease Control (CDC)."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000117	<p>are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>10. The facility's 12-30-13 "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A states, "Perform hand hygiene prior to accessing supplies, handling vials and IV solutions and preparing or administering medications."</p> <p>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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>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.</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure clean supplies were stored away from potentially contaminated areas creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On 9-17-14 at 8:30 AM, observation noted clean supplies for the initiation of the dialysis treatments at stations numbered 12 through 16 were on a countertop ledge overhanging the dirty sink area.</li> <li>2. The above-stated observation was discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the supplies had been moved away from the dirty sink area and placed in a clean area.</li> </ol>	V000117	<p>The Clinical Manager met with staff on 9/18/14 &amp; 9/19/14 and reviewed the Dialysis Precautions Policy, FMS-CS-IC-II-15-070A with emphasis on the definitions of clean and dirty areas. The need for clear separation between clean supplies on a countertop ledge overhanging the dirty sink area. The supplies were moved immediately on 9/18/14 and staff education provided by the clinic manager. A process change was implemented that supplies used for the initiation of dialysis treatment at stations numbered 12 – 16 would be placed on a designated clean area away from dirty sink area. The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
V000122	<p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure dialysis machines and all surfaces had been cleaned and disinfected when indicated in 3 (#s 1, 2, and 3) of 3 cleaning and disinfection of the dialysis station observations completed. (Employees C, D, and I)</p> <p>The findings include:</p>	V000122	<p>referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to evaluate and present audit findings in the monthly QAI meeting minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p> <p>The Director of Operations met with the Clinical Manager on September 26, 2014 and emphasizing her responsibility to ensure all staff members are educated on the policy FMS-CS-IC-II-155-110A, FMS-CS-IC-II-155-110C1, FMS-CS-IC-II-155-110C2 and the requirement that staff follow policy and procedure as written. All current staff will be in-serviced by the Clinical Manager on disinfection and Infection Control</p>	10/19/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(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			
	<p>1. On 9-17-14 at 10:35 AM, observation noted patient number 14 holding a blood soaked gauze on a needle insertion site. A quarter size spot of blood and 2 smears approximately 1 to 2 inches long of blood were observed on the left chairside table. Employee I, a patient care technician (PCT), was observed to replace the blood-soaked gauze with a clean and dry gauze. The PCT was not observed to clean the blood from the chairside table.</p> <p>At 11:00 AM, 11:15 AM, 11:30 AM, 11:40 AM, 12:00 PM, and 12: 20 PM, observation continued to note the blood on the chairside table.</p> <p>2. On 9-18-14 at 10:10 AM, employee D, a PCT, was observed to clean and disinfect the dialysis machine at station number 13. The employee was not observed to clean the Hansen connectors on the machine.</p> <p>The PCT was observed to clean the dialysis chair at the station at 10:40 AM. Observation noted a brown dried substance approximately the size of a quarter on the front of the left arm of the chair. The PCT was not observed to clean the substance from the arm of the chair.</p> <p>3. On 9-18-14 at 10:45 AM, employee</p>		<p>Practices the week of 10/06/2014, specifically focusing on the following policies:</p> <ul style="list-style-type: none"> <li>·FMS-CS-IC-II-155-110A</li> <li>“Cleaning and Disinfection Policy</li> <li>·FMS-CS-IC-II-155-110C1</li> <li>“Work Surface Cleaning &amp; Disinfection Without Visible Blood Using Bleach Solutions”</li> <li>·FMS-CS-IC-II-155-110C2</li> <li>“Work Surface Cleaning &amp; Disinfection With Visible Blood Less Than 10mls Using Bleach Solutions”</li> </ul> <p>In addition, the staff will be educated on their responsibility to ensure all equipment including Hanson’s. All areas must be considered potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded. The “Infection Control Information Acknowledgment” form will be placed in each staff members personnel/education file. The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to evaluate and present the audit</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>C, a licensed practical nurse (LPN), was observed to clean and disinfect the dialysis machine at station number 11. The LPN was not observed to clean the Hansen connectors on the machine.</p> <p>The LPN was observed to clean the dialysis chair at the station at 11:20 AM. The LPN was not observed to clean the front of the arms of the chair, including the area where the patient's hands are placed.</p> <p>4. The above-stated observations were discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the blood on the chairside table should have been cleaned immediately and the dialysis machines had not been cleaned appropriately.</p> <p>5. The facility's 1-4-12 "Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C1 states, "Use a cloth wetted with 1:100 bleach solution to clean and disinfect the dialysis station (bed, tables, machines, television, IV pole, B/P cuff, hand sanitizer dispenser and holder, etc.) . . . clean all surfaces . . . While wiping, remember to wipe all surfaces of the machine."</p>		findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000142	<p>6. The facility's "Work Surface Cleaning and Disinfection with Visible Blood &lt; 10 mls [milliliters] and OPIM [?] using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C2 states, "Use a cloth wetted with 1:100 bleach solution to clean the surface. Clean up all visible blood. Discard the used cloth and gloves in appropriate waste container. Perform hand hygiene and don new gloves. After cleaning up all visible blood, use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface."</p> <p>494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&amp;P The facility must-</p> <p>(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit;</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure its own infection control policies and procedures had been implemented by failing to ensure staff had changed gloves and cleansed their hands appropriately in 6 (#s 2, 6, 8, 9, 12, and 13) of 14 infection control observations completed (Employees C, K, N, O, P, and Q) and by failing to ensure dialysis machines and all surfaces had been cleaned and disinfected</p>	V000142	The Governing Body for the facility met on September 29, 2014 to review the Statement of Deficiencies and direct the Plan of Correction. The Governing Body acknowledges oversight of monitoring and implementing biohazard and infection control policies and activities within the dialysis unit. All current staff will be in-serviced by the Clinical Manager on disinfection and Infection Control Practices the week of 10/06/2014, specifically focusing on the following	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>when indicated in 3 (#s 1, 2, and 3) of 3 cleaning and disinfection of the dialysis station observations completed (Employees C, D, and I) creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p> <p>Regarding hand hygiene and glove changes:</p> <p>1. On 9-18-14 at 11:20 AM, employee C, a licensed practical nurse (LPN), was observed to pick up trash from the chairside table and the floor at station number 11 in preparation to clean the dialysis station. The LPN was observed to place her left hand on the floor while retrieving a piece of trash from under the dialysis chair. After retrieving the trash and placing it in the waste can, the LPN then entered data into the computer using the keyboard on the dialysis machine. The LPN was then observed to proceed to clean the dialysis machine without changing her gloves or cleansing her hands.</p> <p>2. Employee P, a patient care technician (PCT), was observed to prepare to perform central venous catheter (CVC) exit site care and initiate the dialysis treatment on patient number 15 on</p>		<p>policies:</p> <ul style="list-style-type: none"> <li>·FMC-CS-IC-II-155-090A "Hand Hygiene"</li> <li>·FMC-CS-IC-II-155-060A "Infection Control Overview"</li> </ul> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate. The specific area of focus during the monitoring will be proper aseptic technique is observed during Central Venous Catheter dressing changes The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>9-17-14 at 12:10 PM. The PCT was observed to draw up 10,000 units of heparin into a syringe, retrieve gloves, tape, and the dialysis initiation kit and then don clean gloves without cleansing her hands. The heparin was drawn from a multi-dose vial touched and used by other employees.</p> <p>3. Employee K, a PCT, was observed to discontinue the dialysis treatment on patient number 7, with a CVC, on 9-18-14 at 4:45 PM. The PCT was observed to touch the dialysis machine and tubing, access the CVC to draw blood for a laboratory specimen, and start the reinfusion of the extracorporeal circuit. The PCT failed to change her gloves and cleanse her hands after touching the machine and prior to accessing the CVC to draw the blood for the specimen.</p> <p>4. Employee N, a registered nurse (RN), was observed to administer medications to patient number 12 on 9-17-14 at 8:30 AM. The RN prepared the medications at the medication preparation area and proceeded to station number 12. The RN donned clean gloves without cleansing her hands and administered the medication (Hectorol 1 microgram).</p> <p>5. Employee O, a PCT, was observed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>initiate the dialysis treatment on patient number 16 on 9-17-14 at 11:35 AM. The PCT was observed to evaluate the access and locate and touch the needle insertion sites. Without changing his gloves and cleansing his hands, the PCT then applied antiseptic to the skin and inserted the needles.</p> <p>6. Employee Q, an RN, was observed to discontinue the dialysis treatment on patient number 17 on 9-17-14 at 10:00 AM. The RN was observed to retrieve gloves, tape, and gauze from the supply cart and then don clean gloves without cleansing her hands prior to starting the discontinuation process.</p> <p>7. The above-stated observations were discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the employees had not changed their gloves and cleansed their hands in accordance with facility policy.</p> <p>8. The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A states, "Hands Will Be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water . . . Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>Immediately after removing gloves . . . After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site of the same patient."</p> <p>9. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC-II-155-060A states, "All infection control policies for patient care are consistent with recommendation of the Centers for Disease Control (CDC)."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>10. The facility's 12-30-13 "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A states, "Perform hand hygiene prior to accessing supplies, handling vials and IV solutions and preparing or administering medications."</p> <p>Regarding cleaning of dialysis stations and blood spills:</p> <p>1. On 9-17-14 at 10:35 AM, observation noted patient number 14 holding a blood</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>soaked gauze on a needle insertion site. A quarter size spot of blood and 2 smears approximately 1 to 2 inches long of blood were observed on the left chairside table. Employee I, a patient care technician (PCT), was observed to replace the blood-soaked gauze with a clean and dry gauze. The PCT was not observed to clean the blood from the chairside table.</p> <p>At 11:00 AM, 11:15 AM, 11:30 AM, 11:40 AM, 12:00 PM, and 12: 20 PM, observation continued to note the blood on the chairside table.</p> <p>2. On 9-18-14 at 10:10 AM, employee D, a PCT, was observed to clean and disinfect the dialysis machine at station number 13. The employee was not observed to clean the Hansen connectors on the machine.</p> <p>The PCT was observed to clean the dialysis chair at the station at 10:40 AM. Observation noted a brown dried substance approximately the size of a quarter on the front of the left arm of the chair. The PCT was not observed to clean the substance from the arm of the chair.</p> <p>3. On 9-18-14 at 10:45 AM, employee C, a licensed practical nurse (LPN), was observed to clean and disinfect the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(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			
	<p>dialysis machine at station number 11. The LPN was not observed to clean the Hansen connectors on the machine.</p> <p>The LPN was observed to clean the dialysis chair at the station at 11:20 AM. The LPN was not observed to clean the front of the arms of the chair, including the area where the patient's hands are placed.</p> <p>4. The above-stated observations were discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the blood on the chairside table should have been cleaned immediately and the dialysis machines had not been cleaned appropriately.</p> <p>5. The facility's 1-4-12 "Work Surface Cleaning and Disinfection without Visible Blood using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C1 states, "Use a cloth wetted with 1:100 bleach solution to clean and disinfect the dialysis station (bed, tables, machines, television, IV pole, B/P cuff, hand sanitizer dispenser and holder, etc.) . . . clean all surfaces . . . While wiping, remember to wipe all surfaces of the machine."</p> <p>6. The facility's "Work Surface Cleaning and Disinfection with Visible Blood &lt; 10</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000147	<p>mls [milliliters] and OPIM [?] using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C2 states, "Use a cloth wetted with 1:100 bleach solution to clean the surface. Clean up all visible blood. Discard the used cloth and gloves in appropriate waste container. Perform hand hygiene and don new gloves. After cleaning up all visible blood, use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface."</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>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.</p> <p>II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>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].</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure central venous catheter (CVC) care had been provided in accordance with facility policy in 2 (#s 1 and 2) of 2 discontinuation of dialysis with a CVC observations completed. (Employees C and K)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee C, a licensed practical nurse (LPN), was observed to discontinue the dialysis treatment on patient number 11, who had a CVC, on 9-18-14 at 2:50 PM. The LPN failed to place a clean field under the CVC ports prior to starting the discontinuation process.</li> <li>2. Employee K, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 7, who had a CVC, on 9-18-14 at 4:45 PM.</li> </ol>	V000147	<p>The Director of Operations reviewed the following policy FMS-CS-IC-I-105-032A "Changing the Catheter Dressing" Policy with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies and follow policy and procedure as written. All current staff will be in serviced by the Clinic Manager on Infection Control Practices the week of 10/06/2014 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that aseptic technique is maintained when providing catheter care dressing changes with placement of a clean under pad, and the importance of preventing cross contamination. The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file. The Clinical Manager or designee will ensure that infection control</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000245	<p>The PCT failed to place a clean field under the CVC ports prior to starting the discontinuation process.</p> <p>3. The above-stated observations were discussed with facility administrator on 9-18-14 at 5:00 PM. The administrator indicated the employees had not followed facility policy.</p> <p>4. The facility's 1-6-14 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" procedure number FSM-CS-Ic-I-105-028 C states, "Ensure that a clean under pad is below the catheter limbs to protect the work area and the clothing."</p> <p>494.40(a) ACID CONC DIST-CONC LABELED &amp; COLOR-CODED RED 5.5.3 Acid concentrate distribution systems: labeled &amp; color-coded red Acid concentrate delivery piping should be labeled and color-coded red at the point of use (at the jug filling station or the dialysis machine connection).</p> <p>All joints should be sealed to prevent leakage of concentrate. If the acid system remains intact, no rinsing or disinfection is necessary.</p> <p>More than one type of acid concentrate may</p>		<p>audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate. The specific area of focus during the monitoring will be proper aseptic technique is observed during Central Venous Catheter dressing changes The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>be delivered, and each line should clearly indicate the type of acid concentrate it contains.</p> <p>Based on observation and interview, the facility failed to ensure the acid concentrate delivery piping was labeled with the type of concentrate in 17 (#s 1 through 17) of 17 stations observed creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>During a tour of the facility on 9-17-14 at 8:00 AM, observation noted, in the dialysate preparation area, the facility mixed and used 2 different types of acid concentrate, 2K (potassium) 2.5 Ca<sup>++</sup> (calcium) and 3K 2.25 Ca<sup>++</sup>.</li> <li>On 9-17-14 at 11:15 AM, observation noted the 2 acid concentrate ports at the point of delivery to the dialysis machines were labeled "primary" and "secondary." The lines failed to clearly indicate the type of acid concentrate being delivered.</li> </ol> <p>Employee N, a registered nurse, stated, "The primary is 2K and the secondary is 3K."</p> <ol style="list-style-type: none"> <li>The facility administrator indicated, on 9-18-14 at 5:00 PM, the acid concentrate ports at the point of delivery</li> </ol>	V000245	<p>The Director of Operations (DO) reviewed with the Regional Technical Operations Managers the following policy FMS-CS-IC-II-140-310A "Concentrate Labeling Requirements" Policy on Oct 6, 2014. Specially the DO will review the following requirements as the relate to valve panels/boxes:</p> <p>Valve Panels · Valve Panels or wall boxes, must be labeled to identify the fluid that is delivered. These include the following: Water, Bicarbonate and Acid/Granuflo. · Bicarbonate concentrate connectors must be color coded "blue". · Acid concentrate connectors will be color coded "red" · If more than one acid concentrate is delivered, each acid must use a differing color. · If more than one acid is delivered, each must be identified by acid type. · For example, 2K, 3K or by catalog number; e.g., 3231, 2201etc. Valve panels must use appropriate HMIS labeling. On September 18, 2014 the valve boxes were corrected to identify the accurate acid types. Ongoing compliance will be verified and maintained during the quarterly physical and environmental audits. The technical department is responsible for performing the quarterly audits of the physical plant. The Clinical Manager is responsible to evaluate and</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
V000407	<p>to the dialysis stations had not been labeled to clearly indicate the type of acid concentrate being delivered.</p> <p>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). Based on clinical record and facility policy review and interview, the facility failed to ensure patients had been monitored at least every 30 minutes in accordance with facility policy in 9 (#s 1, 2, 3, 4, 5, 6, 7, 8, and 9) of 9 records reviewed creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-21-14 evidenced the patient had been checked at 11:37 AM and not again until 12:31 PM, a period of 54 minutes between checks.</p> <p>B. A hemodialysis treatment flow</p>	V000407	<p>present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p> <p>The Director of Operations (DO) met with the Clinical Manager (CM) on September 26, 2014 and reviewed FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy", emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staffs are required to follow policy and procedure as written. Staff will be reeducated by the DO and CM the week of Oct 6, 2014 on the policy listed above, with an emphasis placed on the following responsibilities: ·Vital signs will be monitored at initiation of treatment of dialysis and every 30 minutes, or more frequently as necessary. ·Appropriate interventions in response to changes in vital signs, treatment parameters, or machine adjustments shall be documented in the treatment record including referral to the RN and assessment findings.</p>	10/19/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>sheet dated 8-23-14 evidenced the patient had been checked at 12:00 PM and not again until 1:04 PM, a period of 1 hour and 4 minutes between treatment checks. The flow sheet evidenced the patient had been checked at 1:34 PM and not again until 5:30 PM, a period of 3 hours and 56 minutes between checks.</p> <p>C. A hemodialysis treatment flow sheet dated 9-4-14 evidenced the patient had been checked at 10:29 AM and not again until 11:36 AM, a period of 1 hour and 7 minutes between treatment checks.</p> <p>D. A hemodialysis treatment flow sheet dated 9-13-14 evidenced the patient had been checked at 11:04 AM and not again until 12:03 PM, a period of 59 minutes between treatment checks.</p> <p>2. Clinical record number 2 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-21-14 evidenced the patient had been checked at 2:03 PM and not again until 3:01 PM, a period of 58 minutes between treatment checks. The flow sheet evidenced the patient was not checked again until 4:02 PM, a period of 1 hour and 1 minute since the last treatment check.</p>		<p>The Clinical Manager or designee will audit 10% of treatment sheets 3 random days per week for the next 4 weeks, if substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar. The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>B. A hemodialysis treatment flow sheet dated 8-23-14 evidenced the patient had been checked at 2:05 PM and not again until 3:30 PM, a period of 1 hour and 25 minutes between treatment checks.</p> <p>C. A hemodialysis treatment flow sheet dated 8-26-14 evidenced the patient had been checked at 2:32 PM and not again until 3:51 PM, a period of 1 hour and 19 minutes between treatment checks.</p> <p>D. A hemodialysis treatment flow sheet dated 8-30-14 evidenced the patient had been checked at 3:15 PM and not again until 4 PM, a period of 45 minutes between treatment checks.</p> <p>E. A hemodialysis treatment flow sheet dated 9-13-14 evidenced the patient had been checked at 1:59 PM and not again until 3:09 PM, a period of 1 hour and 10 minutes between treatment checks.</p> <p>F. A hemodialysis treatment flow sheet dated 9-16-14 evidenced the patient had been checked at 12:07 PM and not again until 12:49 PM, a period of 42 minutes between treatment checks.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
	<p>3. Clinical record number 3 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 9-1-14 evidenced the patient had been checked at 12:04 PM and not again until 1:04 PM, a period of 1 hour between checks.</p> <p>B. A hemodialysis treatment flow sheet dated 9-10-14 evidenced the patient had been checked at 2:00 PM and not again until 2:58 PM, a period of 58 minutes between treatment checks.</p> <p>C. A hemodialysis treatment flow sheet dated 9-12-14 evidenced the patient had been checked at 11:30 AM and not again until 12:37 PM, a period of 1 hour and 7 minutes between treatment checks. The flow sheet evidenced the patient had been checked at 2:06 PM and not again until 3:03 PM, a period of 57 minutes between treatment checks.</p> <p>4. Clinical record number 4 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A hemodialysis treatment flow sheet dated 9-17-14 evidenced the patient had been checked at 6:02 PM and not again until 7:05 PM, a period of 1 hour and 2</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>minutes between treatment checks. The flow sheet evidenced the next treatment check was at 8:02 PM, 57 minutes later.</p> <p>5. Clinical record number 5 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A hemodialysis treatment flow sheet dated 9-2-14 evidenced the patient had been checked at 3:52 PM and not again until 4:41 PM, a period of 49 minutes between checks.</p> <p>6. Clinical record number 6 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-27-14 evidenced the patient had been checked at 3 PM and not again until 4:05 PM, a period of 1 hour and 5 minutes between treatment checks.</p> <p>B. A hemodialysis treatment flow sheet dated 9-5-14 evidenced the patient had been checked at 3:01 PM and not again until 3:59 PM, a period of 58 minutes between treatment checks.</p> <p>C. A hemodialysis treatment flow sheet dated 9-15-14 evidenced the patient had been checked at 3:33 PM and not again until 4:14 PM, a period of 42</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
	<p>minutes between treatment checks.</p> <p>7. Clinical record number 7 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-30-14 evidenced the patient had been checked at 2:33 PM and not again until 3:13 PM, a period of 41 minutes between treatment checks. The flow sheet evidenced the patient had been checked at 3:32 PM and not again until 4:35 PM, a period of 1 hour and 3 minutes between treatment checks.</p> <p>B. A hemodialysis treatment flow sheet dated 9-11-14 evidenced the patient had been checked at 1 PM and not again until 2:05 PM, a period of 1 hour and 5 minutes between treatment checks.</p> <p>C. A hemodialysis treatment flow sheet dated 9-13-14 evidenced the patient had been checked at 1:35 PM and not again until 3:36 PM, a period of 2 hours and 1 minute between checks.</p> <p>8. Clinical record number 8 failed to evidence the patient had been monitored at least every 30 minutes.</p> <p>A hemodialysis treatment flow sheet dated 9-4-14 evidenced the patient had</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
	<p>been checked at 3:46 PM and not again until 4:40 PM, a period of 54 minutes between treatment checks.</p> <p>9. Clinical record number 9 failed to evidence the patient had been checked at least every 30 minutes.</p> <p>A. A hemodialysis treatment flow sheet dated 8-19-14 evidenced the patient had been checked at 3:44 PM and not again until 4:31 PM, a period of 47 minutes between treatment checks.</p> <p>B. A hemodialysis treatment flow sheet dated 8-30-14 evidenced the patient had been checked at 4:34 PM and not again until 5:34 PM, a period of 1 hour between treatment checks.</p> <p>10. The facility administrator stated, on 9-17-14 at 4:50 PM, "Greater than 30 minutes is too long between checks."</p> <p>11. The Director of Operations stated, on 9-18-14 at 5:00 PM, "This is an IT [information technology] problem. The patients are visible to staff at all times while they are on the machines. The dialysis machines check the patient every 30 minutes and more often if set to do so. The machine checks the settings and vital signs. The staff have to physically push a button to get the information to enter</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000543	<p>onto the treatment flow sheet. The machines would alarm if there were problems with the patient."</p> <p>12. The facility's 8-20-14 "Patient Monitoring During Patient Treatment" policy number FMS-CS-IC-I-110_133A states, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary."</p> <p>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; Based on clinical record and facility policy review and interview, the facility failed to ensure the necessary care and services had been provided to achieve the desired estimated dry weight in 2 (#s 3 and 5) of 9 records reviewed creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p>	V000543	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. The Clinical Manager will</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
	<p>1. Clinical record number 3 included physician orders dated 6-4-14 that identified the desired weight after the dialysis treatment (estimated dry weight, EDW) was 100.5 kilograms (kg).</p> <p>A. A hemodialysis treatment flow sheet dated 8-25-14 evidenced the patient's weight after the dialysis treatment was 107.4 kg.</p> <p>B. A hemodialysis treatment flow sheet dated 9-1-14 evidenced the patient's weight after the dialysis treatment was 104.8 kg</p> <p>C. A hemodialysis treatment flow sheet dated 9-12-14 evidenced the patient's weight after the dialysis treatment was 102.2 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 9-15-14 evidenced the patient's weight after the dialysis treatment was 103.4 kg.</p> <p>2. Clinical record number 5 included physician orders dated 8-28-14 that identified the EDW was 63 kg.</p> <p>A. A hemodialysis treatment flow sheet dated 9-9-14 evidenced the patient's weight after the dialysis treatment was 67.6 kg.</p>		<p>educate and review with all staff the following policy on the week of 10/06/14: FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on managing volume status and adjusting estimated dry weights as needed with physician's order. The Clinical Manager or designee will audit 10% of treatment sheets 3 random days per week for the next 4 weeks, if substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar. . The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000544	<p>B. A hemodialysis treatment flow sheet dated 9-11-14 evidenced the weight after treatment was 67.3 kg.</p> <p>C. A hemodialysis treatment flow sheet dated 9-13-14 evidenced the weight after treatment was 66.9 kg.</p> <p>D. A hemodialysis treatment flow sheet dated 9-16-14 evidenced the patient's weight after the dialysis treatment was 66.8 kg.</p> <p>3. The facility administrator was unable to provide any additional documentation and/or information when asked on 9-18-14 at 1 PM.</p> <p>4. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Dose of dialysis . . . Provide necessary care and services to manage the patient's volume status."</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record review, interview, and observation, the facility failed to ensure it had achieved and sustained the prescribed dose of dialysis by failing to ensure intermittent heparin had been administered as ordered in 1 (# 3) of 1 record reviewed of patients with intermittent heparin orders, by failing to ensure blood flow rates had been maintained as ordered in 3 (#s 2, 3, and 9) of 9 records reviewed, and by failing to ensure the correct dialyzer was in use in 1 (patient number 10) of 6 dialysis prescription observations completed creating the potential to affect all of the facility's 92 current patients.</p> <p>The findings include:</p> <p>Regarding intermittent heparin:</p> <p>1. Clinical record number 3 included physician orders dated 5-5-14 that state, "Heparin Sodium (Porcine) 1,000 units/mL [milliliter] Systemic-Intermittent Dose(s) 5000 units IVP [intravenous push] mid run, Every Treatment." Physician orders dated 6-4-14 evidenced the treatment was for 4 hours and 15 minutes.</p>	V000544	<p>The Director of Operations reviewed the following policies FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" and FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment" with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. A mandatory in-service is scheduled for all staff the week of 10/06/2014 and the clinic manager will review &amp; re-educate the following policies: · FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment" · FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" Special emphasis was placed on ensuring that the patient's prescribed blood flow rate, dialyzer and heparinization is delivered according to the physician's prescription and requirement to achieve adequate clearance. This will be monitored daily by the nurse using the rounding tool. The Clinical</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>A. A hemodialysis treatment flow sheet dated 9-1-14 evidenced the treatment had been initiated at 11:11 AM and the intermittent heparin had been administered at 1:55 PM.</p> <p>B. A hemodialysis treatment flow sheet dated 9-10-14 evidenced the treatment had been initiated at 11:12 AM and the intermittent heparin had been administered at 3:52 PM.</p> <p>C. A hemodialysis treatment flow sheet dated 9-12-14 failed to evidence any intermittent heparin had been administered.</p> <p>2. The Director of Operations stated, on 9-19-14 at 12:15 PM, "We found the heparin had not been administered mid treatment after the record was reviewed. The order has been discontinued."</p> <p>Regarding blood flow rates (BFR):</p> <p>1. Clinical record number 2 evidenced the physician had ordered a BFR of 450 mL/min (minute) on 8-16-14.</p> <p>A. A hemodialysis treatment flow sheet dated 8-21-14 evidenced a BFR of 300.</p>		<p>Manager will monitor the results of the Rounding Tool audits weekly for 4 weeks and ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue. The Clinical Manager is responsible to report a summary of findings monthly in QAI. If resolution is not evident, the QAI Committee will complete a root cause analysis and the Plan of Correction will be revised as necessary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>B. A hemodialysis treatment flow sheet dated 8-23-14 evidenced a BFR of 350.</p> <p>C. A hemodialysis treatment flow sheet dated 8-26-14 evidenced a BFR of 300.</p> <p>D. A hemodialysis treatment flow sheet dated 9-2-14 evidenced a BFR of 400.</p> <p>E. A hemodialysis treatment flow sheet dated 9-4-14 evidenced a BFR of 275.</p> <p>F. Hemodialysis treatment flow sheets, dated 9-6-14, 9-9-14, 9-11-14, and 9-16-14, evidenced a BFR of 300.</p> <p>G. The facility administrator stated, on 9-17-14 at 4:45 PM, "We are supposed to be using [the patient's] fistula but [the patient] refuses. [The patient] wants to use the central venous catheter. We did not change the BFR for the catheter."</p> <p>2. Clinical record number 3 evidenced the physician had ordered a BFR of 400 on 6-4-14.</p> <p>A. Hemodialysis treatment flow sheets, dated 8-25-14, 9-1-14, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>9-12-14, evidenced a BFR of 300.</p> <p>B. Hemodialysis treatment flow sheets, dated 9-10-14 and 9-15-14, evidenced a BFR of 350.</p> <p>3. Clinical record number 9 evidenced the physician had ordered a BFR of 300 on 7-26-14.</p> <p>A. Hemodialysis treatment flow sheets dated 9-9-14, 8-23-14, and 8-19-14, evidenced a BFR of 400.</p> <p>B. A hemodialysis treatment flow sheet dated 9-2-14 evidenced a BFR of 350 mL/min.</p> <p>Regarding incorrect dialyzer:</p> <p>1. On 9-18-14 at 10:50 AM, observation noted a 160 Optiflux dialyzer in use at station number 5 on patient number 10. Physician orders dated 9-4-14 evidenced a 180 Optiflux dialyzer had been ordered by the physician.</p> <p>2. Employee AA, a registered nurse, indicated, on 9-18-14 at 11:00 AM, the incorrect dialyzer was in use on patient number 10 and that a 180 had been ordered.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000545	<p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. Based on clinical record and facility policy review and interview, the facility failed to ensure nutritional services had been provided as ordered to achieve and sustain an effective nutritional status in 2 (#s 4 and 6) of 5 records reviewed of patients with nutritional supplements ordered during dialysis creating the potential to affect all of the facility's patients with nutritional supplements ordered during dialysis.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included physician orders dated 6-9-14 that evidenced the patient could choose from 1 of 3 different nutritional supplements (Zone Perfect Bar, Body Quest Icecream, or Nepro Carb Steady Bar) to ingest during the dialysis treatment. The record evidenced a physician order dated 9-3-14 for LiquaCel 1 ounce by mouth every treatment.</p> <p>A. Hemodialysis treatment flow</p>	V000545	<p>The Director of Operations met with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" &amp; FMS-CS-IC-I-111-005C3 "Oral Nutritional Supplements Administration Procedure: eCube Clinicals Procedure" and the requirement that staff follow policy and procedure as written. The Clinical Manager will educate and review with all staff policies at a mandatory staff in-service the week of 10/06/2014: · FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" · FMS-CS-IC-I-111-005C3 "Oral Nutritional Supplements Administration Procedure: eCube Clinicals Procedure" The education will specifically address monitoring administration of protein supplements. All patients are required to be offered the</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>sheets, dated 8-25-14 and 9-1-14, failed to evidence the nutritional supplements had been offered or administered to the patient.</p> <p>B. The facility administrator indicated, on 9-18-14 at 3:00 PM, the flow sheets did not evidence the supplements had been offered or provided to the patient.</p> <p>C. Laboratory results evidenced the patient's albumin levels were less than the desired 4.0 g/dL (grams per deciliter) according to the Centers for Medicare and Medicaid Services (CMS) Measures Assessment Tool (MAT).</p> <p>1.) Laboratory results dated 8-22-14 evidenced the value was 3.1.</p> <p>2.) Laboratory results dated 8-27-14 evidenced the value was 3.2.</p> <p>3.) Laboratory results dated 9-1-14 evidenced the value was 2.9.</p> <p>2. Clinical record number 6 included physician orders dated 11-8-13 that evidenced the patient could choose 1 from 3 different nutritional supplements (Body Quest Icecream, Nepro Carb Steady Bar, or Zone Perfect Bar) to ingest during the dialysis treatment.</p>		<p>supplement per order and in the event that the patient refuses the supplement the staff will be directed to create a multi-disciplinary note of refusal. The Clinical Manager or designee will audit 10% of treatment sheets 3 random days per week for the next 4 weeks, if substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar. The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>A. A hemodialysis treatment flow sheet dated 9-3-14 failed to evidence the supplement had been offered or administered to the patient during the treatment.</p> <p>B. Laboratory results evidenced the patient's albumin levels were less than the desired 4.0 g/dL according to the CMS MAT.</p> <p>1.) Laboratory results dated 7-21-14 evidenced the value was 3.3.</p> <p>2.) Laboratory results dated 8-18-14 and 9-15-14 evidenced the value was 3.6.</p> <p>C. The facility administrator was unable to provide any additional documentation and/or information when asked on 9-18-14 at 3:05 PM.</p> <p>3. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FSM-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Nutritional Status. Provide the necessary care and counseling services to achieve and sustain an effective nutritional status."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000550	<p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure post treatment access care had been completed in accordance with facility policy in 2 (#s 1 and 2) of 2 discontinuation of dialysis and post access care for arteriovenous fistula (AVF) observations completed creating the potential to affect all of the facility's patients with AVFs. (Employees K and Q)</p> <p>The findings include:</p> <p>1. On 9-17-14 at 10 AM, employee Q, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 17 with an AVF. The RN was observed to pull the venous needle out from under a Band-Aid that was in</p>	V000550	<p>The Director of Operations met with the Clinical Manager on September 26, 2014 emphasizing her responsibility to ensure all staff members are educated on the policy FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" and the requirement that staff follow policy and procedure as written. The Clinical Manager will educate and review with all staff the following policy at a mandatory staff in-service the week of 10/06/2014 with emphasis on changing dressing after hemostasis has been achieved. · FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then</p>	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>place. The Band-Aid remained in place after the needle was removed. The RN placed a folded 2 X 2 gauze over the insertion site, held pressure, and then applied tape. After the bleeding had stopped the RN was observed to remove the tape and gauze and leave the original Band-Aid in place.</p> <p>The RN repeated the same procedure for the arterial needle. A small amount of blood was observed on the 2 X 2 gauze placed over the Band-Aid after the needle had been removed. After the bleeding had stopped, the RN applied a second piece of clean gauze over the soiled Band-Aid and first piece of gauze and taped it in place.</p> <p>2. On 9-17-14 at 10:20 AM, employee K, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 12 with an AVF. The PCT was observed to pull the venous needle out from under the Band-Aid and apply a folded 2 X 2 gauze over the Band-Aid, held pressure, and then taped the gauze into place.</p> <p>The PCT repeated the same procedure for the arterial needle. The gauze placed over the Band-Aid on the arterial site was observed to be soaked with blood. The PCT removed the blood-soaked gauze</p>		<p>as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate. The Clinical Manager is responsible to evaluate and present audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
V000713	<p>and replaced it with clean gauze after the bleeding had stopped. The Band-Aid was left in place.</p> <p>3. The facility administrator indicated, on 9-18-14 at 5:00 PM, the RN and the PCT had not provided post treatment access care in accordance with facility policy.</p> <p>4. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "Once hemostasis has been achieved, remove the gauze used for hemostasis and replace the sites with Band-Aids or adhesive dressing or clean tape with gauze dressing."</p> <p>494.150(b) MD RESP-STAFF ED, TRAINING &amp; PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance. Based on observation, interview, and review of facility policy, the medical director failed to ensure staff were aware of specific parameters for conductivity checks of the dialysis machines prior to treatments in 1 (staff P) of 2 patient care technicians observed creating the potential to affect all of the facility's 92 current patients.</p>	V000713	The Director of Operations met (DO) with the Medical Director on 9/29/2014 to review the medical director citation and reviewed with him, the Medical Director's role in ensuring staff education, training, and performance. Specifically reviewed was the following: ·FMS-CS-IC-II-140-510C1 Checking Conductivity and pH of Final Dialysate with pHoenix	10/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
--	---

(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
	<p>The findings include:</p> <p>1. On 9-17-14 at 11:50 AM, employee P, a patient care technician (PCT), was observed to check the conductivity on the dialysis machine at station number 15 using a Phoenix meter. The PCT was unable to verbalize the desired range into which the values should fall. The PCT stated, "If it is 13.6 or under I check with the nurse."</p> <p>Employee Z, a registered nurse (RN), demonstrated to the PCT the dialysis machine and the desired range. The RN explained to the PCT the difference can only be "0.3 either direction."</p> <p>2. The facility's 11-5-13 "Checking Conductivity and pH of Final Dialysate with the pHoenix Meter" procedure number FMS-CS-IC-II-140-510C1 states, "The conductivity displayed on the dialysis machine must be within 0.3mS/cm of the reading taken with the handheld conductivity meter or dialysis treatment(s) may NOT be initiated or current treatment must be discontinued."</p>		<p>Meter Procedure</p> <ul style="list-style-type: none"> <li>The conductivity displayed on the dialysis machine must be within 0.3mS/cm of the reading taken with the handheld conductivity meter or dialysis treatment(s) may NOT be initiated or current treatment must be discontinued.</li> </ul> <p>On 9/29/2014, the Medical Director directed the Director of Operations to meet with the Clinical Manager to reinforce her role to ensure that all staff are trained and held accountable to policy and procedures. Training on the above mentioned policy will occur during the week of Oct 06, 2014. Included in the training was the following:</p> <ul style="list-style-type: none"> <li>The conductivity displayed on the dialysis machine must be within 0.3mS/cm of the reading taken with the handheld conductivity meter or dialysis treatment(s) may NOT be initiated or current treatment must be discontinued.</li> </ul> <p>The clinic manager will perform monthly phoenix meter log review and randomly quiz staff weekly for 4 weeks, then monthly and then resume corporate education guidelines if all staff can verbalize understanding. The Clinical Manager is responsible to evaluate and present audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/19/2014
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(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	
			resolution is both occurring and is sustained.		