

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2012
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CIRCLE CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 N SENATE STE 100 INDIANAPOLIS, IN 46202
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 7/23/12, 7/24/12, and 7/25/12</p> <p>Facility #: 004927</p> <p>Medicaid Vendor #: 200470050B</p> <p>Surveyor: Kelly Ennis, RN, BSN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 108 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 0</p> <p>Total: 108</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 27, 2012</p>	V0000	<p>On or before 8/27/2012, the members of the Governing Body will meet by conference or in person to review the Statement of Deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. A copy of the Statement of Deficiencies and Plan of Correction was provided to the members of the Governing Body on 8/20/2012.</p>	

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

TITLE

(X6) DATE

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

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V0111	<p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> <p>Based on observation and staff interview, the facility failed to ensure a sanitary environment had been maintained by failing to provide for the protection of clean supplies used to initiate and discontinue dialysis treatments in 8 of 20 stations (#s 3, 4, 5, 6, 12, 16, 17, and 18) observed creating the potential for the transmission of disease causing organisms among staff and all of the facility's 108 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 7/24/12 at 10:00 AM, 7 bedside tables, #s 3, 4, 5, 6, 12, 16, and 17, had tape torn and open to air prior to patient initiation or discontinuation of dialysis treatment. On 7/24/12 at 10:15 AM, employee K, Patient care technician (PCT), opened a gauze packet and applied iodine in preparation for a Central Venous Catheter patient that had not yet arrived at station #18. 	V0111	<p>On or before 8/27/2012, the members of the Governing Body will meet by conference or in person to review the Statement of Deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. A copy of the Statement of Deficiencies and Plan of Correction was provided to the members of the Governing Body on 8/20/2012. The Clinical Manager will ensure that all staff members follow the "Dialysis Precautions" policy to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff inservices to futher educate all staff members on following policy "Dialysis Precautions", FMS-CS-IC-II-155-070A. Emphasis will be placed on not opening supplies or tearing tape until immediately ready to use. Training will be completed by 8/30/2012, and an inservice attendance sheet will be available at the facility for review. Clinical Manager will ensure that infection control</p>	08/30/2012			

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	3. The facility administrator, employee A, indicated, on 7/24/12 at 5:10 PM, supplies should not be opened and prepared prior to the patient's arrival.		audits utilizing the QAI Infection Control Audit Tool are done weekly for four (4) weeks; monthly for six (6) months, then ongoing monitoring will occur per the QAI Calendar. The Clinical Manager will report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.		

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V0113	<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, staff interview, and policy and procedure review, the facility failed to ensure staff followed the facility's infection control policies and procedures in 5 of 7 observations completed (#1, 2, 3, 5 and 6) creating the potential for the transmission of disease causing organisms among staff and all of the facility's 108 current patients.</p> <p>The findings include:</p> <p>1. Observation number 1: On 7/23/12 at 12:25 PM, employee D, a Registered Nurse (RN), was at machine number 18 writing on a flowsheet that was placed on top of the dialysis machine. No gloves were worn.</p> <p>2. Observation number 2: On 7/24/12 10:06 AM, employee K, Patient Care Technician (PCT), grabbed a flow sheet that was placed on top of the dialysis machine. No gloves were worn.</p>	V0113	<p>The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene" and "Personal Protective Equipment" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff inservices on the following policies: "Hand Hygiene", FMS-CS-IC-II-155-090A and "Personal Protective Equipment", FMS-CS-IC-II-155-080A, with emphasis placed on appropriate glove usage, glove changes and hand hygiene using hand sanitizer. Training will be completed completed on 8/30/2012, and an inservice attendance sheet will be available at the facility for review. After completion of the inservices on 8/30/12, a follow up audit of the identified deficiencies with skills checks will be completed for all staff by 9/7/12. The Clinical Manager held counseling sessions for Employee D, K, M and Q which were completed during the week ending 7/27/12. Expectations for improvement were discussed and</p>	09/07/2012

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	<p>3. Observation number 3: On 7/24/12 at 10:40 AM, employee M, PCT, was at machine number 1 writing on a flowsheet that was placed on top of the dialysis machine. No gloves were worn. Employee M then moved to machine number 2 and wrote on the flowsheet that was placed on top of the dialysis machine. No gloves were worn. Employee M then proceeded to machine number 3 and wrote on the flowsheet that was placed on top of the dialysis machine. No gloves were worn. No hand hygiene was performed in between stations or after touching the flowsheet.</p> <p>4. Observation number 5: On 7/24/12 10:15 AM employee K, PCT, was initiating dialysis on patient #6 who had a central venous catheter (CVC). Employee K removed the old dressing from the CVC site and then, without changing gloves, began to clean around catheter site with iodine soaked gauze.</p> <p>5. Observation number 6: On 7/24/2012 at 10:55 AM, employee Q, PCT, initiated treatment on a patient with an arteriovenous graft (AVG) at machine number 7. Employee Q transferred the patient to the bed and, with same gloves, opened supplies.</p>		<p>documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control Audit Tool are done weekly for four (4) weeks, monthly for six (6) months, and then as determined by the QAI calendar. Any deficiencies noted in 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 report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.</p>				

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	<p>Without changing gloves, employee Q prepped the first access site using an alcohol swab and inserted the first needle.</p> <p>6. On 7/24/12 at 5:00 PM, during the daily exit conference, employee A, facility administrator, indicated the flowsheets should have been placed in a plastic sheet in order to be sanitized after use. She also indicated gloves should be used when touching the the flowsheets on the dialysis station, when changing a CVC dressing, and before initiating treatment on a AVG patient.</p> <p>7. The facility's policy titled "Personal Protective Equipment" document number FMS-CS-IC-II-155-080A, effective date 1/4/2012, states, "Disposable gloves must be used: When handling contaminated dialysis equipment and accessories; when touching blood, body fluids, secretions, excretions, or items or surfaces potentially contaminated with these substances ... when touching any part of the dialysis machine or equipment at the dialysis station ... Change gloves and practice hand hygiene between each patient and/or station to prevent</p>			

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	<p>cross-contamination; remove gloves and wash hands after each patient contact, and after exposure to blood and body fluids. If hands are not visibly soiled, use of a waterless antiseptic hand rub is acceptable. Avoid touching surfaces with gloved hands that will be touched with ungloved hands (for ex. patient charts and computers.) If gloves are visibly contaminated, change gloves. Wash hands before putting on new gloves, touching any surfaces and before performing other activities."</p> <p>8. Facility policy titled "Hand Hygiene" document number FMS-CS-IC-II-155-090A, revision date 1/04/2012, states, "Hands will be decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct contact with patients, Entering and leaving the treatment area ... 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>				

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V0117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS</p> <p>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> <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, staff interview, and policy and procedure review, the facility failed to ensure staff kept clean areas clearly separated from contaminated areas where used supplies and equipment are handled in 2 of 2 days of observation creating the potential to spread infectious and communicable disease to affect all 108 patients of the facility.</p>	V0117	The Clinical Manager is responsible to ensure that all staff members follow the "Dialysis Precautions" policy to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff inservices to re-educate all staff members on following policy, "Dialysis Precautions", FMS-CS-IC-II-155-070A, with emphasis on clean versus	08/30/2012			

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	<p>The findings include:</p> <ol style="list-style-type: none"> On 7/23/12 at 12:15 PM, the clean supply cart was pushed up beside the dirty hand washing station on treatment floor. On 7/23/12 at 12:25 PM, flowsheets were found on top of dialysis station 17 and 18 with no protective covering. On 7/23/12 at 12:50 PM, flowsheets were found on the bedside tables of dialysis station 1, 2, and 3. There was no protective covering on the flowsheet. On 7/24/12 at 9:55 AM, a patient nursing home document was on the bedside table at dialysis station 8 with no protective covering. On 7/23/12 at 1:20 PM, employee K, a patient care technician, indicated when treatment is completed, the flowsheets are taken to the nursing station and placed in a black file holder where the registered nurse enters them into the computer. On 7/24/12 at 5:00 PM, during the daily exit conference, employee A, facility administrator, indicated the 		<p>contaminated areas and where supply carts can be kept, and how to handle paper folow sheets when used. Training will be completed on 8/30/12, and an inservice atendance sheet will be available in the facility for review. The Clinical Manager will ensure that Infection Control Audits, utilizing the QAI Infection Control Audit Tool, will be conducted weekly for four (4) weeks, monthly for six (6) months, 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 report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.</p>		

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	<p>flowsheets should have been placed in a plastic sheet in order to be sanitized after use.</p> <p>7. The facility's policy titled "Dialysis Precautions" policy number FMS-CS-IC-II-155-070A, effective date 1/4/12 states, "Clean area: An area designated for clean and unused equipment, supplies and medications. Dirty Area: An area where this is a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored and handled. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are handled or stored."</p>			

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V0119	<p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure staff stored clean supplies in a designated area to avoid contamination with blood and failed to ensure staff did not carry supplies in pockets in 2 of 2 days of observation creating the potential to spread infectious and communicable disease to affect all 108 patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On 7/23/12 at 12:10 PM, the clean supply cart was pushed up beside the dirty hand washing station on treatment floor. 2. On 7/23/12 at 12:15 PM, employee K, a patient care technician (PCT), wrote on patient flowsheet on the bedside table with a pen and then placed the pen back into their pocket. 	V0119	<p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff inservices to address cross contamination issues with supplies/carts and proper hand hygiene with all staff to be completed by 8/30/2012. An inservice attendance sheet will be available at the facility for review. The Education Coordinator will also emphasize proper hand hygiene when using a pen for paper flow sheets, as described in policy FMS-CS-IC-II-155-080A, "Personal Protective Equipment". The Clinical Manager will ensure that Infection Control Audits, utilizing the QAI Infection Control Audit Tool, are conducted weekly for four (4) weeks, monthly for six (6) months, 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</p>	08/30/2012	

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	<p>3. employee D, a registered nurse, reached into pocket and got a pen while on the treatment floor.</p> <p>4. On 7/23/12 at 1:08 PM, employee K, PCT, was observed writing on the patient's flowsheet with a pen at station #2. Employee K then placed the pen back into their pocket.</p> <p>6. On 7/23/12 at 4:48 PM, employee A, facility administrator indicated staff should not carry pens in their pockets.</p> <p>7. The facility's policy titled "Dialysis Precautions" policy number FMS-CS-IC-II-155-070A, effective date 1/4/12 states, "Clean area: An area designated for clean and unused equipment, supplies and medications. Dirty Area: An area where this is a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored and handled. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are handled or stored."</p>		<p>address the issue with each employee, including corrective action as appropriate. The Clinical Manager is responsible to report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.</p>	

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V0146	<p>494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html</p> <p>Based on observations, staff interview, and policy and procedure review, the facility failed to ensure 1 of 1 Patient Care Technicians (PCT) (employees K) observed treating a CVC patient provided care in compliance with central venous catheter policies and procedures creating the potential to spread infectious and communicable disease which could affect all patients with a central venous catheter (CVC).</p>	V0146	The Clinical Manager is responsible to ensure that all staff members follow the "Hand Hygiene" and "Changing the Catheter Dressing" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff inservices to re-educate all staff members on the following policies: "Hand Hygiene", FMS-CS-IC-II-155-090A and	09/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CIRCLE CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1420 N SENATE STE 100 INDIANAPOLIS, IN 46202		
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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation number 1: On 7/24/12 10:15 AM, employee K, a patient care technician, was initiating dialysis on patient #6, who had a central venous catheter (CVC). Employee K removed the old dressing from the CVC site and then, without changing gloves, began to clean around catheter site with iodine soaked gauze. 2. On 7/24/12 at 5:00 PM, during the daily exit conference, employee A, facility administrator, indicated gloves should be changed after removing the old dressing and before applying a new one. 3. Facility policy titled "Changing the Catheter Dressing" document number FMS-CS-IC-I-105-032C with an effective date of 4/4/12 states, "Don gloves, inspect and remove the old dressing. Check to see if dressing looks visibly soiled with exudate or blood, visually inspect the exit site and surround areas ... discard dressing and remove gloves, perform hand hygiene, tear open one (1) chlorehexidine swabstick package and place on the underpad surface. Keep swab stick in package until use, peel back dressing and gauze packages and place on underpad 		<p>"Changing the Catheter Dressing", FMS-CS-IC-II-105-032C with emphasis placed on appropriate glove changes. Training will be completed on 8/30/2012, and an inservice attendance sheet will be available in the facility for review. After completion of the inservices on 8/30/12, a follow up audit of the identified deficiencies with skills checks will be completed for all staff by 9/7/12. The Clinical Manager held a counseling session for Employee K on 7/27/2012 to discuss policy violations on July 24, 2012 as noted in the Statement of Deficiencies. Expectation for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage. The Clinical Manager will ensure that Infection Control Audits utilizing the QAI Infection Control Audit Tool are completed weekly for four (4) weeks, monthly for six (6) 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 report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.</p>		

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	surface. Keep dressing materials inside package until use, tear open antibacterial ointment package, apply clean gloves, ... using aseptic technique, apply the catheter dressing over dry exit site, being careful not to touch the patient side of the dressing with gloved hands or to any surface."			

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V0544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of 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.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure patients had achieved and sustained the prescribed dose of dialysis by failing to ensure heparin had been administered as ordered in 2 (#s 1 and 10) of 10 records reviewed of patients that had heparin ordered and by failing to ensure saline flushes had been administered as ordered in 1 (#3) of 1 records reviewed of patients that had saline flushes ordered creating the potential to affect all of the facility's 108 current patients.</p> <p>The findings include:</p> <p>Regarding heparin:</p> <p>1. Clinical record number 1 included physician orders dated 7/11/2012 that evidenced Heparin - Pork 1000 2 ML (milliliters) of heparin bolus was to be administered during each treatment; Heparin - Pork 1000 1.00 ML of heparin was to be administered</p>	V0544	<p>The Clinical Manager is responsible to ensure that all staff members administer heparin and normal saline according to the physician's prescription. Installation of heparin pumps on all machines was completed 8/13/2012. The Clinical Manager met with the Education Coordinator to arrange and schedule staff inservices on 8/28/12 and 8/30/12 to educate all staff regarding the Heparin Pump Procedure, FMS-CS-IC-I-105-035C and re-educate staff regarding the Heparinization Policy, FMS-CS-IC-I-105-035A. In addition, compliance with administration of heparin and normal saline according to the physician's prescription will be emphasized. An inservice attendance sheet will be available at the facility for review. Compliance with the administration of heparin and normal saline according to the physician's prescription will be monitored by the Clinical Manager through review of the monthly chart audits via the QAI Calendar schedule. Any deficiencies noted during the</p>	08/30/2012

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	<p>hourly during each treatment; and Heparin - Pork 1000 1.8 ML and 1.7 ML heparin dwell was to be administered at the end of each treatment.</p> <p>A. A post treatment flow sheet dated 7/11/12 evidenced treatment began at 10:14 AM and ended at 14:14 PM. The hourly doses of Heparin 1 ML were administered at 11:08, 14:29, and 14:29, not hourly as ordered. The flow sheet also failed to evidence the heparin 1.8 ML and 1.7 ML dwell was administered at the end of treatment.</p> <p>B. A post treatment flow sheet dated 7/13/12 evidenced treatment began at 10:31 AM and ended at 14:46 AM. The record failed to evidence the heparin 1.8 ML and 1.7 ML dwell was administered at the end of treatment.</p> <p>C. A post treatment flow sheet dated 7/16/12 evidenced treatment began at 10:35 AM and ended at 14:42 PM. The hourly doses of Heparin 1 ML were administered at 11:28 and 12:28, not hourly as ordered. The flow sheet also failed to evidence the heparin 1.8 ML and 1.7 ML dwell was administered at the end of treatment.</p> <p>D. A post treatment flow sheet dated 7/18/12 evidenced treatment began at</p>		<p>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 report a summary of findings monthly in QAI, and compliance will be monitored by the Governing Body.</p>		

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	<p>10:45 AM and ended at 14:46 PM. The hourly doses of Heparin 1 ML were administered at 12:40 PM and 1:40 PM, not hourly as ordered.</p> <p>E. A post treatment flow sheet dated 7/20/12 evidenced treatment began at 10:05 AM and ended at 14:08 PM. The flow sheet failed to evidence the heparin 1.8 ML and 1.7 ML dwell was administered at the end of treatment.</p> <p>F. A post treatment flow sheet dated 7/23/12 evidenced treatment began at 11:40 AM and ended at 14:37 PM. No hourly doses of Heparin 1 ML were given.</p> <p>2. Clinical record number 10 included physician orders dated 4/27/12 that evidenced Heparin - Pork 1000 1 ML (milliliters) of heparin bolus was to be administered during each treatment; Heparin - Pork 1000 0.5 ML of heparin was to be administered hourly every hour and discontinue heparin 60 minutes before the end of treatment.</p> <p>A. A post treatment flow sheet dated 7/4/12 evidenced treatment began at 7:21 AM and ended at 11:28 AM. The record failed to evidence any hourly doses of Heparin 0.5 ML were given.</p>			

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	<p>B. A post treatment flow sheet dated 7/6/12 evidenced treatment began at 9:20 AM and ended at 13:23 PM. The record evidenced an hourly doses of Heparin 0.5 ML was given at 11:15 AM, not hourly as ordered.</p> <p>C. A post treatment flow sheet dated 7/9/12 evidenced treatment began at 9:32 AM and ended at 13:29 AM. The record failed to evidence any hourly doses of Heparin 0.5 ML was given.</p> <p>3. On 7/24/12 at 5:05 PM, he facility administrator, employee A, verified the heparin was not given as ordered.</p> <p>Regarding saline flushes:</p> <p>4. Clinical record number 3 included physician orders dated 6/18/12 that evidenced saline flushes 100 cc/hr [cubic centimeters per hour] were to be given during treatment.</p> <p>A. A post treatment flow sheet dated 7/9/12 evidenced treatment began at 9:06 AM and ended at 13:11 PM. The record evidenced saline flushes were given at 10:00 AM and 10:35 AM, not hourly as ordered.</p> <p>B. A post treatment flow sheet dated</p>						

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	<p>7/18/12 evidenced treatment began at 9:45 AM and ended at 13:23 PM. The record evidenced saline flushes were given at 10:30 AM and 11:30 AM, not hourly as ordered. A note by employee Z, PCT states, "pt [patient] bfr [blood flow rate] decreased d/t [due to] clot formation in arterial chamber. RN [registered nurse] aware."</p> <p>C. A post treatment flow sheet dated 7/20/12 evidenced treatment began at 9:17 AM and ended at 13:14 PM. The record evidenced saline flushes were given at 10:30 AM and 11:23 AM, not hourly as ordered.</p> <p>D. On 7/25/12 at 5:00 PM employee A, facility administrator, indicated the saline flushes were not given hourly as ordered.</p>			