

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152510	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE ANDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 1815 JACKSON STREET ANDERSON, IN 46016
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V000000	<p>This visit was a ESRD federal recertification survey.</p> <p>Survey date: June 2, 3, 4, and 5, 2014</p> <p>Facility #: 005155</p> <p>Medicaid Vendor #: 100172360A</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Incenter hemodialysis census 119 Peritoneal dialysis census 21 Home hemodialysis census 1</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 10, 2014</p>	V000000		
V000116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies</p>			

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>(syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure staff cleaned Phoenix meters and returned them to the clean area after cleaning for 1 of 3 days of observations creating the potential to affect all 119 of the facility's current patients. (Employees G and B)</p> <p>Findings Include</p> <p>1. During observation on 6/12/14 at 10:15 AM, employee G was observed using the phoenix meter at station 17. Upon completion of the conductivity check, employee G carried the meter to the common station, picked up a bleach cloth, and proceeded to clean the meter at the common station. The meter was then laid on its side on the common station which is a designated dirty station. The meter was then picked up taken to station 15 by employee B and used to test conductivity without cleaning. This process was repeated multiple times by all the personal care technicians.</p> <p>2. On 6/12/14 at 11:10 AM, employee C, Registered Nurse, indicated staff should clean the phoenix meter with bleach after</p>	V000116	<p>V 116</p> <p>The Clinical Manager educated all direct patient care staff on the following policy by 6/5/14 with an emphasis on the proper storage of the phoenix meter:</p> <ul style="list-style-type: none"> Dialysis Precautions Policy, FMS-CS-IC-II-155-070A <p>The Clinical Manager/designee will perform daily audits until compliance is achieved. All non-compliance will be addressed immediately.</p> <p>When compliance is achieved, ongoing monitoring will be completed per the QAI calendar.</p> <p>All training documentation is on file at the facility.</p> <p>All findings will be reported to the QAI committee monthly by the Clinical Manager/Director of Operations.</p>	06/05/2014			

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V000117	<p>use. Employee C indicated that the common cart is a dirty area that items are cleaned on, where the bleach solution is kept, and where the biohazard container is located.</p> <p>3. The facility's policy titled "Dialysis Precautions," FMS-CS-IC-II-155-070A" revised 04-Jan-2012 states, "Clean area: An area designated for clean and unused equipment, supplies and medications. Dirty area: An area where this is a potential for contamination with blood or bloody fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. Clean areas should be clearly designed for the preparation and handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are handled or stored."</p> <p>494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where</p>			

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	<p>used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled.</p> <p>When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station.</p> <p>Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure staff cleaned Phoenix meters and returned them to the clean area after cleaning for 1 of 3 days of observations creating the potential to affect all 119 of the facility's current patients. (Employees G and B)</p> <p>Findings Include</p> <p>1. During observation on 6/12/14 at 10:15 AM, employee G was observed using the phoenix meter at station 17. Upon completion of the conductivity check, employee G carried the meter to the common station, picked up a bleach cloth, and proceeded to clean the meter at the common station. The meter was then</p>	V000117	<p>V 117</p> <p>The Clinical Manager educated all direct patient care staff on the following policy by 6/5/14 with an emphasis on the proper location of the phoenix meter:</p> <ul style="list-style-type: none"> Dialysis Precautions Policy, FMS-CS-IC-II-155-070A <p>The Clinical Manager/designee will perform daily audits until compliance is achieved. All non-compliance will be addressed immediately.</p> <p>When compliance is achieved, ongoing monitoring will be completed per the QAI calendar.</p> <p>All training documentation is on file at the facility.</p>	06/05/2014

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	<p>laid on its side on the common station, which is a designated dirty station. The meter was then picked up taken to station 15 by employee B and used to test conductivity without cleaning. This process was repeated multiple times by all the patient care technicians.</p> <p>2. On 6/12/14 at 11:10 AM, employee C, Registered Nurse, indicated staff should clean the phoenix meter with bleach after use. Employee C indicated that the common cart is a dirty area that items are cleaned on, where the bleach solution is kept, and where the biohazard container is located.</p> <p>3. The facility's policy titled "Dialysis Precautions," FMS-CS-IC-II-155-070A" revised 04-Jan-2012 states, "Clean area: An area designated for clean and unused equipment, supplies and medications. Dirty area: An area where this is a potential for contamination with blood or bloody fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. Clean areas should be clearly designed for the preparation and handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from dirty areas where used supplies, equipment or blood samples are</p>		All findings will be reported to the QAI committee monthly by the Clinical Manager/Director of Operations.	

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V000119	<p>handled or stored."</p> <p>494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies.</p> <p>Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. Based on observation and interview, the facility failed to ensure the registered nurse (RN) did not carry supplies in her pocket while preparing and administering medications in 1 of 1 observations of medication administration with the potential to affect all 119 patients. (C)</p> <p>Findings:</p> <p>1. On 6/4/14 at 12:45 PM, Employee C, RN, was observed preparing medications for administration. The RN reached under her personal protective equipment into her scrub pocket and retrieved a black marker. She marked the entry date on the vial she had just opened and returned the pen to her pocket. She then went to the floor and administered the</p>	V000119	<p>V 119 The Clinical Manager educated all direct patient care staff on the following policies by 6/5/14 with an emphasis on "clean vs. dirty" and cross contamination: · Dialysis Precautions Policy, FMS-CS-IC-II-155-070A · Cleaning and Disinfection Policy, FMS-CS-IC-II-155-110A</p> <p>The Clinical Manager/designee will perform daily audits until compliance is achieved. All non-compliance will be addressed immediately.</p> <p>When compliance is achieved, ongoing monitoring will be completed per the QAI calendar.</p> <p>All training documentation is on file at the facility.</p>	06/05/2014

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	<p>medicine.</p> <p>2. On 6/4/14 at 1:15 PM, Employee P, Facility Manager (FM), was asked to check the pockets of the RN. The FM returned with two black markers, a pad of post-it notes, and 5 alcohol prep pads indicating the items were from the pocket of the RN.</p>		All findings will be reported to the QAI committee monthly by the Clinical Manager/Director of Operations.		