

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219		
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V0000	<p>This was a federal ESRD complaint investigation.</p> <p>Complaint #: IN00114583 - Substantiated: Federal deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 005149</p> <p>Survey Date: 10-01-12</p> <p>Medicaid Vendor #: 100227200A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>October 5, 2012</p>	V0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V0113	<p>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.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure staff changed gloves and performed hand hygiene appropriately during the provision of care in 5 (#s 1, 2, 3, 4, & 5) of 5 patient care observations creating the potential to affect all of the facility's 132 current patients.</p> <p>The findings include:</p> <p>1. The facility's 1-4-12 "Infection Control Overview" policy number FMS-CS-IC,II,155-060A states, "All infection control policies are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulation . . .</p> <p>Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and</p>	V0113	<p>V 113 On October 15 th . 2012 the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene, Personal Protective Equipment and Infection Control Overview" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A, "Personal Protective Equipment" FMS-CS-IC-II-155-080A and "Infection Control with emphasis placed on appropriate glove usage, glove changes and hand hygiene using hand sanitizer.</p>	10/26/2012			

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	<p>storage of reused items conforming to CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, 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>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloves hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline</p>		<p>Training was completed on October 26 th 2012 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by October 26 th 2012</p> <p>The Clinical Manager held a counseling session for Employee AA, H, Q and I on October 15 th . 2012, to discuss policy violations on October 1, 2012 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene.</p> <p>The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 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 report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>		

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	<p>for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>3. Patient care observation # 1 was completed on 10-1-12 at 8:35 AM. Employee AA, a patient care technician (PCT), was observed to don clean gloves without cleansing her hands while approaching patient number 7. The employee had not donned a cover gown prior to approaching patient number 7 but was observed to be holding the cover gown to the front of her body with her left hand and touched the machine and computer keyboard with her right hand.</p> <p>4. Patient care observation # 2 was completed on 10-1-12 at 8:55 AM. Employee H, a PCT, was observed to touch the keyboard at station number 17 (patient number 8) and then don clean gloves without cleansing her hands. The</p>				

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	<p>employee then touched the front of the machine at station number 17.</p> <p>5. Patient care observation # 3 was completed on 10-1-12 at 9:00 AM. Employee AA, a PCT, was observed to obtain approximately 6 clean gloves from the supply at the nurse's station.</p> <p>A. The PCT placed the gloves on the computer stand between stations 13 and 14 (patient numbered 9 and 10). The PCT touched the keyboard and donned clean gloves without cleansing her hands. The PCT touched the front of the machine at station 14 (patient number 10). The PCT removed her gloves and cleansed her hands. The PCT then touched the keyboard and donned clean gloves without cleansing her hands and touched the front of the machine at station 13 (patient number 9).</p> <p>B. The PCT removed her gloves and cleansed her hands after touching the front of the machine at station 13. The PCT then picked up the remaining gloves from the computer stand between stations 13 and 14 and placed them on the computer stand between stations 15 and 16 (patients numbered 11 and 7). The PCT touched the keyboard and donned clean gloves from the supply she had brought with her without cleansing her</p>				

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	<p>hands. The PCT then touched the front of the machine at station # 15 (patient number 11).</p> <p>6. Patient care observation # 4 was completed on 10-1-12 at 9:10 AM. Employee Q, a PCT, was observed to obtain a 1000 milliliter bag of intravenous fluid from a supply at the nurse's station. The PCT donned clean gloves without cleansing her hands and hung the bag on the pole on the machine at station number 7 (patient number 1).</p> <p>7. Patient care observation # 5 was completed on 10-1-12 at 9:20 AM. Employee I, a PCT, was observed to obtain clean gloves and packages of gauze from the supply at the nurse's station. The employee then donned clean gloves without cleansing his hands. The employee then proceeded to pull the needles from the arm of patient number 3 to discontinue the dialysis treatment.</p> <p>8. The above-stated observations were presented to the clinic manager, employee A, and the administrator, employee BB, on 10-1-12 at 12:50 PM. The clinic manager and the administrator did not comment on the observations.</p>				

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V0544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on clinical record review and interview, the facility failed to ensure prescribed treatment times had been achieved in 4 (#s 1, 2, 4, & 5) of 6 records reviewed creating the potential to affect all of the facility's 132 current patients.</p> <p>The findings include:</p> <p>1. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 1.</p> <p>A post treatment flow sheet dated 9-17-12 evidenced the treatment had been initiated at 6:30 AM and had been discontinued at 10:20 AM, a treatment time of 3 hours and 50 minutes.</p> <p>2. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 2.</p> <p>A post treatment flow sheet dated 9-14-12 evidenced the treatment had been</p>	V0544	<p>A mandatory in-service is scheduled for all staff on October 15 th 2012 with emphasis on ensuring that the patient's prescribed time is delivered according to the physician's prescription.</p> <p>This will be monitored daily by the Charge Nurse using the Rounding Tool. Frequency of ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue. Any treatment times found out of compliance will be corrected immediately and corrective action will be taken as appropriate.</p> <p>The Clinical Manager will monitor the results of the Rounding Tool audits weekly for 4 weeks and ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI. If resolution is not evident, the QAI</p>	10/26/2012			

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	<p>initiated at 6:25 AM and discontinued at 9:45 AM, a treatment time of 3 hours and 20 minutes.</p> <p>3. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 4.</p> <p>A. A post treatment flow sheet dated 9-7-12 evidenced the treatment had been initiated at 5:50 AM and discontinued at 9:06 AM, a treatment time of 3 hours 16 minutes.</p> <p>B. A post treatment flow sheet dated 9-10-12 evidenced the treatment had been initiated at 6:15 AM and discontinued at 9:45 AM, a treatment time of 3 hours 30 minutes.</p> <p>C. A post treatment flow sheet dated 9-12-12 evidenced the treatment had been initiated at 6:35 AM and discontinued at 9:37 AM, a treatment time of 3 hours and 2 minutes.</p> <p>D. A post treatment flow sheet dated 9-14-12 evidenced the treatment had been initiated at 5:58 AM and discontinued at 9:47 AM, a treatment time of 3 hours and 49 minutes.</p> <p>E. A post treatment flow sheet dated</p>		<p>Committee will complete a root cause analysis and the Plan of Correction will be revised as necessary.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body</p>		

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	<p>9-19-12 evidenced the treatment had been initiated at 5:57 AM and discontinued at 9:43 AM, a treatment time of 3 hours and 46 minutes.</p> <p>F. A post treatment flow sheet dated 9-28-12 evidenced the treatment had been initiated at 5:39 AM and discontinued at 9:25 AM, a treatment time of 3 hours and 46 minutes.</p> <p>4. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 5.</p> <p>A post treatment flow sheet dated 9-19-12 evidenced the treatment had been initiated at 6:42 AM and discontinued at 9:34 AM, a treatment time of 2 hours and 52 minutes.</p> <p>5. The administrator, employee BB, was unable to provide any additional documentation and/or information when asked on 10-1-12 at 11:35 AM and 12:50 PM.</p>			

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V0559	<p>494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC</p> <p>If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must-</p> <p>(i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure plans of care included identification of problems related to shortened treatment times and missed treatments in 2 (#s 2 and 4) of 2 records reviewed of patients that missed and/or shortened treatment times creating the potential to affect all of the facility's 132 current patients.</p> <p>The findings include:</p> <p>1. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 2. The record included post dialysis treatment flow sheets that evidenced the patient had arrived late for the treatment on 9-5-12,</p>	V0559	<p>V 559</p> <p>The Director of Operations met with the facility's Interdisciplinary Team on October 15 th 2012 to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care available emphasizing that each Plan of Care will be updated with reasons why patient's are shortening their treatment times or missing treatments.</p> <p>The Clinical Manager completed a 100% chart review of all</p>	10/31/2012			

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	<p>9-7-12, 9-10-12, 9-17-12, 9-19-12, 9-24-12, 9-26-12, and 9-28-12.</p> <p>The record failed to evidence documentation of the reasons why the patient was chronically late for treatments or that the plan of care had been adjusted to address the identified reasons.</p> <p>2. A "Hemodialysis Setup Detail" summary of physician orders dated 10-1-12 identified a treatment time of 4 hours for patient number 4. The record included post dialysis treatment flow sheets that evidenced the patient had arrived late for treatment on 9-5-12; had requested to discontinue the treatment early on 9-17-12, 9-21-12, and 9-24-12; and had not come to treatment on 9-26-12.</p> <p>The record failed to evidence documentation of the reasons why the patient had shortened and/or missed treatments or that the plan of care had been adjusted to address the identified reasons.</p> <p>3. The administrator, employee BB, was unable to provide any additional documentation and/or information when asked on 10-1-12 at 11:35 AM and 12:50 PM.</p>		<p>patients Plans of Care by October 26 th 2012 focusing on the patient's that shorten treatment times or are missing treatments. Any patient found with shortened treatment times or missed treatments will be presented at the Interdisciplinary Team meeting by October 31 st 2012 including patient's #2 and 4. Patient specific issues as identified will be included in the patient's specific Plan of Care.</p> <p>All members of the IDT, including the Dietitian and Social Worker, will review specific patient issues on a monthly basis. Any patients not meeting any of their specific goals, including shortened treatment times or missed treatments will be included on a monthly list of patients. The Clinical Manager will include patients on the list on the agenda for review by the Interdisciplinary team at the monthly care plan meeting for the purpose of making an adjustment to the Plan of Care. Recommendations of the IDT and actions taken monthly will be documented in each patient's specific Plan of Care update/progress note section.</p> <p>Monthly monitoring of all Plans of Care completed that month will be done by the Clinical Manager, to ensure that patients not meeting a goal have been identified, are addressed and</p>				

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	4. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-110-125A states, "If the patient is unable to achieve the desired outcomes, the team must adjust the Plan of Care to reflect the patient's current condition, and Document in the medical record the reason(s) why the patient is unable to achieve the goal. Implement the Plan of Care changes to address the identified issues."		<p>Plans of Care are being updated timely and appropriately. Any Plan of Care found out of compliance will be scheduled for completion within the next 30 days and corrective action will be taken as appropriate.</p> <p>Ongoing, the Clinical Manager will ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on all patients meeting goals and interventions when that does not occur.. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues.</p> <p>The Clinical Manager is responsible to analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee for oversight and review.</p> <p>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.</p> <p>The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan</p>	

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			of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee	