

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152582	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2015
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SPENCER	STREET ADDRESS, CITY, STATE, ZIP CODE 11 CRANE AVE SPENCER, IN 47460
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V 0000 Bldg. 00	This was a Federal ESRD [CORE] recertification survey. Survey Dates: 6-17-15, 6-18-15, & 6-19-15 Facility #: 0110328 Medicaid Vendor #: 200389370 QR: JE 6/24/15	V 0000		
V 0113 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 as required in 3 (#s 5, 7, and 9) of 14 infection control observations completed. (Employees L, D, E The findings include: 1. Employee L, a patient care technician (PCT) was observed to discontinue the dialysis treatment on patient number 6 on	V 0113	The Governing Body for the facility met on 7/2/15 to review the statement of deficiencies, The operations team developed the plan of correction. The Director of Operations reviewed the following policies "Infection Control Overview" policy number FMS-CS-IC-II-155-060A, "Hand Hygiene Policy" FMS-CS-IC-I-115-013C, "PostTreatment Fistula Needle Removal" with the Clinical Manager on 6/29/15 emphasizing his responsibility to ensure all	07/17/2015

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>6-17-15 at 12:55 PM using a central venous catheter (CVC). The employee reinfused the extracorporeal circuit and failed to cleanse her hands and change her gloves prior to disinfecting the hubs and disconnecting the blood lines from the CVC hubs.</p> <p>2. Employee D, a PCT, was observed to initiate the dialysis treatment on patient number 7 on 6-18-15 at 9:05 AM using an arteriovenous graft. The PCT evaluated the access by palpating the cannulation sites and listening to the blood flow with a stethoscope. The employee failed to change her gloves and cleanse her hands prior to disinfecting the needle insertion sites and inserting the cannulation needles.</p> <p>3. Employee E, a PCT, was observed to discontinue the dialysis treatment on patient number 1 on 6-17-15 at 12:40 PM using an arteriovenous fistula. The PCT was observed to push the footrest down on the dialysis chair and assist the patient to stand to obtain a post treatment blood pressure. The PCT assisted the patient to sit back down and proceeded to remove the needles from the patient's access. The PCT failed to cleanse her hands and change her gloves prior to removing the needles.</p>		<p>staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. All current staff will participate in a mandatory in-service by the clinic manager regarding infection control practices the week of 7/6/15 specifically focusing on the policies listed above. In addition, the staff will be educated on their responsibility to wear 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. 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 actions as appropriate. The clinical manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI committee is responsible to</p>		

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	<p>4. The clinic manager, employee A, indicated, on 6-19-15 at 11:15 AM, the employees had not provided services in accordance with facility policy.</p> <p>5. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "The person who is removing needles must perform hand hygiene and don new gloves."</p> <p>6. 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 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.</p>		review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.	

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V 0502 Bldg. 00	<p>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 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>494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the</p>			

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	<p>following:</p> <p>(1) Evaluation of current health status and medical condition, including co-morbid conditions.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the comprehensive assessment accurately and comprehensively addressed the patient's current health status in 1 (# 4) of 4 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included an initial comprehensive interdisciplinary assessment completed by the interdisciplinary team (IDT). The assessment failed to evidence an evaluation of the patient's status with regards to a noted C. diff infection, Clostridium difficile, a bacterial infection of the gastrointestinal tract that causes diarrhea and is associated with antibiotic use. The Centers for Disease Control (CDC) identifies that hand sanitizer does not kill C. difficile, and hand washing may not be sufficient. (www.cdc.gov/HAI).</p> <p>A. The assessment included a "Provider Rounding Note Comp HD" completed by the attending nephrologist, employee M, on 5-15-15. The note</p>	V 0502	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on 6/29/15 emphasizing her responsibility to ensure all attending physicians, interdisciplinary team and staffmembers are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. The Clinical Manager will educate and review with all physicians, interdisciplinary team and staff the following policy on the week of 7/6/15.</p> <p>·FMS-CS-IC-I-110-125A"Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on assessment of current health status and medical conditions,including co-morbid conditions.</p> <p>All interdisciplinary progress notes will be brought to the plan of care meeting. The Clinical Manager or designee will audit 10% of the medical record weekly for the next 4 weeks to verify documentation from the interdisciplinary team regarding</p>	07/17/2015			

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	<p>states, "[The patient] has diarrhea from C. diff." The physician note failed to evidence a complete and accurate assessment of the patient's status with regards to the C. diff infection.</p> <p>B. The nursing portion of the comprehensive assessment dated 5-6-15 identifies the patient as a resident of an extended care facility and states, "Gastrointestinal Issues Problem type N/A." The assessment failed to evidence follow up on the C. diff infection or any reference to C. diff.</p> <p>C. The registered dietitian portion of the comprehensive assessment dated 4-10-15 failed to evidence any mention of any gastrointestinal issues.</p> <p>2. The record included an "Initial Nursing Assessment" dated 4-10-15 that identifies the patient has diarrhea and states, "getting better."</p> <p>3. The clinic manager, employee A, stated, on 6-19-15 at 10:25 AM, "We did not know anything about that [the physician's notation the patient had a C. diff infection.]"</p> <p>4. The clinic manager, employee A, telephoned the attending physician on 6-19-15 at 10:40 AM. The manager</p>		<p>assessment of current health status and medical conditions including co-morbidities. If substantial compliance is achieved at 4 weeks, then medical record audits will be conducted monthly per the QAI calendar. 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>reported the physician "does not remember and will have to look at the patient's records."</p> <p>5. The clinic manager, employee A, telephoned the patient on 6-19-15 at 10:55 AM. The manager reported the patient indicated there was a C. diff infection but the hospital told the patient upon discharge "it was okay now."</p> <p>6. An electronic mail message was received from the Director of Operations, employee O, on 6-19-15 at 6:05 PM. The message identifies the attending physician, employee M, stated that she did not inform the facility staff of the May note that identified the patient had C. diff because "there was nothing to inform, the patient was negative for c-diff and better than before when [the patient] had c-diff." The physician "agrees the term 'better' was left to interpretation and she could have documented more clearly." The message states, "The H&P [history and physical], ECF [extended care facility] and patient all verbalized that [the patient] was cleared from c-diff when [the patient] started treatment . . . Please consider this a near miss and evaluate the entire clinic experience." The message included an attached document with laboratory results dated 4-1-15 that identified the test for the C.</p>			

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V 0504 Bldg. 00	<p>diff toxin was "negative."</p> <p>7. An electronic mail message was received from the facility's Medical Director, employee N, on 6-20-15. The message identifies he had reviewed the patient's hospital records and the patient did not have C. diff. The message states, "[the patient] was treated with multiple antibiotics for Sepsis . . . diarrhea was mentioned 3 times the entire time and could have been antibiotic related (but no mention of C. diff anywhere in the record including many notes from [the attending nephrologist, employee M]. Antibiotic treatment can indeed give diarrhea and [the attending nephrologist, employee M] as documented in the patient medical record in our dialysis unit should have said something in reference to diarrhea NOT C. diff. Patient did not have C. diff."</p> <p>8. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy states, "The comprehensive interdisciplinary assessment must include the following: Current health status including co-morbid conditions."</p> <p>494.80(a)(2) PA-ASSESS B/P, FLUID MANAGEMENT NEEDS The patient's comprehensive assessment</p>				

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	<p>must include, but is not limited to, the following:</p> <p>Blood pressure, and fluid management needs.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure the comprehensive assessment had been updated to address the patient's fluid volume management needs and status in 1 (#) of 4 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included physician orders dated 5-23-15 that identified the desired weight at the end of the treatment, the estimated dry weight (EDW), was 64.6 kilograms (kg). Hemodialysis treatment flow sheets failed to evidence the EDW had been attained at the end of each treatment.</p> <p>A. A hemodialysis treatment flow sheet dated 5-26-15 evidenced the patient's weight at the end of the treatment was 74 kg and 4.8 kg had been removed.</p> <p>B. A hemodialysis treatment flow sheet dated 5-28-15 evidenced the patient's weight at the end of the treatment was 74 kg and 5.5 kg had been removed.</p>	V 0504	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the clinical manager on 6/29/15 emphasizing her responsibility to ensure all attending physicians, interdisciplinary team and staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. The Clinical Manager will educate and review with all physicians and staff the following policy on the week of 7/6/15 FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on assessment of blood pressure and estimated dry weight needs. All interdisciplinary progress notes will be brought to the plan of care meeting. The clinical manager or designee will audit 10% of the medical records weekly for the next 4 weeks to verify documentation from the interdisciplinary team regarding assessment of blood pressure and estimated dry weight needs. If substantial compliance is achieved at 4 weeks, then medical</p>	07/17/2015

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	<p>C. A hemodialysis treatment flow sheet dated 5-30-15 evidenced the patient's weight at the end of the treatment was 73 kg and 5.4 kg had been removed.</p> <p>D. A hemodialysis treatment flow sheet dated 6-1-15 evidenced the patient's weight at the end of the treatment was 72.5 kg and 4.8 kg had been removed.</p> <p>E. A hemodialysis treatment flow sheet dated 6-2-15 evidenced the patient's weight at the end of the treatment was 70 kg and 5.3 kg had been removed.</p> <p>F. A hemodialysis treatment flow sheet dated 6-4-15 evidenced the patient's weight at the end of the treatment was 70.5 kg and 5.2 kg had been removed.</p> <p>G. A hemodialysis treatment flow sheet dated 6-6-15 evidenced the patient's weight at the end of the treatment was 70.3 kg and 5.4 kg had been removed.</p> <p>H. A hemodialysis treatment flow sheet dated 6-9-15 evidenced the patient's weight at the end of the treatment was 70.9 kg and 5.3 kg had been removed.</p> <p>I. A hemodialysis treatment flow sheet dated 6-10-15 evidenced the</p>		<p>record audits will be conducted monthly per the QAIcalendar. 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>patient's weight at the end of the treatment was 68.5 kg and 4.4 kg had been removed.</p> <p>J. A hemodialysis treatment flow sheet dated 6-11-15 evidenced the patient's weight at the end of the treatment was 66.9 kg and 3.8 kg had been removed.</p> <p>K. A hemodialysis treatment flow sheet dated 6-13-15 evidenced the patient's weight at the end of the treatment was 68.1 kg.</p> <p>L. A hemodialysis treatment flow sheet dated 6-16-15 evidenced the patient's weight at the end of the treatment was 69.5 kg and 3.8 kg had been removed.</p> <p>2. The clinical record failed to evidence the comprehensive assessment had been updated to address the patient's fluid management problems and inability to attain the EDW at the end of the treatments.</p> <p>3. The clinic manager, employee A, was unable to provide any additional documentation and/or information when asked on 6-19-15 at 10:45 AM.</p> <p>4. The facility's 7-4-12 "Comprehensive</p>			

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V 0508 Bldg. 00	<p>Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The comprehensive interdisciplinary assessment must include the following: . . . blood pressure and fluid management needs."</p> <p>494.80(a)(5) PA-ASSESS RENAL BONE DISEASE The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(5) Evaluation of factors associated with renal bone disease. Based on clinical record and facility policy review and interview, the facility failed to ensure the comprehensive assessment had been updated to include an evaluation of factors associated with the patient's elevated phosphorous levels in 1 (# 3) of 3 records reviewed of patients with elevated phosphorous levels.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The Centers for Medicare and Medicaid Services (CMS) Measures Assessment Tool (MAT) identifies the desired phosphorous level as 3.5 to 5.5 milligrams per deciliter (mg/dL). Clinical record number 3 included 	V 0508	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on 6/29/15 emphasizing her responsibility to ensure all attending physicians, interdisciplinary team and staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. The clinical manager will educate and review with all physicians and staff the following policy on the week of 7/6/15 FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on evaluation of factors associated</p>	07/17/2015

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V 0543 Bldg. 00	<p>laboratory results dated 6-9-15 that identified the phosphorous level was 10.1 mg/dL. The record included a "Nutrition Monthly Progress Note" dated 6-16-15 that states, "Phos [phosphorous] above goal at 10.1 (6/15)."</p> <p>The progress note failed to evidence an evaluation of the factors related to the elevated phosphorous levels.</p> <p>3. The clinic manager, employee A, was unable to provide any additional documentation and/or information when asked on 6-19-15 at 10:45 AM.</p> <p>4. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The comprehensive interdisciplinary assessment must include the following: . . . Evaluation of factors associated with renal bone disease."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record and facility policy review and interview, the facility</p>	V 0543	<p>with renal bone disease. All disciplinary progress notes will be brought to the plan of care meeting. The clinical manager or designee will audit 10% of the medical records weekly for the next 4 weeks to verify documentation from the interdisciplinary team regarding the evaluation of factors associated with renal bone disease. If substantial compliance is achieved at 4 weeks, then medical record audits will be conducted monthly per the QAI calendar. 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> <p>The Director of Operations reviewed the following policies</p>	07/17/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152582		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2015	
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	<p>failed to ensure it had provided the necessary care and services to manage the patient's fluid volume status in 1 (#) of 4 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included physician orders dated 5-23-15 that identified the desired weight at the end of the treatment, the estimated dry weight (EDW), was 64.6 kilograms (kg). Hemodialysis treatment flow sheets failed to evidence the facility had provided the care and services to attain the physician ordered EDW and evidenced greater than 5% of the EDW (3.2 kg) had been removed during the treatments.</p> <p>A. A hemodialysis treatment flow sheet dated 5-26-15 evidenced the patient's weight at the end of the treatment was 74 kg and 4.8 kg had been removed.</p> <p>B. A hemodialysis treatment flow sheet dated 5-28-15 evidenced the patient's weight at the end of the treatment was 74 kg and 5.5 kg had been removed.</p> <p>C. A hemodialysis treatment flow sheet dated 5-30-15 evidenced the</p>		<p>"FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on 6/29/15 emphasizing her responsibility to ensure all staff members are educated on the policies ,competency is assessed and staff understands the requirement to follow policies and procedures as written. The clinical manager will educate and review with all staff the following policy on the week of 7/6/15 FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on managing volume status and adjusting estimated dry weights as needed with physician's order. The Clinical Manager or designee will audit 10% of the medical record for the next 4 weeks to verify documentation from the interdisciplinary team regarding management of fluid volume status and adjustment of estimated dry weights as directed by the physician. If substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar. 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</p>				

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	<p>patient's weight at the end of the treatment was 73 kg and 5.4 kg had been removed.</p> <p>D. A hemodialysis treatment flow sheet dated 6-1-15 evidenced the patient's weight at the end of the treatment was 72.5 kg and 4.8 kg had been removed.</p> <p>E. A hemodialysis treatment flow sheet dated 6-2-15 evidenced the patient's weight at the end of the treatment was 70 kg and 5.3 kg had been removed.</p> <p>F. A hemodialysis treatment flow sheet dated 6-4-15 evidenced the patient's weight at the end of the treatment was 70.5 kg and 5.2 kg had been removed.</p> <p>G. A hemodialysis treatment flow sheet dated 6-6-15 evidenced the patient's weight at the end of the treatment was 70.3 kg and 5.4 kg had been removed.</p> <p>H. A hemodialysis treatment flow sheet dated 6-9-15 evidenced the patient's weight at the end of the treatment was 70.9 kg and 5.3 kg had been removed.</p> <p>I. A hemodialysis treatment flow sheet dated 6-10-15 evidenced the patient's weight at the end of the treatment was 68.5 kg and 4.4 kg had been removed.</p>		resolution is both occurring and is sustained.		

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	<p>J. A hemodialysis treatment flow sheet dated 6-11-15 evidenced the patient's weight at the end of the treatment was 66.9 kg and 3.8 kg had been removed.</p> <p>K. A hemodialysis treatment flow sheet dated 6-13-15 evidenced the patient's weight at the end of the treatment was 68.1 kg.</p> <p>L. A hemodialysis treatment flow sheet dated 6-16-15 evidenced the patient's weight at the end of the treatment was 69.5 kg and 3.8 kg had been removed.</p> <p>2. The clinic manager, employee A, was unable to provide any additional documentation and/or information when asked on 6-19-15 at 10:45 AM.</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 . . . Provide necessary care and services to manage the patient's volume status."</p>			

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V 0546 Bldg. 00	<p>494.90(a)(3) POC-MANAGE MINERAL METABOLISM Provide the necessary care to manage mineral metabolism and prevent or treat renal bone disease. Based on clinical record and facility policy review and interview, the facility failed to ensure it had provided the necessary care and services to manager the patient's phosphorous levels in 1 (# 3) of 3 records reviewed of patients with elevated phosphorous levels.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The Centers for Medicare and Medicaid Services (CMS) Measures Assessment Tool (MAT) identifies the desired phosphorous level as 3.5 to 5.5 milligrams per deciliter (mg/dL). Clinical record number 3 included laboratory results dated 6-9-15 that identified the phosphorous level was 10.1 mg/dL. The record included a "Nutrition Monthly Progress Note" dated 6-16-15 that states, "Phos [phosphorous] above goal at 10.1 (6/15)." <p>The progress note failed to evidence interventions to address the elevated phosphorous level.</p> <ol style="list-style-type: none"> The clinic manager, employee A, was 			V 0546	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on 6/29/15 emphasizing her responsibility to ensure all attending physicians, interdisciplinary team and staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written. The Clinical Manager will educate and review with all physicians and staff the following policy on the week of 7/6/15 FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on management of renal bone disease. All interdisciplinary progress notes will be brought to the plan of care meeting. The Clinical Manager or designee will audit 10% of the medical records weekly for the next 4 weeks to verify documentation from the interdisciplinary team regarding management of renal bone disease and mineral metabolism. If substantial compliance is achieved at 4 weeks, then medical records audits</p>		07/17/2015

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V 0550 Bldg. 00	<p>unable to provide any additional documentation and/or information when asked on 6-19-15 at 10:45 AM.</p> <p>4. 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: . . . Mineral Metabolism. Provide the necessary care to manage mineral metabolism and prevent or treat renal bone or cardiovascular disease."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS 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 post dialysis access care had been completed in accordance with</p>	V 0550	<p>will be conducted monthly per the QAI calendar. The Clinical Manageris responsible to evaluate and present audit findings in the monthly QAImeeting/minutes. The QAI Committee is responsible to review, analyze and trendall monitoring results to ensure resolution is both occurring and is sustained.</p> <p>The Director of Operations met with the Clinical Manager on 6/29/15 emphasizing his responsibility to ensureall staff members are educated on the</p>	07/17/2015	

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	<p>facility policy in 2 (#s 1 and 2) of 2 post dialysis access care observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee E, a patient care technician (PCT), was observed to remove the needles from the access site post dialysis on patient number 1 on 6-17-15 at 12:40 PM. The PCT was not observed to apply a clean dressing to the venous needle removal site prior to the patient leaving the facility. 2. Employee I, a registered nurse (RN), was observed to provide post needle removal access site care to patient number 5 on 6-17-15 at 2:45 PM. The RN was not observed to apply a clean dressing to the venous needle removal site prior to the patient leaving the facility. The RN stated, "I did not replace the venous dressing." 3. The clinic manager, employee A, indicated, on 6-19-15 at 11:15 AM, the employees had not provided services in accordance with facility policy. 4. 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, 		<p>policy FMS-CS-IC-I-115-013C "PostTreatment Fistula Needle Removal" and the requirement that staff follow policy and procedure as written. The Clinical Manager will educate and review with all staff the following policy at a mandatory staff in-service the week of 7/6/15 with emphasis on changing dressing after hemostasis has been achieved and access evaluation and assessment.</p> <p>FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" The Clinical Manager or designee will ensure compliance with infection control and appropriate dressing changes utilizing the QAI Infection Control audittool 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 Managerwho is responsible to address the issue with each employee including correctiveaction as appropriate The Clinical Manager is responsible to evaluateand present audit findings in the monthly QAI meeting/minutes. The QAI committee is responsible to review, analyze and trend all monitoring results toensure resolution is both occurring and is sustained.</p>	

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	remove the gauze used for hemostasis and replace the sites with Band-Aids of adhesive dressing or clean tape with gauze dressing."				