

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152584	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE LOGANSPOORT			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 SMITH ST LOGANSPOORT, IN 46947		
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V0000	<p>This visit was an ESRD recertification survey.</p> <p>Survey dates: July 9, 10, and 11, 2012</p> <p>Facility #: 003399</p> <p>Medicaid Vendor #: 200413110</p> <p>Surveyor: BridgetBoston, RN, PHNS - Team Leader Ingrid Miller, RN, PHNS Team Member</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 16, 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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V0116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure staff disinfected equipment as required by policy and procedure for 1 of 1 facility with the potential to affect all patients and staff exposed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility policy numbered 132-020-256 titled "Venipuncture Site Clamps" states, "All clamps must be disinfected after each use by submersion in 1:100 bleach solution. The clamp must be completely submerged and must remain in the bleach solution for a minimum of 20 minutes." 2. Observation on July 9, 2012, between 	V0116	<p>V116-The Clinic Manager addressed cross-contamination issues with proper disinfection with staff through an in-service conducted by the Clinic Manager on July 16, 2012.</p> <p>Proper disinfection should be used when disinfecting clamps ensuring that they are completely submerged for a minimum of 20 minutes.</p> <p>The Clinic Manager will be responsible for ensuring proper disinfection of clamps is performed as evidenced by conducting an infection control audit daily for 1 week, weekly for 4 weeks and monthly thereafter.</p> <p>Compliance with this policy will be maintained by the clinic manager</p>	07/16/2012	

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	<p>1:20 PM 2:45 PM:</p> <p>A. At 1:40 PM, a plastic container labeled "dirty clamps" and another label stated, "bleach 1:100" was observed with multiple blue clamps inside the container. The clamps and handles were extended upward and exposed to the air and the solution did not cover all the items in the bucket.</p> <p>B. At 2:45 PM, the same plastic container was observed to contain the same multiple clamps extending out of the liquid and clamps exposed to the air. The clamps were not submerged in the bleach solution.</p> <p>3. Observation on July 11, 2012, at 4:25 PM, the one container identified on the unit as "dirty clamps" was observed to contain multiple blue clamps with parts of their handles and pads exposed and one entire clamps was fully exposed. A label on the container stated, "1:100 bleach ... 7/11/12 ... 0630."</p> <p>4. On July 11, 2012, at 4:25 PM, employee A, a registered nurse, indicated the contact time for disinfection of the clamps was to be at least 20 minutes with a solution of 1:100 bleach and that the entire clamp is to be immersed in the disinfection solution.</p>		on an ongoing basis and will be reviewed through the QAI team on a monthly basis.				

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V0715	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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;</p> <p>Based on clinical record and facility policy review and staff interview, the medical director failed to ensure policies relative to patient admission were followed for an initial admission assessment for 1 of 3 new patients admitted on or after March 5, 2012, with the potential to effect new patients receiving dialysis services at this facility. (Patient 5)</p> <p>The findings include:</p> <p>1. The facility's policy number 138-020-091 and presented for review, titled "Comprehensive Interdisciplinary Assessment and Plan Of Care" stated, "A registered nurse must evaluate patients new to dialysis and before initiation of their first treatment to determine immediate needs. Chairside - The RN must at a minimum, complete the PreDialysis Assessment screen that includes a systems assessment."</p> <p>2. Clinical record # 5 failed to evidence</p>	V0715	V715-The Director of Operations and/or Operations Manager will meet with the Medical Director on July 27, 2012 for QAI to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individuals who treat patients in the facility emphasizing the requirement for an initial nursing assessment prior to a patient's first dialysis treatment. The Plan of Correction will be reviewed and plans below to be instituted to correct this issue going forward. The Clinical Manager will meet with all nursing personnel by July 20, 2012 to review the requirement that an initial assessment of the patient will be completed by the RN prior to the initiation of the first dialysis treatment per policy. This will be done through the completion of the Multi-Disciplinary note - Nursing Evaluation on the Chair-side computer system and will be evidenced by being completed and signed off prior to	07/20/2012			

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	<p>the registered nurse on duty, prior to the patients first treatment on 5/4/12, had completed an initial evaluation per policy guidelines.</p> <p>3. On July 11, 2012, at 5:44 PM, employee A indicated the registered nurse was to complete the initial assessment prior to the patient care technician initiating the dialysis treatment and the documentation does not support this occurred.</p>		<p>the initiation of the new patient's first treatment. The facility's nursing staff will be in-serviced on the following policies, FMS 138-020-091 "Comprehensive Interdisciplinary Assessment", "Evaluating the Patient Pre-Dialysis" and "Evaluating the Patient Post-Dialysis" by July 20, 2012 by Clinic Manager with a record of training reviewed by the QAI committee. The Clinical Manager or designee will audit 100% of all new patient dialysis flow sheets to ensure the Initial Nursing Assessment has been completed prior to the initiation of treatment. Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will be determined by the QAI Committee upon review of the audit results and resolution of the issue. The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the monthly QAI Committee Meeting. The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a</p>		

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			root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee	