STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152576	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE FORT WAYNE DUPONT	10204 E DUPONT CIRCLE DR FORT WAYNE, IN 46825

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V000000	This was a federal ESRD recertification survey. Survey Dates: March 10-13, 2014 Facility #: 003170 Medicaid #: 200389100 Surveyors: Miriam Bennett, RN, BSN, PHNS Michelle Weiss, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN March 17, 2014	V000000		
V000116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.			

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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	Based on observation, policy review, and interview, the facility failed to ensure staff cleaned Phoenix meters prior to returning them to clean area for 2 of 2 observations creating the potential to affect all 71 of the facility's current patients. (Employees J and K) Findings Include 1. During observation on 3/10/14 at 11:15 AM, employee J was observed using the pHoenix meter at station 5. Upon completion of the conductivity check, employee J carried the meter to the clean sink, picked up a bleach cloth, and proceeded to clean the meter at the clean station. 2. During observation on 3/11/14 at 8:35 PM, employee K was observed using the pHoenix meter at station 6. Upon completion of the conductivity check, employee K cleaned the meter at the station and proceeded over to the Tri Station to perform Reverse Osmosis water rinse of the meter. Employee K failed to clean the meter prior to returning it to the clean station. 3. On 3/12/14 at 11:10 AM, employee A indicated staff should clean the pHoenix meter with bleach after use. Employee A indicated that she gets a	V000116	The Clinical Manager provided an in-service to the patient care staff on March 25 & 26, 2014 to review the requirements of the following policy: FMC-CS-IC-II-140-510C1 "Checking Conductivity and pH of Final Dialysate with the pHoenix Meter." The Clinical Manager emphasized to the staff that "If the meter is brought to the chairside, it must be externally disinfected with 1:100 bleach solution before leaving the chairside." Effective immediately, current practice for checking the conductivity with the pHoenix Meter will include collection of the dialysate sample at chairside with a disposable medicine cup and taking the dialysate sample to the pHoenix Meter station for testing. Additionally, the pHoenix Meter is kept in the designated 'Dirty Area'. The staff members acknowledged understanding of this practice and of the policy. The Clinical Manager or designee will conduct an infection control audit which will include observation of the treatment area and use of the conductivity testing with pHoenix Meter. The audits will be performed daily x 2 weeks, then weekly x 2 weeks. Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will further be determined by the QAI committee upon review of the audit results and	03/26/2014

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	bleach cloth when picking up the meter and takes it to the station, then cleans the meter at the station. 4. On 3/12/14 at 11:30 AM, employee A indicated the Tri Station is considered a dirty station. 5. The facility's policy titled "Checking Conductivity and pH of final Dialysate with the pHoenix Meter," #IC-II-140-510C1, IS-I-600-028C2, HT-II-310-007C2, revised 11/5/13 states, "6. ... NOTE: If the meter is brought to the chairside, it must be externally disinfected with 1:100 bleach solution before leaving the chairside."		resolution of the issue. The Clinical Manager is responsible for reviewing and analyzing all data prior to the QAI meeting and presenting it monthly to the QAI team. The Area Manager is responsible to ensure the Clinical Manager presents all data as defined within the plan of correction to the QAI committee. The QAI committee is responsible to provide oversight and ensure resolution is occurring.	

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V000117	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. 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. 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. Based on observation, policy review, and interview, the facility failed to ensure the separation of clean and potentially contaminated items or supplies within the designated clean areas for 2 of 2 clean stations observed creating the potential to affect all 71 of the facility's current patients. Findings include 1. On 3/10/14 at 11:20 AM, the station	V000117	The Clinical Manager provided an in-service to the patient care staff on March 25 & 26, 2014 to review the requirements of the following policy: FMC-CS-IC-II-155-070A "Dialysis Precautions Policy" defining "Dirty area: An area where this is a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. Clean areas should be clearly separated from dirty	03/13/2014

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	marked "clean" across from dialysis station #5 was observed to contain a sink, rolling cart with bleach solution bin, a phoenix meters, an eye wash station, and a dirty linen hamper pushed up against the eye wash station. 2. On 3/10/14 at 11:22 AM, the station marked "clean" across from dialysis stations #6 and 7 was observed to contain a sink and dirty linen hamper within approximately 5 inches of sink. 3. On 3/12/14 at 11:05 AM, employee A indicated the dirty linen hampers have been at the clean stations for many years, but also indicated it increases the potential for cross contamination. 4. The facility's policy titled "Dialysis Precautions," #FMS-CS-IC-II-155-070A, revised 1/4/12 states, "Clean Versus Dirty Areas Clean area: An area designated for clean and unused equipment, supplies and medications. Dirty area: An area where this is a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled."		areas where used supplies, equipment or blood samples are handled or stored." This issue was identified during the survey on March 10, 2014; effective immediately, the dirty linen hamper will be located next to the dirty bleach containers. The Clinical Manager emphasized to the staff that the dirty linen hamper is considered contaminated and must be kept separate of designated clean areas in the facility. The staff members acknowledged understanding of this practice and of the policy. The Clinical Manager or designee will conduct an infection control audit which will include observation of the treatment area and proper storage and location of the dirty linen hamper. The audits will be performed daily x 2 weeks, then weekly x 2 weeks. Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will further be determined by the QAI committee upon review of the audit results and resolution of the issue. The Clinical Manager is responsible for reviewing and analyzing all data prior to the QAI meeting and presenting it monthly to the QAI team. The Area Manager is responsible to ensure the Clinical Manager presents all data as defined within the plan of correction to the QAI committee. The QAI committee is responsible	

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			to provide oversight and ensure resolution is occurring.	
V000543	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 review, policy review, and interview, the facility failed to ensure the staff monitored patients every half hour while dialyzing for 1 of 7 clinical records reviewed (#7) and failed to ensure the Registered Nurse (RN) completed an assessment within 1 hour of starting dialysis for 3 of 7 records reviewed (#1, 5, and 7) creating the potential to affect all 71 of the facility's current patients. Findings include 1. Clinical record #1 contained a treatment sheet dated 3/7/14 that evidenced treatment was started at 6:01 AM. The treatment sheet failed to evidence a RN assessed the patient that day. On 3/11/14 at 10:15 AM, employee A reviewed the treatment sheet for patient #1 and indicated the RN assessment was not there.	V000543	The Clinical Manager provided an in-service to the patient care staff on March 25 & 26, 2014 to review the requirements of the following policies: #FMS-CS-IC-I-110-149A "Nursing Supervision and Delegation Policy" and FMS-CS-IC-I-110-133A "Monitoring During Patient Treatment Policy", emphasizing that patient evaluation by a nurse must be completed during the patient's treatment, preferably within the first hour, and that vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed. The staff members acknowledged understanding of the policies. The Clinical Manager or designee will audit 100% of all patient dialysis flow sheets daily x 2 weeks to ensure compliance with the policies. At the conclusion of the 2 week period, the Clinical Manager or designee will audit 50% of all patient dialysis flow sheets weekly x 2 weeks, then 25% of all patient dialysis flow sheets monthly x 1 month. Any evidence of non-compliance will be addressed immediately including corrective	03/26/2014

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	2. Clinical record #5 contained a treatment sheet dated 3/1/14 that evidenced the treatment was started at 10:57 AM and the RN did not assess the patient until 12:29 PM. 3. Clinical record #7 contained a treatment sheet dated 2/23/14 that evidenced the treatment was started at 8:27 PM and the RN did not assess the patient until 10:15 PM. A. The record contained a treatment sheet dated 2/25/14 that evidenced the treatment was started at 8:26 PM and the RN did not assess the patient until 10:04 PM. B. The treatment sheet dated 2/25/14 evidenced a check was done at 8:26 PM, not again until 9:36 PM, and not again until 10:30 PM. C. The treatment sheet dated 3/2/14 evidenced a check was done at 8:28 PM and not again until 10:02 PM. 4. The facility's policy titled "Nursing Supervision and Delegation," #FMS-CS-IC-I-110-149A, revised 9/25/13 states, "Patient evaluation by the nurse must be completed during the patient's treatment, preferably within the first hour or as specified by stricter state		action as appropriate. Frequency of ongoing audits will further be determined by the QAI committee upon review of the audit results and resolution of the issue. The Clinical Manager is responsible for reviewing and analyzing all data prior to the QAI meeting and presenting it monthly to the QAI team. The Area Manager is responsible to ensure the Clinical Manager presents all data as defined within the plan of correction to the QAI committee. The QAI committee is responsible to provide oversight and ensure resolution is occurring.	

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	regulations."			