

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 312325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2020
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NAME OF PROVIDER OR SUPPLIER MERIDIAN-FRESENIUS DIALYSIS AT RED BANK	STREET ADDRESS, CITY, STATE, ZIP CODE 48 EAST FRONT STREET RED BANK, NJ 07701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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V 000	INITIAL COMMENTS This was a COVID-19 Focused Infection Control Survey (NJ00136746) conducted on 6/17/20. The Facility was in compliance with 42 CFR, Part 494, Conditions for Coverage (CfC) for End Stage Renal Disease Facilities. Standard level deficiencies were evident.	V 000		
V 113	IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) 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. This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility policy review on 6/17/20, it was determined that the facility failed to ensure that visitors do not enter clean areas while wearing contaminated gloves. Findings include: Reference #1: Facility policy titled, Visitor Policy, states, "... Visitors have a responsibility to abide by FKC policies and procedures. ..." Reference #2: Facility policy titled, Personal Protective Equipment, states, "... Gloves ... Change gloves and practice hand hygiene between each patient and/or station to prevent cross contamination. ... Remove gloves and wash hands after each patient contact, ... " 1. During observations on the treatment floor at 10:41 AM, Staff #11, an ambulance transport staff	V 113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 07/02/2020
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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V 113	<p>Continued From page 1</p> <p>member, moved a patient from a stretcher to a hemodialysis chair while wearing gloves.</p> <p>a. While wearing the contaminated gloves, Staff #11 went to the clean sink located at the nursing station, entered the clean cloth box, and wetted the cloths with a bleach solution.</p> <p>2. Upon interview at 1:10 PM, Staff #1 stated that the transport staff should not be retrieving any supplies that belong to the facility. Staff #1 stated that the transport staff should have removed his/her gloves, performed hand hygiene, and then asked a facility staff member to get him/her a bleach cloth. Staff #1 confirmed that the sink where the white cloths and bleach are kept is a clean area.</p>	V 113		