

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/27/2014
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2150 GETTLER ST DYER, IN 46311
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V000000	<p>This visit was for an ESRD recertification survey.</p> <p>Facility #: 011994</p> <p>Survey dates: February 24 - 28, 2014</p> <p>Medicaid Vendor #: 200922510</p> <p>Surveyor: Ingrid Miller, PHNS, RN Janet Brandt, PHNS, RN</p> <p>Patient Census: 42 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 5, 2014</p>	V000000		
V000111	<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 review of policy, the facility failed to ensure the bleach solutions for clean use</p>	V000111	By 03/21/14 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-110A Cleaning and Disinfection Policy with emphasis on proper labeling of	03/21/2014

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>and dirty use were covered with opaque container lids for 1 of 1 dialysis facility with the potential to affect all of the facility's patients.</p> <p>Findings</p> <p>1. The facility policy titled "Cleaning and Disinfection" with an effective date of March 20, 2013, stated, "Bleach solution will be stored in labeled covered opaque containers to prevent disintegration of the chemical (sodium hypochlorite) when exposed to sunlight and air."</p> <p>2. The facility policy titled "Mixing Bleach" with an effective date of March 20, 2013, stated, "Label opaque container with 'Bleach solution', strength of solution, date and time prepared and your initials."</p> <p>2. On February 24, 2014, at 2:13 PM, a one liter container of bleach solution was observed to have no lid on and was not labeled with the strength or time or preparer's initials.</p> <p>3. On 2/24/14 at 2:15 PM, Employee F, Registered Nurse, indicated the bleach was 1:10 strength and was not labeled with the strength. This solution was to</p>		<p>bleach solution in opaque covered containers with strength of solution, date and time prepared and preparer's initials. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee will perform Infection Control Audits per the QAI Workflow Calendar and immediately follow up if issues are identified. The Clinical Manager will report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure a sanitary environment to minimize the transmission of infectious agents.</p>		

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V000122	<p>be used for blood spills.</p> <p>4. On 2/25/14 at 2:25 PM, the operations manager indicated the lids should be on the bleach containers with the strength of the solution and the time the solution was prepared.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observations, staff interview, and review of policies and procedure, the facility failed to ensure the prime bucket was emptied of saline solution and cleaned with bleach for 1 of 2 cleaning and disinfecting of the dialysis station observations (Employee J) with the potential to affect all the active patients of the dialysis facility.</p> <p>Findings</p>	V000122	<p>By 03/21/14 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-110A Cleaning and Disinfection policy with emphasis on disinfection of equipment post treatment/between patients inclusive of machine priming bucket. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee</p>	03/21/2014			

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	<p>1. The facility policy titled "Priming Bucket Disinfection" with a date of 4/4/12 stated, "Purpose: to disinfect the priming bucket post patient treatment ... follow the steps below to perform surface disinfection of the priming bucket post treatment ... dispose of saline solution down any marked dirty sink or utility room hopper 2. Clean all surfaces of the priming bucket or approved receptacle with a wipe that has been wetted with 1:100 bleach solution as per facility surface disinfection procedures. 3. Return clean priming bucket or approved receptacle to the machine."</p> <p>2. On 2/26/14 at 9:55 AM, Employee J, patient care technician, was observed to clean station #5, machine #20. Employee J failed to empty the prime bucket or clean it with bleach solution.</p> <p>3. On 2/26/14 at 10:25 AM, Employee J was observed to clean station #3, machine #12. Employee J failed to empty the prime bucket or clean it with bleach solution.</p> <p>4. On 2/26/14 at 10:55 AM, Employee F, Registered Nurse, indicated the prime buckets should be emptied and cleaned with bleach after each treatment.</p>		<p>will perform Infection Control Audits per the QAI Workflow Calendar and immediately follow up if issues are identified. The Clinical Manager will report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure prime buckets are emptied of saline solution and cleaned with bleach as required.</p>				

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V000143	<p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and</p> <p>Based on observation and interview, the facility failed to ensure medications were discarded when expired for 1 of 1 facility with the potential to affect all the patients and staff of the facility.</p> <p>Findings</p> <p>1. On February 24, 2014, at 2:30 PM, the medication area was observed to contain a bottle of iodine prep solution, a topical antiseptic, with approximately 8 ounces left in the 16 ounce bottle. This topical antiseptic was noted to have been opened on 4/20/12 by Employee P. The expiration date was December 2013.</p> <p>2. On February 24, 2014, at 2:35 PM, Employee G, Registered Nurse, indicated the above vial was expired and needed to be discarded.</p>	V000143	<p>The Clinical Manager immediately disposed of the expired Betadine and audited all inventory for expiration dates.</p> <p>By 03/21/14 The Clinical Manager will meet with all responsible staff to review and reinforce Infection Control Standards with emphasis on the facility process for monitoring supply expiration dates and immediately discarding expired supplies. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee will perform Infection Control Audits per the QAI Workflow Calendar and immediately follow up if issues are identified. The Clinical Manager will report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to</p>	03/21/2014

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V000401	<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.</p> <p>Based on observation and interview, the facility failed to ensure the treatment area had been maintained in a clean manner in 1 of 3 days of observation (#1 day) creating the potential to affect all of the facility's current patients.</p> <p>The findings include</p> <p>1. On 2/24/14 at 2:25 PM, a shelf under the dirty area of 1 of 4 treatment counters was observed to contain face shields (which did not appear to be clean), garbage sacks, debris, and rolled up kits for the next shift of patients which included a clean drape, gauze, and syringes. These kits were in a cardboard box. The shelf was dusty and full of debris.</p>	V000401	<p>determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure medications and other supplies are discarded when expired.</p> <p>The Clinical Manager immediately disposed of referenced supplies and thoroughly cleaned and reorganized storage shelf.</p> <p>By 03/21/14 the Clinical Manager will meet with all direct patient care staff to review and reinforce FMS-CS-IC-II-155-070A Dialysis Precautions Policy with emphasis on treatment floor storage and maintenance including designated storage space for PPE (face shields) and plastic container for clean dialysis supplies (kits). The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee will perform Infection Control audits per the QAI Workflow Calendar and immediately follow up if issues are identified. The</p>	03/21/2014	

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V000544	<p>2. On 2/24/14 at 2:25 PM, Employee F, Registered Nurse, indicated the kits were to be used for the nocturnal patients for the next shift that evening. These supplies were to be clean and were stored on a dirty shelf under the dirty side of the treatment counter.</p> <p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record review and interview, the facility failed to ensure the blood flow rate prescription was followed for 1 of 6 records (#4) reviewed with the potential to affect all patients of the facility.</p> <p>Findings</p> <p>1. Clinical record #4 included hemodialysis orders that identified the blood flow rate (BFR) was to be 450 mL/min (milliliters per minute). The</p>	V000544	<p>Clinical Manager will report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure the treatment floor is maintained in a clean manner.</p> <p>By 03/21/14 the Clinical Manager will meet with the Interdisciplinary Team (IDT) to review and reinforce FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy requirements for ensuring that each patient has a specific KT/V goal identified with a time line to achieve that goal. In addition the Clinical Manager reviewed:</p> <ul style="list-style-type: none"> <li>FMS 138-030-040-2.2 Physician Order Documentation requiring staff to provide treatment based on physician orders emphasizing that if the physician order cannot be</li> </ul>	03/21/2014

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	<p>flow sheet dated 2/5/14 evidenced a BFR of 300 with no explanation as to why the BFR prescription was not followed. The flow sheet dated 2/21/14 evidenced a BFR of 300 with no explanation as to why the BFR was not followed.</p> <p>2. On 2/27/14 at 12:45 PM, the operations manager indicated the blood flow rates were to match the orders unless an explanation was given on the treatment flow sheet.</p>		<p>achieved staff must notify the nurse and document reasons unable to carry out orders as written.</p> <p>· FMS 132-020-425 Monitoring During Patient Treatment with emphasis on delivering blood flow rate as prescribed and, if BFR cannot be maintained, notifying the RN and/or physician as appropriate and making adjustments as ordered.</p> <p>In addition the Clinical Manager will review and reinforce with RNs their responsibility for reviewing treatment records each patient shift to verify orders are carried out as written and documentation is present if ordered BFR is not achieved. The meeting agenda and attendance records will be available for review at the facility.</p> <p>The Clinical Manager or designee RN will perform Medical Record Audits per the QAI Workflow Calendar including verifying patient achieves ordered BFR or actions taken as required per policy. The Clinical Manager will address observed noncompliance and report audit findings and actions taken during QAI Committee meetings. In the event of discrepancies or problematic outcomes the committee investigates to determine the root cause of deficiencies and develops, implements, and tracks a corrective action plan through to</p>		

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			resolution. The Clinical Manager is responsible and the QAI Committee monitors to ensure BFR prescription is followed.		