

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152571	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE TERRE HAUTE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 351 MAIDEN LN TERRE HAUTE, IN 47804
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V000000	This was an ESRD Federal [CORE] recertification survey. Survey Dates: 8-11-14, 8-12-14, 8-13-14, and 8-14-14 Facility #: 005141 Medicaid Vendor #: 200470050D Surveyor: Vicki Harmon, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN August 18, 2014	V000000		
V000113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE 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. Based on observation, interview, and facility policy review, the facility failed to ensure staff had provided care in accordance with the facility's infection control policies and procedures in 4 (#s 1, 3, 5, and 6) of 14 infection control observations completed creating the potential to affect all of the facility's 137 current patients. The findings include:	V000113	The Governing Body for the facility met on 8/22/2014 to review the Statement of deficiencies and directed the Midwest Group Vice President of Quality to assist the Management team in developing the plan of Correction. The Director of Operations reviewed the following policies "Hand Hygiene Policy" FMS-CS-IC-II-155-090A and "Hand Hygiene Procedure"	09/12/2014

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>1. Employee FF, a patient care technician (PCT), was observed to retrieve patient number 3 from the lobby per wheelchair. The PCT moved the wheelchair footrests out and obtained an oxygen concentrator. As the PCT was attempting to plug in the concentrator, she knocked the supplies to be used to complete a central venous catheter (CVC) dressing change that were laying on the chairside table onto the floor. After plugging in the concentrator, the PCT picked up the supplies from the floor and threw them in the trash. Without cleansing her hands, the PCT then obtained clean supplies.</p> <p>A. After obtaining the clean supplies, the PCT then obtained new oxygen tubing . The PCT then connected the tubing to the concentrator and placed it on the patient. Without cleansing her hands, the PCT donned a glove to her right hand and assisted the patient from the wheelchair to the dialysis chair. The PCT retrieved more supplies from the clean area using her ungloved left hand. The PCT then drew up normal saline with no glove on the left hand and a glove on the right hand.</p> <p>B. After drawing up the normal saline, the PCT removed the glove from</p>		<p>FMS-CS-IC-II-155-090C with the Clinical Manager on Aug. 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>All current staff will participate in a mandatory in-service by the clinic manager regarding Infection Control Practices the week of 8/25/2014 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that all staff wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. The importance of hand sanitation before and after glove change will be reinforced. The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical</p>				

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	<p>the right hand. Without cleansing her hands, the PCT then drew up the bolus heparin dose. The PCT then donned gloves to both hands without cleaning her hands. The PCT removed the dressing from the patient's CVC exit site, and without changing her gloves or cleansing her hands, cleansed the exit site and applied a clean dressing.</p> <p>2. Employee S, a PCT, was observed to initiate the dialysis treatment on patient number 13 on 8-11-14 at 4:30 PM. After connecting the patient to the machine, the arterial would not run. The PCT disconnected the lines from the patient. The PCT called over employee L, another PCT, and he adjusted the needle. Employee S then reconnected the lines to the patient. A small amount of blood was observed on her gloves. The employee then changed her gloves without cleansing her hands.</p> <p>3. Employee S, a PCT, was observed to initiate the dialysis treatment on patient number 1 on 8-11-14 at 6:00 PM. The employee was observed to touch the data entry station and then don clean gloves without cleansing her hands. The PCT then connected the patient to the machine.</p> <p>4. Employee S, a PCT, was observed to</p>		<p>Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>				

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	<p>discontinue the dialysis treatment on patient number 15 on 8-11-14 at 4:55 PM. The PCT was observed to have a glove on her left hand touching the dialysis machine. The PCT did not have a glove on her right hand and was entering information at the data entry station. Without cleansing her hands, the PCT then donned a glove on her right hand and reinfused the extracorporeal circuit.</p> <p>5. The above-stated observations were discussed with the clinic manager on 8-13-14 at 9:25 AM. The manager indicated the employees had not provided care in accordance with the facility's own infection control policies and procedures.</p> <p>6. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC-II-155-060A states, "All dialysis programs will incorporate the FMS infection control program . . . All infection control policies for patient care are consistent with recommendation of the Centers for Disease Control (CDC) . . . Mandatory Components of Program: Adherence to standard and dialysis precautions."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand</p>			

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	<p>Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially</p>			

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V000122	<p>infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>7. The facility's 3-20-13 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water . . . Immediately after removing gloves, After contact with body fluids . . . After contact with inanimate objects near the patient. When moving from a contaminated body site to a clean body site of the same patient."</p> <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- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation, interview, and facility policy review, the facility failed to ensure dialysis machine and stations</p>	V000122	The Director of Operations met with the Clinical Manager on August 19, 2014 and	09/12/2014

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	<p>had been cleaned and disinfected in accordance with facility policy in 4 (#s 1, 2, 3, and 4) of 4 cleaning and disinfection of the dialysis station observations completed creating the potential to affect all of the facility's 137 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8-11-14 at 3:07 PM, employee X, a patient care technician (PCT), was observed to clean and disinfect the dialysis machine at station number 3. The PCT was not observed to clean the Hansen connectors, the dialysate hoses, or the outside of the prime bucket. On 8-11-14 at 5:15 PM, employee S, a PCT, was observed to clean and disinfect the dialysis machine at station # 19. The PCT failed to clean the Hansen connectors, the dialysate hoses, or the inside of the blood pump. On 8-12-14 at 9:55 AM, employee X, a PCT, was observed to clean and disinfect the dialysis chair and surrounding area at station number 3. The PCT was not observed to clean the data entry station or counters around the dialysis station. On 8-12-14 at 6:00 PM, employee S, a PCT, was observed to clean and disinfect 		<p>emphasizing her responsibility to ensure all staff members are educated on the policy FMS-CS-IC-II-155-110A "Cleaning and Disinfection Policy" and the requirement that staff follow policy and procedure as written.</p> <p>All current staff will be in-serviced by the Clinical Manager on disinfection and Infection Control Practices the week of 8/25/14, specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that after use, all equipment, including televisions, data entry stations, machine parts to include hansons, prime buckets and non-disposable supplies must be considered as potentially blood contaminated, and should be separated, handled with caution and either disinfected or discarded. The machine shall be placed in such a manner as to prevent the patient from touching the machine once it is cleaned and prepared for the next patient.</p> <p>The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection</p>	

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	<p>the dialysis chair and surrounding area at station 19 The PCT was not observed to clean the television controls, the data entry station, or the counters around the dialysis station.</p> <p>5. The above-stated observations were discussed with the clinic manager on 8-13-14 at 9:25 AM. The manager indicated the PCTs had not cleaned and disinfected the dialysis machine and station in accordance with facility policy.</p> <p>6. The facility's 3-20-13 "Cleaning and Disinfection" policy number FMS-CS-IC-II-155-110A policy states, "Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are frequently touched and potentially contaminated . . . Discard all fluid and clean and disinfect all containers associated with the prime waste (including buckets attached to the machines) . . . Non-disposable items such as blood pressure cuffs, IV poles, TVs, TV remotes, portable phones, etc., as well as clipboards or plastic hemostat clamps placed on the machine used or unused, should be disinfected with 1:100 bleach solution after each treatment."</p>		<p>Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to evaluate and present POC Monitoring Tool audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</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, interview, and facility policy review, the facility failed to ensure medications had been prepared and administered in accordance with facility policy in 1 (# 2) of 2 medication preparation and administration observations completed creating the potential to affect all of the facility's 137 current patients.</p> <p>The findings include:</p> <p>1. Employee DD, a registered nurse (RN), was observed to prepare medications for patient number 12 on 8-12-14 at 11:15 AM. The RN was observed to cleanse the top of an Epogen vial with an alcohol pad and draw up the medication. The RN was then observed to use the same alcohol pad to cleanse the top of a Hectorol vial. The RN drew up the Hectorol into a different syringe.</p> <p>The RN took the 2 medications to the station and cleansed the injection port with an alcohol pad and administered the Epogen. The RN then used the same</p>	V000143	<p>The Director of Operations met with the Clinical Manager on August 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies FMC-CS-IC-I_120_040A "Medication Preparation and Administration" Procedure and the requirement that staff follow policy and procedure as written.</p> <p>A mandatory in-service for all direct patient care staff is scheduled the week of 8/25/14 and the Clinical Manager 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 the cap of a newly opened vial and an alcohol prep should be used once and then discard..</p> <p>The Clinical Manager or designee will ensure that infection control</p>	09/12/2014

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V000147	<p>alcohol pad to cleanse the port and administer the Hectorol.</p> <p>2. The above-stated observations were discussed with the clinic manager on 8-13-14 at 9:25 AM. The manager indicated the RN should have used a clean alcohol pad each time.</p> <p>3. The facility's 12-30-13 "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A states, "Disinfect IV [intravenous] ports prior to accessing, using friction and 70% alcohol, iodophor or chlorhexidine/alcohol agent . . . cleanse the diaphragm of a vial prior to accessing the vial."</p> <p>The facility's 9-25-13 "Medication Preparation and Administration" procedure number FMS-CS-IC-I-120-040C states, "Remove protective cap from vial and wipe the rubber stopped with alcohol prep pad. Do not touch stopper after cleaning. Use a new alcohol prep for each vial."</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of</p>		<p>audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager or designee will complete the Medication Preparation and Administration portion of the Infection Control audit monthly. The Clinical Manager will present the audit results to the QAI Committee monthly. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

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	<p>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>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]. Based on observation, interview, and facility policy review, the facility failed to ensure central venous catheter (CVC) exit site care and discontinuation of dialysis with a CVC had been completed in accordance with facility policy in 2 (#s 4 and 5) of 6 CVC observations completed creating the potential to affect all of the facility's current patients with CVCs.</p>	V000147	The Director of Operations reviewed the following policy FMS-CS-IC-I-105-032A "Changing the Catheter Dressing" Policy with the Clinical Manager on August 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies and follow policy and procedure as written.	09/12/2014

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	<p>The findings include:</p> <ol style="list-style-type: none"> Employee S, a patient care technician (PCT), was observed to change the CVC exit site dressing on patient number 1 on 8-11-14 at 6:00 PM. The CVC was located in the patient's left groin. Two additional sites with stitches that anchored the CVC to the patient's leg were located approximately 1 inch away from the exit site. The PCT was observed to cleanse the exit site with a Chlor-prep swab and then use the same swab to cleanse around both anchor sites. After cleansing the exit site and the anchor sites with 1 swab, the PCT removed her left hand from the abdominal fold held back to clean the exit site and the abdominal fold touched the cleaned exit site. The PCT was not observed to clean the exit site again prior to applying a clean dressing. Employee T, a PCT, was observed to discontinue the dialysis treatment on patient number 11 on 8-12-14 at 10:15 AM. The PCT was not observed to place a clean field under the CVC ports prior to starting the discontinuation process. The above-stated observations were discussed with the clinic manager on 		<p>All current staff will be in serviced by the Clinic Manager on Infection Control Practices the week of 8/25/2014 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that aseptic technique is maintained when providing catheter care dressing changes, including removing of dried crusted debris around exit site, avoidance of recontamination, placement of a clean under pad, and the importance of preventing cross contamination. The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate. The specific area of focus during the monitoring will be proper aseptic technique is observed during</p>	

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V000541	<p>8-13-14 at 9:25 AM. The manager indicated the PCTs had not provided CVC care in accordance with facility policy.</p> <p>4. The facility's 1-6-14 "Changing the Catheter Dressing" procedure number FMS-CS-IC-I-105-032 C states, "Remove swabstick from package by stick end without touching foam applicator . . . Use both sides of the swab stick to clean an area the size of the dressing to be applied."</p> <p>The facility's 1-6-14 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use E-beam Dialyzer" procedure number FMS-CS-IC-I-105-028 C states, "Ensure that a clean under pad is below the catheter limbs to protect the work are and the clothing."</p> <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these</p>		<p>Central Venous Catheter dressing changes</p> <p>The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>				

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	<p>outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included measurable outcomes in 3 (#s 1, 3, and 10) of 4 records reviewed of patients that had been on service for less than 90 days creating the potential to affect all of the facility's 137 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a "Patient Plan of Care" established by the interdisciplinary team (IDT) on 7-3-14. The plan of care states, "Pt [patient] BP [blood pressure] will continue to be WNLs [within normal limits]. Pt will manage fluid gain between txs [treatments]."</p> <p>The plan of care identified elevated blood pressure and high fluid gain between treatments were problems. The plan of care failed to evidence the IDT had established a "normal" blood pressure for this patient and failed to evidence the amount of fluid gain between treatments that would be acceptable.</p>	V000541	<p>The Director of Operations reviewed the following policies FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy with the Clinical Manager on Aug. 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>On 8/27/14, the Clinic Manager will meet with the members of the IDT to emphasize the policy Comprehensive Interdisciplinary Assessment and Plan of Care that all patients must have a Plan of Care that is specific to address the patient's needs and is based upon that patient's specific Comprehensive Assessment.</p> <p>All Plans of Care will be reviewed with a focus on specific measurable outcomes primarily but not limited to blood pressures and fluid management. Any Plans of Care noted to be without measurable outcomes will be updated to include specific and measurable outcomes.</p> <p>On-going compliance with be</p>	09/12/2014

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	<p>2. Clinical record number 3 included a "Patient Plan of Care" established by the IDT on 7-16-14. The plan of care states, "Pt B/P will remain WNL." The plan of care identified elevated blood pressure was a problem for the patient. The plan failed to evidence the IDT had established a "normal" blood pressure for the patient.</p> <p>The record included a subsequent plan of care dated 8-11-14. The plan of care states, "Pt B/P will remain WNL." The plan of care identified elevated blood pressure was a problem for the patient. The plan failed to evidence the IDT had established a "normal" blood pressure for the patient.</p> <p>3. Clinical record number 10 included a plan of care established by the IDT on 8-11-14. The plan of care states, "Pt B/P will be within normal limits." The plan of care identified elevated blood pressure was a problem for the patient. The plan failed to evidence the IDT had established a "normal" blood pressure for the patient.</p> <p>4. The clinic manager indicated, on 8-14-14 at 10:30 AM, the plans of care did not include measurable outcomes.</p> <p>5. The facility's 4-4-12 "Comprehensive</p>		monitored by use of the monthly medical record audit. The Clinical Manager is responsible to evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.	

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V000543	<p>Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The Plan of Care must include measurable and expected outcomes and an estimated timetable to achieve these outcomes."</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; Based on clinical record and facility policy review and interview, the facility failed to ensure intermittent heparin had been administered as ordered by the physician in 1 (# 6) of 1 record reviewed of patients with intermittent heparin orders creating the potential to affect all of the facility's current patients with intermittent heparin orders.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included physician orders dated 7-10-14 that state, "Heparin Sodium (Porcine) . . . Intermittent Dose(s) 10000 units IVP [intravenous push] mid run, 3X Week [3 times per week]." Physician orders, dated 7-17-14 identified the hemodialysis treatment duration was 4 hours.</p>	V000543	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on Aug. 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>The Clinical Manager will educate and review with all staff policy FMS-CS-IC-I-105-035A "Heparinization Policy" August 27, 2014 with emphasis on proper administration times for mid-treatment heparin and efficient documentation of times in patient medical record.</p>	09/12/2014

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	<p>A. A hemodialysis treatment flow sheet dated 7-19-14 evidenced the treatment had been initiated at 4:15 PM and the intermittent dose of heparin had been administered at 4:05 PM.</p> <p>B. A hemodialysis treatment flow sheet dated 7-22-14 evidenced the treatment had been initiated at 5:40 PM and the intermittent dose of heparin had been administered at 6:00 PM.</p> <p>C. A hemodialysis treatment flow sheet dated 7-26-14 failed to evidence the intermittent heparin dose had been administered.</p> <p>D. A hemodialysis treatment flow sheet dated 7-29-14 evidenced the treatment had been initiated at 5:52 PM. The flow sheet evidenced documentation the intermittent heparin had been administered at 4 PM.</p> <p>E. A flow sheet dated 7-31-14 evidenced the treatment had been initiated at 5:18 PM. The flow sheet evidenced the treatment had been terminated early per the patient's request at 8:05 PM. The flow sheet evidenced documentation the intermittent heparin had been administered at 8:43 PM.</p>		<p>The Clinical Manager or designee will audit 10% of treatment sheets 3 random days per week for the next 4 weeks, if substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar. .</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>	

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V000545	<p>F. A flow sheet dated 8-2-14 evidenced the treatment had been initiated at 4:44 PM and the intermittent heparin had been administered at 6:00 PM.</p> <p>G. A flow sheet dated 8-7-14 failed to evidence the intermittent heparin had been administered.</p> <p>H. A flow sheet dated 8-9-14 failed to evidence the intermittent heparin had been administered.</p> <p>2. The clinic manager stated, on 8-14-14 at 10:30 AM, "This has to be an IT [computer] problem."</p> <p>3. The facility's 12-30-13 "Medication Preparation and Administration" policy number FMS-CS-IC-I-120-040A states, "Medications must be administered with a written order by a physician (or physician extender where allowed) on the medical staff of the facility."</p> <p>494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition</p>						

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	<p>indicators may be monitored, as appropriate. Based on clinical record review and interview, the facility failed to ensure protein supplements had been administered as ordered in 1 (# 2) of 5 records reviewed of patients with supplemental protein orders creating the potential to affect all of the facility's current patients with supplemental protein orders.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included physician orders dated 5-1-14 that state, "Nutritional Supplement Zone Perfect Bar - 1 bar PO [by mouth] 3X [three times] Week." <ul style="list-style-type: none"> A. Hemodialysis treatment flow sheets, dated 7-29-14, 7-31-14, and 8-9-14, failed to evidence the protein supplement had been offered or administered to the patient. B. The record included laboratory results that evidenced the patient's albumin levels were below the desired 4.0 grams per deciliter according to the Centers for Medicare and Medicaid Services Measures Assessment Tool. The laboratory results evidenced the albumin level was 3.2 on 5-13-14, 3.1 on 6-10-14, and 3.4 on 7-15-14. 	V000545	<p>The Director of Operations met with the Clinical Manager on August 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies FMS-CS-IC-I-111-005C3 "Oral Nutritional Supplements Administration Procedure: eCube Clinicals Procedure" and the requirement that staff follow policy and procedure as written.</p> <p>The Clinical Manager will educate and review with all staff policy FMS-CS-IC-I-111-005C3 "Oral Nutritional Supplements Administration Procedure: eCube Clinicals Procedure" The education will specifically address monitoring administration of protein supplements. All patients are required to be offered the supplement per order and in the event that the patient refuses the supplement the staff will be directed to create a multi-disciplinary note of refusal.</p> <p>The Clinical Manager or designee will audit 10% of treatment sheets 3 random days per week for the next 4 weeks, if substantial compliance is achieved at 4 weeks, the medical record audits will be conducted monthly per the QAI calendar.</p>	09/12/2014

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V000550	<p>2. The clinic manager indicated, on 8-12-14 at 1:00 PM, the record did not evidence the protein supplement had been offered to the patient on 7-29-14, 7-31-14, or 8-9-14.</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, interview, and facility policy review, the facility failed to ensure staff had provided appropriate access care prior to the initiation of the dialysis treatment in 1 (#2) of 2 access of arteriovenous fistula (AVF) or graft for initiation of dialysis observations and failed to ensure post access care had been provided in accordance with facility policy in 2 (#s 1 and 2) of 2 discontinuation of dialysis and post dialysis access care for arteriovenous fistula or graft observations completed creating the potential to affect all of the</p>	V000550	<p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p> <p>The Director of Operations met with the Clinical Manager on August 19, 2014 emphasizing her responsibility to ensure all staff members are educated on the policies FMS-CS-IS-I-520-005C "Cannulation Site Selection and Skin Preparation" FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" and the requirement that staff follow policy and procedure as written.</p>	09/12/2014

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	<p>facility's current patients with arteriovenous fistulas or grafts.</p> <p>The findings include:</p> <p>Regarding initiation of dialysis:</p> <ol style="list-style-type: none"> 1. Employee S, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 12 on 8-11-14 at 4:30 PM. The PCT was observed to cleanse the insertion sites. The PCT then palpated the insertion site prior to inserting the needles. The PCT failed to cleanse the insertion sites again after touching them. 2. The above-stated observation was discussed with the clinic manager on 8-13-14 at 9:25 AM. The manager indicated the PCT should not have touched the insertion sites after cleansing and prior to the insertion of the needles. 3. The facility's 01-16-09 "Cannulation Site Selection and Skin Preparation" procedure number FMS-CS-IS-I-520-005C states, "Clean the site for one minute using multiple swab IMMEDIATELY prior to cannulation due to alcohol has a short bacteriostatic time . . . DO NOT TOUCH THE CLEANED SITE AFTER DISINFECTION. Recontamination of 		<p>To specifically address appropriate vascular access care prior to the initiation of the dialysis treatment and post treatment with a fistula or graft, the following has occurred: Reeducation of the facility staff on cleansing a patient's access prior to initiation of their treatment, "Cannulation Site Selection and Skin Preparation" FMS-CS-IC-I-520-005C Reeducation of the facility staff on FMS-CS-IC-I-115-013C "Post Treatment Fistula Needle Removal" by 8/27/2014</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done weekly for 4 weeks, monthly for 3 months, and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to evaluate and present POC Monitoring Tool audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is</p>	

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	<p>site occurs if touched after cleansing with antiseptic solution."</p> <p>Regarding discontinuation of dialysis:</p> <p>1. Employee X, a PCT, was observed to discontinue the dialysis treatment on patient number 14 on 8-11-14 at 3:00 PM. The PCT was observed to remove the needles and place Band-aids over the insertion sites. The PCT then placed folded gauze and tape over the Band-aids. After the needle sticks had stopped bleeding, the PCT removed the blood-stained gauze from both sites. Observation noted the Band-aids to be soaked with blood. The PCT failed to replace the blood-soaked Band-aids with clean ones prior to the patient leaving the facility.</p> <p>2. Employee S, a PCT, was observed to discontinue the dialysis treatment on patient number 15 on 8-11-14 at 5:00 PM. The PCT was observed to remove the needles and place Band-aids over the insertion sites. The PCT then placed folded gauze and tape over the Band-aids. After the needle sticks had stopped bleeding, the PCT removed the blood-stained gauze from both sites. Observation noted the Band-aids to be soaked with blood. The PCT failed to replace the blood-soaked Band-aids with</p>		sustained.				

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	<p>clean ones prior to the patient leaving the facility.</p> <p>3. The above-stated observations were discussed with the clinic manager on 8-13-14 at 9:25 AM. The manager indicated the PCTs had not provided post access care in accordance with facility policy.</p> <p>4. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "Position the gauze over the insertion site but do not apply pressure . . . Carefully remove the needle . . . Compress the needle exit site with two fingers following complete removal of the needle . . . Apply pressure continuously for 5-10 minutes before checking for hemostasis. Once hemostasis has been achieved, remove the gauze used for hemostasis and replace the sites with Band-Aids or adhesive dressing or clean tape and gauze dressing."</p>				