

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152591	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/16/2016
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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
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V 0000  Bldg. 00	<p>This was a Federal ESRD complaint investigation survey.</p> <p>Complaint #: IN00183173; Substantiated, deficiencies related to the complaint are cited.</p> <p>Survey Dates: 3-15-16 &amp; 3-16-16</p> <p>Facility #: 004839</p> <p>Medicare Provider # 15-2591</p> <p>Medicaid Vendor #: 200815900A</p> <p>Census: 74 incenter patients</p> <p>FMC Terre Haute South was found to be out of compliance with the Conditions for Coverage 42 CFR 494.90 Patient Plan of Care and 42 CFR 494.150 Responsibilities of the Medical Director.</p>	V 0000		
V 0113  Bldg. 00	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff had performed gloves changes and</p>	V 0113	As such, the Governing Body met on 3/17/16 to review the surveyor's	04/15/2016

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>hand hygiene in accordance with facility policy in 2 (#s 2 and 6) of 6 infection control observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Employee E, a licensed practical nurse (LPN), was observed to initiate the dialysis treatment on patient number 8 with an arteriovenous fistula on 3-16-16 at 10:30 AM (observation number 2). The LPN was observed to don a glove to her right hand and apply soap and water to a paper towel. The LPN was observed to obtain dry paper towels in place them in her left hand. The LPN washed the patient's access site in the left mid-arm with the wet paper towel using her gloved right hand while still holding the dry paper towel in her non-gloved left hand. After washing the skin over the access site, the LPN placed the wet paper towel on the chairside table and donned a glove on her left hand and dried the access site.</li> <li>Employee J, a patient care technician (PCT), was observed to clean and disinfect dialysis station number 13 on 3-16-16 at 10:10 AM (observation # 6). The PCT was observed to clean the top half of the machine. The PCT then picked up an orange, laminated card and a piece of trash from the floor. The PCT</li> </ol>		<p>comments made during the exit interview and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage. The Governing Body, inclusive of the Medical Director met again on 4/5/16 after the receipt of the Statement of Deficiencies, to review the citations and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage.</p> <p>A quorum of the Governing Body will continue to meet weekly, pending CMS' determination of the facility's full compliance to provide oversight to the following implemented corrective actions and review the progress of the Plan of Correction ensuring that the processes developed to correct and prevent deficiencies are addressed, both immediately and long term. The Governing Body shall ensure compliance to the following Plan of Correction and follow-up by the QAPI committee. The minutes of the meetings are available for review at the facility.</p> <p>The Governing Body for the facility along with the Regulatory Compliance Manager met on 4/5/16 to review the Statement of deficiencies and directed the Midwest Group Vice President of Quality to assist the Management team in developing the plan of Correction.</p>	

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	<p>placed the orange card on the intravenous hanger and discarded the trash. The PCT resumed cleaning the dialysis machine. The PCT failed to change her gloves or cleanse her hands prior to resuming cleaning the dialysis machine.</p> <p>3. The facility administrator and charge nurse indicated, on 3-16-16 at 11:00 AM, employees E and J had not changed gloves and cleansed hands in accordance with facility policy.</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 for patient care are consistent with recommendation of the Centers for Disease Control (CDC). All infection control policies will adhere to CMS and OSHA rules and regulations . . . Mandatory Components of Program: Adherence to standard and dialysis precautions."</p> <p>The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from</p>		<p>The Director of Operations reviewed the following policies "Infection Control Overview" FMS-CS-IC-II-155-060A with the Clinical Manager on April 4, 2016 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>All current staff will participate in a mandatory in-service by the clinic manager regarding Infection Control Practices the week of 4/4/16 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that all staff wears disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. The importance of hand sanitation before and after glove change will be reinforced. The "Infection Control Information Acknowledgment" form will be placed in each staff members personnel/education file.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tools are done weekly for 4 weeks, monthly for 3 months, and then as determined</p>	

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	contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."		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 evaluate and present the audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.	

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V 0540  Bldg. 00	<p>494.90 CFC-PATIENT PLAN OF CARE</p> <p>Based on record review and interview it was determined the facility failed to maintain compliance with this condition by failing to ensure interdisciplinary plans of care had been revised and updated to include the facility's arteriovenous fistula protocol for newly placed fistulas in 5 of 5 records reviewed of patients with newly placed arteriovenous fistulas of the 11 total clinical records reviewed (See V 541) and by failing to ensure vascular access care had been provided in accordance with facility policy in 1 of 2 initiation of the dialysis treatment with an arteriovenous fistula (AVF) observations completed (See V 550).</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>	V 0540	<p>As such, the Governing Body met on 3/17/16 to review the surveyor's comments made during the exit interview and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage. The Governing Body, inclusive of the Medical Director met again on 4/5/16 after the receipt of the Statement of Deficiencies, to review the citations and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage.</p> <p>A quorum of the Governing Body will continue to meet weekly, pending CMS' determination of the facility's full compliance to provide oversight to the following implemented corrective actions and review the progress of the Plan of Correction ensuring that the processes developed to correct and prevent deficiencies are addressed, both immediately and long term. The Governing Body shall ensure compliance to the following Plan of Correction and follow-up by the QAPI committee. The minutes of the meetings are available for review</p>	04/15/2016

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			<p>at the facility. The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on April 4, 2016 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>The Clinical Manager will educate and review with all staff the following policy on the week of April 4, 2016: FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on fistula protocol for newly placed fistulas and needed with physician's order.</p> <p>The Clinical Manager or designee will audit 100 % of care plans and audit updates on patients on the Vascular Access protocol every month until the protocol is complete.</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is</p>	

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V 0541 Bldg. 00	<p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p> <p>Based on record review and interview, the facility failed to ensure interdisciplinary plans of care had been revised and updated to include the facility's arteriovenous fistula protocol for newly placed fistulas in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed of patients with newly placed arteriovenous fistulas of the 11 total clinical records reviewed.</p> <p>The findings include:</p> <p>1. The facility administrator indicated, on 3-15-16 at 1:50 PM, patients with new arteriovenous fistulas (AVF) are placed</p>	V 0541	<p>sustained.</p> <p>The Director of Operations reviewed the following policies "FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with the Clinical Manager on April 4, 2016 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff understands the requirement to follow policies and procedures as written.</p> <p>The Clinical Manager will educate and review with all staff the following policy on the week of April 4, 2016:</p>	04/15/2016

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	<p>on the facility's November 2004 "Cannulation Protocol" in accordance with the facility's 3-20-13 "Assessment and Cannulation of a New A-V Fistula" procedure number FMS-CS-IC-I-115-015C.</p> <p>2. Clinical record number 1 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF cannulation protocol. The record included a physician order dated 2-22-16 that identified the AVF could be used for the dialysis treatment. The order states, "may use fistula close to [?]. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-24-16.</p> <p>3. Clinical record number 2 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF use protocol. The record included a physician order dated 12-29-15 that identified the AVF could be used for the dialysis treatment. The order states, "may use fistula in 2 weeks." The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 1-27-16.</p>		<p>FMS-CS-IC-I-110-125A "Comprehensive Interdisciplinary Assessment and Plan of Care Policy" with emphasis on FMS-CS-IC-I-115-015C fistula protocol for newly placed fistulas and needed with physician's order</p> <p>The Clinical Manager or designee will audit all physician order, AV fistula protocol and daily treatment sheets of patients on fistula protocol until protocol complete.</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p>				

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	<p>4. Clinical record number 3 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF protocol. The record included a physician order dated 2-17-16 that identified the fistula could be used for the dialysis treatment. The order states, "may use access in 1 week." The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-26-16.</p> <p>5. Clinical record number 4 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF protocol. The record failed to include a physician order to use the AVF for the dialysis treatment. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-29-16.</p> <p>6. Clinical record number 5 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF protocol. The record failed to include a physician order to use the AVF for the dialysis treatment. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 3-3-16.</p>			

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	<p>7. The facility administrator was unable to provide any additional documentation and/or information when asked on 3-15-16 at 1:50 PM and on 3-16-16 at 11:30 AM. The facility administrator stated, "We call the physician and get a verbal order, but it is not written and sent for signature." The administrator indicated the plans of care did not evidence updates and revisions to include the new AVF protocol.</p> <p>8. The Medical Director stated, per telephone interview on 3-16-16 at 12:50 PM, "We always need an order to cannulate a new fistula."</p> <p>9. The facility's 3-20-13 "Assessment and Cannulation of a New A-V Fistula" procedure number FMS-CS-IC-I-115-015C states, "Prior to cannulation it's important to: Know and document in the medical record the type of (i.e., radiocephalic-Cimino-Brescia}, brachiocephalic, or brachiobasilic [transpositions}). Confirm the direction of blood flow for the specific access site - check with surgeon to confirm direction of flow and obtain a diagram showing direction of flow for patient charts. Determine if reverse flow (i.e., proximal radial artery) has been created, blood flow direction dictates placement of the</p>			
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V 0550 Bldg. 00	<p>arterial and venous needles. Discuss with the physician a heparin management plan during the initial cannulation period to minimize bleeding into the surrounding tissues should infiltration occurs [sic]. Saline flushes may be necessary during treatments with decreased heparinization . . . Week One: Obtain order form physician to cannulate AVF."</p> <p>494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure vascular access care had been provided in accordance with facility policy in 1 (# 1) of 2 initiation of the dialysis treatment with an arteriovenous fistula (AVF) observations completed.</p> <p>The findings include:</p> <p>1. Employee L, a patient care technician (PCT), was observed to initiate the dialysis treatment on patient number 9</p>	V 0550	<p>The Director of Operations reviewed the following policies "FMS-CS-IS-I-520-005C "Assessment and Preparation of Internal Access Needle Placement Policy" with the Clinical Manager on April 4, 2016 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed and staff.</p>	04/15/2016

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V 0710  Bldg. 00	<p>with an AVF on 3-15-16 at 12:15 PM (observation number 1). The PCT was observed to cleanse the arterial needle insertion site with an alcohol pad. The PCT was observed to touch the site, and without cleansing the site again, inserted the needle.</p> <p>2. The facility administrator and charge nurse indicated, on 3-16-16 at 11:00 AM, employee L had not provided vascular access care in accordance with facility policy.</p> <p>3. The facility's 1-28-15 "Assessment and Preparation of Internal Access Needle Placement" procedure number FMS-CS-IS-I-520-005C states, "Using gentle friction, clean the acs [sic] site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry before cannulating . . . DO NOT TOUCH THE CLEANED SITE AFTER DISINFECTION. Recontamination of the site occurs if touched after cleansing with antiseptic solution."</p> <p>Based on record review and interview, it was determined the facility failed to</p>	V 0710	<p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control 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.</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p> <p>As such, the Governing Body met</p>	04/15/2016

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	<p>maintain compliance with this condition by failing to ensure the facility's policies and procedures regarding newly placed arteriovenous fistulas had been adhered to in 5 of 5 records reviewed of patients with newly placed AVFs of the 11 total records reviewed, and by failing to ensure the facility's physician orders policy had been adhered to by all individuals in 2 of 11 total clinical records reviewed.</p> <p>The cumulative effect of these systemic problems resulted in the facility being found out of compliance with this condition, 42 CFR 494.150 Responsibilities of the Medical Director.</p>		<p>on 3/17/16 to review the surveyor's comments made during the exit interview and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage. The Governing Body, inclusive of the Medical Director met again on 4/5/16 after the receipt of the Statement of Deficiencies, to review the citations and to formulate a corrective action plan to bring this facility into compliance with the ESRD Conditions of Coverage.</p> <p>A quorum of the Governing Body will continue to meet weekly, pending CMS' determination of the facility's full compliance to provide oversight to the following implemented corrective actions and review the progress of the Plan of Correction ensuring that the processes developed to correct and prevent deficiencies are addressed, both immediately and long term. The Governing Body shall ensure compliance to the following Plan of Correction and follow-up by the QAPI committee. The minutes of the meetings are available for review at the facility.</p> <p>The Director of Operations met (DO) with the Medical Director on</p>	

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NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE TERRE HAUTE SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 315 E SPRINGHILL DR TERRE HAUTE, IN 47802
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			<p>4/5/16 to review the medical director citation and reviewed with him, the Medical Director's role in ensuring staff education, training, and performance.</p> <p>Specifically reviewed was the following:</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-II-150-033A"Physician Order Documentation"</li> <li>· FMS-CS-IC-II-115-015C "Assessment and Cannulation of a New A-V Fistula"</li> </ul> <p>On 4/5/16, the Medical Director directed the Director of Operations to meet with the Clinical Manager to reinforce her role to ensure that all staff are trained and held accountable to policy and procedures. Specific to</p> <ul style="list-style-type: none"> <li>· FMS-CS-IC-II-150-033A"Physician Order Documentation"</li> <li>· FMS-CS-IC-II-115-015C "Assessment and Cannulation of a New A-V Fistula"</li> <li>· AV fistula protocol</li> </ul> <p>Training on the above mentioned</p>	

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V 0715 Bldg. 00	<p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&amp;P The medical director must-</p> <p>(2) Ensure that-</p> <p>(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 record review and interview, the medical director failed to ensure the facility's policies and procedures regarding newly placed arteriovenous fistulas had been adhered to in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed of patients with newly placed AVFs of the 11 total records reviewed, and failed to ensure the facility's physician orders policy had been adhered to by all individuals in 2 (#s 4 and 5) of 11 total clinical records reviewed.</p>	V 0715	<p>policy will occur during the week of 4/4/16.</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.</p> <p>The Director of Operations met (DO) with the Medical Director on 4/5/16 to review the medical director citation and reviewed with him, the Medical Director's role in ensuring staff education, training, and performance.</p> <p>Specifically reviewed was the following:</p>	04/15/2016

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	<p>The findings include:</p> <p>Regarding the policy and procedure for newly placed AVFs:</p> <p>1. The Medical Director failed to ensure the facility's 3-20-13 "Assessment and Cannulation of a New A-V Fistula" procedure number FMS-CS-IC-I-115-015C and November 2004 "Cannulation Protocol" had been adhered to by all individuals that provided care to patients.</p> <p>A. The facility's 3-20-13 "Assessment and Cannulation of a New A-V Fistula" procedure number FMS-CS-IC-I-115-015C and November 2004 "Cannulation Protocol"state, "Week One: Obtain order from physician to cannulate AVF . . . 1st Week: Cannulate AVF with a 17-gauge needle for arterial/venous or use catheter for venous/arterial according to MD preference. Blood flow - maximum 250 cc [cubic centimeters]. If no catheter is present, use two 17-gauge needles. 2nd Week: Cannulate with two 17-gauge needles. Blood flow - maximum of 300 cc. 3rd Week: Cannulate with 16-gauge needles. Blood flow - maximum of 350 cc. 4th Week: Cannulate with 16/15-gauge needles. Blood flow per</p>		<p>FMS-CS-IC-II-150-033A"Physician Order Documentation"</p> <p>FMS-CS-IC-II-115-015C "Assessment and Cannulation of a New A-V Fistula"</p> <p>On 4/5/16, the Medical Director directed the Director of Operations to meet with the Clinical Manager to reinforce her role to ensure that all staff are trained and held accountable to policy and procedures.</p> <p>Training on the above mentioned policy will occur during the week of 4/4/16. Included in the training was the following:</p> <p>FMS-CS-IC-II-150-033A"Physician Order Documentation"</p> <p>FMS-CS-IC-II-115-015C "Assessment and Cannulation of a New A-V Fistula"</p> <p>AV Fistula protocol</p> <p>Training on the above mentioned policy will occur during the week of 4/4/16.</p> <p>The Clinical Manager is responsible to evaluate and present the treatment sheet audit</p>	

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	<p>nephrologist orders."</p> <p>B. Clinical record number 1 included a physician order dated 2-22-16 that identified the AVF could be used for the dialysis treatment. The order states, "may use fistula close to [?]. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-24-16. The record failed to evidence the protocol had been followed.</p> <p>1.) The record included hemodialysis treatment flow sheets that evidenced a 16 gauge needle had been used the first treatment of the first week (2-24-16), that one 17-gauge had been used in the arterial site and a 16-gauge had been used in the venous site the second treatment of the first week (2-26-16), and that a 16-gauge had been used in both the arterial and venous sites the 3rd treatment of the first week (2-29-16).</p> <p>2.) The record included hemodialysis treatment flow sheets that evidenced a 16-gauge needle had been used in both the arterial and venous sites for each treatment the 2nd and 3rd weeks (3-2-16, 3-4-16, 3-7-16, 3-9-16, 3-11-16, and 3-14-16).</p>		findings in the monthly QAI meeting/minutes. The QAI Committee is responsible to review, analyze and trend all monitoring results to ensure resolution is both occurring and is sustained.		

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	<p>C. Clinical record number 2 included a physician order dated 12-29-15 that identified the AVF could be used for the dialysis treatment. The order states, "may use fistula in 2 weeks." The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 1-27-16.</p> <p>The record included hemodialysis treatment flow sheets that evidenced one 17-gauge needle had been used weeks 1, 2, and 3 (1-27-16, 1-29-16, 2-1-16, 2-3-16, 2-5-16, 2-8-16, 2-10-16, 2-12-16, &amp; 2-15-16).</p> <p>D. Clinical record number 3 included a physician order dated 2-17-16 that identified the fistula could be used for the dialysis treatment. The order states, "may use access in 1 week." The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-26-16.</p> <p>1.) The record included hemodialysis treatment flow sheets that evidenced a 17-gauge needle had been used in both the arterial and venous sites the first 2 treatments of week 1 (2-26-16 and 2-29-16). The record failed to</p>			

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	<p>evidence what size of needles were used the 3rd treatment of week 1 (3-2-16). The flow sheets evidenced a central venous catheter was in place and available for use the first week per the protocol.</p> <p>2.) The record included hemodialysis treatment flow sheets that evidenced two 16-gauge needles had been used the first and second treatments of week 2 (3-4-16 and 3-7-16). The hemodialysis treatment flow sheet for the 3rd treatment of week 2 failed to evidence what size of needles had been used.</p> <p>3.) The record included a hemodialysis treatment flow sheets that evidenced two 15-gauge needles had been used the first and second treatments of week 3 (3-11-16 and 3-14-16).</p> <p>E. Clinical record number 4 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF protocol. The record failed to include a physician order to use the AVF for the dialysis treatment. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 2-29-16.</p>			

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	<p>F. Clinical record number 5 failed to evidence the interdisciplinary plan of care had been revised and updated to include the facility's new AVF protocol. The record failed to include a physician order to use the AVF for the dialysis treatment. The facility's access records included a "Vascular Access Cannulation Record" that evidenced the protocol had been implemented on 3-3-16.</p> <p>2. The facility administrator was unable to provide any additional documentation and/or information when asked on 3-15-16 at 1:50 PM and on 3-16-16 at 11:30 AM. The facility administrator stated, "We call the physician and get a verbal order, but it is not written and sent for signature." The administrator indicated the plans of care did not evidence updates and revisions to include the new AVF protocol.</p> <p>3. The Medical Director stated, per telephone interview on 3-16-16 at 12:50 PM, "We always need an order to cannulate a new fistula."</p> <p>Regarding the facility's physician orders policy:</p> <p>1. The facility's 6-19-13 "Physician Order Documentation" policy number FMS-CS-IC-II-150-033A states, "All</p>			

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	<p>medical orders must be written in the paper record or entered in the electronic medical record . . . Telephone orders must be: Taken by a licensed nurse who is employed by FMS directly from physician or physician's agent . . . Recorded in the medical record and Medical Information System. Signed by the physician, at the time of the physician's next facility visit, within 30 days, or in accordance with state law, whichever is earliest . . . The use of verbal orders when the physician is in the unit (not a telephone order) is highly discouraged. If the physician is present he/she should write the order directly. Verbal orders must be entered in the clinic system by the nurse who received the verbal order."</p> <p>2. Clinical record number 4 evidenced the patient's newly placed AVF had been utilized for the dialysis treatment and that the facility's vascular access protocol had been implemented. The record included a hemodialysis treatment flow sheet dated 2-17-16 that states, "surgeon gave approval to start protocol 2-29-16." The record failed to evidence an order from the surgeon that had been recorded in the medical record and signed by the physician per the facility's policy.</p> <p>3. Clinical record number 5 evidenced</p>			

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	<p>the patient's newly placed AVF had been utilized for the dialysis treatment and that the facility's vascular access protocol had been implemented. The record included a hemodialysis treatment flow sheet dated 3-3-16 that states, "Dr. [employee Q] here on rounds, ordered to stick AVF. Patient has appt [appointment] for transposition, however MD OK'd to cannulate per protocol." The record failed to evidence an order from the physician that had been recorded in the medical record and signed by the physician per the facility's policy.</p> <p>4. The facility administrator was unable to provide any additional documentation and/or information when asked on 3-15-16 at 1:50 PM and on 3-16-16 at 11:30 AM. The facility administrator stated, "We call the physician and get a verbal order, but it is not written and sent for signature."</p>			