

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219
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V0000	<p>This was a federal ESRD recertification survey.</p> <p>Survey date: February 12 - 13, 2013</p> <p>Facility number: 005149</p> <p>Medicaid vendor number: 100227200A</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 132 Number of Home Hemodialysis Patients: 0 Number of Peritoneal Dialysis Patients: 0</p> <p>Total: 132</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 26, 2013</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 and review of policies, the facility failed to ensure staff removed gloves and disinfected hands per policy guidelines in 1 of 12 observations completed (#7) creating the potential for the transmission of disease causing organisms among staff and all of the facility's 132 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 2/12/13 at 11:00 AM, employee K, Patient Care Technician (PCT), was initiating treatment on patient #14, who had a Central Venous Catheter (CVC), at station #16. The PCT cleansed around the CVC site and flushed catheter ends. The PCT then proceeded to set up and prime the dialysis machine. She then connected the blood lines to the catheter ends and applied a new dressing with no hand sanitation or glove change prior. Facility policy titled "Hand Hygiene" document number 	V0113	<p>V 113 On March 19 th 2013 the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene and Changing the Catheter Dressing" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Changing the Catheter Dressing" FMS-CS-IC-I-105-032C with emphasis placed on appropriate glove changes and hand hygiene using hand sanitizer. Training was completed on February 15 th 2013 and an</p>	03/11/2013			

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	<p>FMS-CS-IC-II-155-090A, revision date 1/04/2012, states, "Hands will be ... Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct contact with patients ... before performing any invasive procedure such as vascular access cannulation or administration ... immediately after removing gloves ... after contact with inanimate objects near the patient, when moving from a contaminated body site to a clean body site of the same patient."</p> <p>3. Facility policy titled "Changing the Catheter Dressing" document number FMS-CS-IC-I-105-032C, revision date 4/4/12, states, "Using aseptic technique, apply the catheter dressing over dry exit site, being careful not to touch the patient side of the dressing with gloved hands or to any surface."</p>		<p>in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by February 15 th 2013</p> <p>The Clinical Manager held a counseling session for Employee K on March 11 th 2013 to discuss policy violations on February 12, 2013 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene.</p> <p>The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>		

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V0117	<p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation and review of policies, the facility failed to ensure clean areas were clearly separated from contaminated areas creating the potential to spread infection causing agents among facility staff and all 132 current in-center patients.</p> <p>The findings include:</p> <p>1. On 2/12/13 at 9:51 AM, pre torn</p>	V0117	<p>V 117</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Dialysis Precautions and Cleaning and Disinfection" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator</p>	03/11/2013			

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	<p>tape was observed applied directly to the chairside table with no barrier underneath at station #15.</p> <p>2. On 2/12/13 at 10:40 AM, the Phoenix meter was observed laying by clean gloves at the nursing station.</p> <p>3. On 2/12/13 at 11:20 AM, pre torn tape was observed applied directly to the chairside table with no barrier underneath at station #8. A flowsheet was also observed on top of the dialysis machine with no barrier underneath.</p> <p>4. On 2/12/13 at 11:25 AM, a flowsheet was observed on top of dialysis machines #3 and #7 with no barrier underneath.</p> <p>5. Facility policy titled "Cleaning and Disinfection" document number FMS-CS-IC-II-155-110A, effective date 1/4/12, states, "After use, all equipment and supplies must be considered as potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded."</p>		<p>to arrange and schedule staff in-services to re-educate all staff members on the following policies "Dialysis Precautions" FMS-CS-IC-II-155-070A and Cleaning and Disinfection FMS-CS-IC-II-155-110A" with emphasis placed on clean versus contaminated areas, where Phoenix meter should be stored after use until disinfected and the use of barriers. Training will be completed on March 11 th 2013, and an in-service attendance sheet will be available in the facility for review.</p> <p>Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</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</p>		

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			<p>root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</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 review of policies, the facility failed to ensure 1 of 2 Patient Care Technicians (PCT) (employee T) observed cleaned and disinfected contaminated surfaces as required creating the potential to spread infectious and communicable disease to facility staff and all 132 current in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 2/12/13 at 9:50 AM, employee T, PCT, was observed cleaning the chair at station #17. The PCT failed to open the sides of the chair to clean. On 2/12/13 at 10:36 AM, employee T, PCT, was observed cleaning the chair at station #17. The PCT failed to open the sides of the chair to clean. Facility policy titled "Cleaning and 	V0122	<p>On March 11 th 2013 the Clinical Manager met with all direct patient care staff to review policy # FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on cleaning all surfaces of the dialysis chair including opening the sides of the chair. All staff acknowledged understanding that all dialysis equipment must be cleaned between patients. Agenda and attendance sheet is available 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</p>	03/11/2013			

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	Disinfection" document number FMS-CS-IC-II-155-110A, effective date 1/4/12 states, "All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures."		root cause analysis completed as appropriate with the subsequent development of action plans. The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.		

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V0146	<p>494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. 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 as 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>Based on observation and review of policy and procedure, the facility failed to ensure 1 of 1 Patient Care Technicians (PCT) (employees K) observed treating a patient with a central venous catheter (CVC) provided care in compliance with central venous catheter policy creating the potential to spread infectious and communicable disease which could affect all patients with a</p>	V0146	<p>V 146 The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene and Changing the Catheter Dressing" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator</p>	03/11/2013			

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	<p>CVC.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 2/12/13 at 11:00 AM, employee K, PCT, was initiating treatment on patient #14, who had a Central Venous Catheter (CVC), at station #16. The PCT cleansed around the CVC site and flushed catheter ends. The PCT then proceeded to set up and prime the dialysis machine. She then connected the blood lines to the catheter ends and applied new dressing with no hand sanitation or glove change prior. Facility policy titled "Hand Hygiene" document number FMS-CS-IC-II-155-090A, revision date 1/04/2012 states, "Hands will be ... Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct contact with patients ... before performing any invasive procedure such as vascular access cannulation or administration ... immediately after removing gloves ... after contact with inanimate objects near the patient, when moving from a contaminated body site to a clean body site of the same patient." Facility procedure titled "Changing 		<p>to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Changing the Catheter Dressing" FMS-CS-IC-I-105-032C with emphasis placed on appropriate glove changes and hand hygiene using hand sanitizer. Training was completed on February 15 th 2013 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by February 15 th 2013</p> <p>The Clinical Manager held a counseling session for Employee K on March 11 th 2013 to discuss policy violations on February 12, 2013 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene.</p> <p>The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 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</p>		

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	<p>the Catheter Dressing" document number FMS-CS-IC-I-105-032C, revision date 4/4/12, states, "Using aseptic technique, apply the catheter dressing over dry exit site, being careful not to touch the patient side of the dressing with gloves hands or to any surface."</p> <p>4. Facility policy titled "Changing the Catheter Dressing" document number FMS-CS-IC-I-105-032A, with an effective date of 4/4/12, states, "Catheter related infections are one of the leading causes of death and reasons for catheter removal in dialysis patients. Strict infection control practices and adherence to the catheter dressing change procedure is essential to prevent serious complications."</p>		<p>action as appropriate</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>		

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V0401	<p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on facility policy review, observation, and interview, the facility failed to ensure all medications were properly labeled for 1 of 1 days medications were observed on the treatment floor with the potential to affect all 132 in-center patients of the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A, with a revision date of 7/4/12, states, "All medications in syringes not being administered immediately shall be labeled appropriately with the name of the medication, route, dose, name of patient, date, time and initials of the person who prepared the medication." 2. On 2/12/13 at 11:20 AM, two pre-drawn syringes of Heparin for patient #15 were lying on the chairside table at station #8 with no 	V0401	<p>The Clinical Manager is responsible to ensure that all staff members follow the "Medication Preparation and Administration" policy to ensure a safe treatment environment that includes proper labeling of medications.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policy "Medication Preparation and Administration" FMS-CS-IC-I-120-040A with emphasis placed on appropriate labeling of syringes with the name of the medication, route, dose, name of patient, date, time and initials of the person who prepared the medication. Training will be completed by March 11 th 2013 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by March 11 th 2013</p> <p>The Clinical Manager will ensure that patient safety audits utilizing the QAI Patient Safety audit tool</p>	03/11/2013			

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	<p>initials or time drawn on the label.</p> <p>3. On 2/12/13 at 11:22 AM, employee U, patient care technician, commented that patient #15 "must not be coming today. His stuff has been sitting here for almost 2 hours."</p>		<p>are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>		

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V0502	<p>494.80(a)(1) PA-ASSESS CURRENT HEALTH STATUS/COMORBIDS The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>(1) Evaluation of current health status and medical condition, including co-morbid conditions.</p> <p>Based on clinical record review, staff interview, and policy review, the facility failed to ensure the comprehensive assessment included co-morbid conditions in 12 of 12 clinical records reviewed with comprehensive assessments creating the potential to affect all of the facility's newly admitted patients. (#1, 2, 3, 4, 5, 6, 7, 9 10, 11, and 12)</p> <p>The findings include:</p> <p>1. Clinical Record #1 included a comprehensive assessment completed by employee Y, Registered Nurse (RN), on 12/15/12 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>2. Clinical Record #2 included a comprehensive assessment completed by employee Y, RN, on 12/15/12 that failed to evidence documentation of the patient's co-morbid conditions.</p>	V0502	<p>V 502 The Clinic Manager will meet with the facilities interdisciplinary team on March 11 th 2013 to review the requirements for the facility's Interdisciplinary Team as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care that includes a review of co-morbid conditions.</p> <p>The Clinical Manager will complete 100% review of all patients' Comprehensive Assessments by March 29 th 2013 to ensure that all Assessments evidence the review of any co-morbid conditions. Any patient's Assessment found to be out of compliance including patient # 1, 2, 3, 4, 5, 6, 7, 9, 10, 11 and 12 will be presented to the IDT for completion by March 29 th</p>	03/29/2013	

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	<p>3. Clinical Record #3 included a comprehensive assessment completed by employee C, RN, on 1/10/13 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>4. Clinical Record #4 included a comprehensive assessment completed by employee Y, RN, on 1/12/13 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>5. Clinical Record #5 included a comprehensive assessment completed by employee B, RN, on 10/18/12 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>6. Clinical Record #6 included a comprehensive assessment completed by employee Y, RN, on 1/3/13 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>7. Clinical Record #7 included a comprehensive assessment completed by employee A, RN, on 1/16/13 that failed to evidence documentation of the patient's co-morbid conditions.</p>		<p>2013</p> <p>The Clinical Manager will utilize the QAI tool for Assessment and Care-Plan tracking of all patients monthly to ensure that a review of all co-morbid conditions was completed.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to include the number of Assessments due, completed and missed to the QAI. Any patient missing any component of the Assessment will be scheduled for completion the following month and corrective action will be taken as appropriate.</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 development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p>		

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	<p>8. Clinical Record #9 included a comprehensive assessment completed by employee B, RN, on 1/24/13 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>9. Clinical Record #10 included a comprehensive assessment completed by employee Y, RN, on 12/8/12 that failed to evidence documentation of the patient's co-morbid conditions.</p> <p>10. Clinical Record #11 included a comprehensive assessment completed by employee A, RN, on 1/16/13 that failed to evidence documentation of the patient's co-morbid conditions</p> <p>11. Clinical Record #12 included a comprehensive assessment completed by employee Y, RN, on 1/12/13 that failed to evidence documentation of the patient's co-morbid conditions</p> <p>12. Clinical Record #13 included a comprehensive assessment completed by employee D, RN, on 1/18/13 that failed to evidence documentation of the patient's co-morbid conditions</p>						

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	<p>13. On 2/13/13 at 5:05 PM, employee Z, Administrator, indicated the comprehensive assessments did not list the co-morbid conditions.</p> <p>14. The facility policy titled "Comorbid Review and Reconciliation (Applies to In-center and Home Patients)" document number FMS-CS-IC-II-150-021A, with an effective date 1/4/12, states, "The purpose of this policy is to provide guidance to all in-center and home programs on obtaining, documenting, and maintaining the patient's current comorbid conditions to give the interdisciplinary team the necessary information to provide appropriate clinical care."</p> <p>15. The facility policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" document number FMS-CS-IC-I-110-125A, with an effective date of 7/4/12, states, "The comprehensive interdisciplinary assessment must include the following: Current health status including co-morbid conditions."</p>			

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V0516	<p>494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.</p> <p>Based on facility policy and clinical record review, the facility failed to ensure an initial comprehensive assessment was completed on new patients within 30 days or 13 hemodialysis sessions in 4 of 7 records with initial assessments reviewed. (#1, 2, 3, and 9).</p> <p>Findings:</p> <p>1. Facility policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A, with an effective date of 7/4/12, states, "An initial comprehensive interdisciplinary assessment must be conducted on all new patients and a Plan of Care developed and implemented within the later of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session."</p> <p>2. Clinical record #1 had a start of care date of 11/13/12. The initial</p>	V0516	<p>V 516 The Clinic Manager will meet with the facility's Interdisciplinary Team on March 11 th 2013 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care completed and available within their medical record that meets all criteria – emphasizing completion of the Assessment on all new patients within 30 days and/or 13 treatments.</p> <p>The Clinical Manager will utilize the QAI tool for Assessment and Care-Plan tracking of all patients monthly to ensure the timely completion of any new patients Comprehensive Assessment. Any CIA's found out of compliance</p>	03/29/2013			

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	<p>comprehensive assessment was not completed by the Registered Nurse (RN) until 12/15/12.</p> <p>3. Clinical Record #2 had a start of care date of 11/10/12. The initial comprehensive assessment was not completed by the RN until 12/15/12.</p> <p>4. Clinical Record #3 had a start of care date of 12/13/12. The initial comprehensive assessment was not completed by the Social Worker until 1/14/13.</p> <p>5. Clinical Record #9 had a start of care date of 12/11/12. The initial comprehensive assessment was not completed by the RN until 1/24/13.</p>		<p>will be scheduled for completion within the next 30 days and corrective action will be taken as appropriate.</p> <p>The Clinic Manager will schedule an additional Plan of Care meeting with the Physician Team within the first two weeks of each month to provide timely review and completion of patient's initial Plan of Care and Comprehensive Assessments within 30 days or 13 treatments of admission to the dialysis facility</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to include the number of Assessments due, completed and missed to the QAI. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>		

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V0557	<p>494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session.</p> <p>Based on facility policy and clinical record review, the facility failed to ensure an initial plan of care was developed for new patients within 30 days or 13 hemodialysis sessions in 8 of 8 records reviewed with an initial plan of care. (#1, 2, 3, 4, 6, 9, and 12).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A, with an effective date of 7/4/12, states, "An initial comprehensive interdisciplinary assessment must be conducted on all new patients and a Plan of Care developed and implemented within the later of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session." 2. Clinical record #1 had a start of 	V0557	<p>The Clinic Manager will meet with the facility's Interdisciplinary Team on March 11 th 2013 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care", to ensure that every patient will have a timely, complete and current Plan of Care available within their medical record that meets all criteria including within the first 30 days or 13 treatments for all new patients.</p> <p>Effective immediately, the Clinical Manager will utilize the Care Plan Tracking tool and all new patients will be entered on this tool at their initial treatment. The Clinical Manager will then utilize the QAI tool for Care-Plan tracking of all patients monthly to ensure the timely completion of any new patients Comprehensive Assessment.</p> <p>The Clinic Manager will schedule an additional Plan of Care meeting with the Physician Team within the first two weeks of each</p>	03/29/2013	

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	<p>care date of 11/13/12. The initial plan of care was not completed until 12/24/12.</p> <p>3. Clinical Record #2 had a start of care date of 11/10/12. The initial plan of care was not completed until 12/24/12.</p> <p>4. Clinical Record #3 had a start of care date of 12/13/12. The initial plan of care was not completed until 1/29/13.</p> <p>5. Clinical Record #4 had a start of care date of 12/20/12. The initial plan of care was not completed until 1/29/13.</p> <p>6. Clinical Record #6 had a start of care date of 12/3/12. The initial plan of care was not completed until 1/21/13.</p> <p>7. Clinical Record #9 had a start of care date of 12/11/12. The initial plan of care was not completed until 1/29/13.</p> <p>8. Clinical Record #10 had a start of care date of 10/12/12. The initial plan of care was not completed until 11/21/12.</p> <p>9. Clinical Record #12 had a start of</p>		<p>month to provide timely review and completion of patient's initial Plan of Care and Comprehensive Assessments within 30 days or 13 treatments of admission to the dialysis facility</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to include the number of Plans of Care due, completed and missed to the QAI. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p>		

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	care date of 12/20/12. The initial plan of care was not completed until 1/29/13.			

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V0562	<p>494.90(d) POC-PT/FAMILY EDUCATION & TRAINING</p> <p>The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.</p> <p>Based on clinical record and policy review, the facility failed to ensure all patients had been provided with education and training in 2 of 13 records reviewed with the potential to affect all new hemodialysis patients. (#8 and #10)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #8, start of care 1/29/13, included a document titled "Education Record for New Patients." Review of the document evidenced no education has been provided to patient #8. 2. Clinical record #10, start of care 10/12/12, included a document titled "Education Record for New Patients." According to the facility policy, all items should have been completed by day 120. The document failed to evidence education on all topics had been completed. 	V0562	<p>The Clinic Manager will meet with the facility's Interdisciplinary Team on March 11 th 2013 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care completed and available within their medical record that meets all criteria including education specific to diabetes self management, diet, exercise, foot checks, dental care, blood glucose monitoring, diabetes medication, quality of life and medication regime adherence.</p> <p>The Clinical Manager will complete 100% review of all patients' Plans of Care by March 29 th 2013 to ensure that all Plans of Care due are complete, current and that educational</p>	03/29/2013			

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	<p>3. Facility policy titled "Patient Education" document number FMS-CS-IC-I-101-007A, with an effective date of 4/4/12, states, "Patient Education must be documented in the Patient's Medical Record as follows: New Patients-Education should be documented in the Education Record for New Patients ... Materials should be distributed to new patients within the 1st or 2nd treatment if possible, and no later than the 6th treatment ... It is the responsibility of the interdisciplinary team (RN, SW, RD, and, if available, the RightStart Case Manager, RSCM) to provide education on all topics listed on the Education Record for New patients ... The Education Record specifies when certain topics must be taught ... all topics should be taught within the first 120 days."</p>		<p>needs are identified with appropriate interventions provided. Any patient's Plan of Care found to be out of compliance will be presented to the IDT for completion by March 29 th 2013 including patients # 8 and 10.</p> <p>Monthly monitoring of all Plans of Care completed that month will be done by the Clinical Manager, to ensure that patients' educational needs are being addressed and Plans of Care are updated timely and appropriately. Any Plan of Care found out of compliance with education will be scheduled for completion within the next 30 days and corrective action will be taken as appropriate.</p> <p>Ongoing, the Clinical Manager will ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on all patients' educational needs. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to identify the number of POC's that do not include specific patient education. The QAI Committee is responsible to analyze the results</p>		

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			<p>and determine a root cause analysis and new Plan of Action if resolution is not occurring.</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 development of action plans.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p> <p>Ongoing compliance will be monitored by the Governing Body.</p>		

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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219			
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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on facility policy and procedure review, the medical director failed to ensure the facility had provided services in accordance with its own policies related to patient care and infection control with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The medical director failed to ensure the facility policy titled "Changing the Catheter Dressing" document number FMS-CS-IC-I-105-032C, revision date 4/4/12, was followed. (See V 113) 2. The medical director failed to ensure the facility policy titled "Cleaning and Disinfection" document number FMS-CS-IC-II-155-110A, effective date 1/4/12, was followed. (See V 117) 3. The medical director failed to 	V0715	<p>V715 Chairperson of the QAI Committee is responsible to analyze the results and The Director of Operations will meet with the Medical Director on March 19 th 2013 to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individual who treat patients in the facility emphasizing adherence to hand hygiene, changing catheter dressings, cleaning and disinfection, medication preparation, co-morbid review and Comprehensive Assessment and Plan of Care. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below.</p> <p>The facility's patient care staff will</p>	03/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
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	<p>ensure the facility policy titled "Changing the Catheter Dressing" document number FMS-CS-IC-I-105-032C, revision date 4/4/12, was followed. (See V 113 and V 146)</p> <p>4. The medical director failed to ensure the facility procedure titled "Changing the Catheter Dressing" policy number FMS-CS-IC-I-105-032C, revision date 4/4/12, was followed. (See V 146)</p> <p>5. The medical director failed to ensure the facility procedure titled "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A, with a revision date of 7/4/12, was followed. (See V 401)</p> <p>6. The medical director failed to ensure the facility policy titled "Comorbid Review and Reconciliation (Applies to In-center and Home Patients)" policy number FMS-CS-IC-II-150-021A, with an effective date 1/4/12, was followed. (See V 502)</p> <p>7. The medical director failed to ensure the facility policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" policy</p>		<p>be in-serviced on the following policies, "Hand Hygiene", "Changing the Catheter Dressing", "Cleaning and Disinfection", "Medication Preparation", "Co-morbid Review", "Comprehensive Assessment and Plan of Care" and "Patient Education" on March 11 th 2013 by education with a record of training reviewed by the QAI committee.</p> <p>The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the monthly QAI Committee Meeting.</p> <p>The Medical Director as direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		

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	<p>number FMS-CS-IC-I-110-125A, with an effective date of 7/4/12, was followed. (See V 502, V 516, and V 557)</p> <p>8. The medical director failed to ensure the facility policy titled "Patient Education" document number FMS-CS-IC-I-101-007A, with an effective date of 4/4/12, was followed. (See V 562)</p>				