

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000  Bldg. 00	This was a Federal ESRD [CORE] recertification survey.  Survey Dates: 4/30/15, 5/1/15, 5/4/15, and 5/6/15  Facility #: 011693  Medicaid #: 201169780B  54 Active Incenter Hemodialysis Patients  QA:JE 5/11/15	V 000		
V 121  Bldg. 00	494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [The facility must demonstrate that it follows standard infection control precautions by implementing-] (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the- (i) Handling, storage and disposal of potentially infectious waste; Based on observation and interview, the facility failed to ensure staff (Employee M, patient care technician) had properly hung up personal protective equipment in 1 of 3 observations.  Findings	V 121	The sharps container was immediately relocated away from area where gowns are hung thus eliminating risk that gown touches sharps container. On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained the all clinic staff	05/13/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. On 5/1/15 at 9:40 AM, Employee M, patient care technician, was observed to hang up her personal protective gown outside the isolation room prior to entering. This gown's ties were observed to dangle onto the top of a sharps container placed on the ground outside the isolation station. The sharps container was placed directly under the hanger for the gowns. She was observed to exit the isolation room and then put the gown back on as she reentered the incenter hemodialysis floor.</p> <p>2. On 5/1/15 at 9:42 AM, Employee M indicated the gown had been touching the sharps container and would need to be discarded and that the sharps container should not be under the hanger.</p> <p>3. The policy titled "Dialysis Precautions" with an effective date of January 1, 2012 stated, "General approach ... approach all blood, body fluids, tissues, needles and sharps as if they are contaminated."</p>		<p>on:</p> <ul style="list-style-type: none"> <li>· Policy</li> </ul> <p>FMS-CS-IC-II-155-070A Dialysis Precautions Policy with special attention to: General Approach</p> <ul style="list-style-type: none"> <li>o Approach all blood, body fluids, tissues, needles and sharps as it they are contaminated.</li> <li>· Designated storage locations sharps containers away from PPE storage locations.</li> <li>· Staff to discard gown if it touches sharps container as it is contaminated</li> </ul> <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>The Clinical Manager and or designee will perform infection control audits for compliance, including monitoring storage of gowns, according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to infection control and proper storage of PPE when not in use.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V 142  Bldg. 00	<p>494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&amp;P The facility must-</p> <p>(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; Based on observations and staff interview, the facility failed to ensure supplies for the patients' use were not expired for 1 of 1 facility.</p> <p>Findings</p> <p>1. On 4/30/15 at 10:30 AM, the treatment and medication preparation area on the incenter treatment floor was observed to contain expired supplies including one bottle of 3 % hydrogen peroxide containing about 15 ounces was expired on 3/15. A bottle of PVP (Povidone / Iodine) Prep Solution topical antiseptic solution in a 16 ounce bottle with about 15 ounces left had an expiration date of 12/14. A bottle of Dynahex 2 % solution in a 16 fluid ounce bottle had an expiration date of 1/15 and contained about 8 ounces.</p> <p>2. On 4/30/15 at 10:30 AM, Employee N, Registered Nurse, indicated the above supplies were expired.</p> <p>3. The facility policy titled "Medication Preparation and Administration" with an</p>	V 142	<p>Immediately all expired solutions, including hydrogen peroxide, Povidone, Dynahex, were discarded. On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained all patient care staff on:</p> <ul style="list-style-type: none"> <li>· Policy FMS-CS-IC-I-120-040A Medication Preparation and Administration with emphasis on: <ul style="list-style-type: none"> <li>o Expiration dates for all stored medications are to be monitored on a monthly basis</li> <li>o Expired medications and solutions are to be discarded via Fresenius Medical Services offsite return program or in accordance with local and/or state law.</li> </ul> </li> <li>· Staff assignment for monitoring expiration dates The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance, including monitoring that supplies are not expired or are discarded immediately when expiration date is reached, according to the QAI Workflow Calendar, address</li> </ul>	05/13/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V 147  Bldg. 00	<p>effective date of January 28, 2015 stated, "The following table including expiration date of bulk type items or floor stock ... floor topical antiseptic liquids</p> <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>identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure supplies for patients' use are not expired.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<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 policy review, observation, and interview, the facility failed to ensure care was provided for a patient with a central venous catheter (CVC) as required by facility policy for 1 of 2 observations of initiation of dialysis for a patient with a CVC (Employee P, Patient Care Technician).</p> <p>The findings include:</p> <p>1. Facility procedure titled "Initiation of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" with an effective date of January 6, 2014 stated, "Check to make sure catheter clamps are closed. Remove cap from clamped arterial limb ... Using a new sterile alcohol pad, scrub the threads of the luer lock [hub] vigorously, using back and forth friction for 15 seconds - let dry and discard pad ... immediately attach a sterile empty 10 mL [milliliter] syringe to limit exposure to air. Repeat steps 3 - 5 for the venous end of the catheter limb."</p>	V 147	<p>On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained all clinic staff on:</p> <ul style="list-style-type: none"> <li>· Policy FMS-CS-IC-520-021C Initiation of Treatment Using a Central Venous Catheter and Optiflux® Single Use Ebeam Dialyzer Policy with emphasis on <ul style="list-style-type: none"> <li>o Preparing the catheter, disinfection of the catheter connections: threads of the luer lock (hub) must be scrubbed with 70% sterile alcohol pad for 15 seconds and any time caps are removed or bloodlines are disconnected (i.e. end of treatment or treatment interruption) to reduce risk of contamination</li> </ul> </li> </ul> <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance, including checking that catheter hubs are scrubbed for 15 seconds as required, according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken</p>	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 401 Bldg. 00	<p>2. On 5/1/15 at 11:30 AM, Employee P, patient care technician, was observed to initiate dialysis on patient #5 at station #19. This patient had a CVC. Employee P scrubbed the arterial limb for 3 seconds and the venous limb for 5 seconds before attaching the 10 mL syringes to each.</p> <p>3. On 5/1/15 at 4:35 PM, the clinic manager indicated scrubbing of the CVC hubs is to be for 15 seconds.</p> <p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>Based on observation, interview, and review of policy, the facility failed to ensure laboratory supplies were not expired in 1 of 1 observations of the laboratory area (4/30/15) and failed to ensure the entrance / exit had safe floor mats for 1 of 1 facility.</p>	V 401	<p>at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure care is provided for a patient with central venous catheter as required by facility policy.</p> <p>Immediately all expired lab supplies were discarded. The referenced rug in the entry way was removed and a heavier grade rug delivered and in place and a pedimat floor will be placed no later than 6-30-15. On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained the all clinic staff on:</p>	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p><b>Findings</b></p> <p>Regarding expired lab supplies</p> <p>1. On 4/30/15 at 10:30 AM, the laboratory supply cabinet the laboratory supply area was observed to have 3 BBL Cultureswab Plus Collection and Transport Swabs for Aerobes and Anaerobes with expiration date of 10/14.</p> <p>2. On 4/30/15 at 10:30 AM, Employee N, Registered Nurse, indicated the lab supply cabinet had expired supplies.</p> <p>3. The facility policy titled "Storage of Supplies" with a date of July 4, 2012 stated, "Stock will be rotated on a regular basis according to expiration dates.</p> <p>Regarding a mat at the entrance / exit area of the clinic</p> <p>4. On 5/1/15 at 12 Noon, the surveyor tripped on the rug in the entry way between the lobby and parking lot when pushing the front door open. The front door, as it opened, caught the mat and caused it to buckle up about 6 inches high. The surveyor stepped into the fold and tripped. Person # O was exiting behind the writer and caught the door to</p>		<p>Policy</p> <p>FMS-CS-IC-I-120-005A Storage of Supplies with emphasis on:</p> <ul style="list-style-type: none"> <li>o Stock will be rotated on a regular basis according to expiration dates</li> <li>o Staff assignment for monitoring expiration dates</li> </ul> <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance, including monitoring that supplies are not expired or are discarded immediately when expiration date is reached, according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure laboratory supplies are not expired and entrance/exit has safe floor mats.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

V 544 Bldg. 00	<p>help the surveyor at this time.</p> <p>5. On 5/1/15 at 12 Noon, Person #O, not a patient or staff member of the facility, indicated the rug often bunched up and had been like this for a while.</p> <p>6. On 5/6/15 at 3 PM, Employee B indicated she was not aware of a policy on rugs at the entryway or the safety of this area.</p> <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 and interview, the facility failed to ensure the blood flow rate on the prescription were followed for 2 of 7 incenter hemodialysis records ( #3 and #6 ) reviewed.</p>	V 544	<p>On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained the all clinic staff on:</p> <ul style="list-style-type: none"> <li>- Policy FMS</li> <li>-CS-IC-II-150-033A Physician Order Documentation Policy with</li> </ul>	05/13/2015
-------------------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p><b>Findings</b></p> <p>1. Clinical record #3 included hemodialysis orders that identified the blood flow rate (BFR) was to be 400 milliliters per minute.</p> <p>A. The flow sheet dated 4/10/15 evidenced BFRs of 450 through the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 4/13/15 evidenced BFRs of 450 through the treatment with no explanation as to why the BFR was not followed.</p> <p>C. On 5/4/15 at 5:15 PM, the clinic manager indicated the BFR did not follow the prescription ordered by the physician.</p> <p>2. Clinical record #6 included hemodialysis orders that identified the BFR was to be 450 milliliters per minute.</p> <p>A. The flow sheet dated 4/15/15 evidenced BFRs of 400 through the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 4/22/15 evidenced BFRs of 342, 400, 402, and 405 through the treatment with no</p>		<p>special emphasis on :</p> <ul style="list-style-type: none"> <li>o Responsibility - It is the nurses' responsibility to ensure that all treatments, medications, labs or any care provided to the patient have an accurately documented physician order.</li> <li>o General Policy - Nurse Practice Act require nurses to carry out treatment care (BFR), medication administration, lab tests, procedures, and other treatments, based on physician orders.</li> </ul> <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform Medical Record audits for compliance, including verifying BFR orders are followed or documented reason why, according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure blood flow rate on the prescription is followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 715  Bldg. 00	<p>explanation as to why the BFR was not followed.</p> <p>C. On 5/6/15 at 4:30 PM, the clinic manager indicated the BFRS weren't followed.</p> <p>3. The policy titled "Physician Order Documentation" with an effective date of 6/19/13 stated, "It is the nurse's responsibility to ensure that all treatments ... or any care provided to the patient have an accurately documented physician order ... Nurse practice acts require nurses to carry out treatment care ... based on physician orders."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on clinical record and policy review and interview, the medical director failed to ensure the pre-assessments had been completed by</p>			V 715	On 5-13-15 the Director of Operations reviewed with the Clinical Manager and the Clinical Manager trained the all clinic RN		05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the registered nurse within 1 hour of starting treatment as required by facility policy in 5 of 7 records reviewed (#2, 3, 4, 5, 6).</p> <p>The findings</p> <p>1. Clinical record #2 evidenced the patient received dialysis treatments 3 times per week for 4 hours per treatment. The nursing assessment occurred after the first hour of treatment. A treatment run document identified patient #2's dialysis was initiated on 4/3/15 at 10:59 AM and completed at 2:59 PM. A nursing evaluation occurred at 12:49 PM.</p> <p>On 5/4/15 at 5:30 PM, the clinic manager indicated the evaluation did not occur until 12:49 PM.</p> <p>2. Clinical record #3 evidenced the patient received dialysis treatments 3 times per week for 3 hours and 30 minutes per treatment. Nursing assessments did not occur within 1 hour after the initiation of dialysis. A treatment run document showed patient #3's dialysis was initiated on 4/22/15 at 5:23 AM and completed at 9 AM. A nursing evaluation occurred at 8:20 AM.</p> <p>On 5/4/15 at 5:10 PM, the clinic manager indicated the nursing evaluation</p>		<p>staff on:</p> <ul style="list-style-type: none"> <li>· Policy</li> </ul> <p>FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy with special emphasis on:</p> <ul style="list-style-type: none"> <li>o Purpose: The purpose of the policy is to provide guidance to the Registered Nurse on his/her responsibilities for patient oversight, which includes making patient rounds preferably within 1 hour of dialysis treatment initiation and reviewing patient treatment information.</li> <li>o Policy: Patient evaluation by the nurse must be completed during the patient's treatment, preferably within the first hour or as specified by stricter state regulations.</li> </ul> <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform Medical Record audits for compliance, including review of documented RN assessment, according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Medical Director as Chairperson of the QAI Committee oversees QAI</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>occurred at 8:20 AM.</p> <p>3. Clinical record #4 evidenced the patient received dialysis treatments 3 times per week for 4 hours per treatment. Nursing assessments did not occur within 1 hour after the initiation of dialysis. A treatment run document showed patient #4's dialysis was initiated on 4/1/15 at 10:35 AM and completed at 2:35 PM. A nursing evaluation occurred at 1:09 PM.</p> <p>On 5/4/15 at 5:15 PM, the clinic manager indicated the nursing evaluation did not occur in the first hour after treatment was initiated.</p> <p>4. Clinical record #5 evidenced the patient received dialysis treatments 3 times per week for 4 hours per treatment. Nursing assessments did not occur within 1 hour after the initiation of dialysis.</p> <p>A. A treatment run document showed patient #5's dialysis was initiated on 4/06/15 at 11:36 AM and completed at 3:40 PM. A nursing evaluation occurred at 2:06 PM.</p> <p>B. A treatment run document showed patient # 5's dialysis was initiated on 4/13/15 at 11:19 AM and completed at 3:26 PM. A nursing evaluation occurred at 2:16 PM.</p>		<p>activities. The Clinical Manager is responsible and the QAI Committee inclusive of the Medical Director monitors to ensure pre-assessments are completed by the RN within one hour of starting treatment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>C. On 5/4/15 at 4:55 PM, the clinic manager indicated the nursing evaluations did not occur in the first hour after treatment was initiated for the treatment runs on 4/6 and 4/13/15.</p> <p>5. Clinical record #6 evidenced the patient received dialysis treatments 3 times per week for 3.5 hours per treatment. Nursing assessments did not occur within 1 hour after the initiation of dialysis.</p> <p>A. A treatment run document showed patient #6's dialysis was initiated on 4/06/15 at 11:47 AM and completed at 3:20 PM. A nursing evaluation occurred at 2:11 PM.</p> <p>B. A treatment run document showed patient #6's dialysis was initiated on 4/22/15 at 12:03 PM and completed at 3:05 PM. A nursing evaluation had not occurred.</p> <p>C. On 5/6/15 at 4:30 PM, the clinic manager indicated the nursing assessment had not occurred in the first hour with the treatment run documents from 4/6 and 4/22/15.</p> <p>6. The policy titled "Nursing Supervision and Delegation" with an effective date of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152631	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/06/2015
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE HOBART			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S WISCONSIN ST HOBART, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9/25/13 stated, "The purpose of the policy is to provide guidance to the registered nurse on his / responsibilities for patient oversight, which includes making patient rounds preferably within 1 hours of dialysis treatment initiation and reviewing patient treatment information ... Patient evaluation by the nurse must be completed during the patient's treatment, preferably within the first hour."				