

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2015
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 851 W BURRELL DR CROWN POINT, IN 46307
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V 0000 Bldg. 00	<p>This was a Federal ESRD recertification survey.</p> <p>Survey Dates: 8/6/15 - 8/12/15</p> <p>Facility #: 005142</p> <p>Medicare #: 152537</p> <p>Medicaid #: 100275180B</p> <p>53 Active Incenter Hemodialysis Patients</p>	V 0000		
V 0113 Bldg. 00	<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 observation, interview, and review of facility policy and Center for Disease Control standards, the facility failed to ensure hand hygiene and glove changes had been performed in</p>	V 0113	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on: ·FMS-CS-IC-II-155-090A:Hand</p>	09/11/2015

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>accordance with facility policy in 1 of 2 discontinuation of dialysis with a central venous catheter observations completed (Employee E, patient care technician and Patient #8) and 1 of 2 access of AV Fistula or Graft observations completed (Employee G with Patient #1).</p> <p>The findings include:</p> <p>Regarding Discontinuation of dialysis with a Central Venous Catheter</p> <ol style="list-style-type: none"> On 8/11/15 at 3:45 PM, Employee E, patient care technician, was observed to leave station #9 while caring for patient # 8. He took off his gloves and failed to wash his hands before donning new gloves and then carried supplies from a central supply cart placed near the nurse's station including a bag of normal saline back to station #9. On 8/12/15 at 12:20 PM, Employee A, the clinic manager, and Employee C, Registered Nurse, indicated handwashing should be completed after removing gloves. <p>Regarding Access of AV Fistula or Graft for Initiation of Dialysis</p>		<p>Hygiene with special attention to:</p> <ul style="list-style-type: none"> ·Policy: HandHygiene: ·Before and after direct contact with patients ·Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications ·Immediately after removing gloves <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to infection control and proper hand hygiene.</p>	

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	<p>3. On 8/7/15 at 9:30 AM, Employee G, patient care technician, was observed to initiate dialysis with patient #1 who had an AV Graft. With gloved hands, Employee G palpated the patient's left arm area with the AV Graft and then inserted the cannulation needles and taped the needles in place.</p> <p>4. On 8/7/15 at 10 AM, Employee F, patient care technician and preceptor, indicated Employee G did not follow the correct procedure for the initiation of dialysis by not removing gloves after palpating the access site prior to inserting the cannulation needles.</p> <p>5. The agency policy titled "Cleaning and Disinfection" with a date of January 28, 2015 stated, "The nature of dialysis treatments with frequent exposure to blood and body fluids, close proximity of patients and staff, and the immunocompromised status of dialysis patients make dialysis a high - risk area for spreading infectious disease. The Occupation safety and Health administration and the Centers for Disease Control standards have been shown to reduce and prevent the spread of infectious diseases."</p>			

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	<p>6. The agency policy titled "Dialysis Precautions" with a date of January 4, 2012 stated, "Dialysis Precautions is a set of standard infection control practices that are used in all situations in the dialysis setting ... Dialysis precautions have been shown to reduce infectious disease transmission, and are recommended by the Centers for Disease Control."</p> <p>7. The Centers for Disease Control "Standards Precautions" with a date of 2007 and retrieved from the URL site: http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html on 8/14/15 states, "IV. Standard Precautions . . . IV.A. Hand 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 . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. 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). IV.3.d. If hands will be moving from a</p>			

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	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 infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."			

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V 0117 Bldg. 00	<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 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 and interview and policy review, the facility failed to ensure medications were kept secure and in a clean medication storage area in 1 of 1 observation of the incenter hemodialysis treatment floor on 8/6/15.</p>	V 0117	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <p>·FMS-CS-IC-I-120-006C2: Stocki</p>	09/11/2015

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V 0122 Bldg. 00	<p>The findings include:</p> <ol style="list-style-type: none"> On 8/6/15 at 2:40 PM, 4 multi - dose vials of heparin were observed on a medication preparation cart on the incenter treatment floor between stations #10 and #14. These medications were not being supervised by the staff at this time. On 8/11/15 at 4:41 PM, the clinic manager indicated medications should be locked up. The agency procedure titled "Receiving and Stocking In - center Medications" with a date of July 4, 2012 stated, "Ensure that medication cabinet and medication cabinet are properly locked for security of medications." <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by</p>		<p>ng In Center Medications Procedure with special emphasis on:</p> <ul style="list-style-type: none"> Ensure that medication cabinet and medication refrigerator are properly locked for security of medications <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to proper storage of medications.</p>		

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	<p>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, staff interview, and policy and procedure, the facility failed to ensure surfaces were not contaminated with blood for 1 of 2 treatment floor observations on 8/11/15 (Patient #4).</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/11/15 at 4:05 PM, a blood smear about 3 inches in diameter was noted on the incenter hemodialysis chair behind patient #4's head and a small amount (size of a quarter) of blood on the patient's blanket covering the patient was observed. Patient #4 was at station #3. On 8/11/15 at 4:15 PM, the blood in finding #1 was still observed on the blanket and behind patient #4's head. On 8/11/15 at 4:15 PM, Employee B, Registered Nurse, indicated this was an ongoing issue with this patient due to some health concerns. 	V 0122	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> FMS-CS-IC-II-155-070A: Dialysis Precautions with emphasis on: Policy: Dialysis precautions will be followed by all employees with potential exposure to bloodborne pathogens and other potentially infectious material (OPIM) in the dialysis setting. <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical</p>	09/11/2015

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V 0147 Bldg. 00	<p>4. On 8/12/15 at 12:20 PM, Employee A, clinic manager and Registered Nurse, and Employee C, Registered Nurse, indicated blood should always be cleaned up immediately.</p> <p>5. The agency policy titled "Dialysis Precautions" with a date of January 4, 2012 stated, "Dialysis Precautions will be followed by all employees with potential exposure to bloodborne pathogens and other potentially infectious material ... in the dialysis setting."</p>		Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to dialysis precautions and infection control.	
	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children			

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	<p>I. Health care worker education and training</p> <p>A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections.</p> <p>B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance</p> <p>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</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure a clean field had been placed under the Central Venous Catheter Ports in accordance with facility policy in 1 of of 2 discontinuation of dialysis with a central venous catheter observations completed (Employee E, patient care technician and Patient #8).</p> <p>The findings include:</p>	V 0147	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all RegisteredNurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-II-155-110A: Dialysis Precautions with emphasis on ·Background: The nature of dialysis treatments with frequent exposure to blood and body fluids, close proximity of patients 	09/11/2015

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V 0407	<p>1. The agency policy titled "Cleaning and Disinfection" with a date of January 28, 2015 stated, "The nature of dialysis treatments with frequent exposure to blood and body fluids, close proximity of patients and staff, and the immunocompromised status of dialysis patients make dialysis a high - risk area for spreading infectious disease. The Occupation safety and Health administration and the Centers for Disease Control standards have been shown to reduce and prevent the spread of infectious diseases."</p> <p>2. On 8/11/15 at 3:45 PM, Employee E was observed to initiate a discontinuation of dialysis with a central venous catheter with patient #8. Before starting this procedure, Employee E used the field already under the CVC ports and did not use a clean field.</p> <p>3. On 8/12/15 at 12:20 PM, Employee A, the clinic manager, and Employee C, Registered Nurse, indicated a clean field should be placed under the CVC ports at the time of the discontinuation of dialysis with a CVC.</p>		<p>and staff, and the immunocompromised status of dialysis patients make dialysis a high-risk area for spreading infectious disease. The Occupational Safety and Health Administration(OSHA) and the Centers for Disease Control (CDC) standards have been shown to reduce and prevent the spread of infectious disease. The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to catheter care and performing discontinuation of a treatment with a catheter.</p>	

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Bldg. 00	<p>PE-HD PTS IN VIEW DURING TREATMENTS</p> <p>Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement).</p> <p>Based on observation, policy review, and interview, the facility failed to ensure all patients' accesses were visible in 1 of 1 observation (patient #2) for visibility of accesses completed on 8/6/15.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/6/15 at 1:25 PM, Patient #2 at station #2 was observed to have the blanket up around his / her neck. His / her access site which was a central venous catheter was not visible. This patient was receiving incenter hemodialysis. On 8/6/15 at 1:35 PM, Patient #2 was observed to have the blanket up around his / her neck. His / her access site was not visible. On 8/6/15 at 1:40 PM, Employee D, patient care technician, indicated the access site was not to be covered up. The agency policy titled "Patient Monitoring During Treatment" with a date of August 20, 2014 stated, "Monitor 	V 0407	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-I-110-133A : Patient Monitoring During Patient Treatment with emphasis on: <ul style="list-style-type: none"> ·Policy:Observation ·Access- Observe and document at the initiation of dialysis and at every safety check that all connections are secure and visible ·Ensure access remains uncovered throughout the treatment <p>The meeting agenda and attendance records are available for review at the facility.</p> <p>The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to</p>	09/11/2015

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V 0470 Bldg. 00	<p>the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary ... access ... ensure access remains uncovered during the treatment."</p> <p>494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO The dialysis facility must prominently display a copy of the patient's rights in the facility, including the current State agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients. Based on clinical record review, staff interview, document review, and policy and procedure review, the facility failed to ensure a copy of the patient's rights was prominently displayed in 1 of 1 facility including the current State Agency and ESRD network mailing addresses and telephone complaint numbers, where it can be easily seen and read by patients (#1 - #7).</p> <p>The findings include</p> <p>1. On 8/11/15 at 1:30 PM, it was observed that the current State agency and ESRD network mailing addresses and telephone complaint numbers were not posted anywhere in the facility where</p>	V 0470	<p>resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to monitoring the access during treatment.</p> <p>The Clinical Manager immediately upon notification from surveyor filled the Rights and Responsibility and Patient Grievance Procedure wall display in the patient lobby with all current information. On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinic Manager will train the Master of Social Work (MSW), Registered Nurses (RN) and Patient Care Technicians (PCT) on: ·FMS-CS-IC-I-103-005A: Patients Rights andResponsibilities Policy with emphasis on: ·Policy: Dialysis facilities must prominently display a copy of the patients rights in a visible and accessible area in the facility and</p>	09/11/2015

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	<p>these phone numbers could be seen by the patients.</p> <p>2. A review of 7 records showed that patients #1 - #7 had received their rights on the day of admission to the dialysis clinic.</p> <p>3. On 8/11/15 at 1:30 PM, Employee A, clinic manager, indicated the document had been posted but was now missing.</p> <p>4. On 8/11/15 at 3:20 PM, Employee A gave the writer a document which showed the phone numbers and addresses for the Indiana State Department of Health and the ESRD Network.</p> <p>The document titled "Patient Grievance Procedure" with a date of 6/20/12 showed the state agency with the name left blank, its address, and phone number and the name and address of the ESRD network in Indianapolis.</p> <p>5. The policy titled "Patient Rights and Responsibilities" with a date of April 4, 2012 stated, "Dialysis facilities must prominently display a copy of the patient rights in the facility and must include contact information for the State Survey agency and ESRD network."</p>		<p>must include contact information for the State survey agency and ESRD Network.</p> <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform clinical audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure that Patient Rights and Responsibilities and Grievance Procedure is permanently available in display inpatient lobby.</p>	

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V 0543 Bldg. 00	<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 policy and clinical record review, and interview, the facility failed to ensure it had provided the necessary care and services to manage the patient's fluid volume status in 2 (#1, 5) of 7 records reviewed and failed to ensure the preassessments had been completed by the registered nurse within 1 hour of starting treatment in 1 of 7 records reviewed (#4).</p> <p>The findings include:</p> <p>1. Clinical record #1 included physician orders dated 7/20/15 that identified the desired weight at the end of the treatment, the estimated dry weight (EDW), was 76 kilograms (kg). Hemodialysis treatment flow sheets failed to evidence the facility had provided the care and services to attain the physician ordered EDW and evidenced greater than 5% of the EDW (3.8) had been removed during the</p>	V 0543	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-I-110-133A : Patient Monitoring During Patient Treatment with emphasis on: ·Policy: Monitor the patient at the initiation and every 30 minutes, or more frequently as necessary ·Bloodflow rate: Check prescribed blood flow is being achieved. Make adjustments as needed ·FMS-CS-IC-I-110-149A:Nursing Supervision and Delegation with emphasis on: ·Purpose: The purpose of the policy is to provide guidance to the registered nurse on his/her responsibilities for patient oversight, which includes making patient rounds preferable within 1 hour of dialysis treatment initiation and reviewing patient treatment information. <p>The meeting agendaand</p>	09/11/2015

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	<p>treatments.</p> <p>A. A hemodialysis treatment flow sheet dated 7/17/15 evidenced the patient's weight was 79 kg and 3.4 kg had been removed. A note on this flow sheet written by Employee B, RN, stated, "Left 4 kg over EDW due to large gains and difficulty removing." [At this time, the EDW was ordered at 75 kg.]</p> <p>B. A hemodialysis treatment flow sheet dated 7/20/15 evidenced the patient's weight at the end of the treatment was 81.8 and 2.6 had been removed. The patient did not achieve the EDW.</p> <p>C. A hemodialysis treatment flow sheet dated 7/22/15 evidenced the patient's weight at the end of the treatment was 80.6 and 3.8 kg had been removed. The patient did not achieve the EDW.</p> <p>D. A hemodialysis treatment flow sheet dated 7/24/15 evidenced the patient's weight at the end of the treatment was 80.0 kg and 3 kg had been removed. The patient did not achieve the EDW.</p> <p>E. A hemodialysis treatment flow sheet dated 7/27/15 evidenced the</p>		<p>attendance records are available for review at the facility. The Clinical Manager and or designee will perform clinical audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure that patients are properly monitored and assessed.</p>	

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	<p>patient's weight at the end of the treatment was 78.6 and 7 kg had been removed. The patient did not achieve the EDW and greater than 5% of the patient's weight had been removed.</p> <p>F. A hemodialysis treatment flow sheet dated 7/29/15 evidenced the patient's weight at the end of the treatment was 80.8 and 2.2 kg had been removed. The patient did not achieve the EDW.</p> <p>G. A hemodialysis treatment flow sheet dated 7/31/15 evidenced the patient's weight at the end of the treatment was 80.20 and 3.8 kg had been removed. The patient did not achieve the EDW.</p> <p>H. A hemodialysis treatment flow sheet dated 8/3/15 evidenced the patient's weight at the end of the treatment was 81.1 kg and 3.5 kg had been removed. The patient did not achieve the EDW.</p> <p>I. A hemodialysis treatment flow sheet dated 8/5/15 evidenced the patient's weight at the end of the treatment was 81.3 kg and 2.9 had been removed. The patient did not achieve the EDW.</p> <p>J. On 8/12/15 at 3 PM, Employee</p>			

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	<p>C, RN, indicated the EDW was not reached at the above treatment visits.</p> <p>2. Clinical record #5 included physician orders dated 7/13/15 that identified the desired weight at the end of the treatment, the EDW, was 103 kg. Hemodialysis treatment flow sheets failed to evidence the facility had provided the care and services to attain the physician ordered EDW and evidenced greater than 5% of the EDW (5.15 kg) had been removed during the treatments at some treatments.</p> <p>A. A hemodialysis treatment flow sheet dated 7/13/15 evidenced the patient's weight was 104.30 and 5.6 kg had been removed and greater than 5% of the patient's weight had been removed.</p> <p>B. On 8/11/15 at 4:35 PM, Employee A, the clinic manager, indicated the EDW was not reached.</p> <p>Regarding a preassessment not completed by the RN in the first hour after treatment was initiated.</p> <p>3. Clinical record #4 evidenced the patient received dialysis treatments 3 times per week for 4 hours per treatment.</p>			

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	<p>The nursing assessment occurred after the first hour of treatment.</p> <p>A. A treatment run document showed patient #4's dialysis was initiated on 8/4/15 at 11:55 AM and completed at 3:48 PM. A nursing evaluation occurred at 2:14 PM.</p> <p>B. On 8/4/15 at 11 AM, Employee A, the clinic manager, indicated the assessment was completed after the first hour of the onset of treatment.</p> <p>4. The policy titled "Patient Monitoring During Treatment" with a date of August 20, 2014 stated, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary ... blood flow rate: check prescribed blood flow is being achieved."</p> <p>5. The policy titled "Physician Order Documentation" with a date of June 20, 2013 stated, "It is the nurse's responsibility to ensure that all treatments, medications, labs or any care provided to the patient have an accurately documented physician order."</p> <p>6. The policy titled "Nursing Supervision and Delegation" with a date of September 25, 2013 stated, "The purpose of the</p>			

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V 0544 Bldg. 00	<p>policy is to provide guidance to the registered nurse on his / her responsibilities for patient oversight, which includes making patient rounds preferably within 1 hour of dialysis treatment initiation and reviewing patient treatment information."</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 Kt/V of at least 1.7 or meet an alternative</p>			

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	<p>equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record review and interview, the facility failed to ensure prescribed hemodialysis prescriptions had been achieved in 4 (#2, #4, #5, #7) of 7 records reviewed.</p> <p>The findings include:</p> <p>1. Clinical record #2 included hemodialysis orders that identified the blood flow rate (BFR) was to be 350 milliliters per minute.</p> <p>A. The flow sheet dated 7/9/15 evidenced BFRs of 402, 405, 407, 410, and 413 during the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 7/21/15 evidenced BFRs of 392, 405, 407, and 410 during the treatment with no explanation as to why the BFR was not followed.</p> <p>C. The flow sheet dated 7/23/15 evidenced BFRs of 397, 400, 405, and 407 during the treatment with no explanation as to why the BFR was not followed.</p>	V 0544	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-I-110-133A Patient monitoring During treatment with emphasis on: ·Machine Parameters and Extracorporeal Circuit ·Blood flow rate: check prescribed blood flow is being achieved. Make adjustments as needed. <p>The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform clinical audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure that dialysis prescription orders are followed.</p>	09/11/2015

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	<p>D. The flow sheet dated 8/1/15 evidenced BFRs of 407, 410, and 413 during the treatment with no explanation as to why the BFR was not followed.</p> <p>E. The flow sheet dated 8/4/15 evidenced BFRs of 400, 407, and 410 during the treatment with no explanation as to why the BFR was not followed.</p> <p>F. The flow sheet dated 8/6/15 evidenced BFRs of 195, 198, and 413 during the treatment with no explanation as to why the BFR was not followed.</p> <p>2. Clinical record #4 included hemodialysis orders that identified the BFR was to be 400 milliliters per minute.</p> <p>A. The flow sheet dated 6/30/15 evidenced BFRs of 447, 450, 453, and 455 during the treatment with no explanation as to why the BFR was not followed.</p> <p>B. The flow sheet dated 7/11/15 evidenced BFRs of 346, 350, 352, 354 during the treatment with no explanation as to why the BFR was not followed.</p> <p>C. The flow sheet dated 8/6/15 evidenced BFRs of 455, 456, and 458 during the treatment with no explanation</p>			

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	<p>as to why the BFR was not followed.</p> <p>3. Clinical record #5 included hemodialysis orders that identified the BFR was to be 450 milliliters per minute.</p> <p>The flow sheet dated 7/8/15 evidenced BFRs of 500, 503, 506 during the treatment with no explanation as to why the BFR was not followed.</p> <p>4. Clinical record #7 included hemodialysis orders that identified the BFR was to be 400 milliliters per minute.</p> <p>The flow sheet dated 8/1/15 evidenced BFRs of 350, 356, 359, 362, 375, 381 during the treatment with no explanation as to why the BFR was not followed.</p> <p>5. On 8/12/15 at 1:45 PM, Employee A, the clinic manager, indicated the BFRs were not at the prescribed rate.</p>			

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V 0550 Bldg. 00	<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 review of facility policy and CDC (Center for Disease Control) standards, the facility failed to ensure hand hygiene and glove changes had been performed in accordance with facility policy in 1 of 2 access of AV Fistula or Graft observations completed (Employee G with Patient #1).</p> <p>The findings include:</p> <p>1. The agency policy titled "Dialysis Precautions" with a date of January 4, 2012 stated, "Dialysis Precautions is a set</p>	V 0550	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-II-155-070A: Dialysis Precautions with emphasis on: ·Dialysis Precautions is a set of standard infection control practices that are used in all situations in the dialysis setting when caring for dialysis patients or performing related activities(i.e. reuse, biomedical services). Dialysis Precautions have been shown to reduce infectious 	09/11/2015

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	<p>of standard infection control practices that are used in all situations in the dialysis setting ... Dialysis precautions have been shown to reduce infectious disease transmission, and are recommended by the Centers for Disease Control."</p> <p>2. The Centers for Disease Control "Standards Precautions" with a date of 2007 and retrieved from the URL site: http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html on 8/14/15 states, "IV. Standard Precautions . . . IV.A. Hand 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 . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. 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). 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</p>		<p>disease transmission, and are recommended by the Centers for Disease Control (CDC). The meeting agenda and attendance records are available for review at the facility. The Clinical Manager and or designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies related to infection control and proper hand hygiene.</p>	

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	<p>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 infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>3. On 8/7/15 at 9:30 AM, Employee G, patient care technician, was observed to initiate dialysis with patient #1 who had an AV Graft. With gloved hands, Employee G palpated the patient's left arm area with the AV Graft and then inserted the cannulation needles and taped the needles in place.</p> <p>4 On 8/7/15 at 10 AM, Employee F, patient care technician and preceptor, indicated Employee G did not follow the correct procedure for the initiation of dialysis by not removing gloves after palpating the access site prior to inserting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2015
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 851 W BURRELL DR CROWN POINT, IN 46307
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V 0713 Bldg. 00	<p>the cannulation needles.</p> <p>494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance.</p> <p>Based on clinical record and facility policy review, and interview, the medical director failed to ensure all personnel had adhered to facility policies and procedures relative to dialysis treatment prescription delivery in 1 of 4 hemodialysis treatments reviewed by observing the hemodialysis machines during treatments (#13).</p> <p>The findings include:</p> <p>1. The facility policy titled "Physician Order Documentation" with a date of June 19, 2013 stated, "The purpose of this policy is to provide instruction on physician orders documented by medical staff included in the medical record ... It is the nurse's responsibly to ensure that all treatments, medications, labs, or any care provided to the patient have an accurately documented physician order ... nurse practice acts require nurses to carry</p>	V 0713	<p>On 9-3-15 the Director of Operations reviewed with the Clinical Manager and by 9-11-15 the Clinical Manager will train all Registered Nurse (RN) and Patient Care Technician (PCT) staff on:</p> <ul style="list-style-type: none"> ·FMS-CS-IC-II-150-033A Physician Order Documentation Policy with emphasis on: <ul style="list-style-type: none"> ·Purpose: The purpose of this policy is to provide instruction on physician orders documented by medical staff included in the medical record ·Responsibility: It is the nurses responsibility to ensure that all treatments, medications, labs, or any care provided to the patient have an accurately documented physician order ·General policy: Nurse practice act require nurses to carry out treatment care, medication administration, lab tests, procedures and other treatments based on physician orders. The meeting agenda and attendance records are available for review at the facility. <p>The Clinical Manager and or</p>	09/11/2015

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	<p>out treatment care, medication administration, lab tests, procedures and other treatments based on physician orders."</p> <p>2. On 8/7/15 at 8 AM, Patient #13 was observed to be receiving hemodialysis at station #14 with machine #20. The machine's bicarb setting was observed to be at 30 milliequivalent / liter (mEq / L) and not 35 mEq / L as ordered.</p> <p>3. On 8/7/15 at 8 AM, Employee F, patient care technician, indicated the bicarb machine setting was ordered at 35 mEq/L but had been set in error at 30 mEq/L.</p>		<p>designee will perform infection control audits for compliance according to the QAI Workflow Calendar, address identified issues, and report findings and actions taken at monthly QAI meetings. In the event of discrepancies or problematic outcomes, the Committee investigates to determine the root cause of the issue and develops, implements, and tracks a corrective action plan through to resolution of the issue at hand. The Clinical Manager is responsible and the QAI Committee monitors to ensure personnel adhere to facility policies.</p>	