

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152525	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE INDIANAPOLIS NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 W 86TH ST INDIANAPOLIS, IN 46260
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V 0000  Bldg. 00	<p>This was a revisit to the Federal [CORE] recertification survey completed on 8-7-15.</p> <p>Survey Date: 9-28-15</p> <p>Facility #: 005139</p> <p>Medicare Provider #: 152525</p> <p>Medicaid Vendor #: 100217180A</p> <p>Census: 83 incenter 38 home peritoneal dialysis 2 home hemodialysis</p> <p>Three (3) Conditions for Coverage and 13 standards were found to be corrected as a result of this survey. Two (2) standards remain uncorrected and were re-cited.</p>	V 0000		
V 0113  Bldg. 00	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</p> <p>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 record review, the facility failed to ensure</p>	V 0113	<b>The Director of Operation has reviewed the following</b>	10/30/2015

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>staff had performed hand hygiene and glove changes appropriately in 1 (# 4) of 4 hand hygiene observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Employee Z, a registered nurse (RN) and the home therapies program manager, was observed to administer an Epogen injection to patint number 20 on 9-29-15 at 1:25 PM (observation number 4). The RN cleansed his hands and retrieved the Epogen from the medication refrigerator in the storage room. The RN also obtained syringes and alcohol pads from the shelves in the storage room. Without cleansing his hands, the RN attempted to don a clean pair of gloves. The gloves ripped and the RN obtained a box of gloves from another room and, without cleansing his hands, donned the clean gloves. The RN then completed the Epogen injection.</li> <li>The home program director of operations indicated, on 9-29-15 at 3:30 PM, employee Z had not followed facility policy.</li> <li>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</li> </ol>		<p><b>policies with the Home Program Manager on 10/19/2015 andemphasized his responsibility to ensure that all direct patient care stafffollow Policy and Procedure.</b></p> <ul style="list-style-type: none"> <li>·Hand HygienePolicy (FMS-CS-IC-II-155-090C)</li> <li>·The Clinical Managerwill meet with all staff on 10/19/2015 to review the above policy with the specificarea of focus being related to the Hand Hygiene prior to glove usage.</li> </ul> <p>Effective 10/19/2015, theHome Program Manager or his designee will complete weekly infection controlmonitoring utilizing "clinic audit checklist" focusing on hand hygiene andproper use of gloves. This audit willcontinue until 100% compliance is obtained by all staff. Issues of noncompliance will be addressedimmediately to include performance improvement plans or corrective action asneeded.</p> <p>The weekly monitoring resultswill be presented by the Home Program Manager at the monthly QAI meeting foranalysis, trending and discussion. If, after 4 weeks of monitoring, the resultsshow 100% compliance is met, the</p>	

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	<p>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 are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of</p>		<p><b>monitoring will be reduced to a monthly basis;then the QAI team will review the results at each meeting and at that time willbe responsible for determining the frequency of the audits utilizing theInfection Control Audit Tools per the QAI calendar schedule.</b></p> <p><b>The Home Program Manager is responsible toevaluate and present the "clinic audit checklist" findings in the monthly QAImeeting. The QAI Committee is responsible to review, analyze and trend allmonitoring results to ensure resolution is both occurring and is sustained</b></p> <p><b>The Director of Operations isresponsible to ensure that the data required within this Plan of Correction ispresented to the QAI Committee on a monthly basis for evaluation.</b></p>	

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V 0122 Bldg. 00	<p>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>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 record review, the facility failed to ensure the dialysis station had been cleaned and disinfected appropriately in 1 (#1) of 1 cleaning and disinfection of the dialysis station observations completed.</p> <p>The findings include:</p> <p>1. Employee S, a patient care technician (PCT), was observed to clean the dialysis</p>	V 0122	On October 19th 2015 the Clinical Manager metwith all direct patient care staff to review policy # FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on cleaning all surfaces ofthe dialysis machine including wiping the sides of the machine, dialysate hosesand data entry station . All staffacknowledged understanding that all dialysis equipment must be cleaned betweenpatients. Agenda and attendance sheet isavailable	10/30/2015

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	<p>machine at station number 17 on 9-29-15 at 2:50 PM. The PCT was observed to clean the front of the dialysis machine and then empty the prime waste receptacle. The PCT then cleaned one side of the machine after emptying the prime waste receptacle. The PCT was not observed to clean the other side of the machine, the dialysate hoses, or the data entry station.</p> <p>2. The clinic manager indicated, on 9-29-15 at 3:30 PM, the PCT had not cleaned and disinfected the dialysis machine in accordance with facility policy.</p> <p>3. The facility's 1-28-15 "Cleaning and Disinfection" policy number 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."</p>		<p>within the facility.</p> <p>Clinical Manager will ensure that infection control audits are completed utilizing the QAI Infection Control audit tool weekly for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent</p>	