STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152567	A. BUILDING 00 B. WING	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SEYMOUR	200 E THIRD ST SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. 00	An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62, for a Medicare participating End Stage Renal Disease Supplier. Survey dates: 03-13, 03-14, and 03-15-2023 ICHD 12-month unduplicated census: 47 Home Peritoneal Dialysis census: 0 Home Hemodialysis census: 0 Stations: 12, without isolation room, waiver granted Total Census: 47 At this Emergency Preparedness survey, Fresenius Medical Care Seymour, was found to have been out of compliance with the Emergency Preparedness Requirements for Medicare at 42 CFR 494.62. QR Completed 3/20/2023 A4	E 0000	FRESENIUS MEDICAL CARE SEYMOUR Plan of Correction for Recertification Provider Identification Number: 15-2567 Date of Survey: 3/15/23 E-0030 Communication plan has required contact information. On March 23, 2023, the Director of Operations met with the Clinic Manager, elicited input, and reinforced the expectations and responsibilities of the facility management on Guidelines for Emergency Preparedness Policy. Please see the Policy reviewed at the bottom of the plan. Emphasis will be placed on: The facility must develop a communication plan for all patients (in-center and home). This plan includes the following: Create and maintain staff, patient and facility emergency information contact lists: * Quarterly, The CM will review and update: -The Emergency and Disaster Patient Contact Information Sheet * A current copy of the emergency lists must: * Be kept locked in the emergency supply boxes, or cart. Effective April 6, 2023, the Clinical Manager or designee will conduct monthly audits utilizing Plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Nelson	Administrator	03/31/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			Correction Audit Tool for three months or until 100% compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency. to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist-Plan of Correction Audit Tool, with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues. identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Guidelines for Emergency Preparedness Completion Date: 4/13/23	
E 0030 Bldg. 00	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under			

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	arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.			

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	*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on observation, record review, and interview the agency failed to follow agency policy to ensure Emergency Patient Contact information was maintained and kept current for 7 of 47 (Patients #6, 7, 16, 23, 24, 25, and 26) patients serviced by the agency.	E 0030	Page 1 of 8External POC Report FRESENIUS MEDICAL CARE SEYMOUR Plan of Correction for Recertification Provider Identification Number:	04/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Findings include: 1. A review of an agency policy dated 05/02/2022 titled, "Guidelines for Emergency Preparedness", indicated but was not limited to, " ...Communication Plan ...The facility must develop a communication plan for all patients ...This plan includes the following: Create and maintain staff, patient, and facility emergency contact information contacts lists: Quarterly, the CM [Clinical Manager] will review and update: ...The Emergency and Disaster Patient Contact Information Sheet. A current copy of the lists must be kept in the emergency supply boxes or cart." 2. During a review of an agency policy dated 08/02/2017 titled, Emergency and Disaster Responsibility Guidelines" page 3 indicated but was not limited to, "Responsible Party ...Clinical Manager ... Action ...Maintain current listing of patients and staff local contact, emergency contact, and evacuation contact information." 3. On 03-13-2023 at 9:00 AM, during a flash tour, the crash cart was inspected. The bottom drawer contained a blue file folder with white labels, "12-16-2022" and "Staff/Patient Emergency Contact List". The pages contained within evidenced the date of printing, "12/16/22". 4. On 03-15-2023 at 2:03 PM, further review of the 'Patient Emergency Contact List' folder failed to evidence the inclusion of information on patients who had been admitted to the facility after 12-16-2022 - Patients #6, 7, 16, 23, 24, 25, and 26. 5. On 03-15-2023 at 10:10 AM, when queried as to how often the 'Patient Emergency Contacts' folder		15-2567 Date of Survey: 3/15/23 E-0030 Communication plan has required contact information On March 23, 2023, the Director of Operations met with the Clinic Manager, elicited input, and reinforced the expectations and responsibilities of the facility management on Guidelines for Emergency Preparedness Policy. Please see the Policy reviewed at the bottom of the plan. Emphasis will be placed on: The facility must develop a communication plan for all patients (in-center and home). This plan includes the following: Create and maintain staff, patient and facility emergency information contact lists: * Quarterly, The CM will review and update: -The Emergency and Disaster Patient Contact Information Sheet * A current copy of the emergency lists must: * Be kept locked in the emergency supply boxes, or cart. Effective April 6, 2023, the Clinical Manager or designee will conduct monthly audits utilizing Plan of Correction Audit Tool for three months or until 100% compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar.	

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	was updated, Administrator #2 indicated this was done quarterly. When queried as to how the agency ensured new patient information was added to the Emergency Contacts folder in between quarterly printings, he indicated the expectation was that with each new patient admission, the list of patients would be re-printed.		Monitoring will be done through the Clinic Audit Checklist- Plan of Correction Audit Tool, with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body	

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			minutes, education and monitoring documentation, are available for review at the clinic. Guidelines for Emergency Preparedness Completion Date: 4/13/23	
V 0000 Bldg. 00	This visit was for a Federal Recertification survey of an ESRD provider conducted by the Indiana Department of Health. Survey dates: 03-13, 03-14, 03-15-2023 ID: 002497 ICHD 12-month unduplicated census: 47 Home Peritoneal Dialysis census: 0 Home Hemodialysis census: 0 Total: 47	V 0000		
V 0113 Bldg. 00	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. Based on observation, record review, and interview the agency failed to ensure infection control practices regarding hand hygiene were maintained as noted over 2 of 3 survey days. (Patient Care Technician (PCT) #3 (nine times),	V 0113	Page 2 of 8External POC Report FRESENIUS MEDICAL CARE SEYMOUR Plan of Correction for Recertification Provider Identification Number:	04/13/2023

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	and #2, Patients: #2, 4 and 9, and Physician Assistant #1). Findings include: 1. During a review of an agency policy dated 11/04/2019, titled, "Hand Hygiene" page 1 indicated but was not limited to, "POLICY ...Hands will be ...Decontaminated using alcohol-based hand rub or by washing hands with antimicrobial soap and water ...When ...Before and after direct contact with patients ...Entering and leaving the treatment area ...Before performing any invasive procedure such as vascular access cannulation ...Immediately after removing gloves ...After contact with body fluids ...non-intact skin or wound dressings, if the hands are not visibly soiled ...After touching inanimate objects near the patient ..." 2. During an observation on 03-14-2023 at 9:40 AM, PCT #3 was observed at Station #9 discontinuing the central venous catheter (CVC) (a vessel inserted into the vein below the collar bone) of Patient #16. After reinfusing the extracorporeal circuit, PCT #3 was observed with gloves on, touching the back of his/her own head and hair, rubbing the back of their neck, and then resting their left hand on their left hip. Gloves were not removed, and hand hygiene was not performed. 3. During an observation on 03-14-2023 at 9:50 AM, PCT #3 was observed at Station #9 completing the discontinuation of a central venous catheter of Patient #16. After flushing both lumens of the CVC and leaving the station, PCT #3 was observed doffing gloves, then immediately applying new gloves. Hand hygiene was not performed.		15-2567 Date of Survey: 3/15/23 V113 IC-Wear gloves/hand hygiene On March 23, 2023, the Clinical Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on: Hand Hygiene Policy: Emphasis will be placed on ensuring infection control practices regarding Hand Hygiene are maintained per policy and procedure. The purpose of this policy is to prevent transmission of pathogenic microorganisms to patients and staff through cross contamination. All staff, patients, patient care givers, including physicians and non-physician practitioners, social workers, dietitians, and any other indirect patient care staff must follow the same requirements for hand hygiene. Hands will be decontaminated using alcohol-based hand rub or by washing hands with antimicrobial soap and water: Before and after direct contact with patients Entering and leaving the treatment area Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications	

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	4. During an observation on 03-14-2023 at 9:53 AM, PCT #3 was observed at the nurse's station doffing gloves and immediately reapplying new gloves. Hand hygiene was not performed. 5. On 03-14-2023 at 2:57 PM, when queried as to the expectation of staff performing hand hygiene at appropriate intervals, Administrator #2 indicated, "staff should sanitize". 6. On 03/14/23 at 9:30 AM, PCT (Patient Care Technician) 3 was observed completing hand hygiene. PCT 3 donned a right glove and entered computer data at station 11. PCT 3 discarded the right glove, donned a left glove, and entered computer data at station 10. PCT 3 discarded the left glove, donned a right glove, and entered computer data at station 9. PCT 3 discarded the right glove, donned a left glove, and entered computer data at station 7. PCT 3 discarded the glove, completed hand hygiene, obtained 2 gloves, and proceeded to sit at the nurse's desk. PCT 3 failed to complete hand hygiene and don new gloves between care stations 7, 9, 10, and 11. 7. On 03/14/23 at 9:46 AM, PCT 2 was observed wearing gloves and exiting the treatment floor via the door to the laboratory hall by using the door handle with gloved hands. PCT 2 entered through the same door with no gloves. PCT 2 was observed walking to the bedside of Patient 5 and lifting the patient's hood. After a short conversation, PCT 2 obtained new gloves and returned to station 4 to clean and sanitize. PCT 2 failed to complete hand hygiene before and after touching a patient prior to donning gloves, and between tasks. 8. On 03/14/23 at 10:09 AM, PCT 3 was observed completing hand hygiene and donning a right		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 After contact with the dialysis wall box, concentrate, drain, or water lines Emphasis will be placed on Hand Hygiene Procedure when decontaminating hands with alcohol-based hand rubs: 1. If gloves are worn, remove and discard in appropriate waste container. Exposes the skin for decontamination. 2. Apply alcohol-based hand rub to the palm of one hand using the amount recommended by the product manufacturer. Adequate amount of product must for maximum effectiveness. 3. Rub hands together covering all surfaces of the hands and fingers, until hands are dry. Note: Duration of the entire procedure: 20-30 seconds By April 5, 2023, 100% of all patients will be re-educated on hand hygiene with documentation of education noted in each patient's EMR. Those patients absent on the day of education will be re-educated on their first	

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	glove. PCT 3 walked to the nurse's desk, obtained a pen, and documented using the gloved right hand. PCT 3 discarded the glove and carried supplies to station 9. PCT 3 donned new gloves and began setting up the pump. PCT 3 failed to perform hand hygiene after doffing gloves, failed to perform hand hygiene and don gloves prior to handling patient supplies, and failed to complete hand hygiene after contact with a contaminated/dirty object. 9. During an observation on 03-13-2023 at 9:15 AM, Patient #2 was observed leaving the treatment floor after their access was decannulated (needles removed) and their weight was obtained by PCT 1. Patient #2 was not offered and did not perform hand hygiene. 10. During an observation on 03-13-2023 at 9:50 AM, Patient #4 was observed leaving the treatment floor after their access was decannulated and their weight was obtained by PCT 2. Patient #4 was not offered and did not perform hand hygiene. 11. During an observation on 03-13-2023 at 10:08 AM, Physician Assistant #1 was observed entering the treatment floor without a face shield. Physician Assistant #1 entered Station #5 to speak with Patient #8. Physician Assistant #1 was given gloves by PCT 2. After speaking with Registered Nurse (RN) 1, Physician Assistant #1 removed their gloves and left the treatment floor. No hand hygiene was performed. 12. During an observation on 03-14-2023 at 9:55 AM, PCT 3 was observed at Station #10 working on the dialysis machine keyboard. PCT 3 moved to gather blood supplies and proceeded to clean the Right Upper Extremity (RUE) Fistula (access site for dialysis) of Patient #10 without changing		treatment back at the facility with documentation noted in the EMR. Effective April 6, 2023, the Clinic Manager or designee will conduct weekly audits utilizing Infection Control Audit Tool for four weeks or until 100% compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis	

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	their gloves or performing hand hygiene. PCT 3 continued to assist Patient #10 to a seated position, obtained the patient's blood pressure and folded the patient's blanket. PCT 3 exited the treatment floor with the blood tubes removing one glove from their left hand to exit the treatment floor. 13. During an observation on 03-14-2023 at 11:03 AM, PCT 3 was observed working on the dialysis machine at Station #4 with a gloved right hand. PCT 3 removed their glove, donned a new glove and moved to Station #11 of Patient 18 and placed bleach soaked gauze on top of the dialysis machine. PCT 3 removed their glove, proceeded to the central station and picked up a marker without performing hand hygiene. 14. During an observation on 03-14-2023 at 11:45 AM, Patient #9 was observed holding their Left Upper Extremity (LUE) Fistula site with their gloved right hand. Once hemostasis was achieved, Patient #9 weighed themselves and left the treatment floor. No hand hygiene was performed. 15. During an observation on 03-14-2023 at 11:52 AM, PCT 3 was observed cleaning the Hoyer Lift (a device used to transfer patients) after use with Patient #14. PCT 3 removed their gloves and applied new gloves without performing hand hygiene. PCT 3 moved to Station #8 and continued to decannulate (remove needles) of Patient #5's LUE Fistula.		process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.Page 3 of 8External POC Report The QAI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Completion Date: 4/13/23	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by			

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	152567	A. BUILDING 00 B. WING	03/15/2023

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FRESENIUS MEDICAL CARE SEYMOUR	200 E THIRD ST SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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, record review, and interview, the facility failed to ensure staff properly cleaned and disinfected the dialysis stations according to agency policy as noted over 2 of 3 survey days. (Patient Care Technician (PCT) #1 (three times) #2 and #3) Findings include: 1. A review of an agency policy dated 11-07-2022, titled, "Cleaning and Disinfection of the Dialysis Station", indicated but was not limited to, "...The chair and dialysis equipment are used by multiple patients during a treatment...it is critical that these items be thoroughly cleaned and disinfected... area including the dialysis machine, and other reusable equipment or supplies...all work surfaces shall be cleaned and disinfected after completion of procedures. Make the surface glisteningly wet and let air dry ..." 2. During an observation on 03-13-2023 at 10:00 AM, Patient Care Technician (PCT) #1 was observed cleaning dialysis station #7. PCT #1 failed to thoroughly wipe down all surfaces (top, front, and sides) of the dialysis machine performing 'spot' cleaning instead, and failed to thoroughly wipe down all surfaces of the station chair. 3. During an observation on 03-13-2023 at 10:05 AM, PCT #1 was observed cleaning dialysis	V 0122	Page 4 of 8External POC Report FRESENIUS MEDICAL CARE SEYMOUR Plan of Correction for Recertification Provider Identification Number: 15-2567 Date of Survey: 3/15/23 V122 IC-Disinfect surfaces/equip/written protocols On March 23, 2023, the Clinic Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on Cleaning and Disinfection of the Dialysis Station Policy. Please see the Policy reviewed at the bottom of the plan. Emphasis will be placed on: The chair and dialysis equipment are used by multiple patients during a treatment day, and it is critical that these items be thoroughly cleaned and disinfected between uses. the dialysis station area including the dialysis machine, chair/bed and other reusable equipment or supplies utilized during dialysis treatment, patient training, and/or patient clinic visits. The dialysis station could become	04/13/2023

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	station #12. PCT #1 failed to thoroughly wipe down all surfaces (top, front, and sides) of the dialysis machine, performing 'spot' cleaning instead, and failed to thoroughly wipe down all surfaces of the station chair. 4. On 03-14-2023 at 2:57 PM, when queried as to what should occur during the cleaning of a dialysis station, Administrator #2 agreed the machine should be 'glistening wet' as per policy, indicating the dialysis machines should be thoroughly cleaned after each use. 5. During an observation on 03-13-2023 at 9:55 AM, PCT 1 was observed cleaning Station #7. PCT 1 failed to clean the inside of the prime container or back of the dialysis machine and swiped the inside of the chair sides. 6. During an observation on 03-13-2023 at 10:12 AM, PCT 2 was observed cleaning Station #3. PCT 2 failed to clean the inside of the prime container or back of the dialysis machine and swiped the inside of the chair sides. 7. During an observation on 03-14-2023 at 10:19 AM, PCT 3 was observed cleaning Station #9. PCT 3 failed to fully open the chair to clean the inside areas and did not clean the television arm or surface.		contaminated with blood and other body fluids during treatment. After use, any non-disposable equipment and supplies brought into the dialysis station (ex. stethoscope) must be disinfected with 1:100 bleach or EPA registered disinfectant before being removed from the dialysis station. Externally disinfect the dialysis machine with 1:100 bleach solutions after each dialysis treatment. All work surfaces shall be cleaned and disinfected with 1:100 bleach solution after completion of procedures. Make the surface glistening wet and let air dry unless otherwise specified by the manufacturer. Follow the steps below to disinfect the dialysis station after each dialysis treatment: Don the appropriate PPE. Remove non-disposable linen or dispose of disposable linen in appropriate waste container. Use a cloth wetted with 1:100 bleach solution or EPA-approved disinfectant to clean and disinfect the dialysis station (chair/bed, tables, machine, prime waste bucket, television, IV pole, B/P cuff, hand sanitizer dispenser and holder, chaise wall behind chair). Place the chair in Trendelenburg position and open side panels if chair has swing open sides so all surfaces of the chair are	

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			accessible. Clean all surfaces. Make the surfaces glisteningly wet and allow to air dry unless otherwise specified by the manufacturer. Give special attention to the cleaning control panel on the dialysis machine and other surfaces that are frequently touched and potentially contaminated with patient's blood and/or body fluids. While wiping, remember to wipe all surfaces of the machine including the air detector chamber, blood pump casing, IV pole and wherever the extracorporeal circuit was in contact with the machine. Pick up all trash or visible medical debris from around the patient chair. Surface disinfect dialysis wall box and the area/wall around the wall box at the end of each treatment day or immediately if splattered with blood. Special attention should be given to removing build-up and/or cleaning splatter and spray of concentrate solution. If concentrate leaks are noted at the wall box, staff should notify biomedical services for repair. Effective April 6, 2023, the Clinic Manager or designee will conduct weekly audits utilizing Infection Control Audit Tool for four weeks or until 100%	

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			compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to	

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			address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic.Page 5 of 8External POC Report Cleaning and Disinfection of the Dialysis Station Completion Date: 4/13/23	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children 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. 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. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery			

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	Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on observation, record review and interview, the facility failed to ensure infection control standards were maintained during the care and dressing change of a central venous catheter as noted over 2 of 3 survey days. (Employee: Patient Care Technician 2 and 3, Registered Nurse 1 and 2) (Patients 12 and 16) Findings include: 1. A review of agency policy "Central Venous Catheter Dressing Change," dated 11/02/2019, indicated to perform hand hygiene and don gloves, remove the old dressing, visually inspect the site and area, then discard the dressing and gloves, and complete hand hygiene. Prepare new dressing by opening the antiseptic and placing the package on the underpad surface, then peel back the dressings and gauze packages and place the opened packages on the underpad surface. Perform hand hygiene and don gloves. Remove the antiseptic from the package and do not contaminate. Clean the CVC site using back and forth friction, about 2 inches, in a concentric circle. Allow to dry for 30 seconds. Apply the clear dressing, being careful not to touch the patient side. The policy failed to indicate a procedure or process to ensure asepsis was maintained throughout the dressing change. 2. On 03/14/23 at 9:15 AM, PCT 2 initiated a CVC dressing change for Patient 12. After preparing	V 0147	Page 6 of 8External POC Report FRESENIUS MEDICAL CARE SEYMOUR Plan of Correction for Recertification Provider Identification Number: 15-2567 Date of Survey: 3/15/23 V147 IC-Staff education-catheters/catheter care On March 23, 2023, the Clinic Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on Changing the Catheter Dressing Policy and Procedure. Please see the Policy reviewed at the bottom of the plan. Emphasis will be placed on: Catheter exit site disinfection and dressing change is to be completed prior to cap and hub connector disinfection. This provides an opportunity to view the exit site for infection or complications and if applicable, notify team leader, charge nurse or home therapy nurse prior to initiating treatment. Removal of Dressing and Inspection of Site: The patient and	04/13/2023

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	supplies, completing hand hygiene, and donning gloves, PCT 2 attempted to position the patient's clothing above and clear of the CVC site, but was unsuccessful. PCT 2 removed and discarded the old dressing and attempted to clamp the hoodie away from the site. The patient's hoodie was observed touching the exposed CVC entry site and surrounding skin. PCT 2 obtained the chlorhexidine swab and cleaned the right side of the CVC site in a back-and-forth motion. The patient's clothing was observed to touch the exposed area multiple times during antiseptic cleaning. Patient 2 was covered with a medication induced and itchy rash and was observed using an unwashed, ungloved hand to aggressively scratch at the catheter entry point and surrounding skin. RN (Registered Nurse) 2 arrived to assist, completed hand hygiene, donned gloves, and positioned the patient's shirt away from the entry site slightly. PCT 2 was observed taking the previously used chlorhexidine swab and beginning the new aseptic site scrub. The PCT and RN failed to maintain asepsis during a CVC dressing change and failed to ensure all patients received CVC care per facility policies and national standard. 3. On 3/14/23 at 9:30 AM, PCT 2 indicated the CVC area should be kept clean and uncontaminated during the dressing change and the patient's clothing should not touch the site without the dressing. 4. On 03/15/23 at 10:28 AM, RN 1 was observed performing a left CVC dressing change on Patient 12. RN 1 cleaned the CVC site aseptically, removed her gloves, and picked up the dressing in ungloved hands to peel the non-stick back off. The RN returned the dressing to the package and completed hand hygiene and donned gloves. RN		caregiver must wear a mask for all procedures that require accessing the catheter. 1. Place an underpad under catheter limbs to protect work area and clothing. 2. Apply mask to patient and caregiver to help prevent contamination by airborne nasal bacteria. 3. Perform hand hygiene. 4. Don clean gloves. 5. Inspect and remove the old dressing. Check to see if dressing looks visibly soiled with exudate or blood. 6. Visually inspect the exit site and surrounding area. Observe for signs and symptoms of infection or complications such as: redness swelling tenderness drainage at the exit site thinning or wearing away of the skin cuff extrusion dislodgement of catheter 7. Notify team leader, charge nurse or home therapy nurse if any of the following are present: Any signs or symptoms as outlined in step 6 Change in the position or appearance of the catheter Dressing visibly soiled with exudate or blood (Do not initiate treatment until instructed by team leader or nurse in charge.)	

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	1 picked up the dressing previously handled with ungloved/unwashed hands and applied it to the patient's CVC site. The RN failed to ensure aseptic technique was maintained during the application of the patient's dressing. On 03/15/23 at 10:38 AM, RN 1 indicated she should have gotten a new dressing. 5. During an observation on 03-13-2023 at 9:45 AM, PCT #3 was observed discontinuing the treatment of Patient #16, a patient with a CVC. PCT 3 failed place a clean field under the CVC ports. PCT 3 removed their gloves and moved to the central desk. PCT 3 donned new gloves without performing hand hygiene documented on the dialysis machine and proceeded to flush one lumen (port of the CVC). PCT 3 removed their gloves, donned new gloves and flushed the second lumen. PCT 3 removed their gloves and did not perform hand hygiene.		8. Discard dressing and remove gloves. Perform hang Hygiene. Cleaning the Site: Follow the steps below to clean the catheter exit site: 1. Perform hand hygiene and don clean gloves. 2. Remove swabstick from package by stick end without touching foam applicator. Handle only the stick portion. 2% Chlorhexidine and 70% alcohol: 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 30 seconds. Use both sides of the swab stick to clean an area the size of the dressing to be applied. If exudate or crusting is noted, an additional swabstick may be necessary to clean the exit site. 3. Triple antibiotic ointment is the preferred therapeutic exit site antibiotic unless otherwise prescribed by physician. Per physician order, apply antimicrobial ointment around exit site minimizing ointment contact with the catheter material. Applying the Dressing: Follow the steps below to apply a dressing to the exit site:Page 7 of 8External POC Report 1. Using aseptic technique, apply the catheter dressing over dry exit site, being careful not to touch the	

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			patient side of the dressing with gloved hands or to any surface. 2. Remove backing of adhesive dressing or apply tape to edges of gauze dressing. note: Gauze dressings must be changed each treatment. Transparent dressings may be changed every 7 days or more often if wet, solied or loose. Effective April 6, 2023, the Clinic Manager or designee will conduct weekly audits utilizing Central Venous Catheter Exit Site Care Audit Tool for four weeks or until 100% compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all	

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			other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Changing the Catheter Dressing Procedure Changing the Catheter Dressing Completion Date: 4/13/23	
V 0543 Bldg. 00	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 record review and interview the agency	V 0543	Page 8 of 8External POC Report FRESENIUS MEDICAL CARE	04/13/2023

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	failed to ensure nursing assessments were completed timely according to agency policy in 2 of 5 patient treatment records (Patients: #5, and #8). Findings include: 1. A review of an agency policy dated 11-01-2021, titled "Nursing Supervision and Delegation" indicated but was not limited to... "Policy, The registered nurse must evaluate each patient preferably within an hour...". 2. On 03-15-2023 at 10:40 AM a clinical record review of Patient #5 was completed. The review indicated 4 of 10 treatment records evidenced the Registered Nurse (RN) assessment failed to meet the one hour limit determined by the agency's policy. The following records indicated: A. On 02-21-2023 at 06:52 AM, approval to start the dialysis treatment of Patient #5 was given. RN #3 completed the assessment at 11:20 AM. B. On 03-02-2023 at 06:56 AM, approval to start the dialysis treatment of Patient #5 was given. RN #5 completed the assessment at 11:51 AM. C. On 03-04-2023 at 07:49 AM, approval to start the dialysis treatment of Patient #5 was given. RN #4 completed the assessment at 07:11 AM. D. On 03-14-2023 at 07:18 AM, approval to start the dialysis treatment of Patient #5 was given. RN #2 completed the assessment at 12:35 PM. 2. On 03-15-2023 at 11:10 AM a clinical record review of Patient #8 was completed. The review indicated 2 of 10 treatment records evidenced the		SEYMOUR Plan of Correction for Recertification Provider Identification Number: 15-2567 Date of Survey: 3/15/23 V543 POC-Manage volume status On March 23, 2023, the Clinic Manager held a staff meeting, elicited input, and reinforced the expectations and responsibilities of the facility staff on Nursing Supervision and Delegation Policy. Please see the Policy reviewed at the bottom of the plan. Emphasis will be placed on: The registered nurse must evaluate each patient preferably within an hour or according to state requirements to: Confirm identify Review the patient's condition. Review accuracy and completeness of treatment and patient data Review patient treatment prescription is being followed. Confirm that the correct vascular access is being used, and that the access is visible. Observe patient's response to treatment. Verify machine safety checks have been completed. Talk to the patient to elicit information such as changes in condition, response to treatment, new injuries, information/education needs or complaints, satisfaction with care.	

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	Registered Nurse (RN) assessment failed to meet the one hour limit determined by the agency's policy. The following records indicated: A. On 03-03-2023 at 07:52 AM, approval to start the dialysis treatment of Patient #8 was given. RN #4 completed the assessment at 9:02 AM. B. On 03-06-2023 at 07:50 AM, approval to start the dialysis treatment of Patient #8 was given. RN #4 completed the assessment at 9:17 AM. 3. On 03-14-2023 at 3:00 PM, Administrator 2 was queried regarding nursing assessments prior to treatment. Administrator 2 indicated they should be completed within an hour of the treatment initiation.		Effective April 6, 2023, the Clinic Manager or designee will conduct weekly audits utilizing Treatment Sheet Audit Tool for four weeks or until 100% compliance is achieved. Once compliance is sustained, the Governing Body will decrease frequency to resume regularly scheduled audits based on the QAI calendar. Monitoring will be done through the Clinic Audit Checklist with any non-compliance noted in the meeting minutes in eQUIP. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152567	A. BUILDING 00 B. WING	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRESENIUS MEDICAL CARE SEYMOUR	200 E THIRD ST SEYMOUR, IN 47274

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			correction is reviewed in QAI monthly. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation, are available for review at the clinic. Nursing Supervision and Delegation Completion Date: 4/13/23	