

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/25/2012
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1051 N STATE ST GREENFIELD, IN 46140
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V0000	<p>This visit was an ESRD federal recertification survey.</p> <p>Survey dates: April 23, 24, and 25, 2012</p> <p>Facility #: 011029</p> <p>Medicaid Vendor #: 200278340</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Census: 42</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 27, 2012</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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V0111	<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 facility policy, the facility failed to ensure a sanitary environment was maintained to prevent cross contamination and minimize the transmission of infectious agents by maintaining clean items separate from dirty items in 2 of 2 days of observation with the potential to effect all 42 dialysis patients.</p> <p>Findings:</p> <p>1. On April 23, 2012, at 10:45 AM, Employee D was observed initiating dialysis at station 2. The dialysis supplies were wrapped in a white chux. The chux was opened and placed under the arm of patient #8. The actual supplies, including the opened sterile catheters, were placed on the uncovered chairside table making all the supplies within the chux dirty supplies. This procedure was consistent throughout the two days of observation.</p> <p>2. On April 23, 2012, at 11:00 AM, Employee F was observed initiating dialysis at station 12 for patient #2 using</p>	V0111	<p>On Wednesday May 9 th 2012 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 will ensure that all staff members follow "Dialysis Precautions" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager will meet with the facility Education Coordinator to arrange and schedule staff in-services to further educate all staff members on the following policy "Dialysis Precautions" FMS-CS-IC-II-155-070. Emphasis was placed on using a barrier between the bed-side table and supplies. Training will be completed by May 18 th 2012 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</p>	05/18/2012			

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	<p>the same techniques described above of no barrier between supplies and the chairside table surface.</p> <p>3. On April 25, 2012, at 9:40 AM, Employee B was observed initiating dialysis at station 2 for patient #8 using the same techniques described above of no barrier between supplies and the chairside table surface.</p> <p>4. On April 25, 2012, at 9:55 AM, Employee C was observed terminating dialysis at station 5 for patient #5. The supplies were on a bare chairside table. The needles were pulled and gauze that had been on the dirty chairside table was rolled and placed on the needle access to hold pressure. This was done twice for both needle accesses.</p> <p>5. On April 25, 2012, at 10:10 AM, Employee D was observed terminating dialysis at station 2 for patient #8. The supplies were on a bare obviously blood covered chairside table. The needles were pulled and gauze that had been laying on the dirty chairside table was rolled and placed on the needle access to hold pressure. This was done twice for both needle accesses.</p> <p>6. The facility's October 10, 2008, "Infection Control Overview" policy</p>		<p>audit tool, are done daily for 1 week, weekly for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>The Clinical Manager will report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>		

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	<p>number FMS-CS-IC,II-155-060A states, "All infection control policies for patient care are consistent with recommendation of the Centers for Disease Control (CDC) . . . Infection control policies includes, but are not limited to: . . . Dialysis unit precautions, (including the use of personal protective equipment).</p> <p>7. The facility's October 10, 2008, "Dialysis Precautions" policy number FMS-CS-IC-II-155-070A states, "Dialysis Precautions will be followed by all employees with potential exposure to bloodborne pathogens and other potentially infectious material (OPIM) in the dialysis setting . . . The patient treatment area shall have designated 'clean' and 'dirty' areas. Clean area: An area designated for clean and unused equipment and supplies . . . Dirty area: An area where there is a potential for contamination with blood or body fluids . . . Examples of dirty areas include . . . the entire patient station while the patient is dialyzing."</p> <p>8. On April 25, 2012 at 2 PM, the Clinical Manager indicated that supplies should not be laying on the chairside table without a barrier as the chairside table is a dirty surface.</p>						

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V0119	<p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS</p> <p>If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the staff followed their own policy and procedure for infection control in 1 of 2 observations with the potential to affect all 42 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On April 25, 2012, at 10:20 AM, Employee D used her foot to compress the trash in station # 2's trash can and then went throughout the unit with the potential to affect all the patients on dialysis.</li> <li>On April 25, 2012, at 10:25 AM, Employee B reached into her left pocket to retrieve an ink pen, made notes on the dialysis sheet in station # 3, and then returned the pen to her pocket.</li> <li>A policy titled "Guidelines for</li> </ol>	V0119	<p>V 119 Clinic Manager addressed cross-contamination issues with trash and proper hand hygiene with staff through an in-service conducted by the clinic educator on Monday May 14 th 2012</p> <p>Proper hand hygiene should be used before and after using a pen as described in policy FMS-CS-IC-II-155-080A.</p> <p>Trash cans are to be emptied, washed and relined when full and at the end of the day as described in policy FMS-CS-IC-II-155-125A.</p> <p>Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool, are done daily for 1 week, weekly for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>Compliance with this policy will</p>	05/14/2012	

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	<p>Cleaning the Dialysis Treatment Area" HP-11-1C-1.04, dated 3/8/05 states, "J. Empty trash, wash trash can if necessary and reline."</p> <p>4. On April 25, 2012, at 2 PM, the Clinical Manager, Employee E, indicated trash should be emptied not compressed with one's foot as it creates the potential of contamination from station to station and at no time are items to be taken from the pocket, used, and returned to the pocket.</p>		<p>be maintained by the clinic manager on an ongoing basis and will be reviewed through the QAI team on a monthly basis.</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, policy review, and interview the facility failed to ensure the staff followed standard infection control precautions in 1 of 2 observations with the potential to effect all 42 dialysis patients.</p> <p>Findings:</p> <p>1. On April 25, 2012, at 10:15 AM, Employee D was observed cleaning the machine at station 2 while patient #8 was waiting for his/her blood pressure to increase. The top of the machine and the foot part of the machine was cleaned with bleach. Employee D then continued to set up the machine for the next patient without cleaning the rest of the machine. The patient, sitting in the chair at the time, was having trouble with blood pressure, so the registered nurse, Employee G, came over, did not sanitize her hands, put on gloves, and reset the blood pressure still attached to the patient.</p>	V0122	<p>On Monday May 14 th 2012 the Clinical Manager met with all direct patient care staff to review policy # FMS-CS-IC-II-155-110C1 "Work Surface Cleaning without visible blood using bleach solutions" with emphasis placed on cleaning the entire dialysis machine including the blood pressure cuff before setting up for the next patient. 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 utilizing the QAI Infection Control audit tool, are done daily for 1 week, weekly for 4 weeks then ongoing monitoring will occur per the QAI calendar.</p> <p>The Clinical Manager is responsible to review, analyze and trend all reports and present them monthly to the QAI Committee for review.</p>	05/14/2012	

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	<p>At this point, the patient was in a chair that had dried blood on the chair side table. The top and foot were the only parts cleaned. The tubing for the next patient had been added and the machine declared ready. The nurse was still taking the blood pressure of the patient in the chair.</p> <p>2. A policy titled "Work Surface Cleaning and Disinfection Without Visible Blood using Bleach Solutions" FMS-CS-IC-II-155-110C1 dated 04-Jan 2012 states, "3. Use a cloth wetted with 1:100 bleach solution to clean and disinfect the dialysis station (bed, tables, machine, televisions, IV poles, B /P cuff, hand sanitizer dispenser and holder, etc.). ..."</p> <p>3. On April 25, 2012, at 2 PM, the Clinical Manager indicated the machines are to be totally cleaned.</p>		<p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p>		