

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS LAFAYETTE II	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 18TH ST LAFAYETTE, IN 47904
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V000000	<p>[CORE]</p> <p>This was a federal ESRD recertification survey.</p> <p>Survey Dates: 8/27/13 through 8/30/13</p> <p>Facility #: 005140</p> <p>Medicaid Vendor #: 200418720</p> <p>Surveyors: Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Census by Service Type:</p> <p>Number of In-Center Hemodialysis Patients: 71 Number of Peritoneal Dialysis Patients: 40 Number of home hemodialysis patients: 7</p> <p>Total: 118</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>September 9, 2013</p>	V000000		

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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V000113	<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 and facility policy review, the facility failed to ensure staff changed gloves and performed hand hygiene appropriately during the provision of care in 2 of 7 (# 1 and 7) patient care observations (employees B and L) creating the potential to affect all of the facility's 118 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>	V000113	<p>On September 23, 2013 the Governing Body met to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene and Changing the Catheter Dressing" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. 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 with emphasis placed on appropriate glove changes and hand hygiene. Training will be completed on September 19, 2013 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 11, 2013. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, weekly for 4 weeks,</p>	10/11/2013			

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	<p>storage of reused items conforming to CMS requirement for use."</p> <p>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>2. On 8/27/13 at 10:55 AM, employee B was observed to prepare the dialysis machine in station 19 for the next patient. The employee was observed to place the dialyzer and tubing into the Fresenius 2008K dialysis machine. While working in station 19, a patient was dialyzing in the neighboring station, station 20. The machine in station 20 alarmed. Employee B was observed to leave station 19, while wearing the same gloves, entered station 20, silenced the alarms on the dialysis machine, returned to the "clean" dialysis machine in station 19, and continued to set up the dialysis machine for the next</p>		<p>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 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>patient without removing her gloves and completing hand hygiene.</p> <p>3. On 8/29/13 at 2:50 PM, patient 14 was through 75 % of the days dialysis treatment when the access, a central venous catheter(CVC) access, clotted. Employee L was observed to restart dialysis treatment with a new tubing and dialyzer. The employee donned a new face mask, which covered her nose and mouth. Just before she connected the new lines to the CVC, the employee placed both gloved hands to her mask, fingers flat against her mask, then, without changing her mask and decontaminating her hands, she connected the CVC and the dialysis treatment continued.</p>				

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V000115	<p>494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK</p> <p>Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on observation, interview, and review of policy, the facility failed to ensure personal protective equipment was utilized appropriately in 3 (employee C and G and L) of 6 patient care technicians (PCT) observed while performing patient care to 4 of 4 (5, 11, 13, and 14) patients observed with a central venous catheter (CVC) for infection control procedures creating the potential to affect all of the facility's patients with a CVC.</p> <p>The findings include:</p> <p>1. At 10:30 AM on 8/27/13, employee G was observed with a lanyard hanging from her neck; multiple keys and a pen were hanging from the lanyard.</p> <p>At 10:35 AM, employee F indicated the employee did not have a reason to wear the lanyard.</p>	V000115	The Governing Body determined that the policy related to Fresenius Catheter Dressing Change will be adopted effective September 23, 2013, replacing existing policies within the facility. This is documented within the GB Minutes of this date. To ensure that all staff understands the correct procedure in Catheter Dressing Changes and the proper use of Personal Protective Equipment (PPE), the Clinical Manager contacted the educational department and arranged for the formal education/reeducation of all staff to be completed no later than September 27, 2013. This education/reeducation is inclusive of but not limited to the following:FMS-CS-IC-I-105-032A Changing the Catheter Dressing PolicyFMS-CS-IC-II-155-080A Personal Protective Equipment Policy The educational agenda and attendance sheet document the training, and participation, and is available for review at the	09/27/2013	

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	<p>2. At 10:50 AM on 8/27/13, employee G was observed to initiate dialysis in station 20 with patient number 5, a patient with a CVC. The employee failed to don a clean facial mask before she initiated the dialysis treatment. Throughout the observation, the employee was observed to wear a lanyard around her neck which hung on the outside of her a gown. From the lanyard hung multiple keys and a pen, which hung and fell into the clean field throughout the initiation of dialysis treatment.</p> <p>3. On 8/27/13 at 11:20 AM, employee C, a PCT was observed to initiate the dialysis treatment for patient number 11 via a central venous catheter. The PCT was observed to cleanse the exit site with an antiseptic swab using one swipe of the swab from one side of the exit site to the other (9 PM to 3 PM on the face of a clock) on the top side of the exit site only.</p> <p>On 8/27/13 at 6 PM, employee I indicated the proper procedure to apply antiseptic to area in a bullseye pattern to prevent cross contamination.</p> <p>4. On 8/27/13 at 12:05 PM, employee G was observed to initiate dialysis in station 24 with patient number 13, a patient with a CVC. The employee failed to don a clean face mask and was observed to have</p>		<p>facility. Staff compliance is further monitored by the Education Coordinators, Director of Operations, Operation Managers and Clinical Manager as follows:</p> <ul style="list-style-type: none"> ∩ Observing staff's adherence to properly wear required PPE ∩ Observing staff compliance to remove all items not related to PPE ∩ Immediate intervention, consisting of reeducation up to disciplinary action, to address and correct identified noncompliance with the appropriate staff member <p>In order to monitor staff adherence to the correct application of personal protective equipment (PPE), the Director of Operations incorporated the observation of the facility's PPE requirements in the Plan of Correction Monitoring Tool. As such, the following has been implemented:</p> <ul style="list-style-type: none"> ∩ Beginning September 9, 2013, the Education Coordinators or Clinical Manager will complete the tool daily for 2 weeks on each employee. Then utilizing the QAI infection control audit tool an audit will be completed weekly for 4 weeks, monthly for 2 months and then according to the QAI calendar ∩ Any identified issues of staff noncompliance will have an immediate intervention by the Education Coordinator or Management team member providing oversight. The noncompliance and intervention will be documented on the POC monitoring tool and then the 				

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	<p>multiple keys and a pen attached to a lanyard, hanging around her neck and on the outside of her PPE, which hung into the clean field while she initiated the dialysis treatment.</p> <p>On 8/27/13 at 12:30 PM, employee I indicated the employee wearing of a lanyard on the outside of her PPE was not appropriate procedure for the in-center floor.</p> <p>5. On 8/29/13 at 2:50 PM, patient 14 was through 75 % of the days dialysis treatment when the access, a central venous catheter, clotted. Employee L was observed to restart dialysis treatment with a new tubing and dialyzer. The employee donned a new face mask, which covered her nose and mouth. Just before she connected the new lines to the CVC, the employee placed both gloved hands to her mask, fingers flat against her mask, and, without changing her mask and decontaminating her hands, she connected the CVC and the dialysis treatment continued.</p> <p>6. The undated "Liberty" policy titled "Subclavian / IJ Catheter" stated, "Use Standard and Contact Precautions. Use aseptic Technique. Mask patient and self."</p>		infection control audit tool ; The Clinical Manager or Director of Operations will review the tool and administer corrective action as needed. The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.				

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	<p>7. The policy dated January 4, 2012, titled "Infection Control Overview" stated, "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 . . . Mandatory Components of Program: Adherence to standard and dialysis precautions."</p> <p>8. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline 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."</p>				

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V000122	<p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and policy review, the facility failed to ensure the staff were trained and competent, implemented appropriate procedures, and cleansed all parts of the dialysis machine prior to preparing use for another patient in 3 of 3 observations of staff (employees A, B, and C) cleansing and disinfection of the dialysis machines and stations.</p> <p>The findings include:</p> <p>1. The policy dated January 4, 2012 titled "Infection Control Overview" stated, "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 . . . Mandatory Components of Program: Adherence to standard and dialysis precautions . . . Infection control training and education, including maintenance of</p>	V000122	<p>On September 19, 2013 the Clinical Manager and Education Coordinator met with all direct patient care staff to review policies FMS-CS-IC-II-155-090A "Hand Hygiene", FMS-CS-IC-II-155-080A "Personal Protective Equipment" and FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on cleaning all surfaces of the dialysis machine including the prime bucket and appropriate glove changes between tasks. All staff acknowledged understanding that all dialysis equipment must be cleaned between patients and gloves changed as needed. Agenda and attendance sheet is available within the facility. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, weekly for 4 weeks, monthly for 3 months and then as determined by the QAI calendar. Any deficiencies noted during the</p>	09/19/2013			

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	<p>training records . . . Infection Control Policies: . . . Hand Hygiene, Dialysis unit precautions (including the use of personal protective equipment) . . . Rinsing, cleaning, disinfection, preparation, and storage of reused items conforming to CMS requirement for use."</p> <p>A. The policy "Hand Hygiene" dated January 4, 2012, stated, "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 policy titled, "Personal Protective Equipment" dated January 4, 2012, stated, "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 gloved hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p>		<p>audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate. In addition, the Clinical Manager will ensure that competency checks are completed as part of an employee's orientation by reviewing the skills checklist on a weekly basis for any new employee. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans. The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p>				

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	<p>2. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline 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. The policy titled "Cleaning and Disinfection" number FMS-CS-IC-II-155-110A, dated March 20, 2013, stated, "Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. ... Discard all fluid and clean and disinfect all containers associated with the prime waste."</p> <p>4. On 8/27/13 at 10:50 AM and 11:12 AM respectively, employee B was observed to clean and disinfect the dialysis machines in stations 19 and 20. The employee failed to cleanse the funnel</p>						

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	<p>attached to the dialysis machines that was in place of the prime waste container.</p> <p>A. As employee B was observed to prepare the dialysis machine in station 19 for the next patient. The employee was observed to place the dialyzer and tubing into the Fresenius 2008K dialysis machine and set up for the next patient. While working in station 19, a patient was dialyzing in the neighboring station, station 20. The machine in station 20 alarmed. Employee B was observed to leave station 19 and, while wearing the same gloves, entered station 20, silenced the alarms on the dialysis machine, then returned to the "clean" dialysis machine in station 19, and continued to set up the dialysis machine for the next patient without removing her gloves and completing hand hygiene.</p> <p>B. On 8/27/13 at 5 PM, employee I indicated the funnel was to be wiped with a bleach cloth or bleach water solution should be poured into the funnel to clean as part of the disinfection of the dialysis machine.</p> <p>C. Personnel record B, a patient care technician, date of hire - August 19, 2013, failed to evidence an orientation, any written competency test, and a demonstration of skills. A document</p>				

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	<p>"Orientation / Skills Checklist" failed to evidence a date of satisfactory performance of any skills, including the teardown / cleaning / decontaminating of a dialysis machine. The skills competency form was blank.</p> <p>5. On 8/27/13 at 12 PM, employee C moved the dialyzer, tubing, and set up from station 20 to station 23. As employee C was inserting into the machine, employee A was observed to be between employee C and the machine, decontaminating the machine by wiping the machine with a white cloth.</p> <p>Personnel record A, a registered nurse, date of hire - August 19, 2013, failed to evidence an orientation, any written competency test, and a demonstration of skills. The document "Orientation / Skills Checklist" failed to evidence a date of satisfactory performance of any skills, including the teardown / cleaning / decontaminating of a dialysis machine. The skills competency form was blank.</p>				

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V000147	<p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of 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].</p> <p>Based on observation and interview, and review of facility policy, the facility failed to ensure the patient care technicians (PCT) provided central venous catheter care in accordance with facility policy in 4 (# patients 5, 11, 13, and 14) of 4</p>	V000147	The Clinical Manager is responsible to ensure that all staff members follow "Hand Hygiene, Personal Protective Equipment and Changing the Catheter Dressing" policies to ensure a safe treatment environment that	10/11/2013	

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	<p>observation of care with patients with a central venous catheter completed by patient care technicians (employee C, G, and L) creating the potential to affect all facility patients with a central venous catheter.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/27/13 at 10:50 AM, employee G was observed to initiate dialysis in station 20 with patient number 5, a patient with a central venous catheter (CVC). The employee failed to don a clean facial mask and was observed with a lanyard around her neck to which several keys and a pen were attached. The lanyard hung around her neck, and on the outside of her PPE, and hung in the clean field while the employee discontinued the dialysis treatment. On 8/27/13 at 11:20 AM, employee C, a PCT, was observed to initiate the dialysis treatment for patient number 11 who had a CVC. The PCT was observed to cleanse the exit site with an antiseptic swab; she cleaned with one swipe of the swab from one side of the exit site to the other [9 PM to 3 PM on the face of a clock] on the top side of the exit site only. On 8/27/13 at 12:05 PM, employee G was observed to initiate dialysis in station 		<p>prevents cross contamination of patients and equipment. 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 "Changing the Catheter Dressing" FMS-CS-IC-I-105-032C with emphasis placed on appropriate exit site care and glove changes between tasks. Training was completed on September 27, 2013 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 11, 2013. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, 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 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>24 with patient number 13, a patient with a CVC. The employee failed to don a clean face mask and was observed to have multiple keys and a pen attached to a lanyard hanging around her neck and on the outside of her PPE which hung into the clean field while she initiated the dialysis treatment.</p> <p>A. On 8/27/13 at 12:30 PM, employee I indicated wearing a lanyard on the outside of her PPE was not appropriate procedure for the in-center floor.</p> <p>B. On 8/27/13 at 6 PM, employee I indicated the proper procedure to apply antiseptic to area in a bullseye pattern to prevent cross contamination.</p> <p>4. On 8/29/13 at 2:50 PM patient 14 was through 75 % of the days dialysis treatment when the access, a CVC clotted. Employee L was observed to restart dialysis treatment with a new tubing and dialyzer. The employee donned a new face mask which covered her nose and mouth. Just before she connected the new lines to the CVC, the employee placed both gloved hands to her mask, fingers flat against her mask, then, without changing her mask and decontaminating her hands, she connected the CVC and the dialysis treatment continued.</p>			

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	<p>5. The undated policy titled "Subclavian / IJ Catheter" stated, ""Mask patient and self."</p> <p>6. The policy dated January 4, 2012 titled "Infection Control Overview" stated, "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 . . . 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)."</p> <p>The policy titled, "Personal Protective Equipment" dated January 4, 2012 stated, "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."</p> <p>7. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline</p>			

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	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."				

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V000250	<p>494.40(a) DIALYS PROPOR-TMONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. Based on observation and interview, the facility failed to ensure the patient care technicians, employees C, D, and G, tested the pH of the dialysate solution with an independent method prior to delivering dialysis treatment in 3 of 3 (patients 11, 13, and 19) observations of initiation of hemodialysis treatment with the potential to harm all current 118 in-center dialysis patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 8/27/13 at 11:22 AM, employee C initiated dialysis with patient 11 in station 25 - 2 [unlabeled station]. The employee failed to measure the pH and conductivity with an independent method prior to starting the treatment. <p>At 11:25 AM, when asked, employee C indicated the pH and conductivity was missed.</p> <ol style="list-style-type: none"> On 8/27/13 at 11:55 AM, employee D 	V000250	<p>The clinic manager met with the facility educator to arrange and schedule a staff in-service on the proper use of the Phoenix meter used to test the pH and conductivity of the dialysate solution. Training will be completed on September 19, 2013 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 11, 2013 The Clinical Manager will ensure that patient safety audits utilizing the QAI Patient Safety 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 Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>	10/11/2013			

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	<p>initiated dialysis with patient number 12 in station 19. The employee failed to measure the pH and conductivity with an independent method prior to starting the treatment.</p> <p>At 12:14 PM, when asked, employee D indicated the pH and conductivity was missed.</p> <p>3. On 8/27/13 at 12:05 PM, employee G initiated dialysis in station 24 with patient number 13. The employee failed to measure the pH and conductivity with an independent method prior to starting the treatment.</p> <p>At 12:10 PM, when asked, employee G indicated she did not test the pH before the dialysis treatment was initiated.</p>				

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V000556	<p>494.90(b)(1) POC-COMPLETED/SIGNED BY IDT & PT The patient's plan of care must-</p> <p>(i) Be completed by the interdisciplinary team, including the patient if the patient desires; and</p> <p>(ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.</p> <p>Based on clinical record and policy review and interview, the facility failed to ensure the patient was involved in the plan of care for 1 of 3 records reviewed of patients admitted after 3/1/13 that required an initial assessment and plan of care (# 2).</p> <p>The findings include:</p> <p>1. The agency policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care" with an effective date of July 4, 2012, stated, "The Plan of Care must be signed by the team members including the patient or patient designee. If the patient is unable or chooses not to sign the Plan of Care, this must be documented on the Plan of Care along with the reason the signature was not provided."</p> <p>2. Clinical record 2, start of care 6/17/13, evidenced an initial assessment and plan</p>	V000556	<p>On September 24th and 25th , the Regional Quality Manager reviewed the "Comprehensive Interdisciplinary Assessment and Plan of Care" policy with the Dietitian, Social Worker and Nursing Staff emphasizing the requirement that each Plan of Care must be reviewed, signed and dated by the patient in a timely manner. Each month any patient due for their Plan of Care review will be given an invitation in which they indicate their desire to participate in the upcoming IDT meeting by checking the appropriate box and signing the form to verify that they were notified. Documentation will be available in the patient record.</p> <p>The Clinical Manager/Program Manager will complete 100% chart audit of all patients' Plans of Care by September 27, 2013 to review for patient or patient's designee timely signatures and dates or for the reason a signature was not provided. Any patient's chart found out of compliance will be presented at</p>	10/11/2013			

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	<p>of care dated 7/16/13. The record failed to evidence the initial plan of care was signed by the patient or patient designee and the reason it was not signed.</p> <p>3. On 8/28/13 at 5 PM, employee E indicated there was no further information available.</p>		<p>the Interdisciplinary Team meeting conducted on October 11, 2013, the patient's will be invited to attend including patient # 2 and all corresponding signatures and dates will be obtained. The Clinical Manager/Program Manager will ensure compliance by auditing 25% of all medical records monthly for a period of 3 months focusing on the patient's participation in their Plan of Care as evidenced by their signature and date. Frequency of ongoing monitoring will be determined by the QAI Committee based on resolution of the issues. The Clinical Manager/Program 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. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		

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V000628	<p>494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS</p> <p>The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves.</p> <p>Based on quality assurance performance improvement (QAPI) document and facility policy review and interview, the facility failed to ensure its QAPI program included monitoring of fluid and blood pressure management and a review and evaluation of all patient deaths in 7 (January through July 2013) of 7 months reviewed creating the potential to affect all of the facility's 118 current patients.</p> <p>The findings include:</p> <p>1. The facility's administrative documents titled "FMC - North America 2013 Facility Quality Assessment and Performance Improvement (QAI) Meeting Minutes" for the months of January 2013 through July 2013, failed to evidence the facility had monitored fluid and blood pressure management by the review and evaluation of the percentage of intradialytic weight loss, blood pressure variances pre and post dialysis, intradialytic symptoms of depletion, and</p>	V000628	<p>On September 23, 2013 the Regional Quality Manager scheduled a meeting with all participants of the QAI committee for the purpose of reeducation on the "Quality Assessment and Performance Improvement Program" FMS-CS-IC-II-101-001A. This education included but was not limited to the following:QAI ProcessesIncluding tools with all minutes monthlyMortality analysis and trendingBlood pressure and fluid management monitoring and trending The Clinical Manager will review the Mortality summary log and trending tool. Reports will be evaluated to determine if any patient death was a result of the care provided by the facility. Fluid and blood pressure management will also be reviewed monthly and discussed in the clinical issues section within the QAI minutes. Any items identified as not meeting an outcome will have an action plan developed and followed monthly. The Clinical Manager is responsible to report a summary of findings monthly.</p>	09/23/2013			

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	<p>compliance to infection control measures. The documents failed to evidence a review of the patient deaths and a completed mortality review and an investigation into potential causes of individual patient deaths, contributory factors, and the relationship to the care received at the facility.</p> <p>2. The facility's 4-4-12 "Quality Assessment and Performance Improvement (QAPI) policy number FMS-CS-IC-I-101-001A states, "The Quality Assessment Performance Improvement (QAI) Program encompasses all aspects of patient care, including in-center, home hemodialysis, home peritoneal dialysis and self care, as well as support services to provide that care . . . Elements to be reviewed in the QAI meeting include: Patient Care Outcomes."</p> <p>3. On 8/30/13 at 6 PM, the clinic manager indicated there was not a review of the patient's records of treatments received at the facility prior to the patient's death or a review for any complication that may have developed and contributed to the death related to the care delivered in the facility. She indicated the data collected for the "Mortality Review Report" was obtained from hospital records and from the</p>		The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.				

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	physician reports.				

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V000681	<p>494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY</p> <p>All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions.</p> <p>Based on observation, interview, and review of personnel records, the facility failed to ensure all staff had completed an initial competency skills evaluation prior to completing assigned tasks in 2 of 2 personnel records reviewed of staff hired in the previous 30 days and observed cleaning and disinfecting the dialysis station and preparing the hemodialysis machine for use (files A and B) with the potential to affect all in-center patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record A, a registered nurse, date of hire - August 19, 2013, failed to evidence an orientation, any written competency test, and a demonstration of skills. <p>The document "Orientation / Skills Checklist" failed to evidence a date of</p>	V000681	As noted in the Statement of Deficiencies, the requirement that the dialysis facility's staff must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The facility staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their position. On September 16, 2013 the Regional Quality Manager met with the Regional Director of Education to discuss the identified deficiency. Preceptor(s) identified and attended annual class on September 23, 2013 Preceptor completes skills checklist with the individual in orientation before the orientee performs any task without the guidance of the preceptor The Clinical Manager will provide oversight by verifying that the skills checklist is being completed to determine staff proficiency	09/23/2013			

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	<p>satisfactory performance of the skills setting up and tearing down the machines. The skills competency form was blank.</p> <p>2. Personnel record B, a patient care technician, date of hire - August 19, 2013, failed to evidence an orientation, any written competency test, and a demonstration of skills.</p> <p>The document "Orientation / Skills Checklist" failed to evidence a date of satisfactory performance of the skills setting up and tearing down the machines. The skills competency form was blank.</p> <p>3. On 8/27/13 at 10:50 AM and 11:12 AM respectively, employee B was observed to clean and disinfect the dialysis machines in stations 19 and 20. The employee failed to cleanse the funnel attached to the dialysis machines that was in place of the prime waste container.</p> <p>On 8/27/13 at 10:55 AM, employee B was observed to prepare the dialysis machine in station 19 for the next patient. The employee was observed to place the dialyzer and tubing into the Fresenius 2008K dialysis machine. While working in station 19, a patient was dialyzing in the neighboring station, station 20. The machine in station 20 alarmed. Employee B was observed to leave station 19 and,</p>		<p>weekly whenever there is staff in training 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>with gloved hands, entered station 20, silenced the alarms on the machine, then returned to the "clean" dialysis machine in station 19, and continued to set up the dialysis machine for the next patient without decontaminating her hands.</p> <p>4. On 8/27/13 at 12 PM, employee C moved the dialyzer, tubing, and set up from station 20 to station 23. As employee C was inserting into the machine, employee A was observed to be between employee C and the machine, decontaminating the machine by wiping the machine with a white cloth.</p> <p>5. At 11 AM, employee C indicated employees A and B were new, were not assigned to patient care tasks, they were assigned to: 1) dismantle the dialysis machines after a patient's dialysis treatment was concluded, 2) clean and disinfect the dialysis machines, and 3) to set up the dialysis machines.</p> <p>6. On August 28, 2013, at 4 PM, employee C indicated she had not evaluated employees A and B on return demonstration yet. When asked, she indicated she was assigned the task to train and evaluate employees and was not scheduled and provided the time to complete.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152601	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS LAFAYETTE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 18TH ST LAFAYETTE, IN 47904		
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	7. On August 28, 2013, at 5 PM, when asked, employee I indicated all employees are to demonstrate tasks and be deemed competent prior to working independently.				