STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152504	A. BUILDING 00 B. WING	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE SOUTHERN INDIANA	810 EASTERN BOULEVARD CLARKSVILLE, IN 47129

(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	This was an ESRD federal recertification survey. Survey Dates: September 8, 9, 10, and 11, 2014 Facility #: 005151 Medicaid Vendor #: 100075990A Surveyor: Susan E. Sparks, RN, PHNS Census: 101 incenter, 15 peritoneal dialysis 6 home hemodialysis Quality Review: Joyce Elder, MSN, BSN, RN Sepatember 18, 2014	V000000		
V000119	494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS If a common supply cart is used to store clean supplies in the patient treatment area, this cart should remain in a designated area at a sufficient distance from patient stations to avoid contamination with blood. Such carts should not be moved between stations to distribute supplies. Do not carry medication vials, syringes, alcohol swabs or supplies in pockets. Based on observation and interview, the	V000119	**The management staff, including the facility's CEO,**	10/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	facility failed to ensure staff did not carry objects in their pockets in 1 of 1 dialysis floors observed with the potential to affect all 101 incenter patients. (Employees A, B, C, and E) Findings: 1. On 9/8/14 at 3:40 PM, Employee B, Certified Care Technician (CCHT), reached into her pants pocket under the personal protective equipment gown (PPE) and retried a pen. She signed a form and returned the pen to the front of her gown. 2. On 9/10/14 at 4:20 PM, Employee A, Registered Nurse (RN), reached into her pants pocket under the PPE and retrieved a pen. She signed a form and returned the pen to her pocket. 3. On 9/10/14 at 3:30 PM, Employee C, RN, was asked by Employee E, RN, for the medication cabinet key. Employee C reached into her pants pocket under her PPE and retrieved the keys and gave them to Employee E who used them and then put them in her pocket. 4. On 9/10/14 at 4 PM, the Facility Manager, Employee F, indicated technicians and RNs are not to carry items in their pockets while providing		**met on September 22, 2014, and reviewed the summary of deficiencies from the September 8- 11, 2014 inspection. After a thorough review of all appropriate policies a POC was developed. The following outlines the plan of correction for each deficiency. The Director of Operations will be responsible for coordinating all disciplines to carry out necessary training. V119 494.30(a)(1) IC- Supply Cart Distant/ No Supplies in Pockets On or before 10/20/14 the Clinical Manager will reeducate all direct patient care staff on the following policy: -FMS-CS-IC-II-155-070A "Dialysis Precautions" Policy Education to emphasize unused supplies and equipment should be stored in designated clean areas. No patient supplies are to be stored in uniform pockets. Clinical Manager (or designee) will monitor for compliance by performing weekly infection control audits for 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed**	

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	care on the floor.		**with the individual employee with progressive disciplinary action if required. The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible with oversight from the QAI committee.**	
V000122	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, and equipment. Based on observation and review of policy, the facility failed to ensure the prime waste container was emptied and disinfected when the hemodialysis	V000122	**V122. 494.30(a)(4)(ii) IC-Disinfect Surfaces/Equip/Written Protocol**	10/20/2014

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	machines were being cleaned in 1 of 1 dialysis unit observed with the potential to effect all 101 incenter patients. (Employees D and F) Findings: 1. On 9/10/14 at 3:45 PM, Employee D, a certified personal technician (CCHT), was observed cleaning the machine at station # 17. The prime waste container was not emptied nor disinfected before being set up for the next patient. 2. On 9/11/14 at 10:50 AM, Employee F, CCHT, was observed cleaning the machine at station # 20. The prime waste container was not emptied nor disinfected before being set up for the next patient. 3. A policy titled "Cleaning and Disinfection", effective 20-Mar-2013, FMS-CS-IC-II-155-110-A, states, "Discard all fluid and clean and disinfect all containers associated with the prime waste (including buckets attached to the machines)."		**On or before 10/20/14 the Clinical Manager will reeducate all direct patient care staff on the following policy:** **FMS-CS-IC-II-155-110-A "Cleaning and Disinfection" Policy** **Education to emphasize:** **Staff are to discard all fluid and clean and disinfect all containers associated with the prime waste (including buckets attached to the machines)** **Clinical Manager or designee will monitor for compliance by performing weekly infection control audits x 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required.** **The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified**	

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			deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. **The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review.** **The Clinical Manager is responsible with oversight from the QAI committee.**	
V000543	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; Based on observation and interview, the facility failed to ensure physician prescriptions were followed as ordered in 1 of 12 prescriptions verified with the potential to affect all 101 patients. (17) Findings: 1. On 9/10/14 at 3:15 PM, patient 17 prescription was noted to be 3.0 K, 2.5 CA, which required the staff to set a jug on the front of the machine with the appropriate identification of bath. The dialysis machine was observed being	V000543	**V543. 494.90(a)(1) POC MANAGE VOLUME STATUS On or before 10/20/14 the Clinical Manager will re-educate all DPC staff on the following policy: FMS-CS-IC-I-110-141 C "Pre-Treatment Safety Checks" Procedure Education to emphasize: The following elements are to be verified by two staff members prior to treatment initiation: · Prescribed Dialyzer · Prescribed Dialysate Flow Rate · Prescribed dialysate composition In addition to the Pre-Treatment Safety Checks,**	10/20/2014

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	attached to the wall which held a prescription of 2.0 K, 2.5 CA. When Employee F, a patient care technician, was made aware she got a jug of the appropriate bath and switched out the lines 53 minutes before the patient was to end dialysis. 2. On 9/10 14 at 4:30 PM, the Facility Manager, Employee G, indicated there was a three way check to make sure this did not occur.		**RN will verify dialysis prescription is met by utilizing the RN Rounding Tool at the beginning of each patient shift. To ensure no reoccurrence of this deficiency, the Clinical Manager or Charge Nurse will perform weekly audits of the pre-treatment safety checks and RN rounding tool x 4 weeks. The Clinical Manager will summarize the findings and present them to the QAI committee. If compliance is found to be sufficient the audit frequency will decrease to monthly x2 and then resume the QAI calendar. Any deficiencies will be addressed with the individual employee with progressive disciplinary action if required.** The Clinical Manager will present the findings at the monthly QAI meetings. Any issues will be addressed by the facility's QAI process with root cause analysis. Identified **deficiencies/ trends will require initiation of a formal action plan to be followed through until resolution. The QAI minutes will document this activity and are available for review at the facility. Documentation of staff education is available at the facility for review. The Clinical Manager is responsible and the QAI committee monitors for compliance.**	