

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152556	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2014
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NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE NOBLESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 165 SHERIDAN RD NOBLESVILLE, IN 46060
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V000000	<p>This was a Federal ESRD recertification survey.</p> <p>Survey Dates: 6-9-14, 6-10-14, 6-11-14, & 6-12-14</p> <p>Facility #: 010516</p> <p>Medicaid Vendor #: 200160250</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>FMC Noblesville was found to be out of compliance with Condition for Coverage 42 CFR 494.90 Patient Plan of Care.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 17, 2014</p>	V000000		
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, facility policy review, and interview, the facility failed to ensure employees provided care in accordance with the facility's own infection control policies and in</p>	V000113	<p>V 113 On Monday June 23rd 2014 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</p>	07/18/2014

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

TITLE

(X6) DATE

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

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	<p>accordance with the Centers for Disease Control (CDC) recommendations in 4 (#s 3, 8, 13, and 15) of 15 infection control observations completed creating the potential to affect all of the facility's 53 current incenter patients. (Employees B, C, and D)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 6-10-14 at 10:35 AM, employee B, a registered nurse (RN), was observed to administer intravenous medications to patient number 9. The RN was observed to prepare the medications and take them to the dialysis station. The RN was observed to touch the computer keyboard upon arrival at the station to enter data and then donned clean gloves without cleansing her hands. On 6-10-14 at 11:15 AM, employee C, a patient care technician (PCT) was observed to change the central venous catheter (CVC) exit site dressing on patient number 8. The PCT was observed to remove the old dressing and proceed with cleaning around the exit site without first changing her gloves and cleansing her hands. <p>On 6-10-14 at 11:40 AM, employee C, a PCT, was observed to change the CVC exit site dressing on patient number</p>		<p>resolution.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Infection Control Overview" "Hand Hygiene and Changing the Catheter Dressing" and Personal Protective Equipment" policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Changing the Catheter Dressing" FMS-CS-IC-I-105-032C and "Personal Protective Equipment" " FMS-CS-IC-II-155-080A with emphasis placed on appropriate glove changes and hand hygiene when changing the catheter dressing, touching inanimate objects and contaminated body site to a clean body site when performing patient care.</p> <p>Training will be completed on July 11th 2014 and an in-service attendance sheet is available in the facility for review in addition, an audit with skills checks will be completed by July 11th 2014</p> <p>The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 2 weeks, weekly</p>				

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	<p>5. The PCT was observed to remove the old dressing and proceed with cleaning around the exit site without first changing her gloves and cleansing her hands.</p> <p>3. On 6-9-14 at 3:00 PM, employee D, a PCT, was observed to discontinue the dialysis treatment on patient number 10. The employee was observed to reinfuse the blood back into the patient and then disconnect the blood lines. The PCT then proceeded to remove the needles from the patient's arm without first donning clean gloves and cleansing his hands.</p> <p>4. 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 . . . 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 storage of reused items conforming to</p>		<p>for 4 weeks, monthly for 3 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>	

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	<p>CMS requirement for use."</p> <p>A. The facility's 1-4-12 "Hand Hygiene" policy number FMS-CS-IC-II-155-090A policy states, "Hands will be . . . Decontaminated using alcohol based hand rub or by washing hands with antimicrobial soap and water before and after direct patient contact . . . Immediately after removing gloves, After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, After contact with inanimate objects near the patient, When moving from a contaminated body site to a clean body site of the same patient."</p> <p>B. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A policy states, "Change gloves and practice hand hygiene between each patient contact and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact . . . Avoid touching surfaces with gloves hands that will be touched with ungloved hands (for ex. patient charts and computers)."</p> <p>5. The CDC Morbidity and Mortality Weekly Report (MMWR) October 25, 2002, Volume 51 No. RR-16 "Guideline</p>			

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V000122	<p>for Hand Hygiene in Health-Care Setting" states, "Recommendations: Indications for handwashing and hand antisepsis . . . Decontaminate hands before having direct contact with patients . . . Decontaminate hands after contact with a patient's intact skin . . . Decontaminate hands if moving from a contaminated body site to a clean body site during patient care. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Decontaminate hands after removing gloves."</p> <p>6. The clinic manager, employee J, indicated, on 6-12-14 at 10:35 AM, the employees noted above had not provided care in accordance with facility policy and procedures.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices,</p>						

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	<p>and equipment.</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure dialysis machines and chairs had been cleaned and disinfected in accordance with facility policy in 2 (#s 1 and 2) of 2 cleaning and disinfection of the dialysis station observations completed creating the potential to affect all of the facility's 53 current incenter patients. (Employees C, F, and J)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 6-11-14 at 3:55 PM, employee C, a patient care technician (PCT), was observed to clean the dialysis machine and chair at station number 3. The PCT failed to clean and disinfect the dialysate hoses and Hansen connectors. <ul style="list-style-type: none"> A. The PCT was then observed to use the same cloth used to clean the dialysis to clean the dialysis chair. The PCT was not observed to clean the top of the left arm of the chair or the entire right side of the dialysis chair to include the arm, sides, and attached table top. B. The PCT was not observed to clean the blood pressure cuff, the television controls, or the data entry station. The PCT was then observed to 	V000122	<p>V 122</p> <p>On Monday June 23rd 2014 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members followpolicy # FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with emphasis placed on cleaning all surfaces of the dialysis chair and machine including cleaning and disinfecting the Dialysate hoses and Hansen connectors and all surfaces of the dialysis chair and machine including the blood pressure cuff.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Cleaning and Disinfection" policy number FMS-CS.IC-II-155-110A, "Cleaning and Disinfection of the Blood Pressure Cuff" policy number FMS-CS-IC-II-155-122A, "Work Surface Cleaning and Disinfection without Visible Blood</p>	07/18/2014

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	<p>place a new patient, number 11, into the chair and prepare the patient for initiation of the dialysis treatment.</p> <p>2. On 6-11-14 at 3:35 PM, employee F, a PCT, was observed to clean the dialysis chair at station number 1. The employee was not observed to clean the outside of the left and right sides of the chair or the data entry station.</p> <p>3. The clinic manager, employee J, indicated, on 6-12-14 at 10:35 AM, the employees noted above had not provided care in accordance with facility policy and procedures.</p> <p>4. The facility's 3-20-13 "Cleaning and Disinfection" policy number FMS-CS.IC-II-155-110A states, "All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures . . . Cleaning the Dialysis Machine. Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. Give special attention to cleaning control panels on the dialysis machines and other surfaces that are frequently touched and potentially contaminated . . . Cleaning Non-Disposable Patient Care Supplies. Non-disposable items such as blood pressure cuff, IV poles, TVs, TV</p>		<p>Using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C1</p> <p>Training will be completed by July 11th 2014 and an in-service attendance sheet is available in the facility for review in addition, an audit with skills checks will be completed by July 11th 2014</p> <p>Clinical Manager will ensure that infection control audits are completed utilizing the QAI Infection Control audit tool daily for two weeks, weekly for 4 weeks and monthly for three months then ongoing monitoring will occur per the QAI calendar.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The QAI Committee is responsible to provide oversight until ongoing resolution has been determined.</p>	

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	<p>remotes, portable phones, etc., as well as clip boards or plastic hemostat clamps placed on machine used or unused, should be disinfected with 1:100 bleach solution after each treatment."</p> <p>A. The facility's 1-4-12 "Cleaning and Disinfection of the Blood Pressure Cuff" policy number FMS-CS-IC-II-155-122A states, "Blood pressure cuffs will be disinfected with a 1:100 dilution of a hypochlorite solution at the completion of each patient treatment."</p> <p>B. The facility's 1-4-12 "Cleaning and Disinfection of the Blood Pressure Cuff" procedures number FMS-CS-IC-II-155-122C states, "Wipe the cuff with a cloth wetted with a 1:100 bleach solution being sure to wipe both sides of the cuff."</p> <p>C. The facility's 1-4-12 "Work Surface Cleaning and Disinfection without Visible Blood Using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C1 states, "Use a cloth wetted with a 1:100 bleach solution to clean and disinfect the dialysis station (bed, tables, machine, television, IV pole, B/P cuff, hand sanitizer dispenser and holder, etc.) . . . Clean all surfaces."</p> <p>D. The facility's 1-4-12 "Cleaning</p>			

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V000147	<p>Individual Patient Televisions and Direct Touch Systems" policy number FMS-CS-IC-II-155-120A states, "The television shall be cleaned after each patient treatment. The television screen should be cleaned with a 1:100 bleach solution."</p> <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</p>			

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	<p>use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on observation, facility policy review, and interview, the facility failed to ensure central venous catheter (CVC) care had been provided in accordance with facility policy in 3 (#s 1, 2, and 4) of 6 CVC observations completed creating the potential to affect all current patients with CVCs. (Employees A, C, and H)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 6-10-14 at 3:40 PM, employee A, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 12. Observation noted the patient had a CVC in place and that the CVC had been used to provide the dialysis treatment. The PCT was not observed to place a clean field under the CVC ports prior to starting the discontinuation process. On 6-10-14 at 3:45 PM, employee H, a PCT, was observed to discontinue the dialysis treatment on patient number 13. Observation noted the patient had a CVC in place and that the CVC had been used to provide the dialysis treatment. The PCT was not observed to place a clean field under the CVC ports prior to 	V000147	<p>V 147</p> <p>On Monday June 23rd 2014 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.</p> <p>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.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies "Hand Hygiene" FMS-CS-IC-II-155-090A and "Changing the Catheter Dressing" FMS-CS-IC-I-105-032C with emphasis placed on placing a clean field under the catheter ports prior to starting the discontinuation process and appropriate technique when cleansing the exit site. Training will be completed by July 11, 2014 and an in-service attendance sheet is available in the facility for review in addition an</p>	07/18/2014

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	<p>starting the discontinuation process.</p> <p>3. On 6-10-14 at 11:15 AM, employee C, a PCT, was observed to change the CVC exit site dressing on patient number 8. The PCT was observed to cleanse the exit site from the area closest to the catheter insertion site outward in concentric circles and then back to the area closest to the insertion site.</p> <p>4. The clinic manager, employee J, indicated, on 6-12-14 at 10:35 AM, the employees noted above had not provided care in accordance with facility policy and procedures.</p> <p>5. The facility's 1-6-14 "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer" procedure number FMS-CS-IC-I-105-028C states, "Ensure that clean under pad is below the catheter limbs to protect the work area and the clothing."</p> <p>The facility's 1-6-14 "Changing the Catheter Dressing" procedure number FMS-CS-IC-I-105-032C procedure states, "Using gentle back and forth friction, clean the exit site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry a minimum of</p>		<p>audit with skills checks will be completed by July 11th 2014.</p> <p>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</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.</p>	

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V000540	<p>30 seconds."</p> <p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on clinical record and facility policy review and interview, it was determined the facility failed to maintain compliance with this condition by failing to ensure patients' abnormal blood pressure readings had been addressed in 2 of 5 records reviewed creating the potential to affect all of the facility's 53 current incenter patients (See V 543); by failing to ensure continuous maintenance heparin had been administered as ordered in 3 of 3 records reviewed of patients with continuous heparin ordered creating the potential to affect all of the patients with continuous heparin pumps (See V 544); and by failing to ensure necessary care and services had been provided to achieve an appropriate hemoglobin level in 1 of 3 records reviewed for anemia management creating the potential to affect all of the facility's 71 current patients (See V 547).</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.90 Patient Plan of Care.</p>	V000540	<p>V 540</p> <p>The Governing Body reviewed the SOD on June 23rd 2014 and determined the immediate corrections required and the following action steps were agreed upon and implemented:</p> <p>Effective immediately:</p> <ul style="list-style-type: none"> · The Governing Body will meet weekly to review the status of the Plan of Correction specific to this Statement of Deficiencies. · The Clinical Manager will continue to analyze and trend all data and monitoring/audit results as related to this Plan of Correction focusing on the specifics that were recently identified in the Statement of Deficiency prior to presenting the monthly data to the QAI Committee for oversight and review. · The Director of Operations will present an update on the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting 	07/18/2014

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			<p>through to the resolution.</p> <ul style="list-style-type: none"> The processes as noted in this POC will be reviewed by the Governing Body at each meeting. These meetings will ensure ongoing progress towards resolution of noted deficiencies is being provided. Minutes of the Governing Body and QAI meetings, as well as monitoring forms, educational documentation will provide evidence of these actions, the Governing Body's direction and monitoring of facility activities. These will be available for review at the facility. <p>As a result of the citations from the June 12th 2014 survey and as part of the developed plan of correction, the following corrective actions have been implemented:</p> <ul style="list-style-type: none"> Reeducation and reinforcement with the DPC staff on the mandatory requirement to ensure that patient blood pressures out of range or addressed and interventions documented. Please refer to V-543 Reeducation and reinforcement with DPC staff of the mandatory requirement to follow physician's heparin orders. Please refer to V-544 	

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V000543	<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 clinical record and facility policy review and interview, the facility failed to ensure patients' abnormal blood pressure readings had been addressed in 2 (#s 2 & 3) of 5 records reviewed creating the potential to affect all of the facility's 53 current incenter patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included hemodialysis treatment flow sheets that evidenced the patient had lower than normal (120/80) blood pressures throughout the treatments. The record failed to evidence the lower than normal blood pressures had been addressed.</p>	V000543	<p>Reeducation and reinforcement with the IDT to make timely adjustments for anemia and document in the plan of care. Please refer to V-547</p> <p>To specifically address inclusion of the patient's volume status to manage blood pressure in the patient care plan, the following has occurred:</p> <ul style="list-style-type: none"> · Reeducation of the IDT and attending physicians on policy FMS-CS-IC-I-110-125A · "Comprehensive Interdisciplinary Assessment and Plan of Care on June 26th 2014 Review of 100% of the patient records by July 4th 2014 · Any patient found out of compliance including patients # 2 and 3 will have a plan of care update completed and reviewed at the Plan of Care meeting on July 24th 2014 · Implemented a weekly monitoring process of running the hemodialysis treatment report and presenting to the physician any abnormal blood pressure issues 	07/18/2014

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	<p>A. A hemodialysis treatment flow sheet dated 5-15-14 evidenced the blood pressure readings had decreased to 69/33 and 72/34 during the treatment. The registered nurse (RN), employee B, had documented at 11:31 AM, "Pt [patient] c/o [complained of] not feeling well, bp [blood pressure] decreased, pt reports taking pain meds prior to coming to tx [treatment]."</p> <p>B. A flow sheet dated 5-17-14 evidenced the blood pressure readings had decreased to 94/42 and 103/44 during the treatment. The registered nurse (RN), employee B, had documented at 11:28 AM, "Pt denies complaints, bp decreased but trends up throughout the as pain meds dialyze off."</p> <p>C. A flow sheet dated 5-20-14 evidenced the blood pressure readings had decreased to 102/46, 100/45, 89/40, and 106/48 during the treatment. Employee B, the RN, had documented "Pt denies complaints, bp decreased and trends down throughout tx so will monitor pt."</p> <p>D. A flow sheet dated 5-22-14 evidenced the blood pressure readings had decreased to 90/37 and 77/45 during the treatment. Employee C, a patient care technician (PCT), had documented at</p>		<p>The Clinical Manager will monitor the results of the treatment sheet reviews daily for two weeks, weekly for 4 weeks and ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue</p> <p>The Clinical Manager is responsible to report a summary of findings monthly to the QAI. 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.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>	

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	<p>12:36 PM, "bp low, rn [registered nurse] notified and we will monitor closely, retaking bp every 15 mins until bp rises." The next blood pressure reading was documented at 12:57 PM and was recorded at 77/45.</p> <p>E. A flow sheet dated 5-24-14 evidenced the blood pressure readings had decreased to 98/42, 104/47, 109/46, and 111/44 during the treatment. The PCT, employee D, documented at 12:40 PM, "bp low, rn notified . . . pt is awake and complaining of pain in ribs." An entry at 1:32 PM by employee D states, "pt feet elevated. diastolic [bottom number] low, rn aware."</p> <p>F. A flow sheet dated 5-29-14 evidenced the blood pressure readings had decreased to 98/38 and 110/47 during the treatment. Employee H, a PCT, documented at 12:03 PM, "diastolic low rn notified." An entry by employee H at 12:37 PM states, "bp low rn notified."</p> <p>G. A flow sheet dated 5-31-14 evidenced the blood pressure readings had decreased to 121/45 and 116/48 during the treatment. Employee F, a PCT, had documented at 1:36 PM, "diastolic low rn aware." Employee A, a PCT, had documented at 3:32 PM, "low diastolic; rn notified."</p>				

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	<p>H. A flow sheet dated 6-3-14 evidenced the blood pressure readings had decreased to 98/41, 112/43, and 116/47 during the treatment. Employee C, a PCT, had documented at 1:02 PM, diastolic low, rn is aware . . . lowered uf [ultrafiltration rate] goal . . . to keep bp from dropping, rn approved." At 1:33 PM, employee F, a PCT, had documented, "diastolic low, rn aware."</p> <p>I. A flow sheet dated 6-5-14 evidenced an entry by employee C, a PCT, that states, "bp diastolic low, rn notified, will monitor closely, pt said nursing home gave [the patient] pain medicine before tx." The BP reading was 117/50 at this time. The blood pressure readings decreased to 108/43 and 55/27 at 12:35 PM. Employee C documented at this time, "bp low uf off, rn notified. 150 cc saline pushed, pt in trendelenburg position, retaking bp in 10 mins [minutes], pt complaining of back pain." The next blood pressure reading was recorded at 1:01 PM, 34 minutes later and was 117/65.</p> <p>J. A flow sheet dated 6-7-14 evidenced the blood pressure decreased to 85/42 at 12:02 PM. Employee H, a PCT, documented "pt b/p low rn notified." At 12:33 PM the blood</p>			

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	<p>pressure reading was 105/40 and employee C, a PCT, had documented "bp diastolic low, rn notified." At 1:03 PM, the blood pressure reading was 104/43 and at 2:04 PM the reading was 132/43. Employee A, a PCT, documented, "diastolic low, rn notified."</p> <p>2. Clinical record number 3 evidenced a physician's order, dated 5-5-14, that states, "Clonidine HCL 0.1 mg ORAL during dialysis prn [if necessary] may repeat X 2 for b/p > 180 up to 3 per run."</p> <p>A. A hemodialysis treatment flow sheet dated 5-7-14 evidenced the treatment had been started at 10 AM. The blood pressure readings were 194/96 at 12:02 PM, 197/100 at 12:33 PM and 182/90 at 1:02 PM. The flow sheet failed to evidence any Clonidine had been administered during the treatment.</p> <p>Employee B, a RN, documented at 10:12 AM, "Pt denies complaints, bp increased but trends down throughout tx." At 11:05 AM and 12:02 PM, employee A, a PCT, documented "bp high; rn notified." At 1:03 PM, employee C, a PCT, documented "bp systolic [top number] high, rn notified."</p> <p>B. A flow sheet dated 5-9-14 evidenced the treatment had been started</p>			

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	<p>at 10:10 AM and the blood pressure reading was 185/92 at 10:12. At 10:32 AM, the blood pressure reading was 185/100 and employee F, a PCT, documented "bp high, rn aware."</p> <p>The RN, employee B, documented at 10:32 AM, "Pt denies complaints, bp increased but usually trends down throughout treatment." The flow sheet failed to evidence the Clonidine had been administered during the treatment.</p> <p>C. A flow sheet dated 5-16-14 evidenced the blood pressure reading was 184/93 at the start of the treatment at 9:51 AM. Employee F, a PCT, documented "systolic high rn aware." At 10:02 AM, the blood pressure reading was 200/99 and employee F documented, "systolic high, rn aware." At 10:31 the blood pressure reading was 183/97. At 11:32, the reading was 199/90 and employee F documented "pt systolic high rn aware." At 12:01 PM, the reading was 197/98 and employee F documented "pt systolic high rn aware." At 12:31 PM, the reading was 197/98 and employee F documented "systolic high rn aware." At 1:00 PM, the reading was 191/100 and employee F documented "pt bp high rn aware."</p> <p>1.) Employee E, a RN,</p>				

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	<p>documented at 10:39 AM, "b/p 194/94 prior to trt [treatment], denies complaints."</p> <p>2.) The flow sheet evidenced the RN, employee E, administered the Clonidine at 1:15 PM, 3.5 hours after the initial blood pressure reading of 194/94.</p> <p>D. A flow sheet dated 5-19-14 evidenced the treatment was started at 10:06 AM. The flow sheet evidenced the blood pressure reading was 205/94 at 10:14, 196/97 at 10:31, and 199/92 at 11:06 AM. The flow sheet evidenced the RN, employee E, administered Clonidine 0.1 mg at 11:06 AM.</p> <p>The flow sheet evidenced the blood pressure reading was 202/94 at 12:33 PM. The flow sheet failed to evidence another dose of Clonidine had been administered per the physician's order.</p> <p>E. A flow sheet dated 5-21-14 evidenced a blood pressure reading of 197/95 at the start of the treatment at 10:08 AM. Employee F, a PCT, documented "bp high, rn aware." At 10:31, the blood pressure reading was 200/96 and employee F documented "pt systolic high rn aware." At 12:03 PM, the blood pressure reading was 196/77 and employee F documented, "systolic</p>						

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	<p>high rn aware." At 12:32, the blood pressure reading was 206/92 and employee F documented, "pt systolic high rn aware." At 1:09 PM, the blood pressure reading was 182/93 and employee H, a PCT, documented the treatment was discontinued at that time.</p> <p>At 10:43 AM, employee B, the RN, documented, "BP increased but trends down throughout treatment." The record failed to evidence the RN had administered any Clonidine during the treatment.</p> <p>F. A flow sheet dated 5-23-14 evidenced a blood pressure reading of 174/91 at the start of the treatment at 10:08 AM. At 10:34, the blood pressure reading was 190/89 and employee F, a PCT, documented "pt systolic high rn aware." At 12:01 PM, the blood pressure reading was 191/94.</p> <p>The RN, employee B, documented at 10:20 AM, "bp increased but trends down throughout tx." The record failed to evidence the RN had administered any Clonidine per the physician's order.</p> <p>G. A flow sheet dated 5-26-14 evidenced the blood pressure reading was 204/101 at the start of treatment at 10:11 AM. Employee D, a PCT, documented,</p>						

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	<p>"bp elevated, rn visited with pt." At 10:31, the blood pressure reading was 201/109 and employee A, a PCT, documented "bp high rn notified." At 11:42 AM, the blood pressure reading was 193/94 and employee A documented, "bp high rn notified." At 1:01 PM, the blood pressure reading was 207/97 and employee A documented, "bp high again, rn notified."</p> <p>1.) The RN, employee E, administered Clonidine 0.1 mg at 13:07, 3 hours after the initial blood pressure reading of 204/101.</p> <p>2.) At 1:36 PM, the blood pressure reading was 192/91 and employee C, a PCT, documented "bp systolic high rn notified." The flow sheet failed to evidence the RN had administered another dose of Clonidine as ordered by the physician.</p> <p>H. A flow sheet dated 5-28-14 evidenced the blood pressure reading was 201/98 at the start of the treatment at 10:24 AM. Employee D, a PCT, documented, "systolic high rn notified." At 10:35 AM, the blood pressure reading was 212/99 and at 11:00 AM the blood pressure reading was 207/107. Employee D documented, "bp elevated, rn aware." At 11:36 AM, the reading was 187/84</p>						

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	<p>and employee D documented "systolic high rn notified." At 12:01 PM, the reading was 202/103 and employee D documented "bp elevated, rn aware." At 12:30 PM, the reading was 193/97 and employee C, a PCT, documented, "bp high rn is aware."</p> <p>The flow sheet evidenced the RN, employee E, administered Clonidine at 1:25 PM, 3 hours after the initial reading of 201/98.</p> <p>I. A flow sheet dated 6-2-14 evidenced the blood pressure reading was 183/104 at the start of the treatment at 10:13 AM. Employee A, a PCT, documented "bp high rn notified." At 10:30 AM, the blood pressure reading was 203/84 and employee A documented, "bp high, rn notified." At 12:31 PM, the blood pressure reading was 196/88 and employee A documented, "bp high; rn aware."</p> <p>Employee E, the RN, documented at 10:53 AM, "b/p 185/91 prior to trt. denies complaints. will continue to monitor." The record failed to evidence any Clonidine had been administered during the treatment per the physician's order.</p> <p>J. A flow sheet dated 6-4-14</p>						

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	<p>evidenced the blood pressure reading was 190/105 at the start of the treatment at 10:05 AM. Employee F, a PCT, documented, "pt over fluid rn aware bp high rn aware." At 10:41 AM, the blood pressure reading was 181/90. At 11:00 AM, the reading was 181/59 and employee F documented, "systolic high rn aware." At 11:31 AM, the reading was 193/93 and employee F documented, "systolic high rn aware." At 2:11 PM, the reading was 181/87.</p> <p>Employee B, a RN, documented at 10:27 AM, "Pt c/o [complained of] stomach pain, bp increased but trends down throughout the tx." The record failed to evidence any Clonidine had been administered per the physician's order.</p> <p>K. A flow sheet dated 6-9-14 evidenced the blood pressure reading was 197/90 at the start of the treatment at 10:31 AM. Employee F, the PCT, documented "bp high rn aware." At 12:01 PM, the blood pressure reading was 182/91 and employee F documented, "systolic high rn aware." At 12:31 PM, the reading was 188/84 and employee F documented, "systolic high rn aware." At 2:01 PM, the reading was 184/92 and employee F documented, "systolic high rn aware."</p>			

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	<p>At 10:43 AM, the RN, employee B, documented, "Pt denies complaints, bp increased but trends down throughout the treatment." The record failed to evidence the RN had administered any Clonidine per the physician's order.</p> <p>L. A flow sheet dated 6-11-14 evidenced the blood pressure reading was 188/96 at 10:32 AM, one-half hour after the start of the treatment. Employee F, a PCT, documented, "systolic high rn aware." At 11:02 AM, the reading was 200/96 and employee F documented, "systolic high rn aware."</p> <p>At 12:44 PM, the RN, employee E, documented, "b/p 191/99 prior to trt. denies complaints. pt requesting to run only 2 hrs due to an appt [appointment]." The record failed to evidence any Clonidine had been administered during the treatment per the physician's order.</p> <p>3. The Medical Director, and the physician that wrote the Clonidine order for patient number 3, was interviewed on 6-11-14 at 2:45 PM. The physician was asked to explain the Clonidine order and what was expected. The physician stated, "I expected the Clonidine to be administered 15 to 20 minutes into the treatment if the blood pressure had not</p>						

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	<p>settled down [below 180 systolic]. If after 20 minutes the reading was still above 180 I would expect another Clonidine to be given. If the reading was still above 180, I would expect to be called."</p> <p>4. The clinic manager, employee J, stated, on 6-12-14 at 10:35 AM, "We have had inservices on ensuring the PCT reports findings to the RN and documents it and then the RN documenting their responses."</p> <p>5. Employee B, the RN, was interviewed on 6-12-14 at 9:50 AM. The RN stated, "I am sure it is just not being charted accurately. Sometimes [the patient] will take her own medicines when [the patient] gets here and sometimes the blood pressure meds are in there. I am sure I have charted when [the patient] does that. It is being followed."</p> <p>6. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to . . . Dose of dialysis . . . Provide necessary care and services to manage the patient's volume status."</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
V000544	<p>494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure continuous maintenance heparin had been administered as ordered in 3 (#s 3, 4, and 5) of 3 records reviewed of patients with continuous heparin ordered creating the potential to affect all of the patients with continuous heparin pumps.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included physician orders dated 3-14-14 that stated, "Heparin Sodium (Porcine) 1000 units/mL Systemic - Infusion Rate 500 units per hour. Turn Heparin Pump Off 60 min [minutes] prior to end of treatment, 3X [times] week."</p> <p>A. A hemodialysis treatment flow sheet dated 5-7-14 evidenced the treatment had been discontinued at 2:04 PM. The flow sheet evidenced the heparin pump had been turned off at 2:01 PM, 3 minutes before the end of the</p>	V000544	<p>V 544 On Monday June 23rd 2014 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.</p> <p>The Clinical Manager is responsible to ensure that all staff members follow "Comprehensive Interdisciplinary Assessment and Plan of Care" Policy number FMS-CS_IC-I-110-125A.</p> <p>The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-IC-I-110-125A. with special emphasis on ensuring that the patient's heparin is delivered according to the physician's prescription Training will be completed by July 11, 2014 and an in-service attendance sheet is available in the facility for review</p>	07/18/2014			

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	<p>treatment.</p> <p>B. A treatment flow sheet dated 5-9-14 evidenced the treatment had been discontinued at 2:15 PM and the heparin pump had been turned off at 1:30 PM, 45 minutes before the end of the treatment.</p> <p>C. A flow sheet dated 5-16-14 evidenced the treatment had been discontinued at 1:50 PM and the heparin pump had been turned off at 1:50 PM, at the end of the treatment.</p> <p>D. A flow sheet dated 5-19-14 evidenced the treatment had been discontinued at 2:07 PM and the heparin pump had been turned off at 2:06 PM, 1 minute before the end of the treatment.</p> <p>E. A flow sheet dated 5-23-14 evidenced the treatment had been discontinued at 2:20 PM. The flow sheet evidenced the heparin pump had been started and stopped at 2:34 PM with 0 total units infused.</p> <p>F. A flow sheet dated 5-26-14 evidenced the treatment had been discontinued at 2:06 PM and the heparin pump had been turned off at 2:07 PM, 1 minute after the end of the treatment.</p> <p>G. A flow sheet dated 6-2-14</p>		<p>The Clinical Manager will monitor the results of the treatment sheet reviews daily for two weeks, weekly for 4 weeks and ongoing monitoring will be determined by the QAI Committee upon review of monitoring results and resolution of the issue</p> <p>Any heparin dosages found out of compliance will be corrected immediately.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly in QAI.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body</p>	

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	<p>evidenced the treatment had been discontinued at 2:03 PM and the heparin pump had been turned off at 4:30 PM.</p> <p>H. A flow sheet dated 6-6-14 evidenced the treatment had been discontinued at 2:06 PM and the heparin pump had been turned off at 2:13 PM, 7 minutes after the end of the treatment.</p> <p>I. A flow sheet dated 6-9-14 evidenced the treatment had been discontinued at 2:28 PM and the heparin pump had been turned off at 2:00 PM, 28 minutes before the end of the treatment.</p> <p>J. A flow sheet dated 6-11-14 failed to evidence the heparin pump had been turned on or off and that any continuous heparin had been infused during the treatment.</p> <p>2. Clinical record number 4 included physician orders dated 11-1-13, that state, "Heparin Sodium (Porcine) 1,000 units/mL Systemic - Infusion Rate 1000 units per hour. Turn Heparin Pump Off 60 min prior to end of treatment, Every Treatment."</p> <p>A. A hemodialysis treatment flow sheet dated 5-12-14 evidenced the treatment had been discontinued at 10:35 AM and the heparin pump had been</p>						

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	<p>turned off at 10:35 AM, at the end of the treatment.</p> <p>B. A treatment flow sheet dated 5-14-14 evidenced the treatment had been discontinued at 10:52 AM and the heparin pump had been turned off at 10:53 AM, 1 minute after the end of the treatment.</p> <p>C. A flow sheet dated 5-16-14 evidenced the treatment had been discontinued at 10:42 AM and the heparin pump had been turned off at 11:00 AM, 18 minutes after the end of the treatment.</p> <p>D. A flow sheet dated 5-19-14 evidenced the treatment had been discontinued at 10:53 AM and heparin pump had been turned off at 10:54 AM, 1 minute after the end of the treatment.</p> <p>E. A flow sheet dated 5-21-14 evidenced the treatment had been discontinued at 10:36 AM and the heparin pump had been turned off at 11:15 AM, 39 minutes after the end of the treatment.</p> <p>F. A flow sheet dated 5-23-14 evidenced the treatment had been discontinued at 10:39 AM and the heparin pump had been turned off at</p>						

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	<p>10:39 AM, at the end of the treatment.</p> <p>G. A flow sheet dated 5-26-14 evidenced the treatment had been discontinued at 5-26-14 and the heparin pump had been turned off at 10:40 AM, 8 minutes prior to the end of the treatment.</p> <p>H. A flow sheet dated 6-2-14 evidenced the treatment had been discontinued at 10:57 AM and the heparin pump had been turned off at 10:49 AM, 8 minutes prior to the end of the treatment.</p> <p>I. A flow sheet dated 6-4-14 evidenced the treatment had been discontinued at 10:38 AM and the heparin pump had been turned off at 10:40 AM, 2 minutes after the end of the treatment.</p> <p>J. A flow sheet dated 6-6-14 evidenced the treatment had been discontinued at 10:35 AM and the heparin pump had been turned off at 10:28 AM, 7 minutes prior to the end of treatment.</p> <p>K. A flow sheet dated 6-9-14 evidenced the treatment had been discontinued at 10:40 AM and the heparin pump had been turned off at 11:25 AM, 45 minutes after the end of</p>			

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	<p>the treatment.</p> <p>3. Clinical record number 5 included physician orders dated 12-24-13 that state, "Heparin Sodium (Porcine) 1,000 units/mL Systemic - Infusion Rate 500 units per hour. Turn Heparin Pump Off 60 min prior to end of treatment, Every Treatment."</p> <p>A. A hemodialysis treatment flow sheet dated 5-6-14 evidenced the treatment had been discontinued at 3:44 PM and the heparin pump had been turned off at 3:40 PM, 4 minutes prior to the end of the treatment.</p> <p>B. A treatment flow sheet dated 5-13-14 evidenced the treatment had been discontinued at 3:28 PM and the heparin pump had been turned off at 3:41 PM, 12 minutes after the end of the treatment.</p> <p>C. A flow sheet dated 5-17-14 evidenced the treatment had been discontinued at 3:02 PM and the heparin pump had been turned off at 3 PM, 2 minutes prior to the end of the treatment.</p> <p>D. A flow sheet dated 5-20-14 evidenced the treatment had been discontinued at 3:31 PM and the heparin pump had been turned off at 3:24 PM, 7</p>			
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	<p>minutes prior to the end of the treatment.</p> <p>E. A flow sheet dated 5-29-14 evidenced the treatment had been discontinued at 3:32 PM and the heparin pump had been turned off at 3:33 PM, 1 minute after the end of the treatment.</p> <p>F. A flow sheet dated 5-31-14 evidenced the treatment had been discontinued at 2:17 PM and the heparin pump had been turned off at 2 PM, 17 minutes prior to the end of the treatment.</p> <p>G. A flow sheet dated 6-3-14 evidenced the treatment had been discontinued at 2:13 PM and the heparin pump had been turned off at 2:01 PM, 12 minutes prior to the end of the treatment.</p> <p>H. A flow sheet dated 6-5-14 evidenced the treatment had been discontinued at 1:53 PM and the heparin pump had been turned off at 11:47 AM, 2 hours and 7 minutes prior to the end of the treatment.</p> <p>4. The clinic manager stated, on 6-12-14 at 10:35 AM, "It probably is a charting error." The manager was unable to provide any additional documentation and/or information when asked.</p> <p>5. The facility's 7-4-12 "Comprehensive</p>				

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V000547	<p>Interdisciplinary Assessment and Plan of Care" policy number FMS-CS_IC-I-110-125A states, "The patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Dose of Dialysis. Sustain the prescribed dose of dialysis to meet FMS target."</p> <p>494.90(a)(4) POC-MANAGE ANEMIA/H/H MEASURED Q MO The interdisciplinary team must provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin/hematocrit level.</p> <p>The patient's hemoglobin/hematocrit must be measured at least monthly. The dialysis facility must conduct an evaluation of the patient's anemia management needs.</p> <p>Based on clinical record and facility policy review and interview, the facility failed to ensure necessary care and services had been provided to achieve an appropriate hemoglobin level in 1 (# 1) of 3 records reviewed for anemia management creating the potential to affect all of the facility's 71 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a "Clinical Notes Report" by the patient's</p>	V000547	<p>To specifically address inclusion of managing anemia and monitoring hemoglobin/hematocrit monthly as part of the developed patient care plan, the following has occurred</p> <ul style="list-style-type: none"> · Reeducation of the IDT and attending physicians on policy FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care" as well as the Electronic Anemia Algorithm Parameters on June 26th 2014 · Review of 100% of the patient records by July 4th 2014 <p>Any patient found out of compliance including patient # 1 will have a plan of care update completed and reviewed at the Plan of Care meeting</p>	07/18/2014

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	<p>nephrologist dated 5-30-14. The note states, "Anemia - protocol." The record included an "Orders Summary Report" that identified the physician had ordered the "CMAB Recommended Anemia Algorithm for Venofer" on 5-31-14 and the "CMAB Recommended Anemia Algorithm for EPO-Epogen AVP Admin." on 6-2-14.</p> <p>A. The record failed to evidence the Epogen and Venofer algorithms had been initiated and the medications administered.</p> <p>B. The record included laboratory results that identified the hemoglobin level was 8.9 g/dL (grams per deciliter) on 5-5-14, 9.6 on 5-12-14, 9.0 on 5-19-14, 9.5 on 5-26-14, and 9.7 on 6-2-14. The desired level is 10 g/dL.</p> <p>2. The clinic manager stated, on 6-10-14 at 1:50 PM, "I notified the physician on 5-30-14 that we needed a starting dose order or the electronic algorithm would not start until we had 2 weeks of results in the record. We finally got an order today."</p> <p>3. The facility's 7-4-12 "Comprehensive Interdisciplinary Assessment and Plan of Care" policy number FMS-CS-IC-I-110-125A states, "The</p>		<p>on July 24th 2014</p> <p>The Clinical Manager is responsible to report a summary of findings monthly to the QAI. 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.</p> <p>The Director of Operations is responsible to ensure the results of the audits will be reviewed during the monthly QAI meeting and reported to the Governing Body.</p>	

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V000715	<p>patient's individualized comprehensive Plan of Care must include, but is not limited to the following: . . . Anemia Provide the necessary care and services to achieve and sustain the clinically appropriate hemoglobin level."</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on clinical record and facility policy review and interview, the medical director failed to ensure the facility's policy regarding central venous catheter (CVC) dressing changes had been implemented in 3 (#s 1, 4, and 5) of 3 records reviewed of patients with CVCs creating the potential to affect all of the facility's patients with CVCs.</p> <p>The findings include:</p> <p>1. The facility's 1-6-14 "Changing the Catheter Dressing" procedure number FMS-CS-IC-I-105-032C states, "Document the dressing change in the patient's medical record. Include any observations of the exit site, catheter</p>	V000715	<p>The Director of Operations met with the Medical Director on June 23rd 2014 to review her requirements as defined in the Condition for Coverage and Medical Staff Bylaws to ensure that all policies and procedures relative to, patient care, infection control and patient safety are adhered to by all individuals who treat patients in the facility, including attending physicians and non-physician providers. Emphasis will be placed on re-education of all Direct Patient Care staff to include documentation of signs and symptoms of infections when performing the CVC dressing change. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below.</p>	07/18/2014

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	<p>integrity, notifications to the team leader/charge nurse of abnormal findings, instructions, or interventions made during the dressing change,"</p> <p>2. Clinical record number 1 included a hemodialysis treatment flow sheet dated 5-14-14 that identified employee F, a patient care technician (PCT), had performed the CVC dressing change. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>A. A treatment flow sheet dated 5-16-14 evidenced the CVC dressing change had been completed employee D, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>B. A flow sheet dated 5-19-14 evidenced the CVC dressing change had been completed by employee H, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>C. A flow sheet dated 5-21-14 evidenced the CVC dressing change had been completed by employee C, a PCT.</p>		<p>The facility's patient care staff will be in-serviced on the following policies, "Hand Hygiene", "Changing the Catheter Dressing", "Medication Preparation and Administration", "Comprehensive Interdisciplinary Assessment and Plan of Care", on June 25th 2014 by education with a record of training reviewed by the QAI committee.</p> <p>The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the monthly QAI Committee Meeting.</p> <p>The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee</p>		

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	<p>The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>D. A flow sheet dated 5-23-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>E. A flow sheet dated 5-26-14 evidenced the CVC dressing change had been completed by employee E, a registered nurse (RN). The record failed to evidence the RN had documented any observations of the exit site and catheter integrity.</p> <p>F. A flow sheet dated 5-28-14 evidenced the CVC dressing change had been completed by employee H, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>G. A flow sheet dated 5-30-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the</p>			

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	<p>exit site, catheter integrity, or any notifications to the nurse.</p> <p>H. A flow sheet dated 6-4-14 evidenced the CVC dressing change had been completed by employee D, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>2. Clinical record number 4 included a hemodialysis treatment flow sheet dated 5-14-14 that evidenced employee F, a PCT had performed the CVC dressing change. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>A. A flow sheet dated 5-16-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>B. A flow sheet dated 5-19-14 evidenced the CVC dressing change had been completed by employee A, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any</p>				

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	<p>notifications to the nurse.</p> <p>C. A flow sheet dated 5-21-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>D. A flow sheet dated 5-23-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>E. A flow sheet dated 5-30-14 evidenced the CVC dressing change had been completed by employee D, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>F. A flow sheet dated 6-2-14 evidenced the CVC dressing change had been completed by employee A, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152556		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2014	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE NOBLESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 165 SHERIDAN RD NOBLESVILLE, IN 46060			
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	<p>G. A flow sheet dated 6-4-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>H. A flow sheet dated 6-6-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>I. A flow sheet dated 6-9-14 evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>3. Clinical record number 5 included a hemodialysis treatment flow sheet dated 5-1514 that evidenced employee H, a PCT, had performed the CVC dressing change. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>A. A flow sheet dated 5-20-14</p>						

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	<p>evidenced the CVC dressing change had been completed by employee F, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>B. A flow sheet dated 6-3-14 evidenced the CVC dressing change had been completed by employee A, a PCT. The record failed to evidence the PCT had documented any observations of the exit site, catheter integrity, or any notifications to the nurse.</p> <p>4. The clinic manager was unable to provide any additional documentation and/or information when asked on 6-12-14 at 10:35 AM.</p>						