

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  04/29/2016
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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 revisit to the complaint investigation survey conducted on 3-15-16 and 3-16-16.</p> <p>Complaint #: IN00183173; Substantiated, deficiencies related to the complaint were cited.</p> <p>Survey Date: 4-29-16</p> <p>Facility #: 004839</p> <p>Medicare Provider # 15-2591</p> <p>Medicaid Vendor #: 200815900A</p> <p>Census: 77 incenter patients</p> <p>Two (2) conditions and 3 standards were found to be corrected as a result of this survey. One (1) standard remains uncorrected and was re-cited. Two (2) new standards were cited.</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</p>			

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

TITLE

(X6) DATE

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

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	<p>patient or station.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff had provided care in accordance with the facility's own hand hygiene and infection control policies and procedures in 2 (#s 1 and 2) of 2 hand hygiene and infection control observations completed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Employee L, a patient care technician (PCT), was observed to discontinue the dialysis treatment on patient number 12, with an arteriovenous fistula, on 4-29-16 at 11:40 AM (observation # 1). The patient was observed to hold gauze over the needle insertion site with a gloved hand after the needle had been removed. The gauze was observed to be soaked with blood. After the bleeding had stopped, the PCT replaced the blood-soaked gauze with a clean gauze. The PCT was not observed to clean the dried blood from around the needle insertion site.</li> </ol> <p>A. The patient removed the glove from the hand, replaced headphones into a bag and was assisted to a wheelchair. Employee B, a registered nurse (RN), pushed the wheelchair to the scales. The RN was not observed to encourage or remind the patient to cleanse the patient's</p>	V 0113	<p>As such, the Governing Body met on 5/3/16 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. On 5/11/16 the Medical Director was made aware 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. The Director of Operations reviewed the following policies "Infection Control Overview" FMS-CS-IC-II-155-060A with the Clinical Manager on May 11, 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. All current staff will participate in a mandatory in-service by the clinic manager regarding Infection Control Practices the week of 5/11 16 specifically focusing on the policy listed above.</p> <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 May 11,</p>	05/28/2016

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	<p>hands after the glove had been removed. The patient stood and placed hands on the grab bar for support. The RN pushed the patient's wheelchair out into the lobby.</p> <p>B. Immediately after patient # 12 weighed, patient number 13 walked to the scales, stepped onto the scales and placed hands on the grab bar in the exact same place patient # 12 had placed hands. Patient number 13 was not observed to be reminded or encouraged to cleanse hands prior to touching the scales grab bar or leaving the facility.</p> <p>2. Employee K, a PCT, was observed to initiate the dialysis treatment on patient number 14, using an arteriovenous fistula, on 4-29-16 at 12:30 PM (observation # 2). The PCT was not observed to cleanse her hands and change gloves after evaluating the access and prior to cleansing the needle insertion sites with an antiseptic.</p> <p>3. The clinic manager indicated, on 4-29-16 at 1:15 PM, employees B, K, and L had not provided care in accordance with the facility's hand hygiene and infection control policies and procedures.</p> <p>4. The facility's 1-4-12 "Infection Control Overview" policy number</p>		<p>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 the week of 5/11 16 regarding assessment and preparation of internal access needle placement specifically focusing on the policy listed above.</p> <p>The Director of Operations reviewed the following policy "FMS-CS-IS-I-115-013C ""Post Treatment Fistula Needle Removal"" emphasizing her responsibility to ensure all staff members are educated on the policies, staff. 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 post treatment fistula needle removal the week of 5/11 16 specifically focusing on the policy listed above. In addition, the staff will be educated on their responsibility to ensure that all patients sanitize their hand after glove removal.</p> <p>The clinic Manager will have lead preceptor re-educate staff, train</p>	

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	<p>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 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</p>		<p>and demonstrate 5/17/16-5/19/16 and training record will be placed in employee file. Facility Educator performed infection control in service on 5/11/16, reviewing policies with staff.</p> <p>All staff will participate in LMS training on Infection control fundamentals the week of 5/15/16 and a certificate will be placed in the employee personal file.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 4 weeks, weekly 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 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>removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>5. The facility's 1-28-15 "Assessment and Preparation of Internal Access for Needle Placement" procedure number FMS-CS-IS-I-520-005C states, "The access must be assessed each treatment for patency, infection, and any abnormal findings . . . Look . . . Listen . . . Feel for thrill . . . Document and report all findings and interventions before proceeding with needle insertion . . . Remove gloves. Perform hand hygiene . . . Follow the steps below to prepare the skin for cannulation: Wash hands and don PPE [personal protective equipment] to remove bacterial and protect the hands."</p>			

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V 0115 Bldg. 00	<p>6. The facility's 3-26-14 "Post Treatment Fistula Needle Removal" procedure number FMS-CS-IC-I-115-013C states, "Instruct the patient to wash hands following glove removal and prior to leaving treatment area."</p> <p>494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurring or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on observation, record review, and interview, the facility failed to ensure paraprofessional health care providers donned appropriate personal protective equipment (PPE) while on the dialysis treatment floor in 1 (# 1) of 1 paraprofessional observations completed.</p> <p>The findings include:</p> <p>1. On 4-29-16 at 12:05 PM, 2 ambulance personnel were observed to be on the treatment floor. The personnel were observed to transfer patient number 3 from the dialysis chair to a cart at the completion of the dialysis treatment. The</p>	V 0115	<p>The Director of Operations reviewed the following policies "FMS-CS-IC-II-155-080A "Personal Protective Equipment" with the Clinical Manager on May 11, 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 Director of Operations reviewed the following policies "FMS-CS-IC-I-101-039A" "Visitor Policy" with the Clinical Manager on May 11, 2016 emphasizing her responsibility to ensure all staff members are educated on the</p>	05/28/2016

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	<p>personnel were not observed to don personal protective equipment [PPE].</p> <p>2. The clinic manager indicated, on 4-29-16 at 1:15 PM, she was not aware ambulance personnel should don PPE while on the treatment floor.</p> <p>3. The facility's 1-4-12 "Personal Protective Equipment" policy number FMS-CS-IC-II-155-080A states, "Personal protective equipment such as a full face shield or mask and protective eyewear with full side shield, fluid-resistant gowns and gloves will be worn to protect and prevent employee from blood or other potentially infectious materials to pass through to or reach the employee's skin, eyes, mouth, other mucous membranes, or work clothes when performing procedures during which spurting or splattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood)."</p> <p>4. The facility's 3-20-13 "Visitor Policy" number FMS-CS-IC-I-101-039A states, "PPE will be provided along with instructions for proper use if there is a likelihood that the visitor may be exposed to bloodborne pathogens during the time that he/she is in the treatment area."</p>		<p>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 Personal Protective Equipment and Visitor Policy the week of 5/11 16 specifically focusing on the policy listed above.</p> <p>The Clinic Manager or designee will provide personal protective equipment to all visitors upon arrival to treatment room floor. On 5/3/16 and 5/11/16 both ambulance crew administrators were provided information on Personal Protective Equipment and Visitor policy and advised of where gowns are stored upon arrival.</p> <p>The Clinical Manager or designee will ensure that visitors are adhering to the Personal Protective Equipment policy by auditing all visitors upon arrival to the clinic daily for 4 weeks, weekly for 3 months, and then as determined by the QAI committee. 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>	

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V 0122 Bldg. 00	<p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the dialysis machine had been cleaned and disinfected appropriately in 1 (#1) of 1 cleaning and disinfection of the dialysis station observations completed.</p> <p>The findings include:</p> <p>1. Employee L, a patient care technician (PCT), was observed to clean and disinfect the dialysis machine and chair at station number 11 on 4-29-16 at 11:50 AM. The PCT was not observed to empty the prime waste container prior to cleaning the machine.</p> <p>Observation noted a small amount of visible blood on the chair side table (less than 10 milliliters). The PCT was observed to clean the blood from the</p>	V 0122	<p>The Director of Operations reviewed the following procedure "FMS-CS-IC-II-155-110C2 "Work Surface Cleaning and Disinfection with Visible Blood (less than), 10 mls (millimeters) and OPIM (Other Potentially Infection Material) using Bleach Solutions" with the Clinical Manager on May 11, 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 Director of Operations reviewed the following policy "FMS-CS-IC-II-155-110A "Cleaning and Disinfection" with the Clinical Manager on May 11, 2016 emphasizing her responsibility to ensure all staff members are educated on the policies, competency is assessed</p>	05/28/2016

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	<p>table using a cloth saturated with 1:100 bleach. The PCT was then observed to continue cleaning the dialysis chair using the same cloth used to clean the blood from the table.</p> <p>2. The clinic manager indicated, on 4-29-16 at 1:15 PM, employee L had not cleaned and disinfected the dialysis chair at station number 11 in accordance with facility policy.</p> <p>3. The facility's 1-4-12 "Work Surface Cleaning and Disinfection with Visible Blood [less than] 10 mls [milliliters] and OPIM [Other Potentially Infectious Material] using Bleach Solutions" procedure number FMS-CS-IC-II-155-110C2 states, "Clean up all visible blood. Discard the used cloth and gloves in appropriate waste container. Perform hand hygiene and don new gloves."</p> <p>4. The facility's 1-28-15 "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. Make the surface glisteningly wet and let air dry unless otherwise specified by the manufacturer . . . After cleaning up all visible blood, use a new cloth with 1:100</p>		<p>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 cleaning and disinfecting the machine and work surface cleaning with visible blood (less than), 10 mls (millimeters) and OPIM (Other Potentially Infection Material) using Bleach Solutions the week of 5/11 16 specifically focusing on the policy and procedure listed above.</p> <p>The clinic Manager will have lead preceptor re-educate staff, train and demonstrate 5/17/16-5/19/16 and training record will be placed in employee file. Facility Educator performed infection control in service on 5/11/16, reviewing policies with staff.</p> <p>The Clinical Manager or designee will ensure that infection control audits utilizing the QAI Infection Control audit tool are done daily for 4 weeks, weekly 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>	

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	bleach solution for a second cleaning of the surface. Make the surface glisteningly wet and let air dry unless otherwise specified by the manufacturer. Clean and disinfect any surfaces contaminated with blood or OPIM immediately or as soon as feasible."				