

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
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NAME OF PROVIDER OR SUPPLIER COMPREHENSIVE RENAL CARE MUNSTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9100 CALUMET AVE MUNSTER, IN 46321
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V0000	<p>This survey was an ESRD recertification and relocation and for the addition of dialysis stations and home peritoneal dialysis services.</p> <p>Survey Dates: February 21, 22, and 23, 2012.</p> <p>Facility number: 010128</p> <p>Medicaid #: 200315330E</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 5, 2012</p>	V0000		

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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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, policy and procedure review, and staff interview, the facility failed to ensure staff members provided care in compliance with hand hygiene infection control policies and procedures in 2 of 2 observations completed creating the potential for spread of infection causing agents among facility staff and patients.</p> <p>The findings include:</p> <p>1. The facility's "Infection Control For Dialysis Facilities" policy number 1-05-01 states, "Hand hygiene is to be performed . . . prior to gloving, after removal of gloves . . . after patient and dialysis delivery system contact . . . before touching clean areas such as supplies . . . Alcohol-based hand rubs may be used: . . . Before gloving and after glove removal . . . Teammates will wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station . . . Gloves should be changed when: . . . When moving from a contaminated body site to a clean body site of the same patient ."</p>	V0113	<p>V113The Facility Administrator (FA) held mandatory in-service for all teammates (TMs) on 3/2/2012. In-service included but was not limited to: review of Dialysis Facilities Policy & Procedure #1-05-01 and Policy & Procedure Use of Alcohol Based Hand Rubs #1-05-01A. wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. 2) TMs must remove gloves and perform hand hygiene between each patient and station. 3) TMs will perform hand hygiene every time gloves are removed. 4) Proper procedure for hand hygiene including when using alcohol based hand rubs apply product in palm of one hand, rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet. FA or designee will conduct Hand Hygiene Audit on TMs 3 times a week for 4 weeks starting week of 3/5/2012 assuring 100% compliance, then weekly for 4 weeks. In addition to Hand Hygiene audit, Infection Control Audit will</p>	03/23/2012	

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	<p>2. Observation on 2/21/12</p> <p>A. At 12:20 PM, employee A was observed to clean the dialysis chair in station 3. She removed her gloves, applied alcohol based gel to the palms of her hands only, then went to the keyboard at the computer located between station 3 and 4. She then went to station #2 and, with gloved hands, wiped a red liquid from the front ledge of the dialysis machine. She then removed her gloves, applied the alcohol based gel to the palms of her hands, and rubbed her palms together only 3 times. She proceeded to the keyboard located between station 1 and 2.</p> <p>B. At 1:05 PM, employee A was observed in station 1. She removed her gloves; applied the alcohol based gel to her hands, palms only; rubbed palms together 5 times; then went to the keyboard located between station 3 and 4.</p> <p>C. At 1:40 PM, employee A was observed to touch the front of the dialysis machine at station #2 with her ungloved left forefinger.</p> <p>D. At 1:44 PM, employee A was observed tending to the patient in station 4. She left the station; applied alcohol</p>		<p>continue to be completed monthly. The FA will be responsible for monitoring these audits to assure that the deficiency is corrected and does not re-occur. The results of the audits will be reviewed with the Medical Director during the monthly Quality Improvement Facility Management Meeting (QIFMM). FA is responsible for compliance with this Plan of Correction</p>				

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	<p>based gel to her hands, palms only; rubbed together only 3 times; then went to a common supply in the center of the room. She opened a drawer and removed a bag of clear liquid. She returned to the station, hung the bag of fluid on the intravenous (IV) pole, then began to terminate the dialysis treatment.</p> <p>3. Observation on 2/23/12</p> <p>A. At 9:18 AM, employee A was observed in station 13 with a patient. She removed her gloves, applied the alcohol based gel to the palms of her hands only, rubbed together 3 times, went to the keyboard between station 13 and 14, donned a pair of gloves, and went into station 12 and touched the front of the dialysis machine. The patient asked employee A what she was doing, and the employee informed the patient she was checking the patient's blood pressure. Employee A then removed her gloves and began typing on the keyboard. She did not decontaminate her hands after removing her gloves.</p> <p>B. At 9:36 AM, employee A was observed to leave the keyboard at station 12 and enter station 8; she donned a pair of gloves and taped the access dressing on the patient. Employee A did not decontaminate her hands after leaving the</p>						

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	<p>keyboard and before applying the gloves to render patient care.</p> <p>C. At 2:25 PM, employee C indicated the above-stated practices were not in compliance with the facility's infection control policies and procedures.</p>			

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V0122	<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 and interview, the facility failed to ensure the employees cleaned and disinfected contaminated surfaces and equipment in 2 of 2 observations with the potential to affect all the facility's patients.</p> <p>The findings include:</p> <p>Observation on 2/21/12:</p> <p>1. At 1:30 PM, employee A, a patient care technician, asked employee F if the dialysis machine in station 2 was clean. Employee F said "no." Employee A was observed to clean the dialysis machine. She failed to clean the clamps which hold the dialysis tubing. She picked up the plastic clip board, rearranged the white papers that were attached, and placed the clipboard on the top of the dialysis machine.</p> <p>2. At 12 PM, employee A was observed</p>	V0122	<p>V122The FA held mandatory in-service for all TMson 3/2/2012. In-service included but was notlimited to: review of Dialysis Facilities Policy & Procedure #1-05-01disinfection with bleach solution betweenpatient treatments of machine, andsurrounding equipment, TMs instructed usingsurveyor observations as examples to thefollowing: 1) TMs must fully clean machineincluding front, top, sides, bottom lip, 2) Allother equipment including IV pumps, clamps,clipboards must be wiped with bleach solutionbetween patients, 3) Attention must be taken to prevent papers attached to clipboard fromcontamination. Verification of attendance atin-service will be evidenced by TMs signatureon in-service sheet.FA or designee will audit TMs cleaning/disinfecting all equipment and worksurfaces 3 times a week for 4 weeks startingweek of 3/5/2012 assuring 100% compliancethen weekly for 4 weeks. In addition to thisaudit,</p>	03/23/2012	

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	<p>in station 4 cleaning the dialysis machine. She picked up the clipboard, rearranged the papers attached, and replaced the clipboard to the top of the dialysis machine. She failed to decontaminated the IV pole which was attached to the dialysis machine.</p> <p>3. At 9 AM, employee B was observed cleaning the dialysis station following treatment. She failed to clean the plastic clipboard which was holding several white pieces of paper.</p> <p>Employee B indicated she keeps the day's patient's prescription and orders on the clipboard. She placed them onto the clipboard before patients arrive and removes them all and disposes of them at the end of the day. She confirmed that she touched all of the papers by shuffling them after the last patient's treatment and had moved the current patient's orders to the top. She indicated she did not decontaminate the clipboard after each patient's treatment when cleaning the station and said, "Maybe it is not a good system."</p> <p>Observation on 2/23/12:</p> <p>4. At 9:32 AM, employee A was observed to clean the dialysis machine in station # 9. She quickly wiped only the</p>		<p>Infection Control Audit will continue to be completed monthly. The FA will be responsible for monitoring these audits to assure that the deficiency is corrected and does not re-occur. The results of the audits will be reviewed with the Medical Director during the monthly QIFMM. FA is responsible for compliance with this Plan of Correction.</p>	

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	<p>front of the machine. She did not clean in between the machine parts, the top of the machine, sides of the machine, the IV pole that was attached, and the clip board which was laying on top of the machine that held a copy of the previous patient's prescription.</p> <p>5. On 2/21/11 at 2:25 PM, employee C indicated the above-stated practices were not in compliance with the facility's infection control policies and procedures.</p>			