

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152577	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2015
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE LINTON	STREET ADDRESS, CITY, STATE, ZIP CODE RR 1 BOX 996 LONE TREE RD LINTON, IN 47441
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V 000 Bldg. 00	This was a Federal ESRD [CORE] recertification survey. Survey Dates: 5-19-15, 5-20-15, & 5-21-15 Facility #: 011044 Medicaid Vendor #: 200389360 QR: JE 5/26/15	V 000		
V 113 Bldg. 00	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. Based on observation, interview, and review of facility policy, the facility failed to ensure hand hygiene and glove changes had been performed in accordance with facility policy in 2 (#s 13 and 14) of 14 infection control observations completed. (Employees B and C) The findings include: 1. Employee B, a registered nurse (RN), was observed to administer intravenous (IV) Epogen to patient number 6 on	V 113	The Governing Body for the facility met on <u>5/28/15</u> to review the Statement of deficiencies and directed the Regional Quality Manager to assist the Management team in developing the plan of Correction. The Director of Operations reviewed the following policy number: FMS-CS-IC-II-155-090A "Hand Hygiene Policy" with the Clinical Manager on <u>5/28/15</u> emphasizing his responsibility to ensure all staff members are educated on the policies, competency is assessed and staff	06/19/2015

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

TITLE

(X6) DATE

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

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	<p>5-19-15 at 12:45 PM. The RN was observed to take the medications to station number 7 and cleanse her hands and don clean gloves. The RN then touched the machine and keyboard. Without cleansing her hands or changing gloves, the RN wiped the injection port with an alcohol pad and administered the medication.</p> <p>2. Employee C, a RN, was observed to administered IV Epogen to patient number 9 on 5-20-15. The RN was observed to take the medications to station number 7 and cleanse her hands and don clean gloves. The RN then touched the machine and keyboard. Without cleansing her hands or changing gloves, the RN wiped the injection port with an alcohol pad and administered the medication.</p> <p>3. The clinic manager, employee A, indicated, on 5-20-15 at 3:50 PM, employees B and C had not followed facility policy by failing to change gloves and cleanse their hands after touching the dialysis machine.</p> <p>4. The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A states, "Hand will be . . . Decontaminated using alcohol based hand rub or by washing hands with</p>		<p>understands the requirement to follow policies and procedures as written.</p> <p>All current staff will participate in a mandatory in-service by the clinic manager regarding Infection Control Practices the week of <u>6/02/15</u> specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that all staff wears 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.</p> <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</p> <p>The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes.</p>	

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V 122 Bldg. 00	<p>antimicrobial soap and water . . . 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>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 stations had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed. (Employees B and E)</p> <p>The findings include:</p> <p>1. Employee B, a registered nurse (RN), was observed to clean the vacated dialysis chair at station number 3 on 5-19-15 at 11:05 AM. The RN was not observed to open the left side of the chair to clean the inside surfaces and was not</p>	V 122	<p>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 <u>5/28/15</u> and emphasizing her responsibility to ensure all staff members are educated on the policy FMS-CS-IC-II-155-110A and the requirement that staff follow policy and procedure as written.</p> <p>All current staff will be in-serviced by the Clinical Manager on disinfection and Infection Control Practices the week of <u>6/02/15</u>, specifically focusing on policy: FMS-CS-IC-II-155-110A "Cleaning and Disinfection."</p> <p>In addition, the staff will be educated on their responsibility to</p>	06/19/2015

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	<p>observed to clean the fronts of the arms of the chair where patients place their hands.</p> <p>2. Employee E, a patient care technician (PCT), was observed to clean the dialysis machine and vacated chair at station number 6.</p> <p>A. The PCT was not observed to clean the intravenous (IV) pole or all the way down the front of the machine. The PCT was not observed to clean the dialysate hoses or the Hansen connectors. After cleaning the machine, the PCT was observed to touch the keyboard and enter data. Upon completion of the data entry, employee F, a PCT, was observed to string the machine with new tubing and a new dialyzer for patient number 16.</p> <p>B. The PCT was not observed to clean the fronts of the arms of the dialysis chair where patients place their hands or the television screen.</p> <p>3. The clinic manager, employee A, indicated, on 5-20-15 at 3:50 PM, employees B and E had not followed facility policy by failing to thoroughly clean the dialysis station.</p> <p>4. The facility's 1-28-15 "Cleaning and Disinfection" policy number</p>		<p>ensure all equipment in the patient care station; including all sections of the dialysis machine, prime waste bucket, chair arms, computer, and counter top. All areas must be considered potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded.</p> <p>The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file.</p> <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</p> <p>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>		

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V 544 Bldg. 00	<p>FMS-CS-IC-II-155-110A states, "All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures . . . Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are frequently touched and potentially contaminated . . . Non-disposable items such as blood pressure cuffs, IV poles, TVs, TV remotes, portable phones etc., as well as clip boards or plastic hemostat clamps placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment."</p> <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. Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure the correct dialyzer had been used in 1 (#3) of 4 verification of dialysis prescription observations completed. (patient #5)</p> <p>The findings include:</p>	V 544	The Director of Operations reviewed the following policy FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on 5/28/15 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed	06/19/2015

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V 550 Bldg. 00	<p>1. On 5-19-15 at 1:30 PM, observation noted an F 160 dialyzer being used for the dialysis treatment on patient number 5. The clinical record for patient number 5 included physician orders dated 3-17-15 that identified a 180 dialyzer was to be used for the dialysis treatment.</p> <p>2. Employee A, the clinic manager, indicated, on 5-19-15 at 1:40 PM, the incorrect dialyzer was being used for patient number 5.</p> <p>3. 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. Sustain the prescribed dose of dialysis to meet FMS target HD eKdrt/V of 1.2"</p>		<p>and staff understands the requirement to follow policies and procedures as written.</p> <p>A mandatory in-service is scheduled for all staff the week of 6/02/15 and the clinic manager will review & re-educate the following policy: FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy"</p> <p>Special emphasis will be placed on ensuring that the patient's prescribed dialyzer is delivered according to the physician's prescription and requirement to achieve adequate clearance.</p> <p>The Clinical 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.</p> <p>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>		
	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS				

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	<p>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 review of facility policy, the facility failed to ensure pre- and post access care had been completed in accordance with facility policy in 3 (#s 1, 3, and 4) of 4 arteriovenous fistula (AVF) access observations completed. (Employees B and E)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee E, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 6 using an AVF on 5-19-15 at 11:20 AM. The PCT was not observed to evaluate the access or locate/palpate the cannulation sites prior to preparing the sites for the insertion of the needles. 2. Employee B, a registered nurse (RN), was observed to discontinue the dialysis treatment on patient number 7 using an AVF on 5-19-15 at 11:00 AM. The RN removed the needles from the insertion sites and placed gauze and tape on the 	V 550	<p>The Director of Operations met with the Clinical Manager on <u>5/28/15</u> emphasizing his responsibility to ensure all staff members are educated on the policy FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" and "Post Treatment Fistula Needle Removal" procedure and the requirement that staff follow policy and procedure as written.</p> <p>The Clinical Manager will educate and review with all staff the following policies at a mandatory staff in-service the week of <u>6/02/15</u> with emphasis on assessing access by auscultation per policy and changing dressing after hemostasis has been achieved..</p> <ul style="list-style-type: none"> · FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" · FMS-CS-IC-I-115-006C "Assessment and Preparation of Internal Access for Needle Placement" <p>The Clinical Manager or designee</p>	06/19/2015

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	<p>sites. The patient was observed to apply pressure to the sites with gloved hand for approximately 10 minutes. A small amount of blood was observed on the venous insertion site gauze. The RN was not observed to replace the dressing with a clean gauze prior to the patient leaving the facility.</p> <p>3. Employee E, a PCT, was observed to discontinue the dialysis treatment on patient number 6 using an AVF on 5-19-15 at 1:55 PM. The PCT removed the needles from the insertion sites and placed gauze and tape on the sites. The patient was observed to apply pressure to the sites with a gloved hand for approximately 10 minutes. A small amount of blood was observed on the venous insertion site dressing. The PCT was not observed to replace the dressing with clean gauze prior to the patient leaving the facility.</p> <p>4. The clinic manager, employee A, indicated, on 5-20-15 at 3:50 PM, employees B and E had not followed facility policy by failing to change the dressings to the insertion sites.</p> <p>5. The facility's 9-25-13 "Assessment and Preparation of Internal Access for Needle Placement" procedure number FMS-CS-IC-I-115-006C states, "The</p>		<p>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</p> <p>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>		

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	<p>access must be assessed each treatment for patency, infection, and any abnormal findings . . . LISTEN: Staff who have been trained to auscultate vascular accesses should listen to the entire length of the access for changes in the sound of the bruit . . . Feel for thrill."</p> <p>6. 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>				