

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE OHIO VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 230 BELLEMEADE AVE EVANSVILLE, IN 47713
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V000000	<p>This was a revisit to the Federal ESRD recertification survey completed on 8-20-14, 8-21-14, 8-22-14, and 8-26-14.</p> <p>Survey Date: 10-7-14</p> <p>Facility #: 005150</p> <p>Medicaid Vendor #: 100248060</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Three (3) conditions and 15 standards were found to be corrected as a result of this survey. One (1) standard remains uncorrected and was re-cited. Three (3) new standards were cited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 8, 2014</p>	V000000		
V000122	<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,</p>			

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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	<p>and equipment.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure dialysis machines were cleaned and disinfected following standard infection control precautions in 1 (# 1) of 1 cleaning and disinfection of the dialysis station observations completed creating the potential to affect all of the facility's 48 incenter patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Employee H, a patient care technician (PCT), was observed to clean and disinfect the dialysis machine at station number 2 on 10-7-14 at 10:20 AM. While cleaning the side and the back of the machine, the prime bucket fell off the machine onto the floor. The PCT was observed to pick the bucket and replace it on the side of the dialysis machine without cleaning it after it had been on the floor. 2. The clinic manager, employee A, indicated, on 10-7-14 at 12:50 PM, the PCT should have re-cleaned the prime bucket prior to replacing it onto the side of the dialysis machine. 3. The facility's 3-20-13 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A states, "Discard 	V000122	<p>On 10/10/2014 education was conducted on policy FMS-CS-IC-II-155-110A. To ensure compliance, monitoring of the staff for compliance will be done via the plan of correction monitoring tool - daily times one week during change-over. It will then go to weekly times four weeks if improved compliance is noted. The monitoring tool is to be implemented starting on 10/09/2014. Any identified non-compliance will have an immediate intervention by the clinical manger (CM)/designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees</p>	10/13/2014

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V000143	<p>all fluid and clean and disinfect all containers associated with the prime waste (including buckets attached to the machines.)"</p> <p>494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation, interview, and review of facility policy, the facility failed to ensure medication vials had been labeled upon opening in 1 (# 1) of 1 medication preparation and administration observation completed creating the potential to affect all of the facility's 48 current incenter patients.</p> <p>The findings include:</p> <p>1. On 10-7-14 at 11:25 AM, employee L, a registered nurse (RN), was observed to prepare medications for administration to patient number 18. The RN was observed to draw up Hectorol from a multi-dose vial that was already open. The vial failed to evidence a label that indicated when the vial had been opened.</p>	V000143	<p>On 10/10/2014 education was conducted on policy FMS-CS-IS-I-525-001A. To ensure compliance, monitoring of the staff for compliance will be done via the plan of correction monitoring tool - daily times one week during change-over. It will go to weekly times four weeks if improved compliance is notes. The monitoring tool is to be implemented starting 10/09/2014. Any identified non-compliance will have an immediate intervention by the clinical manger/designee providing oversight. The noncompliance and intervention will be documented on the plan of correction monitoring tool or in the employees personnel file if warranted.</p>	10/13/2014

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V000245	<p>2. Employee L, the RN, stated, "I opened that this morning. I forgot to label it."</p> <p>3. The facility's 3-26-14 "Guidelines for Administration of Medication" policy number FMS-CS-IS-I-525-001A states, "When preparing medications if the vial is not used immediately in its entirety, the nurse must place the date and time the vial was opened on the medication label along with the nurse initials. Note: To ensure all open vials are properly marked, the nurse must never walk away from an opened multi-dose vial without writing the date and time the vial was opened."</p> <p>494.40(a) ACID CONC DIST-CONC LABELED & COLOR-CODED RED 5.5.3 Acid concentrate distribution systems: labeled & color-coded red Acid concentrate delivery piping should be labeled and color-coded red at the point of use (at the jug filling station or the dialysis machine connection).</p> <p>All joints should be sealed to prevent leakage of concentrate. If the acid system remains intact, no rinsing or disinfection is necessary.</p> <p>More than one type of acid concentrate may be delivered, and each line should clearly indicate the type of acid concentrate it contains.</p> <p>Based on observation and interview, the facility failed to ensure the acid</p>	V000245	On 10/9/2014 Technical placed acid concentrate stickers displaying the	10/09/2014

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	<p>concentrate delivery piping was labeled with the type of concentrate in 18 (#s 1 through 18) of 18 stations observed creating the potential to affect all of the facility's 48 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On 10-7-14 at 11:25 AM, observation noted the acid concentrate port at the point of delivery to the dialysis machines were labeled "acid." The ports failed to clearly indicate the type of acid concentrate being delivered. 2. The clinic manager indicated, on 10-7-14 at 1:00 PM, the acid being delivered through the solution delivery system at the dialysis machines was 2 K (potassium) 2.5 Ca++ (calcium). The manager stated, "We also use 2K 3 Ca++ and 2K 2 Ca++ concentrates at this facility." 3. The facility's 3-20-13 "Concentrate Labeling Requirements" policy number FMS-CS-IC-II-140-310A states, "Valve Panels or wall boxes, must be labeled to identify the fluid that is delivered . . . If more than one acid is delivered, each must be identified by acid type." 		<p>concentrate information. To ensure compliance, monthly technical will review that stickers are in place and legible and document on ER1.</p>	

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V000765	<p>494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED</p> <p>The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services.</p> <p>The grievance process must include-</p> <p>(1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.</p> <p>Based on facility policy review and interview, the facility failed to ensure its grievance process had been implemented by failing to ensure patient complaints had been documented, investigated, and resolutions offered creating the potential to affect all of the facility's 48 current incenter patients.</p> <p>The findings include:</p> <p>1. The facility's 1-2-14 "Patient Grievance" policy states, "Grievance is any complaint or concern raised by the patient or the patient's representative . . . All patient grievances received at the facility must be reported to the QAI [quality assessment and improvement] Committee and to the Governing Body Written documentation of the grievances and the actions taken to</p>	V000765	<p>On 10/13/2014 and 10/14/2014 the grievance policy FMS-CS IC-I-103-006A will be reviewed with each staff member and a sign in sheet will be available along with documentation in each employee file of this inservice. Grievances will be monitored by CM and documented on QAI grievance tool. CM will keep QAI committee briefed monthly at the QAI meetings to ensure that all grievances have been addressed to include patient notification of resolution.</p>	10/14/2014

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	<p>resolve it must be available in the QAI minutes . . . Description of patient grievance and the resolution offered to the patient is documented within the Governing Body meeting minutes."</p> <p>2. During an interview with patient number 19 on 10-7-14 at 10:00 AM, the patient stated, "I don't know why I have to be the only patient in here with my lines like this." The patient pointed out the access was in the patient's left arm and the dialysis machine was positioned on the patient's right side with the dialysis lines crossing the patient's body." The patient stated, "I am afraid I am going to go to sleep and jerk and pull them apart." The patient indicated the patient had spoken with the clinic manager about the problem.</p> <p>The patient also indicated the patient had spoken with the clinic manager about the length of time between pulling the venous and arterial needles. The patient stated, "I don't know why it takes so long. I am not a bleeder and I hold my own sticks."</p> <p>3. The facility's "Patient, Hospital & Physician Complaint/Grievance Log" for 2014 failed to evidence documentation of the patient's complaint.</p>			

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	4. The clinic manager stated, on 10-7-14 at 1:35 AM, "I remember a complaint about the position of the machine in relation to the patient's access site but I just didn't document." The manager stated, "I don't remember any complaints about the length of time between pulling needles."			