

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152595	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/28/2012
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NAME OF PROVIDER OR SUPPLIER DUNELAND DIALYSIS-COFFEE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 VILLAGE POINT STE 101 CHESTERTON, IN 46304
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V0000	<p>This was an ESRD federal recertification survey.</p> <p>Survey Dates: 6/26/12 through 6/28/12</p> <p>Facility #: 011217</p> <p>Medicaid Vendor #: 200834980</p> <p>Surveyor: Bridget Boston, RN, PHNS - team leader Marty Coons, RN, PHNS - team member</p> <p>Census: 77 Total, 26 peritoneal dialysis and 51 in-center hemodialysis</p> <p>Quality Review; Linda Dubak, R.N. July 6, 20121</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 observations and policy and procedures, the facility failed to ensure staff members provided care in compliance with infection control measures policies and procedures in 2 of 2 patients being taken off of dialysis in observations completed on day 2 of the survey creating the potential for spread of infection causing agents among facility staff and other patients.</p> <p>The findings include:</p> <p>1. Policy # 1.400, revision date 02-15-10, titled "Infection Control Measures (BDP)3" stated, "Purpose: to ensure the facility will provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the facility and any public area. Personnel: 2. Hand Hygiene: Staff will follow strict ...hand hygiene. 3. Attire: a. Disposable gloves...will be worn when caring for the patient or touching the patient's equipment at the dialysis station. i. Gloves should be changed when soiled iv. Gloves should be changed if they contact potentially</p>	V0113	<p>2. The In-Center Nurse Manager has inserviced the nursing staff on the need to change gloves when moving from dirty to clean areas on a patient/equipment effective July 12, 2012.</p> <p>The In-Center Nurse Manager will conduct quarterly infection control audits of the staff as part of the ongoing QAPI process.</p> <p>The In-Center Nurse Manager will be responsible to monitor these corrective actions to ensure that the deficiency does not recur.</p> <p>The staff educator will emphasize the rationales for changing gloves when moving from dirty to clean areas upon new hire orientation and yearly staff competencies.</p> <p>3. The In-Center Nurse Manager has inserviced this PCT and all PCTs currently employed at Duneland Dialysis on the need to change gloves when moving from dirty to clean areas on a patient or the dialysis equipment effective July 12,2012.</p> <p>The In-Center Nurse Manager will conduct quarterly infection control audits of the staff as part of an ongoing QAPI process.</p>	07/12/2012			

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	<p>infected material. v. If working on multiple sites on a patient's body, gloves must be changed when moving from site to site. (Example: catheter to foot care).</p> <p>vi. Gloves should be changed when moving from a "dirty" area to a "clean" area either environmental or body sites. A new pair of clean gloves will be used with each procedure involving access site care, vascular access cannulation, administration of parenteral medications or to perform invasive procedures. (The intention is to ensure that clean gloves which have not previously touched potentially a contaminated surfaces, are in use whenever there is a risk for cross contamination to a patient's blood stream to occur.) viii. It may be necessary to change gloves multiple times when caring for one patient."</p> <p>2. On 6/27/12 at 3:45 PM, a registered nurse (RN) was observed with gloved hands touching the dialysis machine # 5 at station 23. The employee touched the computer, then touched the patients access site. Without changing her gloves, the employee then picked up 2 clear liquid filled syringes off the chair-side table and attached the syringes immediately after disconnecting bloodlines to the patients catheter legs access site, the RN with the same gloved hands, untangled the blood pressure</p>		<p>The In-Center Nurse Manager will be responsible to monitor these corrective actions to ensure that the deficiency does not recur.</p> <p>The staff educator will emphasize the rationales for changing gloves when moving from dirty to clean areas upon new hire orientation and yearly staff competencies.</p>	

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	<p>tubing from the blood pressure cuff on the patients right upper arm, reached downward and lowered the chairs leg rest by pushing down on it, touched the patients right ankle while stating out loud "no swelling, that's good" and assisted the patient to a standing position and with the employees right hand held the patients clothing closed across the right side catheter access site as the catheter legs with the syringes still attached dangled on the outside of clothing. The RN assisted the patient back to a sitting position, cupped the 2 catheter legs in her left hand and with her right hand detached one syringe from the arterial bloodline leg and attached a lock cap, she repeated this procedure for the venous line. The employee had never changed gloves or sanitized her hands at anytime during this disconnecting process.</p> <p>3. On 6-27-12 at 3:55 PM, a patient care technician (PCT), was observed to touch the computer keyboard attached to the dialysis machine at station 3 with gloved hands and then touch the patients left forearm access site without changing his gloves or cleansing his hands. The PCT then touched the machine, the patient, the machine again, and then removed the first line from the access site. While the patient was holding the access site area, the PCT without changing his gloves</p>			

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	retrieved a large red bio-hazard container with a slightly rounded top and with both gloved hands rolled the container to the station and disposed of soiled equipment, he then replaced the container back to where he retrieved it and at this time the patient verbally indicated she was ready and nodded her head toward her access site. The PCT again without changing gloves replaced the gauze at the access site and placed a piece of tape over it, the PCT then placed the soiled gauze into the small gray waste container at the chair-side by reaching down into the gray waste container pushing the overflow into it. Without changing gloves or cleansing hands he then removed the needle from the 2nd insertion site and allowed the patient to place pressure on it. The PCT then placed the soiled line into a smaller red-bio-hazard container. The PCT then removed his gloves ambulated over toward the nurses' station sanitized his hands, when the patient again indicated she was ready, the PCT donned clean gloves, replaced the gauze at the access site and taped the access site securely. Without changing his gloves, the PCT then touched the dialysis machine, adjusted the blood pressure cuff, touched the dialysis machine, the computer keyboard, and then gathered the patients belongings, carrying the patients tote and assisting the patient to the front of the			

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	in-center dialysis unit and waited by the scales while the patient weighed, he opened the entrance door into the patient waiting room, handed the patient the tote and held the door as the patient exited, all the while wearing the same soiled gloves.			