

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/14/2013
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE OF LAWRENCE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 3523 SHAWNEE DRIVE SOUTH BEDFORD, IN 47421
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V000000	<p>This visit was for a Federal ESRD relocation, recertification, added service, and added stations survey.</p> <p>Survey Dates: 11-12-13, 11-13-13, and 11-14-13</p> <p>Facility #: 005145</p> <p>Medicaid Vendor #: 200832070A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 15, 2013</p>	V000000		

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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V000113	<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 observation, interview, and facility policy review, the facility failed to ensure the registered nurse (RN) followed appropriate infection control procedures during the administration of medications in 1 (# 2) of 2 parenteral medication preparation and administration observations completed creating the potential to affect all of the facility's 62 current incenter hemodialysis patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee B, a RN, was observed to prepare medications on 11-13-13 at 11:45 AM for administration to patient number 8. The RN donned clean gloves without cleansing his hands after drawing up 3 different syringes of medications. The RN proceeded to the patient's station and administered the medications.</li> <li>2. The clinic manager, employee A, indicated, on 11-14-13 at 12:00 PM, employee B should have cleansed his hands prior to donning clean gloves after drawing up the medications.</li> </ol>	V000113	<p>On November 25, 2013, 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 nursing staff members follow "Hand Hygiene and Medication Preparation and Administration" 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 nursing staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Medication" FMS-CS-IC-I-120-040C with emphasis placed on appropriate hand hygiene before donning gloves for medication administration. Training will be completed on November 26, 2013 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by December 10, 2013. The Clinical Manager will</p>	12/10/2013			

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	3. The facility's 9-25-13 "Medication Preparation and Administration" procedure number FMS-CS-IC-I-120-040C states, "Follow the steps in the table below to prepare for administration of medication . . . Wash hands. Apply PPE [personal protective equipment]."		ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, weekly for 4 weeks, monthly for 3 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 be monitored by the Governing Body.	

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V000147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>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 guidelines periodically for all persons who manage intravascular catheters.</p> <p>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.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>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].</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure the registered nurse (RN) followed appropriate infection control procedures for discontinuation of the dialysis treatment in a patient with a central</p>	V000147	The Clinical Manager is responsible to ensure that all staff members follow "Termination of Treatment using a Central Venous Catheter and Optiflux Single Use Dialyzer" policy to ensure a safe treatment	12/10/2013	

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	<p>venous catheter (CVC) in 1 (#1) of 2 CVC discontinuation of dialysis procedures observed creating the potential to affect all of the facility's current patients with CVCs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Employee C, a RN, was observed to discontinue the dialysis treatment on patient number 7 on 11-13-13 at 11:00 AM. The RN failed to place a clean field under the CVC ports prior to starting the discontinuation procedure.</li> <li>2. The Regional Quality Manager, employee R, indicated, on 11-14-13 at 2:20 PM, the employees are not educated to place a clean field under the CVC ports prior to discontinuing the dialysis treatment unless the current field is visibly soiled.</li> <li>3. The facility's 9-25-13 "Termination of Treatment Using a Central Venous Catheter and Optiflux Since Use Ebeam Dialyzer" procedure number FMS-CS-IC-I-105-028C states, "Ensure that a clean under pad is below the catheter limbs to protect the work area and the clothing."</li> </ol>		<p>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 policy "Termination of Treatment using a Central Venous Catheter and Optiflux Single Use Dialyzer" FMS-CS-IC-I-105-028C with emphasis placed on placing a clean, "unused" field under the catheter ports prior to beginning discontinuation procedure. Training was completed on November 26, 2013 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by December 10, 2013. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, weekly for 4 weeks, monthly for 3 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 be monitored by the Governing Body.</p>				

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V000544	<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. Based on clinical record review, observation, and interview, the facility failed to ensure blood flow rates had been maintained as ordered in 3 (#s 1, 3, and 4) of 5 hemodialysis records and failed to ensure bolus heparin had been administered as ordered in 1 (# 6) of 1 home hemodialysis records reviewed creating the potential to affect the facility's 62 current incenter hemodialysis patients and 1 current home hemodialysis patient.</p> <p>The findings include:</p> <p>Regarding blood flow rates:</p> <p>1. Clinical record number 1 included physician orders dated 10-3-13 that identified the blood flow rate (BFR) was to be maintained at 400 milliliters. Post treatment flow sheets failed to evidence the BFR had been maintained as ordered.</p> <p>A. A post treatment flow sheet dated 10-2-13 evidenced the BFR had been maintained at 200-300.</p>	V000544	<p>A mandatory in-service is scheduled for all staff on November 26, 2013 to review policy "Monitoring During Patient Treatment" FMS-CS-IC-I-110-133A. Special emphasis was placed on ensuring that the patient's prescribed blood flow rate is delivered according to the physician's prescription. This will be monitored daily by the Charge Nurse using the Rounding Tool. Frequency of ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue. Any issues found out of compliance will be corrected immediately and corrective action will be taken as appropriate. The Clinical Manager will monitor the results of the Rounding Tool audits weekly for 4 weeks and ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue. The Director of Operations met with the facility's home therapy patient care staff on November 25, 2013, to review their requirements as stated in the Conditions for Coverage and</p>	12/13/2013	

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	<p>B. A post treatment flow sheet dated 10-4-13 evidenced the BFR had been maintained at 220 - 320.</p> <p>C. A post treatment flow sheet dated 10-7-13 evidenced the BFR had been maintained at 105-250.</p> <p>D. A post treatment flow sheet dated 10-9-13 evidenced the BFR had been maintained at 200-255.</p> <p>E. A post treatment flow sheet dated 10-12-13 evidenced the BFR had been maintained at 175-250.</p> <p>F. A post treatment flow sheet dated 10-15-13 evidenced the BFR had been maintained at 200-280.</p> <p>G. The clinic manager, employee A, stated, on 11-14-13 at 12:15 PM, "[The medical director] has us run it until it is less than 200." The manager indicated the record did not evidence documentation of these instructions or an order to deviate from the ordered BFR.</p> <p>2. Clinical record number 3 included physician orders dated 10-4-13 that identified the BFR was to be maintained at 400. Post treatment flow sheets failed to evidence the BFR had been maintained</p>		<p>detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care", to ensure that every home patients home record sheets will be reviewed at least every two months with documentation showing the review was completed and any deficiencies were addressed. The Home Program Manager will complete 100% chart audit of all patient's monthly visit sheets by December 13, 2013 to ensure that all patients have documentation showing that their home record sheets have been reviewed at a minimum of every two months and any deficiencies have been addressed. Any patient found out of compliance, including patient's # 6 will be reviewed at the monthly clinic visits by December 13, 2013. The Clinical Manager is responsible to report a summary of findings monthly in QAI. If resolution is not evident, the QAI Committee will complete a root cause analysis and the Plan of Correction will be revised as necessary. The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body</p>		

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	<p>as ordered.</p> <p>A. Post treatment flow sheets, dated 10-30-13, 11-1-13, and 11-4-13, evidenced the BFR had been maintained at 350.</p> <p>B. A post treatment flow sheet dated 11-8-13 evidenced the BFR had been maintained at 345.</p> <p>C. The clinic manager, employee A, stated, on 11-14-13 at 12:30 PM, "The patient will not allow us to use the permanent access and the catheter does not run as well."</p> <p>3. Clinical record number 4 included physician orders dated 10-1-13 that identified the BFR was to be maintained at 450.</p> <p>A. A post treatment flow sheet dated 11-2-13 evidenced the BFR had been maintained at 275-355.</p> <p>B. Patient number 4 was observed during the dialysis treatment on 11-12-13 at 10:10 AM. Observation noted the BFR was at 300 during the treatment.</p> <p>Regarding bolus heparin administration:</p> <p>1. Clinical record number 6, of a home</p>				

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	<p>hemodialysis patient, included physician orders dated 6-14-13 that identified the patient was to receive 10,000 units of bolus heparin each treatment. Post treatment flow sheets failed to evidence the ordered dose of heparin had been administered.</p> <p>Post treatment flow sheets, dated 10-2-13, 10-4-13, 10-7-13, 10-9-13, 10-11-3, 10-14-13, 10-16-13, 10-18-13, 10-21-13, 10-23-13, 10-26-13, 10-28-13, 10-30-13, 11-1-13, 11-4-13, 11-6-13, and 11-8-13, evidenced the patient had received 7000 units of bolus heparin each treatment.</p> <p>2. The home training nurse, employee S, indicated, on 11-14-13 at 2:15 PM, the patient had not received the ordered dose of bolus heparin. The nurse stated, "I am sure the patient had a good reason for not administering the ordered dose."</p>			