

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152541	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2014
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NAME OF PROVIDER OR SUPPLIER  MERRILLVILLE DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8670 BROADWAY MERRILLVILLE, IN 46410
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V000000	<p>This visit was a federal ERSD complaint investigation.</p> <p>Complaint # IN00154217 - Substantiated: Federal deficiencies related to allegation are cited.</p> <p>Survey Dates: August 25, 26, 27, 2014</p> <p>Facility Number: 005166</p> <p>Medicaid Vendor # 200114710A</p> <p>Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor</p> <p>Current Census: 95 InCenter Hemodialysis Patients 3 Home Hemodialysis Patients 23 Peritoneal Dialysis Patients</p> <p>Merrillville Dialysis Center was found out of compliance with the Condition for Coverage 42 CFR 494.30 Infection Control.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 9, 2014</p>	V000000		
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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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V000110	<p>494.30 CFC-INFECTION CONTROL</p> <p>Based on observation, facility policy and document review, and interview, it was determined the facility failed to ensure visible blood was cleaned as required in 1 of 1 observation of a blood spill creating the potential to affect the facilities 24 present Incenter hemodialysis patients and 10 staff (See V 111), failed to follow the Centers for Disease Control (CDC) standards related to glove use in 2 out of 16 skilled dialysis procedures, creating the potential to affect all 95 Incenter hemodialysis patients (See V 113), failed to ensure that items taken into the dialysis station were cleaned and disinfected before being taken back to the nurses station in 1 of 16 observations which had the potential to affect all 26 Incenter Hemodialysis patients who were presently being dialyzed at the facility (See V 116), failed to demonstrate that it disinfected surfaces and equipment per CDC guidelines and facility policy having the potential to affect the subsequent patient at the station with cross contamination all 24 patients currently receiving dialysis, and ten present staff (See V 122), and failed to ensure staff wiped the rubberized port before withdrawing medication in 1 out of 4 Post dialysis procedures involving</p>	V000110	<p>The Director of Operations (CEO) and Governing Body take seriously their responsibility to ensure that the facility is in compliance with the CfC of Infection Control including ensuring blood is cleaned and gloves are used as required, cleaning and disinfection of supplies and surfaces occurs per CDC guidelines and facility policy, and saline ports are disinfected before withdrawing medication. As such, the Governing Body met on 09/16/14 to review the Statement of Deficiencies and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions for Coverage. As a result of the citation from the 08/27/14 CMS Recertification survey and to ensure that the facility fully complies with the Centers of Disease Control Standards and as part of the developed plan of correction, the following corrective actions have been implemented:</p> <ul style="list-style-type: none"> <li>·Reeducation and reinforcement of the mandatory requirement that: <ul style="list-style-type: none"> <li>·Direct patient care staff complies with all aspects of the facility cleaning and disinfection policy. Please refer to V-111</li> <li>·PPE is donned per policy including gloves. Please refer to</li> </ul> </li> </ul>	09/17/2014

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V000111	<p>aseptic technique creating the potential to affect all 94 Incenter hemodialysis (See V 143).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with the Condition for Coverage 494.30 Infection Control.</p> <p>494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, facility policy and procedure review, and interview, the facility failed to ensure visible blood was cleaned as required in 1 of 1 observation of a blood spill creating the potential to affect the facilities 24 present InCenter hemodialysis patients and 10 staff.</p> <p>Findings include:</p> <p>1. At station 23, on August 25 at</p>	V000111	<p>V-113</p> <ul style="list-style-type: none"> <li>·Surfaces and equipment are disinfected per cleaning and disinfection policies. Please refer to V-116 and V-122</li> <li>·Medication ports are disinfected prior to entering. Please refer to V-143</li> </ul> <p>Documentation of the education and monitoring process are available for review at the facility. To ensure full implementation of the developed plan of correction, the Governing Body has committed to meet at a minimum monthly until the Condition is lifted and compliance has been achieved. The Governing Body is responsible and will continue to monitor the corrective plan through to completion.</p> <p>Immediately on 08/26/14 the Clinical Manager and Education Coordinator retrained all direct patient care staff on policy and procedure related to blood spills in the dialysis clinic.</p> <p>On 09/10/14 the Director of Operations reviewed with the Clinical Manager and by 09/17/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT)</p>	09/17/2014			

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	<p>10:35, there was an observation of discontinuation of dialysis and post dialysis access care by Employee U. At 10:45, blood from the patient's left arm access spilled from beneath the pressure-applied gauze, down the chair, trickling in front of the dialysis machine on the floor, and a significant amount weeping from the access before more pressure by the nurse was again applied, leaving a visable amount streaking the seat, the left wheel, and brakes of the chair. At 11:15, Employee B cleaned the floor in front of the machine, the machine, and areas of visable blood on the attached side table, except for the chair. The patient had not yet vacated the station. At 11:45 the visable blood on the chair remained. Then the patient and chair were wheeled from the station toward the nurses station, approximately 4 feet away from its original location.</p> <p>2. At 12:00, the visable blood remained on the floor and chair. Employee K assisted the patient, whose access stopped bleeding and was being discharged. The employee cleaned the floor and the chair with 1:100 bleach solution.</p> <p>3. At 12:15, the nurse manager stated, "I wanted to make sure it was done correctly. The nurse knows it is our</p>		<p>staff on:</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-II-155-110A: Cleaning and Disinfection with special attention to: <ul style="list-style-type: none"> <li>o Work Surface Cleaning and Disinfection with visible blood greater than 10ml and other potentially infectious material using bleach solutions: <ul style="list-style-type: none"> <li>§ Use 1:100 bleach to clean surfaces with visible blood (&lt;10mls)</li> <li>§ Use 1:10 bleach dilution to clean surfaces with visible blood &gt;10mls</li> <li>§ Clean and disinfect any surfaces contaminated with blood or OPIM immediately or soon as feasible.</li> </ul> </li> </ul> </li> <li>· FMS-CS-IC-II-155-110C3: Work Surface Cleaning and Disinfection with Visible Blood &gt; than 10 mls and OPIM using Bleach Solutions, with special attention to: <ul style="list-style-type: none"> <li>o Procedure: <ul style="list-style-type: none"> <li>§ Use a cloth wetted with 1:10 bleach solution to clean the surface</li> <li>§ Clean up all visible blood. Discard used cloth and gloves in appropriate waste container. Perform hand hygiene and don new gloves.</li> <li>§ After cleaning up all visible blood, using a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface. Make the surface glisteningly wet and let air dry unless otherwise specified by the manufacturer.</li> </ul> </li> </ul> </li> </ul>	

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V000113	<p>policy to use 1:10 solution that the staff mixes every day."</p> <p>4. Facility Policy titled "Cleaning and Disinfection", document number FMS-CS-IC-II-155-110A, dated 20-MAR-2013, states, "... Clean and disinfect any surfaces contaminated with blood or OPIM immediately or as soon as feasible... ."</p> <p>5. Facility Procedure titled "Work Surface Cleaning and Disinfection with Visible Blood &gt;10mLs and OPIM using Bleach Solutions," FMS-CS-IC-II-155-110C3, dated 04-JAN-2012, states, " ... Use a cloth wetted with 1:10 bleach solution to clean the surface. Clean up all visible blood. Discard used cloth and gloves in an appropriate waste container. Perform hand hygiene and don new gloves. After cleaning up all visible blood use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface ... ."</p> <p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</p>		<p>§ Discard the cloth and gloves in the appropriate waste container. Perform hand hygiene. The meeting agenda and attendance records will be available at the facility for review. The Clinical Manager and or designee will perform infection control audits daily for 2 weeks, and then weekly for 2 weeks, then monthly until compliance is achieved and Condition is lifted. The Clinical Manager will immediately 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 that visible blood is cleaned as required.</p>	

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	<p>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 and review of documents, the facility failed to follow the Centers for Disease Control (CDC) standards related to glove use in 2 out of 16 skilled dialysis procedures, creating the potential to affect all 95 Incenter hemodialysis patients. (employees D and U)</p> <p>Findings:</p> <p>1. On August 25, 2014, at 10:35 central standard time, there was an observation at station 23 of a discontinuation of dialysis and post dialysis access care by Employee U. At 10:45, blood from the patient's left arm access spilled from beneath the pressure-applied gauze, which the patient was holding with an ungloved hand. The nurse had not provided the patient with a glove until after the access site started bleeding, at which time Employee B handed the patient a glove. "Well, it's my blood," the patient said.</p> <p>According to the CMS Interim Final Version 1.2 (2008) originally cited in the Center for Disease Control (CDC), "Recommendations for Preventing</p>	V000113	<p>On 09/10/14 the Director of Operations reviewed with the Clinical Manager and by 09/17/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-II-155-090A: Hand Hygiene with special attention to: <ul style="list-style-type: none"> <li>o Hand Hygiene: <ul style="list-style-type: none"> <li>§ Gloves must be provided to patients when performing procedures which risk exposure to blood or body fluids, such as when self cannulating or holding access sites post treatment to achieve hemostasis</li> </ul> </li> </ul> </li> <li>· FMS-CS-IC-II-155-080A: Personal Protective Equipment with special attention to: <ul style="list-style-type: none"> <li>o Gloves: <ul style="list-style-type: none"> <li>§ Disposable gloves must be used:</li> <li>§ When touching any part of the dialysis machine or equipment at the dialysis station</li> <li>§ Gloves must be worn appropriately</li> <li>§ Change gloves and practice hand hygiene between each patient and /or station</li> </ul> </li> </ul> </li> </ul> <p>The meeting agenda and attendance records will be available at the facility for review.</p>	09/17/2014

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V000116	<p>Transmission of Infections Among Chronic Hemodialysis Patients", Vo. 50 No. RR-5, "Gloves must be provided to patients and visitors if these individuals assist with procedures which risk exposure to blood or body fluids, such as when self-cannulating or holding access sites post treatment to achieve hemostasis."</p> <p>2. On August 25, 2014, at 06:30 central standard time, patient care technician D, was observed holding a glove over the tips of her fingers to touch a computer screen at the dialysis station.</p> <p>The May 2013 "Protocol for Hand Hygiene and Glove Use Observations" by the Centers for Disease Control and Prevention states, "... In general, gloves should be worn prior to contact with patients at the treatment station and potentially contaminated surfaces (e.g., dialysis machine, environmental surfaces) ... Holding a glove in one's hand instead of wearing it is not considered acceptable ... ."</p> <p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR</p>		<p>The Clinical Manager and or designee will perform infection control audits daily for 2 weeks, and then weekly for 2 weeks, then monthly until compliance is achieved and Condition is lifted. The Clinical Manager will immediately 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 gloves are worn as required per CDC and facility policy.</p>	

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	<p><b>DISINFECT</b></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 and review of facility policy, the facility failed to ensure that items taken into the dialysis station were cleaned and disinfected before being taken back to the nurses station in 1 of 16 observations which had the potential to affect all 26 Incenter Hemodialysis patients who were presently being dialyzed at the facility. (Employee U)</p> <p>Findings:</p> <p>1. On August 25, 2014, at 06:40 Central Standard time, the nurse, employee U, listened to lung sounds as part of an assessment at station 10 using a stethoscope. The stethoscope was not disinfected before it was returned to a clean area. It was then set down on the</p>	V000116	<p>Immediately on 08/26/14 the Clinical Manager and Education Coordinator retrained all direct patient care staff on policy and procedure related to cleaning and disinfection of items brought to station.</p> <p>On 09/10/14 the Director of Operations reviewed with the Clinical Manager and by 09/17/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <p>§ FMS-CS-IC-II-155-123-A: Policy: Cleaning and Disinfection with special emphasis on:</p> <ul style="list-style-type: none"> <li>o Policy: All reusable instruments and equipment will be thoroughly cleaned and disinfected prior to being returned to a clean area (including stethoscope).</li> </ul> <p>· FMS-CS-IC-II-155-123C:</p>	09/17/2014

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V000122	clean counter at the nurses station where medications were prepared.  2. The policy FMS-CS-IC-II-155123A & C, "Cleaning and Disinfection of the Stethoscope", March, 2013, states, " ... The stethoscope should be wiped with either 70% isopropyl alcohol wipe or cloth dampened with 1:100 hypochlorite solution after each use ... ."  494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows		Procedure: Cleaning and Disinfection with special emphasis on: o Using 70% alcohol or 1:100 hypochlorite solution to clean stethoscope diaphragm: · The stethoscope should be wiped with either a 70% alcohol wipe or cloth after each use. The meeting agenda and attendance records will be available at the facility for review. The Clinical Manager and or designee will perform infection control audits daily for 2 weeks, and then weekly for 2 weeks, then monthly until compliance is achieved and Condition is lifted. The Clinical Manager will immediately 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 items taken into the dialysis station are cleaned and disinfected before being taken back to the nurses' station.		

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	<p>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, and equipment.</p> <p>Based on policy and document review and observations of 2 out of 18 dialysis procedures requiring standard infection control precautions, the facility failed to demonstrate that it disinfected surfaces and equipment per CDC guidelines and facility policy having the potential to affect the subsequent patient at the station with cross contamination all 24 patients currently receiving dialysis and ten present staff. (Employees B and U)</p> <p>Findings:</p> <p>1. On August 25, 2014, at 10:45 AM, at station 22, several employees, including patient care technician, employee B were observed cleaning and disinfecting the dialysis station. The television screen and TV controls were not disinfected. The television is a Direct Touch System.</p> <p>FMS-CS-IC-II-155-120A policy from the facility's Bloodborne Pathogen Program titled "Cleaning Individual Patient Televisions and Direct Touch Systems" dated 04-JAN-2012 states, " ...</p>	V000122	<p>Immediately on 08/26/14 the Clinical Manager and Education Coordinator retrained all direct patient care staff on policy and procedure related to cleaning and disinfection of surfaces, equipment, and blood spills in the dialysis clinic.</p> <p>On 09/10/14 the Director of Operations reviewed with the Clinical Manager and by 09/17/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-II-155-110A: Policy: Cleaning and Disinfection with special attention to: <ul style="list-style-type: none"> <li>o Work Surface Cleaning and Disinfection with visible blood greater than 10ml and other potentially infectious material using bleach solutions: <ul style="list-style-type: none"> <li>§ Use 1:100 bleach to clean surfaces with visible blood (&lt;10mls)</li> <li>§ Use 1:10 bleach dilution to clean surfaces with visible blood &gt;10mls</li> <li>§ Clean and disinfect any surfaces contaminated with blood or OPIM immediately or soon as feasible.</li> </ul> </li> </ul> </li> </ul>	09/17/2014

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	<p>The television shall be cleaned after each patient treatment. The television screen should be cleaned with a 1:100 bleach solution ... ."</p> <p>2. At station 23, on August 25 at 10:35, there was an observation of discontinuation of dialysis and post dialysis access care by Employee U. At 10:45, blood from the patient's left arm access spilled from beneath the pressure-applied gauze, down the chair, trickling in front of the dialysis machine on the floor, and a significant amount weeping from the access before more pressure by the nurse was again applied, leaving a visible amount streaking the seat, the left wheel, and brakes of the chair. At 11:15, Employee B cleaned the floor in front of the machine, the machine, and areas of visible blood on the attached side table, except for the chair. The patient had not yet vacated the station. At 11:45 the visible blood on the chair remained. Then the patient and chair were wheeled from the station toward the nurses station, approximately 4 feet away from its original location.</p> <p>A. At 12:00, the visible blood remained on the floor and chair. Employee K assisted the patient, whose access stopped bleeding and was being discharged. The employee cleaned the</p>		<ul style="list-style-type: none"> <li>· FMS-CS-IC-II-155-120A: Policy: Cleaning Individual Patient Televisions and Direct Touch Systems with special attention to : <ul style="list-style-type: none"> <li>o General cleaning:</li> <li>o The television shall be cleaned after each patient treatment.</li> <li>o The television screen should be cleaned with a 1:100 bleach solution.</li> <li>o Use dampened cloth; ring out excess of 1:100 bleach solution. DO NOT use a saturated cloth to clean any part of the television.</li> <li>o Any blood contamination should be cleaned immediately.</li> <li>o Do not use spray liquids or aerosol cleaners for cleaning the television.</li> </ul> </li> <li>· FMS-CS-IC-II-155-110C3: Procedure: Work Surface Cleaning and Disinfection with Visible Blood &gt; than 10 mls and OPIM using Bleach Solutions, with special attention to: <ul style="list-style-type: none"> <li>o Procedure: <ul style="list-style-type: none"> <li>§ Use a cloth wetted with 1:10 bleach solution to clean the surface</li> <li>§ Clean up all visible blood. Discard used clothe and gloves in appropriate waste container. Perform hand hygiene and don new gloves.</li> <li>§ After cleaning up all visible blood, using a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface. Make the surface glisteningly wet</li> </ul> </li> </ul> </li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152541	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2014
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NAME OF PROVIDER OR SUPPLIER  MERRILLVILLE DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8670 BROADWAY MERRILLVILLE, IN 46410
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	<p>floor and the chair with 1:100 bleach solution.</p> <p>B. At 12:15, the nurse manager stated, "I wanted to make sure it was done correctly. The nurse knows it is our policy to use 1:10 solution that the staff mixes every day."</p> <p>C. Facility Policy titled "Cleaning and Disinfection", document number FMS-CS-IC-II-155-110A, dated 20 -MAR-2013, states, "... Clean and disinfect any surfaces contaminated with blood or OPIM immediately or as soon as feasible... ."</p> <p>D. Facility Procedure titled "Work Surface Cleaning and Disinfection with Visible Blood &gt;10 mLs [milliliters] and OPIM using Bleach Solutions," FMS-CS-IC-II-155-110C3, dated 04 -JAN-2012, states, "... Use a cloth wetted with 1:10 bleach solution to clean the surface. Clean up all visible blood. Discard used cloth and gloves in an appropriate waste container. Perform hand hygiene and don new gloves. After cleaning up all visible blood use a new cloth wetted with 1:100 bleach solution for a second cleaning of the surface ... ."</p>		<p>and let air dry unless otherwise specified by the manufacturer. § Discard the cloth and gloves in the appropriate waste container. Perform hand hygiene. The meeting agenda and attendance records will be available at the facility for review. The Clinical Manager and or designee will perform infection control audits daily for 2 weeks, and then weekly for 2 weeks, then monthly until compliance is achieved and condition is lifted. The Clinical Manager will immediately 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 that the facility disinfects surfaces and equipment per CDC guidelines and facility policy.</p>	

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V000143	<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 and review of policy, the facility failed to ensure staff wiped the rubberized port before withdrawing medication in 1 out of 4 Post dialysis procedures involving aseptic technique creating the potential to affect all 94 Incenter hemodialysis. (Employee C)</p> <p>Findings:</p> <p>1. On August 25, 2014, at 11:20, Employee C was observed to withdraw saline using a syringe from a saline bag from the self-sealing rubberized port without first wiping with alcohol or disinfecting.</p> <p>2. FMS-CS-IC-I-120-040A policy titled "Medication Preparation and Administration" dated 30-DEC-2013 states, "... The following steps must be taken to ensure infection control ... Disinfect IV ports prior to accessing, using friction and 70% alcohol, iodophor or chlorhexidine/alcohol agent. Allow to dry prior to accessing ... ."</p>	V000143	<p>Immediately on 08/26/14 the Clinical Manager and Education Coordinator retrained all direct patient care staff on policy and procedure related to disinfecting medication port. On 09/10/14 the Director of Operations reviewed with the Clinical Manager and by 09/17/14 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-120-040-A: Medication Preparation and Administration with special attention to: <ul style="list-style-type: none"> <li>o Infection Control: <ul style="list-style-type: none"> <li>· Disinfect IV port prior to accessing, using friction and 70% alcohol, iodophor or chlorhexidine/alcohol agent. Allow to dry prior to accessing.</li> <li>· Cleanse the diaphragm of a vial prior to accessing the vial. If the vial is a multidose vial, cleanse the diaphragm with alcohol each time the vial is accessed with a needle, using friction and 70% alcohol. Allow to dry before inserting a device into the vial.</li> </ul> </li> </ul> </li> </ul> <p>The meeting agenda and attendance records will be</p>	09/17/2014

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