

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152500	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2014
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2480 N MERIDIAN ST INDIANAPOLIS, IN 46208
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V000000	<p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: June 9-12, 2014</p> <p>Facility #: 005147</p> <p>Medicaid Vendor #: 100172360C</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 18, 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, and equipment.</p> <p>Based on observation and interview, the facility failed to ensure staff followed infection control guidelines while cleaning equipment for 3 of 4</p>	V000122	A mandatory inservice for all direct patient care staff is scheduled for Wednesday, July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Prime Bucket	07/02/2014

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>observations creating the potential to affect all the facility's 157 in-center patients. (Employees A, C, and S)</p> <p>Findings include</p> <p>1. During observation on 6/9/14 at 2:00 PM, station #25 with patient #16, employee A disconnected the dialysate lines from the machine and a pink colored fluid flowed out onto the machine dialyzer side arm, machine bottom ledge, and floor before being capped and taken to discard. Employee A then proceeded to clean the machine from the bottom up, through the pink fluid, then up the side with the dialyzer side arm and through that pink fluid, then up to keyboard area, then the top of the machine and down the left side. Employee A failed to clean the machine from cleanest to dirtiest areas. Employee A also failed to empty the prime waste bucket.</p> <p>2. During observation on 6/9/14 at 2:05 PM, at station #24 with patient # 19, employee A cleaned the dialysis machine from bottom to top and failed to empty the prime waste bucket.</p> <p>3. During observation on 6/9/14 at 2:10 PM, employee A was observed preparing the machine for the next patient. The</p>		<p>Disinfection" procedure, FMS-CS-IC-I-105-007C and completion of the steps: 1. Dispose of saline solution down any marked dirty sink or utility room hopper. 2. Clean all surfaces of the priming bucket with a wipe that has been wetted with 1:100 bleach solution as per facility surface disinfection procedures. Clinical Manager, Charge Nurse and/or Educator will also review the "Work Surface Cleaning and Disinfection with Visible Blood &lt; 10 mls using Bleach Solutions" procedure, FMS-CS-IC-II-155-110C2 and "Cleaning and Disinfection Policy", FMS-CS-IC-II-155-110A and will emphasize the general principal of infection control to work from a clean to dirty area, top to bottom of the dialysis machine and use of a new cloth after cleaning visible blood. The Clinical Manager or designee will complete the Dialysis Station portion of the Infection Control Audit weekly for four weeks, then monthly for three months and then resume quarterly schedule per the QAI Calendar. The Clinical Manager will provide the audit results to the QAI Committee monthly. The Director of Operations is responsible to ensure all documentation required as part of the QAI process is presented, current, analyzed, trended and a root cause analysis completed as appropriate, with the subsequent</p>	

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	<p>prime wasted bucket still had fluid in it, about 1/2 inch. Employee A proceeded to prepare the machine and run the lines into the prime waste bucket. Employee A failed to empty the prime waste bucket prior to set up.</p> <p>4. During observation on 6/9/14 at 2:20 PM, employee C was observed preparing station #24. The prime waste bucket had not been emptied prior to set up for the next patient. Employee C proceeded to prepare the machine and set up lines into the prime waste bucket. Employee C failed to empty the prime waste bucket prior to set up.</p> <p>5. During interview on 6/10/14 at 5:45 PM, employee P indicated the prime waste containers should be emptied between patients and the machines should be cleaned from top to bottom.</p> <p>6. During interview on 6/12/14 at 12:50 PM, employee P indicated the machine policy does not say the machines have to be cleaned from top to bottom and the employee was using a bleach rag.</p> <p>7. During interview on 6/10/14 at 5:35 PM, employee J indicated cleaning of the machines is always from cleanest to dirtiest part.</p>		development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new plan of action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.	

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V000143	<p>8. During observation on 6/10/14 at 12:00 PM, employee S cleaned the machine from top to bottom.</p> <p>9. The facility's policy titled "Priming Bucket Disinfection," # FMS-CS-IC-I-105-007C, revised 4/4/12, states "Follow the steps below to perform surface disinfection of the priming bucket post treatment: 1 Dispose of saline solution down any marked dirty sink or utility room hopper, 2 Clean all surfaces of the priming bucket or approved receptacle, with a wipe that has been wetted with 1:100 bleach solution as per facility surface disinfection procedures."</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</p> <p>Based on observations, policy review, and interview, the facility failed to ensure the staff wiped medication vials with alcohol prior to inserting needles for 1 of 3 medication preparation observations with the potential to affect all the facility's 157 in-center patients. (Employee D)</p> <p>Findings include</p>	V000143	A mandatory inservice for all direct patient care staff is scheduled for Wednesday, July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Medication Preparation and Administration Procedure", FMS-CS-IC-I-120-040C with emphasis on the requirement to clean the rubber stopper of all medication vials with an alcohol prep, including after removal of	07/02/2014

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V000245	<p>1. On 6/10/14 at 11:20 AM, employee D was observed preparing Hectorol for administration to patient #14. Employee D opened the new vial and failed to sanitize the stopper with an alcohol wipe prior to inserting needle.</p> <p>2. On 6/10/14 at 5:45 PM, employee P indicated new medication vials should be wiped with alcohol prior to inserting needle.</p> <p>3. The facility's policy titled "Medication Preparation and Administration," #FMS-CS-IC-I-120-040C, revised 9/25/13 states "Follow the procedure below to drawing medications from a vial: Step 1 Gather supplies: ... Alcohol prep pad ... 2 Select appropriate size syringe. Remove protective cap from vial and wipe rubber stopper with alcohol prep pad."</p> <p>494.40(a) ACID CONC DIST-CONC LABELED &amp; COLOR-CODED RED 5.5.3 Acid concentrate distribution systems: labeled &amp; 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</p>		<p>the cap of a newly opened vial. The Clinical Manager or designee will complete the Medication Preparation and Administration portion of the Infection Control audit weekly for four weeks, then monthly for three months, then resume the regular audit schedule per the QAI calendar. The Clinical Manager will present the audit results to the QAI Committee monthly. The Director of Operations is responsible to ensure all documentation required as part of the QAI process is presented, current, analyzed, trended, and a root cause analysis completed as appropriate, with subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.</p>	

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	<p>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 each treatment room station wall outlets for dialysate were labeled to differentiate 2K and 3K outlets for 16 of 41 dialysis stations with the potential to affect all the facility's 157 in-center patients. (stations # 2, 7, 12, 18, 20, 21, 22, 23, 29, 30, 32, 35, 36, 9, 40 and 41)</p> <p>Findings include</p> <p>1. During observation on 6/9/14 at 2:35 PM, dialysis station #2 wall outlets failed to contain labeling for the 3 K dialysate solution.</p> <p>a. Dialysis station #7 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>b. Dialysis station #12 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>c. Dialysis station #18 wall outlets failed to contain labeling for the 3K dialysate solution.</p>	V000245	<p>On 6/9/2014, the Area Technical Operations Manager labeled the 2K and 3K concentrate spigots at each patient station. The 2K was labeled as 2K2.25C, and 3K was labeled as 3K2.25C to match the concentrate selections programmed in the dialysis machines. A mandatory inservice for all direct patient care staff is scheduled for Wednesday, July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Concentrate Labeling Requirements Policy", FMS-CS-IC-II-140-310A. All direct patient care staff will be trained to verify the presence of the concentrate spigot label when connecting the dialysis machine to the acid concentrate. The RNs will be trained to verify the presence of the concentrate spigot label during the completion of machine checks/RN Rounding Tool. The Bio-Medical Technician and/or Area Technical Operations Manager will print a supply of extra 2K and 3K concentrate spigot labels and place them in envelopes at the nurses' station. The Direct Patient Care staff will be instructed to replace any missing labels. On June 25, 2014, the Bio-Medical Technician was</p>	07/02/2014

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	<p>d. Dialysis station #20 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>e. Dialysis station #21 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>f. Dialysis station #22 wall outlets failed to contain labeling for the 2K and 3K dialysate solutions.</p> <p>g. Dialysis station #23 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>h. Dialysis station #29 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>i. Dialysis station #30 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>j. Dialysis station #32 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>k. Dialysis station #35 wall outlets failed to contain labeling for the 2K dialysate solution.</p> <p>l. Dialysis station #36 wall outlets</p>		<p>retrained to observe the concentrate spigot for the presence of the label when verifying the presence of HMIS labels on the wallbox during the quarterly completion of the Physical Environment Audit. The results of the RN Rounding tool and quarterly Physical Environment Audit will be presented to the QAI Committee by the Clinical Manager and Bio-Medical Technician on a monthly and quarterly basis respectively. The Director of Operations is responsible to ensure all documentation required as part of the QAI process is presented, current, analyzed, trended and a root cause analysis completed as appropriate, with the subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.</p>	

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	<p>failed to contain labeling for the 3K dialysate solution.</p> <p>m. Dialysis station #39 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>n. Dialysis station #40 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>o. Dialysis station #41 wall outlets failed to contain labeling for the 3K dialysate solution.</p> <p>2. During interview on 6/9/14 at 2:35 PM, employee P indicated the first port is always 2 K and the second is 3K but wasn't sure how long they had not had labels. At 2:53 PM employee P indicated the caps at the ports are red and yellow (underneath the ports, they are rings) red is for 2K and yellow is for 3K.</p> <p>3. During interview on 6/9/14 at 2:15 PM, employee A indicated the dialysate outlets at the wall are supposed to be labeled, but 2 K is always the first port and 3 K the second port from the left.</p> <p>4. During interview on 6/9/14 at 2:10 PM, employee G indicated the Dymo labels fall off the walls occasionally and they were unaware some had fallen off</p>			

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V000401	<p>recently. At 3:00 PM, employee G indicated the rings on the outlets from the wall are red for 2K and yellow for 3K.</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, document review, interview, and policy review, the facility failed to ensure the maintenance records for hot water heater and blending valve for treatment side #1 were up to date per reports for 1 of 2 hot water heater and blending valve logs creating the potential to affect all the facility's 157 in-center patients.</p> <p>Findings include</p> <p>1. On 6/10/2014 12:36 PM, employee G indicated the water heater on side one is about 10 years old and over the winter they recorded low water temperatures. Employee G indicated the water heater needs to be replaced as there is a line inside somewhere that is deteriorating and several times they have had to remove plastic pieces from the blending valve.</p>	V000401	<p>On June 10, 2014, the Area Technical Operations Manager contacted vendors to obtain bids for the replacement of the water heater on side 1. B&amp;W Plumbing came to the facility on June 11, 2014. Fite and Deem came to the facility on June 12, 2014. The vendors requested two weeks to prepare the quotes. Once available from the vendors, the bids will be shared with the QAI Committee members for review in preparation for discussion at the QAI Committee meeting scheduled for July 11, 2014. Out of range readings on the RO Log will be addressed by the Bio-Medical Technician as they occur, with any equipment repair or replacement documented on the ER-1 Log, and presented for discussion at the monthly QAI meeting. On June 25, 2014, Employee G was retrained on the "Equipment Repair Records Policy", 153-060-020, including the requirement to document cleaning, repair or replacement of equipment, including the water</p>	07/11/2014

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	<p>2. On 6/10/14 at 1:53 PM, employee G indicated the plumbing company that services the water heaters are the ones who said there is plastic pieces coming from the water heater. Employee G also indicated the production of the reverse osmosis (RO) went down when the temperatures were low so they adjusted the pressure, then the hemodialysis machines regulate the temperature of the dialysate, and the machines will shut off the dialyzer flow if the temps are off, but they do not recall if issues were addressed in quality assessment improvement (QAI).</p> <p>3. On 6/10/14 at 2:07 PM, employee G indicated they were not sure when the plastic pieces began to need being removed, and they did not document that they removed this from the blending valve, but have done it about half a dozen times in a year.</p> <p>4. The RO Machine Log dated February 2014 evidenced the water temperatures ranged from 62 to 76 degrees and biomed was notified. The note on the back dated 2/7/14 stated, "The side 1 water heater is being exhausted because of the unusually cold weather. At this time it is not hurting anything and there is nothing we can do about it. Everything is working as it was intended to work."</p>		<p>heater and blending valve, on the ER-1 form. Any issues identified with the operation of the equipment, including the water heater and blending valve, will be noted in the "additional comments" section of the "Equipment Maintenance" tab on the QAI Water and Physical Environment Tool 2014 and presented for review and discussion at the monthly QAI meeting. The Area Technical Operations Manager or designee will review the RO logs monthly for six months to ensure that out of range readings are identified. The Area Technical Operations Manager will review the ER-1 logs for the water heater and blending valve monthly for six months to ensure that out of range readings are addressed as they occur, and documentation of cleaning, repair or replacement is completed per policy. The Director of Operations is responsible to ensure all documentation required as part of the QAI process is presented, current, analyzed, trended and a root cause analysis completed as appropriate, with the subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.</p>	

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	<p>5. The RO Machine Log dated February 2014 evidenced on 2/27/14 the side 1 blend valve was stuck, bio unstuck it, and they considered replacement.</p> <p>6. The RO Machine Logs dated March, April, May, and June, 2014, failed to evidence the blending valve had been replaced.</p> <p>7. The RO Machine Log dated May 2014 evidenced on 5/31/14 the Feed Water Temperature was 84 degrees, and the action was the water heater was turned off for the summer.</p> <p>8. The Plumbing invoice from 1/22/14 evidenced both water heaters for the treatment room were serviced but failed to evidence any notes about plastic pieces or deteriorating pipes in them.</p> <p>9. The Equipment Repair Record for the hot water heater side 1 failed to evidence any notes of blending valve replacement or plastic pieces coming from water heater.</p> <p>10. On 6/11/14 at 11:40 AM, employee Q indicated this facility does a heat disinfect through the dialysis machines, not the loop, and the water heater was last serviced 1/22/14. At 2:15 PM,</p>			

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	<p>employee Q indicated water heater #1 is turned off currently and the temperature of the city water coming into the facility is affected by the outside temperatures so there is not a need to have the water heater turned on during the summer months even though the water coming in still flows through the water heater. Employee Q also indicated this winter was so cold outside that when the temperatures of the water coming in were lower, the system could not keep up with it. The facility can turn up the water heater and did, but the amount of water the facility uses daily sometimes does not allow the water heater to keep up with the demand. Employee Q also indicated there is an alarm in the water room that if the water temperature reaches 90 degrees will sound and the RO shuts off, giving them time to turn off the water heaters and protect the RO membranes. The dialysis machines will sense temperatures of water and go into bypass and stop flow until the temperatures are back in range if it would get to that point. Employee Q indicated they do not have a policy that says when to turn the water heaters off or on according to temperatures of water, and the manufacturer's directions for use do not tell them when to turn the water heater on or off. The facility just does it.</p> <p>11. During observation on 6/11/14 at</p>			

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V000543	<p>2:15 PM, the water temperature at water heater #1 was 72 degrees.</p> <p>12. The facility's policy titled "Equipment Repair Records," # 153-060-020, dated 3/17/00, states "1. The facility will maintain records of repairs and preventative maintenance made to all equipment outlined herein. ... Water Temperature Mixing Valves, ... Hot Water Heaters ... D. The Chief Technician will be responsible for: ... 2. Establishing a separate ER-1 form for each piece of equipment and noting the appropriate manufacturer, model number, and asset number on the form. ... 6. Ensuring that all equipment repair and preventative maintenance is accurately documented in a timely manner."</p> <p>494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;</p> <p>Based on clinical record review, policy review, and interview, the facility failed to ensure patients' blood pressure (BP) was monitored every 30 minutes while dialyzing for 2 of 6 in-center clinical records reviewed creating the potential to affect all the facility's 157 in-center</p>	V000543	<p>A mandatory inservice for all direct patient care staff is scheduled for July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Patient Monitoring During Treatment", FMS-CS-IC-I-110-133A with emphasis on monitoring and documentaiton of blood</p>	07/03/2014			

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	<p>patients. (# 1 and 3)</p> <p>Findings include</p> <p>1. Clinical record #1 contained treatment flowsheets that failed to evidence the patient's BP had been check at least every 30 minutes.</p> <p>A. The foresheet dated 5/26/14 evidenced the treatment started at 12:27 PM, the next BP check was not performed until 1:15 PM, not again until 2:07 PM, and not again until 4:03 PM.</p> <p>B. The flowsheet dated 5/28/14 evidenced the treatment started at 10:52 AM and not checked again until 11:40 AM.</p> <p>C. The flowsheet dated 6/2/14 evidenced a BP was taken at 11:46 AM and not again until 12:41 PM.</p> <p>D. The flowsheet dated 6/4/14 evidenced a BP was taken at 2:19 PM and not again until 3:09 PM.</p> <p>E. The flowsheet dated 6/6/14 evidenced a BP was taken at 11:19 AM and not again until 12:09 PM.</p> <p>F. The flowsheet dated 6/9/14 evidenced the treatment started at 10:44</p>		<p>pressures every 30 minutes. RNs will be instructed to review documentation in Chairside to observe for timely monitoring and documentation of vital signs throughout the treatment. The Clinical Manager or designee will conduct live audits to observe that vital signs are completed and documented every 30 minutes with immediate feedback and address any issues of non compliance real time. The audit will be conducted daily, on a minimum of one patient shift, for four weeks beginning July 3, 2014. The Clinical Manager will present the audit results to the QAI Committee monthly. Ongoing compliance will be montioered through the monthly review of the Medical Record audits by the QAI Committee. The Director of Operations is responsible to ensure all documentaiton required as part of the QAI process is presented, current, analyzed, trended and a root cause analysis completed as appropriate with subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.</p>				

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V000544	<p>AM and not again until 11:33 AM.</p> <p>2. Clinical record #3 contained treatment flowsheets that failed to evidence the patient's BP had been check at least every 30 minutes. The foresheet dated 4/29/14 evidenced a BP was taken at 9:57 AM, and was not checked again until 10:49 AM.</p> <p>3. During interview on 6/11/2014 at 4:42 PM, employee P indicated the facility is aware of half hour BP checks not being done and have an action plan in place, but BP checks are to be done every 30 min.</p> <p>4. The facility's policy titled "Patient Monitoring During Patient Treatment," # FMS-CS-IC-I-110-133A, revised 7/4/12, states "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary. ... Vital Signs/Mental Status, Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed. Observe for changes in the patient's respirations, heart rate and blood pressure."</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</p>			

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	<p>Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record review, policy review, and interview, the facility failed to ensure staff identified reasons for decreasing the blood flow rate (BFR) on the treatment sheets for 1 of 6 in-center clinical records reviewed creating the potential to affect all of the facility's 157 in-center patients. (#5)</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>Clinical record #5 contained orders for the blood flow rate (BFR) to run at 400 during dialysis. The treatment sheet dated 3/6/14 evidenced the BFR was decreased to 250 at 2:28 PM through 4:01 PM but failed to evidence a reason why.</li> <li>On 6/12/14 at 10:20 AM, employee P indicated they could not find a reason why the BFR was reduced on 3/6 for patient #5.</li> <li>The facility's policy titled "Patient Monitoring During Patient Treatment," # FMS-CS-IC-I-110-133A, revised 7/4/12, states "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary. ... Machine Parameters and</li> </ol>	V000544	<p>A mandatory inservice for all direct patient care staff is scheduled for July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Patient Monitoring During Treatment ", FMS-CS-IC-I-110-133A with emphasis on documentation of inability to achieve prescribed Blood Flow Rate, notification of RN and documented assessment of patient by RN. The Clinical Manager or designee will conduct live audits to allow immediate feedback and address any issues of non-compliance real time. Clinical Manager or designee will observe that the prescribed Blood Flow Rate is achieved or that the Patient Care Technician documented inability to achieve prescribed Blood Flow Rate, notified the RN and that documentation of patient assessment and intervention by the RN is present. The audit will be conducted daily, on a minimum of one patient shift, for four weeks beginning July 3, 2014. The Clinical Manager will present the audit results to the QAI Committee monthly. Ongoing compliance will be monitored through the monthly Medical Record Audits by the QAI Committee. The Director of Operations is responsible to ensure all documentation</p>	07/03/2014

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V000550	<p>Extracorporeal Circuit, Blood Flow Rate: Check prescribed blood flow rate is being achieved. Make adjustments as needed. ... Documentation of monitoring will be completed on the treatment record. Appropriate interventions in response to changes in vital signs, treatment parameters, or machine adjustments shall be documented in the treatment record."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure the staff did not touch cleaned arterial-venous fistula (AVF) sites at point of needle entry for 1 of 2 AVF access observations with the potential to affect all the facility's in-center patients with and AVF access.</p> <p>Findings include</p>	V000550	<p>required as part of the QAI process is presented, current, analyzed, trended and a root cause analysis completed as appropriate, with subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongonig compliance will be monitored by the QAI Committee and Governing Body.</p> <p>A mandatory inservice for all Direct Patient Care Staff is scheduled for July 2, 2014. The Clinical Manager, Charge Nurse and/or Educator will review the "Assessment and Preparation of Internal Access for Needle Placement Procedure", FMS-CS-IC-I-115-006C, with emphasis on the need to repeat skin antisepsis if the insertion site is touched after cleaning. The Clinical Manager or designee will complete the Access portion of the Infection Control audit weekly</p>	07/03/2014

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	<p>1. During observation on 6/9/14 at 3:30 PM, employee C was observed accessing an AVF. Employee C cleaned the sites to be accessed and then touched both sites at the point of needle insertion just prior to inserting needle. Employee C failed to repeat skin antisepsis.</p> <p>2. On 6/10/14 at 5:47 PM, employee P indicated the AVF sites should not be touched at the point of entry just prior to insertion of the needle and, if they are, those areas need to be re-cleaned first.</p> <p>3. The facility's policy titled "Assessment and Preparation of Internal Access for Needle Placement," # FMS-CS-HT-II-320-005C, revised 6/19/13 states "Once sites are chosen, disinfect the needle insertion site to prevent infection. ... 2. If using... ... 70 % Isopropyl Alcohol pad ... Do not go back over the area already wiped."</p>		<p>for four weeks, then monthly for three months, then as regularly scheduled per the QAI calendar. The Clinical Manager will present the audit results to the QAI Committee monthly. The Director of Operations is responsible to ensure that all documentation required as part of the QAI process is presented, current, analyzed, trended, and a root cause analysis completed as appropriate, with the subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis and a new Plan of Action if the resolution is not occurring. Ongoing compliance will be monitored by the QAI Committee and Governing Body.</p>		