

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 | | | |
| V0000 | <p>This was a federal ESRD recertification survey.</p> <p>Survey dates: May 2, 3, and 4, 2012.</p> <p>Facility: 002456</p> <p>Medicaid Vendor: 200279440A</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>Census: 33 Incenter patients</p> <p>QA: Linda Dubak, R.N. 5/10/12</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.

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|---|----------------------|
| 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, interview, and facility policy review, the facility failed to ensure the staff followed infection control policies during the provision of care in 2 of 3 days of patient care observations creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC,II,155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation . . .</p> <p>Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and storage of reused items conforming to</p> | V0111 | <p>Immediately and as observed the Operations Manager and/or Clinical Manager corrected employee A's practice related to infection control procedure breaks.</p> <p>On 5/7/12 the Clinical Manager met with all staff to review infection control standards and, by 6/15/12, will meet with 100% of staff to review and reinforce policies FMS CS-IC-11-155-060A Infection Control Overview, FMS-CS-IC155-080A Personal Protective Equipment, and FMS-CS-IC-155-090A Hand Hygiene Policy with emphasis on use of PPE including glove storage and changes, hand hygiene, and the requirement that all reusable equipment must be disinfected upon removal from patient station (including clipboards). Meeting agendas and attendance records are available for review at the facility.</p> <p>The Clinical Manager or designee will audit staff compliance according to the QAI calendar and the Clinical Manager will immediately address continued noncompliance. The Clinical Manager will report findings and</p> | 06/15/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, 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>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloved hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting"</p> | | actions taken during QAI monthly meetings. In the event of ongoing issues the QAI Committee will determine root cause of deficiencies, implement a plan and track plans through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure the dialysis facility provides and monitors a sanitary environment to minimize transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Observations on May 2, 2012:</p> <p>A. At 12 PM, observed employee A providing patient care in dialysis station 11 with patient # 6. Observed employee A with both hands gloved, infusing clear liquid from an intravenous bag to the patient, the dialyzer was clear. In her right gloved hand she was holding yellow line end caps. While the clear liquid was infusing and holding the yellow line caps in her right gloved hand, she took her gloved right hand and touched her face shield. She was resting her left gloved hand on the front of the dialysis machine, # 4, then she removed her left hand from the dialysis machine and touched her face shield, and then went under the face shield and touched her face. At 12:05 PM, she disconnected the patient and</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>placed each of the 2 yellow caps from her right hand onto the patients dialysis tubing lines. The patient had requested to temporarily stop dialysis to use the restroom. At 12:09 PM, employee A removed her gloves, applied an alcohol based gel to her hands and rubbed only the palms of her hands 4 times, she then left the incenter unit and obtained a wheelchair for patient # 6 to use for mobility to the restroom. The employee failed to change her gloves once contaminated. Then once she did remove her gloves, she failed to adequately cleanse her hands.</p> <p>B. At 12:20 PM, observed employee A to restart the dialysis treatment on patient # 6. Twice, while restarting this patient's treatment, she has rubbed her nose with the back side of her gloved hands. She failed to remove her gloves and decontaminate her hands once she rubbed her nose.</p> <p>C. At 12:36 PM, observed employee A between station 13 and 14 at the computer keyboard. She removed her gloves and decontaminated her hands, then she placed the palms of both hands on the sides of her face, then she placed her hands on the keyboard. While at keyboard, she took her right hand to her nose and then back onto the keyboard.</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
|---|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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>She failed to decontaminate her hands after she touched her face and before she touched the keyboard.</p> <p>D. At 12:38 PM, observed employee A at the computer keyboard between station 11 and 12. After decontamination of her hands, she took her right hand to her nose and then back to the keyboard. She then left the computer keyboard and went to a box of gloves that were located between station 12 and 13. She obtained a handful of gloves from the box and deposited them on top of the dialysis machine in station 11. She failed to decontaminate her hands after she touched her face and before she touched the keyboard and obtained the clean gloves for use with patient # 6.</p> <p>4. Observation on May 4, 2012:</p> <p>Observed employee F, enter dialysis station # 14 where patient # 6 was dialyzing and retrieve a clip board and its contents from the patients right chair side table. Employee F carried the clipboard and its contents off of the in center unit without decontaminating the clip board or her hands.</p> <p>5. On May 3, 2012 at 3:20 PM, employee M indicated that a quarterly audit was conducted on site within the past 4 weeks</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>and there were breaks in the infection control practices on the treatment floor. She indicated reports were sent to corporate level and the clinical manager that identified the offenders.</p> <p>6. On May 4, 2012 at 11 AM, employee D indicated employee A was observed during the most recent quarterly audit to have broke infection control protocols. Employee D indicated the breaks in infection control policies and procedures were addressed individually and as a group at the staff meeting which followed the audit.</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
|---|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 | | | |
| V0112 | <p>494.30(a) IC-CDC MMWR 2001 The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. 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 at 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>The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure staff provided care per the implemented infection control policies in</p> | V0112 | Immediately and as observed the Operations Manager and/or Clinical Manager corrected employee A's practice related to infection control procedure | 06/15/2012 | | | |

| | | | | | |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | |
| (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>2 of 3 days of patient care observations creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC,II,155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and storage of reused items conforming to CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After</p> | | <p>breaks.</p> <p>On 5/7/12 the Clinical Manager met with all staff to review infection control standards and, by 6/15/12, will meet with 100% of staff to review and reinforce policies FMS CS-IC-11-155-060A Infection Control Overview, FMS-CS-IC-155-080A Personal Protective Equipment, and FMS-CS-IC-155-090A Hand Hygiene Policy with emphasis on use of PPE including glove storage and changes, hand hygiene, and the requirement that all reusable equipment must be disinfected upon removal from patient station (including clipboards). Meeting agendas and attendance records are available for review at the facility.</p> <p>The Clinical Manager or designee will audit staff compliance according to the QAI calendar and the Clinical Manager will immediately address continued noncompliance. The Clinical Manager will report findings and actions taken during QAI monthly meetings. In the event of ongoing issues the QAI Committee will determine root cause of deficiencies, implement a plan and track plans through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure the dialysis facility provides and monitors a sanitary environment to minimize transmission of</p> | | |

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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 body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, 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>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloved hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical</p> | | infectious agents within and between the unit and any adjacent hospital or other public areas. | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Observations on May 2, 2012:</p> <p>A. At 12 PM, observed employee A providing patient care in dialysis station 11 with patient # 6. Observed employee A with both hands gloved, infusing clear liquid from an intravenous bag to the patient, the dialyzer was clear. In her right gloved hand she was holding yellow line end caps. While the clear liquid was infusing and holding the yellow line caps in her right gloved hand, she took her gloved right hand and touched her face shield. She was resting her left gloved hand on the front of the dialysis machine, # 4, then she removed her left hand from the dialysis machine and touched her face shield, and then went under the face shield and touched her face. At 12:05 PM, she disconnected the patient and placed each of the 2 yellow caps from her right hand onto the patients dialysis tubing lines. The patient had requested to temporarily stop dialysis to use the restroom. At 12:09 PM, employee A removed her gloves, applied an alcohol based gel to her hands and rubbed only the palms of her hands 4 times, she then left the incenter unit and obtained a wheelchair for patient # 6 to use for</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>mobility to the restroom. The employee failed to change her gloves once contaminated. Then once she did remove her gloves, she failed to adequately cleanse her hands.</p> <p>B. At 12:20 PM, observed employee A to restart the dialysis treatment on patient # 6. Twice, while restarting this patient's treatment, she has rubbed her nose with the back side of her gloved hands. She failed to remove her gloves and decontaminate her hands once she rubbed her nose.</p> <p>C. At 12:36 PM, observed employee A between station 13 and 14 at the computer keyboard. She removed her gloves and decontaminated her hands, then she placed the palms of both hands on the sides of her face, then she placed her hands on the keyboard. While at keyboard, she took her right hand to her nose and then back onto the keyboard. She failed to decontaminate her hands after she touched her face and before she touched the keyboard.</p> <p>D. At 12:38 PM, observed employee A at the computer keyboard between station 11 and 12. After decontamination of her hands, she took her right hand to her nose and then back to the keyboard. She then left the computer keyboard and went to a</p> | | | |

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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>box of gloves that were located between station 12 and 13. She obtained a handful of gloves from the box and deposited them on top of the dialysis machine in station 11. She failed to decontaminate her hands after she touched her face and before she touched the keyboard and obtained the clean gloves for use with patient # 6.</p> <p>4. Observation on May 4, 2012:</p> <p>Observed employee F, enter dialysis station # 14 where patient # 6 was dialyzing and retrieve a clip board and its contents from the patients right chair side table. Employee F carried the clipboard and its contents off of the in center unit without decontaminating the clip board or her hands.</p> <p>5. On May 3, 2012 at 3:20 PM, employee M indicated that a quarterly audit was conducted on site within the past 4 weeks and there were breaks in the infection control practices on the treatment floor. She indicated reports were sent to corporate level and the clinical manager that identified the offenders.</p> <p>6. On May 4, 2012 at 11 AM, employee D indicated employee A was observed during the most recent quarterly audit to have broke infection control protocols.</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | Employee D indicated the breaks in infection control policies and procedures were addressed individually and as a group at the staff meeting which followed the audit. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
|---|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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 | | | |
| 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, interview, and facility policy review, the facility failed to ensure staff changed gloves and performed hand hygiene appropriately during the provision of care in 2 of 3 days of patient care observations creating the potential to affect all of the facility's 33 current patients.</p> <p>The findings include:</p> <p>1. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC,II,155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation . . . Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and</p> | V0113 | <p>Immediately and as observed the Operations Manager and/or Clinical Manager corrected employee A's practice related to infection control procedure breaks.</p> <p>On 5/7/12 the Clinical Manager met with all staff to review infection control standards and, by 6/15/12, will meet with 100% of staff to review and reinforce policies FMS CS-IC-11-155-060A Infection Control Overview, FMS-CS-IC155-080A Personal Protective Equipment, and FMS-CS-IC-155-090A Hand Hygiene Policy with emphasis on use of PPE including glove storage and changes, hand hygiene, and the requirement that all reusable equipment must be disinfected upon removal from patient station (including clipboards). Meeting agendas and attendance records are available for review at the facility.</p> <p>The Clinical Manager or designee will audit staff compliance according to the QAI calendar and the Clinical Manager will immediately address continued noncompliance. The Clinical Manager will report findings and</p> | 06/15/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>storage of reused items conforming to CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, 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>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloved hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline</p> | | <p>actions taken during QAI monthly meetings. In the event of ongoing issues the QAI Committee will determine root cause of deficiencies, implement a plan and track plans through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure the dialysis facility provides and monitors a sanitary environment to minimize transmission of infectious agents within and between the unit and any adjacent hospital or other public areas.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Observations on May 2, 2012:</p> <p>A. At 12 PM, observed employee A providing patient care in dialysis station 11 with patient # 6. Observed employee A with both hands gloved, infusing clear liquid from an intravenous bag to the patient, the dialyzer was clear. In her right gloved hand she was holding yellow line end caps. While the clear liquid was infusing and holding the yellow line caps in her right gloved hand, she took her gloved right hand and touched her face shield. She was resting her left gloved hand on the front of the dialysis machine, # 4, then she removed her left hand from the dialysis machine and touched her face shield, and then went under the face shield and touched her face. At 12:05</p> | | | |

| | | | | | | | |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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>PM, she disconnected the patient and placed each of the 2 yellow caps from her right hand onto the patients dialysis tubing lines. The patient had requested to temporarily stop dialysis to use the restroom. At 12:09 PM, employee A removed her gloves, applied an alcohol based gel to her hands and rubbed only the palms of her hands 4 times, she then left the incenter unit and obtained a wheelchair for patient # 6 to use for mobility to the restroom. The employee failed to change her gloves once contaminated. Then once she did remove her gloves, she failed to adequately cleanse her hands.</p> <p>B. At 12:20 PM, observed employee A to restart the dialysis treatment on patient # 6. Twice, while restarting this patient's treatment, she has rubbed her nose with the back side of her gloved hands. She failed to remove her gloves and decontaminate her hands once she rubbed her nose.</p> <p>C. At 12:36 PM, observed employee A between station 13 and 14 at the computer keyboard. She removed her gloves and decontaminated her hands, then she placed the palms of both hands on the sides of her face, then she placed her hands on the keyboard. While at keyboard, she took her right hand to her</p> | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | |
| (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>nose and then back onto the keyboard. She failed to decontaminate her hands after she touched her face and before she touched the keyboard.</p> <p>D. At 12:38 PM, observed employee A at the computer keyboard between station 11 and 12. After decontamination of her hands, she took her right hand to her nose and then back to the keyboard. She then left the computer keyboard and went to a box of gloves that were located between station 12 and 13. She obtained a handful of gloves from the box and deposited them on top of the dialysis machine in station 11. She failed to decontaminate her hands after she touched her face and before she touched the keyboard and obtained the clean gloves for use with patient # 6.</p> <p>4. Observation on May 4, 2012:</p> <p>Observed employee F, enter dialysis station # 14 where patient # 6 was dialyzing and retrieve a clip board and its contents from the patients right chair side table. Employee F carried the clipboard and its contents off of the in center unit without decontaminating the clip board or her hands.</p> <p>5. On May 3, 2012 at 3:20 PM, employee M indicated that a quarterly audit was</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 05/04/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 |
|---|---|

| (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>conducted on site within the past 4 weeks and there were breaks in the infection control practices on the treatment floor. She indicated reports were sent to corporate level and the clinical manager that identified the offenders.</p> <p>6. On May 4, 2012 at 11 AM, employee D indicated employee A was observed during the most recent quarterly audit to have broke infection control protocols. Employee D indicated the breaks in infection control policies and procedures were addressed individually and as a group at the staff meeting which followed the audit.</p> | | | |

| | | | | | | | |
|---|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 | |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | | |
| (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 | | | |
| V0124 | <p>494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B</p> <p>The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit.</p> <p>Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results.</p> <p>Based on clinical record, administrative records, and policy and procedure review, and interview, the facility failed to ensure monthly antigen testing had been completed for 1 of 19 patients known to be susceptible creating the potential to affect the facility's other 18 current in-center patients who were susceptible. (patient #1)</p> <p>The findings include:</p> <p>1. The policy with effective date January 4, 2012 titled "Patient Testing and Vaccination for Hepatitis B" policy number FMS-CS-IC-II-155-142A policy states, "The following schedule shall be adhered to when testing patients for Hepatitis B: . . . All patients on admission HBsAg [hepatitis B surface antigen], Anti-HBc [antibody to hepatitis B core antigen], Anti-HBs [antibody to hepatitis</p> | V0124 | <p>The Operations Manager and Clinical Manager immediately received and implemented physician order to draw monthly Hepatitis B AG test on Patient #1. Results were obtained and verified as negative.</p> <p>On 5/21/12 the Director of Operations met with the Clinical Manager to review and reinforce policy FMS-CS-IC-11-155-142A Patient Testing and Vaccination for Hepatitis B with emphasis on monthly testing of susceptible patients (Hepatitis B AB < 10). Effective this same date the Clinical Manager completes the Hepatitis Vaccine Record which lists Hepatitis testing and vaccine status for active facility patients. The Clinical Manager verifies that all susceptible patients are tested as required per policy and immediately addresses continued noncompliance.</p> | 05/21/2012 | | | |

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152565 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/04/2012 |
| NAME OF PROVIDER OR SUPPLIER PORTAGE DIALYSIS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5972 US HWY 6 PORTAGE, IN 46368 | | |
| (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 surface antigen], HBV -(susceptible), including non-responders to vaccine HBsAg monthly, Anti-HBs positive (10 mIU/mL), anti-HBc negative: annual Anti-HBs, Anti-HBs positive and positive anti_HBc: no additional HBV testing needed."</p> <p>2. The facility's "Hepatitis Vaccine Record" report dated 2012 evidenced the hepatitis B antibody status as "Susceptible" for 19 current patients. The report evidenced monthly hepatitis B antigen testing had not been completed for patient #1, who was known to be susceptible.</p> <p>3. Clinical record # 1 evidenced the antibody to hepatitis B surface antigen lab value was less than 10 on February 1, 2012. The record failed to evidence monthly antigen testing had been completed in March and April 2012.</p> <p>4. On May 4, 2012 at 11:30 AM, employee D indicated this was her oversight and when the laboratory result of 2/1/12 was received, monthly antigen surface level testing should have been ordered.</p> | | <p>The Clinical Manager will review testing and vaccine tracking and actions taken during monthly QAI Committee meetings. In the event of ongoing issues the QAI Committee will determine root cause of deficiencies, implement a plan and track plans through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure monthly Hepatitis AG testing is completed as required based on Hepatitis status.</p> | | |