STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152609	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE CARMEL	12400 N MERIDIAN ST CARMEL, IN 46032

(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
V 000 Bldg. 00	This was a Federal ESRD recertification survey. Survey Dates: 5-12-15, 5-13-15, & 5-14-15 Facility #: 011350 Medicaid Vendor #: 200858170A QR: JE 5/18/15	V 000		
V 113 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 facility policy review, the facility failed to ensure staff cleansed their hands and changed gloves appropriately in 1 (# 8) of 14 hand hygiene observations completed. The findings include: 1. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 2, using an arteriovenous fistula (AVF), on 5-13-15 at 10:45 AM. The PCT was	V 113	**V 113** On Thursday May 28th 2015, the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical Manager is responsible to ensure that all staff members	06/15/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 12400 N MERIDIAN ST CARMEL, IN 46032	

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	observed to obtain a syringe from the clean supply cart and return to the station. The PCT removed a disposable thermometer from the patient's mouth without donning gloves. The PCT then donned clean gloves without cleansing her hands. The PCT touched the front of the dialysis machine. The PCT then changed her gloves without cleansing her hands. The PCT then opened the packages of clean needles to start the dialysis treatment. The PCT then completed the initiation procedure. 2. The above-stated observation was discussed with the clinic manager, employee N, on 5-14-15 at 10:15 AM. The manager indicated employee C had not changed her gloves and cleansed her hands in accordance with facility policy. 3. 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		follow "Hand Hygiene, Personal Protective Equipment and Infection Control Overview" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. 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, "Personal Protective Equipment" FMS-CS-IC-II-155-080A and "Infection Control with emphasis placed on appropriate glove usage, glove changes and hand hygiene using hand sanitizer. Training will be completed by June 15,2015 and an in-service attendance sheet will be available in the facility for review in addition an audit with skills checks will be completed by June 15th 2015 The Clinical Manager or designee 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	

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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 12400 N MERIDIAN ST CARMEL, IN 46032	

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	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." 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." 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 gloves hands that will be touched with ungloved hands (for ex. patient charts and		employee including corrective action as appropriate The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.	

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	computers)." 4. 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 equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."			
V 147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to			

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	guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].			
	Based on facility policy review, observation, and interview, the facility failed to ensure discontinuation of the dialysis treatment with a central venous catheter (CVC) had been completed in accordance with facility policy in 2 (Employees D and F) of 2 discontinuation of the dialysis treatment using a CVC observations completed. The findings include: 1. The facility's 1-6-14 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" procedure number FMS-CS-IC-I-105-028C states, "Ensure	V 147	**V 147** On Thursday May 28th 2015 the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical Manager is responsible to ensure that all staff members follow “Hand Hygiene and “Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use EBearm Diallyzer” policies to ensure a safe treatment environment that	06/15/2015

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	that a clean under pad is below the catheter limbs to protect the work area and the clothing." 2. Employee D, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 7, using a CVC, on 5-12-15 at 2:00 PM. Observation noted a small amount of a dried red substance on the pad under the CVC limbs. The PCT was not observed to place a clean pad under the CVC limbs prior to starting the termination procedure. 3. Employee F, a PCT, was observed to discontinue the dialysis treatment on patient number 8 on 5-12-15 at 2:55 PM. The PCT was not observed to place a clean pad under the CVC limbs prior to starting the termination procedure. 4. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, employees D and F had not terminated the dialysis treatments on patients numbered 7 and 8 in accordance with facility policy.		prevents cross contamination of patients and equipment. 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 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use EBearm Dialyzer" procedure #"FMS-CS-IC-I-105-028C with emphasis placed on placing a clean field under the catheter ports prior to starting the discontinuation process and appropriate technique when cleansing the exit site. Training will be completed by June 15, 2015 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by June 15th 2015. The Clinical Manager or designee, will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly x 6 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the	

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	152609		05/14/2015

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FRESENIUS MEDICAL CARE CARMEL	12400 N MERIDIAN ST CARMEL, IN 46032

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			Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.	
V 407 Bldg. 00	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on clinical record and facility policy review and interview, the facility failed to ensure blood pressures and pulse readings had been completed at least every 30 minutes during the dialysis treatment in accordance with facility policy in 4 (#s 2, 3, 4, & 5) of 5 records reviewed. The findings include:	V 407	**V407** On Thursday May 28th, 2015 the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution.	06/15/2015

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	1. Clinical record number 2 failed to evidence blood pressure and pulse readings had been recorded at least every 30 minutes during the dialysis treatment. A. A hemodialysis treatment flow sheet dated 4-17-15 evidenced a blood pressure and pulse reading had been recorded at 10:33 AM and not again until 11:33 AM, a period of 1 hour. B. A hemodialysis treatment flow sheet dated 4-24-15 evidenced a blood pressure and pulse reading had been recorded at 11:32 AM and not again until 12:33 PM, a period of 1 hour and 1 minute. C. A hemodialysis treatment flow sheet dated 4-27-15 evidenced a blood pressure and pulse reading had been recorded at 10:14 AM and not again until 11:14 AM, a period of 1 hour. D. A hemodialysis treatment flow sheet dated 4-29-15 evidenced a blood pressure and pulse reading had been recorded at 10:33 AM and not again until 11:34 AM, a period of 1 hour and 1 minute. E. A hemodialysis treatment flow sheet dated 5-1-15 evidenced a blood		The Clinical Manager is responsible to ensure that all staff members follow policy FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy" 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 FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy" with emphasis placed on blood pressures and pulse readings be completed at least every 30 minutes during the dialysis treatment. Training will be completed by June 15th 2015 and an in-service attendance sheet is available in the facility for review The Clinical manager or designee will conduct audits via the QAI Treatment Sheet Audit tool. These audits will be completed and monitored per the QAI calendar audit schedule which is monthly.	

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	pressure and pulse reading had been recorded at 10:32 AM and not again until 11:38 AM, a period of 1 hour and 6 minutes. F. A hemodialysis treatment flow sheet dated 5-4-15 evidenced a blood pressure and pulse reading had been recorded at 10:37 AM and not again until 11:31 AM, a period of 54 minutes. G. A hemodialysis treatment flow sheet dated 5-9-15 evidenced a blood pressure and pulse reading had been recorded at 11:19 AM and not again until 12:05 PM, a period of 46 minutes. H. A hemodialysis treatment flow sheet dated 5-11-15 evidenced the treatment had been initiated at 10:15 AM and a blood pressure and pulse reading was documented. The flow sheet evidenced the next blood pressure and pulse reading at 11:12 AM, a period of 57 minutes. 2. Clinical record number 3 failed to evidence blood pressure and pulse readings had been recorded at least every 30 minutes in accordance with facility policy. A. A hemodialysis treatment flow sheet dated 4-18-15 evidenced a blood		The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review. The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.	

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	pressure and pulse reading had been recorded at 9:04 AM and not again until 10:12 AM, a period of 1 hour and 8 minutes. B. A hemodialysis treatment flow sheet dated 4-21-15 evidenced a blood pressure and pulse reading at 9:31 AM and not again unit 10:20 AM, a period of 49 minutes. C. A hemodialysis treatment flow sheet dated 4-23-15 evidenced a blood pressure and pulse reading had been recorded at 9:34 AM and not again unit 10:32 AM, a period of 58 minutes. D. A hemodialysis treatment flow sheet dated 4-25-15 evidenced a blood pressure and pulse reading had been recorded at 7:07 AM and not again until 8:03 AM, a period of 56 minutes. The next blood pressure and pulse reading was recorded at 9:03 AM, a period of 1 hour. E. A hemodialysis treatment flow sheet dated 4-28-15 evidenced a blood pressure and pulse reading had been recorded at 7:03 AM and not again until 8:04 AM, a period of 1 hour and 1 minute. The flow sheet evidenced a blood			

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	pressure and pulse reading had been recorded at 9:36 AM and not again until 10:30 AM, a period of 54 minutes. F. A hemodialysis treatment flow sheet dated 4-30-15 evidenced a blood pressure and pulse reading had been recorded at 9:03 AM and not again until 10:33 AM, a period of 1 hour and 30 minutes. G. A hemodialysis treatment flow sheet dated 5-7-15 evidenced a blood pressure and pulse had been recorded at 8:03 AM and not again until 9:39 AM, a period of 1 hour and 36 minutes. 3. Clinical record number 4 failed to evidence blood pressure and pulse readings had been recorded at least every 30 minutes. A. A hemodialysis treatment flow sheet dated 5-2-15 evidenced a blood pressure and pulse reading had been recorded at 5:42 AM and not again until 6:32 AM, a period of 50 minutes. B. A hemodialysis treatment flow sheet dated 5-9-15 evidenced a blood pressure and pulse reading had been recorded at 6:01 AM and not again until 7:00 AM, a period of 59 minutes.			

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	The flow sheet evidenced a blood pressure and pulse reading had been recorded at 7:39 AM and not again until 8:41 AM, a period of 1 hour and 2 minutes. 4. Clinical record number 5 failed to evidence blood pressure and pulse readings had been recorded at least every 30 minutes. A. A hemodialysis treatment flow sheet dated 4-18-15 evidenced a blood pressure and pulse reading had been recorded at 1:01 PM and not again until 2:01 PM, a period of 1 hour. B. A hemodialysis treatment flow sheet dated 4-21-15 evidenced a blood pressure and pulse reading had been recorded at 10:59 AM and not again until 1:37 PM, a period of 2 hours and 38 minutes. C. A hemodialysis treatment flow sheet dated 4-25-15 evidenced a blood pressure and pulse reading had been recorded at 2:08 PM and not again until 3:02 PM, a period of 54 minutes. D. A hemodialysis treatment flow sheet dated 5-2-15 evidenced a blood pressure and pulse reading had been recorded at 1:34 PM and not again until			

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	3:09 PM, a period of 1 hour and 35 minutes. 5. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, blood pressures and pulses were to be recorded at least every 30 minutes. 6. The facility's 8-20-14 "Patient Monitoring During Patient Treatment" policy number FMS-CS-IC-I-110-133A states, "Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed."			
V 544 Bldg. 00	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. Based on clinical record and facility policy review and interview, the facility failed to ensure the prescribed dose of dialysis had been sustained by failing to ensure continuous heparin had been administered as ordered in 1 (# 2) of 1 record reviewed with continuous heparin administration orders. The findings include: 1. Clinical record number 2 included	V 544	**V 544** On Thursday May 28th 2015 the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical	06/15/2015

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	physician orders dated 11-10-14 that state, "Heparin Sodium (Porcine) 1,000 Units/mL [milliliter] Systemic Infusion (Pump) 1000 units IVP per hour, turn pump off 60 min [minutes] prior to end of treatment, Every treatment". A. A hemodialysis treatment flow sheet dated 4-20-15 evidenced the treatment had ended at 2:25 PM and the heparin pump had been stopped at 2:06 PM, 19 minutes prior to the end of the treatment. B. A hemodialysis treatment flow sheet dated 4-24-15 evidenced the treatment had ended at 2:58 PM and the heparin pump had been stopped at 4:56 PM, after the treatment. C. A hemodialysis treatment flow sheet dated 4-27-15 evidenced the treatment had ended at 2:22 PM and the heparin pump had been stopped at 2:22 PM, at the end of the treatment. D. A hemodialysis treatment flow sheet dated 4-29-15 evidenced the treatment had ended at 1:58 PM and the heparin pump had been stopped at 1:30 PM, 28 minutes prior to the end of the treatment. E. A hemodialysis treatment flow		Manager is responsible to ensure that all staff members follow "Comprehensive Interdisciplinary Assessment and Plan of Care" Policy number FMS-CS_IC-I-110-125A. 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 "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-IC-I-110-125A. with special emphasis on ensuring that the patient's continuous heparin dose and heparin stop time are delivered according to the physician's prescription. Training will be completed by June 15, 2015 and an in-service attendance sheet is available in the facility for review The Clinical manager or designee will conduct audits via the QAI Treatment Sheet Audit tool. These audits will be completed and monitored per the QAI calendar audit schedule which is monthly. The Clinical Manager is responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152609	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 12400 N MERIDIAN ST CARMEL, IN 46032	

(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
	sheet dated 5-1-15 evidenced the treatment had ended at 2:26 PM and the heparin pump had been stopped at 2:25 PM, a minute prior to the end of the treatment. F. A hemodialysis treatment flow sheet dated 5-9-15 evidenced the treatment had ended at 2:16 PM and the heparin pump had been stopped at 3:11 PM, after the treatment had ended. G. A hemodialysis treatment flow sheet dated 5-11-15 evidenced the treatment had ended at 2:34 PM and the heparin pump had been stopped at 2:32 PM, 2 minutes prior to the end of the treatment. 2. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, the flow sheets in record number 2 did not evidence the heparin pump had been stopped 60 minutes prior to the end of the treatment as ordered by the physician. 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. Sustain the prescribed dose of		to review, analyze and trend all reports and present them monthly to the QAI Committee for review. The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.	

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	152609		05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE CARMEL	12400 N MERIDIAN ST CARMEL, IN 46032

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	dialysis to meet FMS target."			
V 550 Bldg. 00	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. Based on facility policy review, observation, and interview, the facility failed to ensure pre- and post-treatment access care using an arteriovenous fistula (AVF) had been completed in accordance with facility policy in 1 (# 1) of 2 pre-treatment observations and 2 (#s 1 and 2) of 2 post-treatment access care observations completed and failed to ensure evaluations of accesses had been completed in 2 (#s 1 and 2) of 2 initiation of dialysis observations completed. The findings include: Regarding pre-treatment access care: 1. Employee C, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 9 using an AVF on 5-13-15 at 10:35 AM.	V 550	**V 550** On Thursday May 28th, 2015 the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical Manager is responsible to ensure that all staff members follow policies “Assessment and Preparation of Internal Access for Needle Placement” and “Post Treatment Fistula Needle Removal” The Clinical Manager met with the facility Education Coordinator to	06/15/2015

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	Observation noted the left arm was wrapped in plastic wrap with a white cream under the wrap. The PCT was observed to wipe the cream away using a dry cloth prior to starting the initiation procedure. The PCT was not observed to ask the patient if the access had been washed or to wash the access with soap and water. 2. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, the PCT should have washed the patient's access with soap and water prior to starting the initiation procedure. 3. The facility's 9-25-13 "Assessment and Preparation of Internal Access for Needle Placement" procedure states, "Ask your patient to wash access area with liquid soap for one minute, rinsing well. Dry with clean paper towel." Regarding post-access care: 1. Employee E, a PCT, was observed to discontinue the dialysis treatment on patient number 10, using an AVF, on 5-12-15 at 2:10 PM. The PCT was observed to remove the needles from the arterial and venous insertions sites and apply a Band-Aid and gauze and secure them with tape. The patient held the sites for a approximately 10 minutes to stop		arrange and schedule staff in-services to re-educate all staff members on the following policies. FMS-CS-IC-I-115-006C and FMS-CS-IC-I-115-013C with emphasis placed during pre-assessment on asking the patient if the access had been washed or to wash the access with soap and water as well as during the post assessment to replace the Band-Aid and gauze prior to the patient leaving the facility. Training will be completed by June 15th 2015 and an in-service attendance sheet is available in the facility for review The Clinical Manager or designee, 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 The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will	

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	the bleeding. The PCT was not observed to replace the Band-Aid and gauze prior to the patient leaving the facility. 2. Employee D, a PCT, was observed to discontinue the dialysis treatment on patient number 11 on 5-12-15 at 2:35 PM. The PCT was observed to remove the needles from the arterial and venous insertions sites and apply a Band-Aid and gauze and secure them with tape. The patient held the sites for a approximately 10 minutes to stop the bleeding. The PCT was not observed to replace the Band-Aid and gauze prior to the patient leaving the facility. 3. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, the employees had not provided post access care 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, remove the gauze used for hemostasis and replace the sites with Band-Aids or adhesive dressing or clean tape with gauze dressing." Regarding evaluation of accesses for initiation of treatment:		be monitored by the Governing Body.	

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	1. Employee C, a PCT, was observed to initiate the dialysis treatment on patient number 9 using an AVF on 5-13-15 at 10:35 AM. The PCT was not observed to evaluate the access and locate/palpate the cannulation sites prior to inserting the needles. 2. Employee C, a PCT, was observed to initiate the dialysis treatment on patient number 2 on 5-13-15 at 10:45 AM. The PCT was not observed to evaluate the access and locate/palpate the cannulation sites prior to inserting the needles. 3. The clinic manager, employee N, indicated, on 5-14-15 at 10:15 AM, employee C had not followed facility policy. 4. The facility's 9-25-13 "Assessment and Preparation of Internal Access for Needle Placement" procedure number FMS-CS-IC-I-115-006C states, "The access must be assessed each treatment for patency, infection, and any abnormal findings . . . Listen: Staff who have been trained to auscultate vascular accesses should listen to the entire length of the access . . . Feel for thrill."			