STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152507	A. BUILDING 00 B. WING	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BATESVILLE DIALYSIS CENTER	232 SR 129 S BATESVILLE, IN 47006

(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		E 0000		
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: May 3rd, 4th, 5th, and 6th of 2021. Facility Number: 005152 Census: 26 in-center hemodialysis 0 peritoneal dialysis 0 home hemodialysis At this Emergency Preparedness survey, Batesville Dialysis Center, was found to be in compliance with the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. Quality Review completed on 5/18/2021 A4			
V 0000 Bldg. 00		V 0000		
	This visit was for a federal core ESRD (Core) recertification survey in conjunction with a COVID-19 infection control focused survey. Survey Dates: May 3rd, 4th, 5th, and 6th of 2021 Facility Number: 005152 Census: 26 in-center hemodialysis 0 home peritoneal dialysis 0 home hemodialysis			

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

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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 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 all staff demonstrated proper infection control procedures for cleaning and disinfection of contaminated surfaces and equipment to safeguard against potential transmission of COVID-19 with the potential to affect all patients and staff during 5 out of 5 weight observations. Findings include: 1. A policy titled, "Infection Control for Dialysis Facilities" revised October 2020 provided by the manager of clinical services on 5/4/2021 at 9:00 a.m., indicated but was not limited to, "surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of the procedures, before being used on another patient, after spills of blood, throughout the workday, and after each treatment." 2. During an observation on 5/3/2021 at 10:12 a.m., observed a patient entered the treatment area, and step on scale. Non-Entity Employee 2 touched keypad to obtain weight. Patient and Non-Entity Employee 2 exited the treatment floor. No disinfection of scale button or grab bar observed.	V 0122	100% of facility teammates will be in-serviced by the the MCS on Policy 1-05-01 “Infection Control For Dialysis Facilities”. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) …all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient, after spills of blood, throughout the work day, and after each treatment. The scale grab bar and keypad will be disinfected after being touched by patients and teammates. The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly infection	06/04/2021

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	Patient 6 stepped on the scale and pushed the keypad to obtain post weight. No disinfection of scale button or grab bar observed. 3. During an observation on 5/3/2021 at 10:26 a.m., observed Non-Entity Employee 2 entered treatment area with patient, push keypad to obtain patient weight, and exited treatment area with patient. No disinfection of scale button or grab bar observed. 4. During an observation on 5/3/2021 at 10:32 a.m., observed Non-Entity Employee 2 entered treatment area with patient, push keypad to obtain patient weight, and exited treatment area with patient. No disinfection of scale button or grab bar observed. 5. During an observation on 5/3/2021 at 10:46 a.m., observed Non-Entity Employee 2 entered treatment area with patient, push keypad to obtain patient weight, and exited treatment area with patient. No disinfection of scale button or grab bar observed. 6. An interview with the manager of clinical services and the regional operations director was conducted on 5/3/2021 at 3:40 p.m. during the daily conference meeting. Discussed findings found with staff and patients utilizing the scale button and grab bar without disinfecting between patients. The manager of clinical services stated that the scale button and grab bar should be disinfected between patients.		control audit. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction.	
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			

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	team must provide the necessary care and services to manage the patient's volume status; Based on observation, record review, and interview, the facility failed to follow their policy and ensure blood pressures were assessed at a minimum of every thirty minutes during dialysis treatment in 2 of 5 patients reviewed (Patient 3 and 5) and failed to follow facility policy and ensure the PCT (Patient Care Technician) notified a licensed nurse of BP (blood pressure) rates not within parameters in 4 of 5 patients reviewed (Patient 1, 2, 3, and 5). Findings include: 1. A policy published September 2007 and updated April 2021 was provided by the manager of clinical services on 5/4/2021 at 11:46 a.m. titled "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment." The policy indicated, but was not limited to, "Vital signs and treatment monitoring. For non-nocturnal treatments is completed at least every thirty (30) minutes." ... "Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately." ... "All findings, interventions and patient response will be documented in the patient's medical record." ... "Abnormal findings: the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record. Blood Pressure: Pre dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg, Diastolic greater than or equal to 100 mm/Hg. Blood pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from the patient's last intradialytic treatment BP reading. Blood Pressure	V 0543	100% of clinical teammates will be in-serviced on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment”. Verification of attendance at thein- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Vital signs and treatment monitoring: For nonnocturnal treatments is completed every thirty (30) minutes. 2) Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately…3) All findings, interventions and patient response will be documented in the patient’s medical record. 4) Abnormal Findings: ..the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient’s medical record. Blood Pressure: Pre dialysis: Systolic greater than 180 mm/Hg…Diastolic greater than or equal to 100 mm/Hg; Blood Pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from patient’s last intradialytic treatment BP reading. Blood Pressure Post Treatment:	06/04/2021

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	Post Treatment: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg, Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg. Sitting BP for patient's that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg." 2. The clinical record for patient 1 was reviewed on 5/4/2021 for treatments dated 4/2/2021, 4/23/2021, 4/26/2021, 4/28/2021, and 4/30/2021 and evidenced the following: On 4/2/2021 at 11:19 a.m. patient 1's treatment sheet evidenced a BP (blood pressure) of 136/68 with a subsequent BP of 107/76 at 11:58 a.m. by PCT (patient care technician) E. At 1:28 p.m. patient 1's treatment sheet evidenced a BP of 112/85 with a subsequent BP reading of 140/70 at 2:04 p.m. by PCT E. Greater than 20 mm/Hg SBP (systolic blood pressure) reading noted from the previous BP reading. PCT E failed to notify the RN (registered nurse) of a SBP difference of 20 mm/Hg increase/decrease from the patient's last intradialytic (during dialysis) treatment BP reading. On 4/23/2021 at 3:20 p.m., patient 1's treatment sheet evidenced a BP of 146/93 post treatment by PCT F. PCT F failed to notify a licensed nurse of a SBP greater than 140 mm/Hg post dialysis treatment. On 4/26/2021 at 3:02 p.m., patient 1's treatment sheet evidenced a BP of 154/79 post treatment by PCT D. PCT D failed to notify a licensed nurse of SBP greater than 140 mm/Hg post dialysis treatment. On 4/28/2021 at 2:55 p.m., patient 1's treatment		Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg; Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg; Sitting BP for patient that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90mm/Hg or less than 50 mm/Hg. A summary of “Abnormal Findings” will be post on the Chairside Snappy Stations. The Facility Administrator or designee will audit 10% of post treatment records daily x 1 week and then weekly until 90% adherence is achieved to verify compliance with facility policy. Ongoing compliance will be verified with 10% of post treatment record review monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan oin-service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Vital signs and treatment monitoring: For nonnocturnal treatments is completed every thirty (30) minutes. 2) Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the	

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	sheet evidenced a BP of 149/73 post treatment by PCT E. PCT E failed to notify a licensed nurse of SBP greater than 140 mm/Hg post dialysis treatment. On 4/30/2021 at 12:31 p.m., patient 1's treatment sheet evidenced a BP of 102/78 with subsequent BP's of 177/115 at 1:02 p.m., 209/90 at 1:32 p.m., 170/43 at 2:03 p.m., and 143/ 71 at 2:31 p.m. by PCT D. PCT D failed to notify a licensed nurse of a BP difference of 20 mm/Hg greater than the previous reading. 3. The clinical record for patient 2 was reviewed on 5/4/2021 for treatments dated 4/5/2021, 4/7/2021, 4/9/2021, 4/12/2021, 4/16/2021, 4/19/2021, 4/21/2021, 4/23/2021, 4/26/2021, and 4/30/2021 and evidenced the following: On 4/5/2021 at 6:13 a.m. patient 2's treatment sheet evidenced a BP of 142/82 with subsequent BP of 102/88 at 6:43 a.m., and 138/82 at 7:04 a.m. by PCT D. PCT D failed to notify a licensed nurse of a BP difference of greater than 20 mm/Hg from the previous BP reading. On 4/7/2021 at 9:47 a.m. patient 2's treatment sheet evidenced a post BP of 155/97 by PCT D. PCT D failed to notify a licensed nurse of a post SBP reading of greater than 140 and a post DBP (diastolic blood pressure) greater than 90. On 4/9/2021 at 9:45 a.m. patient 2's treatment sheet evidenced a post BP of 161/93 by PCT E. PCT E failed to notify a licensed nurse of a post SBP greater than 140 and post DBP greater than 90. On 4/12/2021 at 6:29 a.m. patient 2's treatment sheet evidenced a BP reading of 129/75 with a subsequent BP reading of 100/66 at 7:00 a.m. by		licensed nurse immediately…3) All findings, interventions and patient response will be documented in the patient's medical record. 4) Abnormal Findings: ..the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record. Blood Pressure: Pre dialysis: Systolic greater than 180 mm/Hg…Diastolic greater than or equal to 100 mm/Hg; Blood Pressure-Intradialytic: Difference of 20 mm/Hg increase or decrease from patient's last intradialytic treatment BP reading. Blood Pressure Post Treatment: Standing systolic BP greater than 140 mm/Hg or less than 90 mm/Hg; Standing diastolic BP greater than 90 mm/Hg or less than 50 mm/Hg; Sitting BP for patient that cannot stand: Sitting systolic BP greater than 140 mm/Hg or less than 90 mm/Hg. Sitting diastolic BP greater than 90mm/Hg or less than 50 mm/Hg. A summary of "Abnormal Findings" will be post on the Chairside Snappy Stations. The Facility Administrator or designee will audit 10% of post treatment records daily x 1 week and then weekly until 90% adherence is achieved to verify compliance with facility policy. Ongoing compliance will be verified with 10% of post treatment record	

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	PCT E. PCT E failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading. On 4/16/2021 at 6:02 a.m. patient 2's treatment sheet evidenced a BP of 146/91 with a subsequent BP of 120/80 at 8:32 a.m. by PCT D. PCT D failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading. At 9:43 a.m. a post BP of 151/102 was noted by PCT E. PCT E failed to notify a licensed nurse of a post SBP greater than 140 and a post DBP greater than 90. On 4/19/2021 at 9:44 a.m. patient 2's treatment sheet evidenced a BP of 153/93 by Employee D. Employee D failed to notify a licensed nurse of a post SBP greater than 140 and a post DBP greater than 90. On 4/21/2021 at 8:31 a.m. patient 2's treatment sheet evidenced a BP of 139/88 with subsequent BP of 117/78 at 9:01 a.m. by PCT D. PCT D failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading. On 4/23/2021 at 6:12 a.m. patient 2's treatment sheet evidenced a BP of 161/90 with subsequent BP's of 140/76 at 6:30 a.m., 108/88 at 7:00 a.m., 118/81 at 7:30 a.m., 150/91 at 8:01 a.m., 154/87 at 8:31 a.m., 125/81 at 9:01 a.m., and 95/53 at 9:12 a.m. by PCT D. PCT D failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading. At 9:43 a.m. a post BP of 159/97 was noted by PCT D. PCT D failed to notify a licensed nurse of post SBP greater than 140 and a post DBP greater than 90. On 4/26/2021 at 7:14 a.m. patient 2's treatment		review monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of correction.	

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	sheet evidenced a BP of 117/79 with a subsequent BP of 145/89 at 7:38 a.m. by PCT D. At 9:45 a.m. a post BP reading of 149/99 was noted by PCT D. PCT D failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading and failed to notify a licensed nurse of a post SBP greater than 140 and post DBP greater than 90. On 4/30/2021 at 7:31 a.m. patient 2's treatment sheet evidenced a BP of 146/90 with a subsequent BP of 118/79 by PCT E. At 10:01 a.m. a post BP of 168/104 was noted by PCT F. PCT E failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading and PCT F failed to notify a licensed nurse of a post SBP greater than 140 and a post DBP greater than 90. 4. The clinical record for patient 3 was reviewed on 5/4/2021 for treatments dated 4/6/2021, 4/8/2021, 4/10/2021, 4/15/2021, 4/17/2021, 4/20/2021, 4/24/2021, and 5/1/2021 and evidenced the following: On 4/6/2021 patient 3's treatment sheet evidenced a BP of 184/99 at 7:05 a.m. at treatment initiation and BP of 176/92 at the end of treatment by PCT E. At 9:29 a.m. a BP of 169/90 with a subsequent BP reading of 197/103 at 10:00 a.m. was noted by PCT E. PCT E failed to notify a licensed nurse of SBP greater than 180 mm/Hg before starting treatment, a SBP greater than 140 at end of treatment, and failed to notify a licensed nurse of a BP difference greater than 20 mm/Hg from the previous BP reading. On 4/8/2021 patient 3's treatment sheet evidenced a post BP of 186/102 at 11:01 a.m. by PCT D. PCT D failed to notify a licensed nurse of a post SBP			

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	greater than 180, and a post DBP greater than 90. On 4/10/2021 patient 3's treatment sheet evidenced a BP of 205/165 at 7:00 a.m. at the initiation of treatment and a BP of 190/104 at 10:58 a.m. at the end of treatment by PCT G. PCT G failed to notify a licensed nurse of a SBP greater than 180 and a DBP greater than 100 mm/Hg prior to starting treatment and a SBP greater than 140 and a DBP greater than 90. On 4/15/2021 patient 3's treatment sheet evidenced a BP of 198/125 prior to starting treatment by PCT D. PCT D failed to notify a licensed nurse of SBP greater than 180 and DBP greater than 100 prior to starting treatment. On 4/17/2021 patient 3's treatment sheet evidenced a BP of 206/105 at 6:58 a.m. prior to starting treatment and a BP of 196/117 at 10:58 at end of treatment by PCT G. PCT G failed to notify a licensed nurse of SBP greater than 180 and DBP greater than 100 prior to starting treatment and failed to notify a licensed nurse of SBP greater than 140 and DBP greater than 90. On 4/20/2021 patient 3's treatment sheet evidenced a post BP of 166/101 at 11:01 a.m. by PCT E. PCT E failed to notify a licensed nurse of a SBP greater than 140 and a DBP greater than 90. On 4/24/2021 patient 3's treatment sheet evidenced a post BP of 158/72 at 11:00 a.m. by PCT D. PCT D failed to notify a licensed nurse of a SBP greater than 140. On 5/1/2021 patient 3's treatment sheet evidenced a post BP of 152/68 at 11:00 a.m. by PCT F. PCT F failed to notify a licensed nurse of a post SBP greater than 140. A vital sign check at 9:00 a.m.			

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	with subsequent vital sign check at 9:55 a.m. evidenced a lapse in vital checks of 55 minutes. The facility failed to check vital signs every 30 minutes. 5. The clinical record for patient 5 was reviewed on 5/4/2021 for treatments dated 4/5/2021, 4/7/2021, 4/10/2021, 4/14/2021, 4/21/2021, 4/23/2021, 4/26/2021, and 4/28/2021 and evidenced the following: On 4/5/2021 patient 5's treatment sheet evidenced a BP of 156/88 at 1:02 p.m. with a subsequent BP of 187/98 at 1:32 p.m. by PCT E. A BP of 198/112 at 2:32 p.m. with a subsequent BP of 172/97 at 3:02 p.m. by PCT D. PCT E and PCT D failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. On 4/7/2021 patient 5's treatment sheet evidenced a BP of 170/82 at 3:32 p.m. with a subsequent BP of 192/94 at 4:05 p.m. by PCT G. PCT failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. On 4/10/2021 patient 5's treatment sheet evidenced a BP of 124/107 at 7:58 a.m. with a subsequent BP of 166/81 at 8:29 a.m. A BP of 177/93 at 10:01 a.m. followed by subsequent BP readings of 140/87 at 10:31 a.m. and 195/122 at 11:26 a.m. PCT G failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading and failed to notify the RN of a DBP greater than 110 post treatment. Vital check taken at 10:31 a..m showed a lapse of 55 minutes until the next vital check at 11:26 a.m. The facility failed to assess vital checks at a minimum of every 30 minutes. On 4/14/2021 patient 5's treatment sheet			

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	evidenced a BP of 177/88 at 2:30 p.m. with subsequent BP's of 144/85 at 3:00 p.m., 173/92 at 3:30 p.m., and 150/88 at 3:35 p.m. by PCT G. PCT G failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. On 4/21/2021 patient 5's treatment sheet evidenced a lapse of 58 minutes between vital sign checks. BP reading of 198/90 at 11:54 a.m. with subsequent BP of 204/96 at 1:02 p.m. The facility failed to monitor vital signs every 30 minutes. On 4/23/2021 patient 5's treatment sheet evidenced a BP of 147/109 at 12:13 p.m. with a subsequent BP of 189/97 at 12:32 p.m. A BP of 190/100 at 3:32 p.m. with a subsequent BP of 163/85 at 3:44 p.m. by PCT D. PCT failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. On 4/26/2021 patient 5's treatment sheet evidenced a BP of 176/110 at 3:01 p.m. with a subsequent BP's of 126/91 at 3:31 p.m. by PCT D. PCT D failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. On 4/28/2021 patient 5's treatment sheet evidenced a BP of 172/109 at 3:02 p.m. with a subsequent BP of 201/106 at 3:30 p.m. by PCT E. PCT E failed to notify a licensed nurse of a difference greater than 20 mm/Hg from the previous BP reading. 6. An interview with the manager of clinical services was conducted on 5/5/2021 at 9:15 a.m. Discussed findings found with medical record review, including but not limited to, unreported			

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	152507	A. BUILDING 00 B. WING	05/06/2021

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	blood pressures outside the parameters defined in the facility's policy, unmet target weights post treatment, and wrong blood flow rates documented during treatment. Manager of clinical services did not verbalize any additional response to these findings.			
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review and interview, the facility failed to ensure patient's prescribed BFR (blood flow rates) was maintained throughout dialysis treatment in 2 or 5 patients reviewed (Patient 3 and 5). Findings include: 1. A policy published September 2007 and updated April 2021 was provided by the manager of clinical services on 5/4/2021 at 11:46 a.m. titled "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment." The policy indicated, but was not limited to, "If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed." 2. On 4/3/2021 patient 3's treatment sheet evidenced a prescribed BFR (blood flow rate) of 450 ml/min (millimeters per minute). Patient 3 ran a BFR of 400 during the entire treatment. The facility failed to follow the prescribed BFR during	V 0544	100% of clinical teammates will be in-serviced on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment”. Verification of attendance at the in- service will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reason will be documented and the license nurse informed. The Facility Administrator or designee will audit 10% of post treatment records daily x 1 week and then weekly until 90% adherence is achieved to verify compliance with facility policy. Ongoing compliance will be verified with	06/04/2021

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	treatment. On 4/15/2021 patient 3's treatment sheet evidenced a prescribed BFR of 450 ml/min. Patient 3 ran a BFR of 400 ml/min the entire treatment except at 8:31 a.m., patient ran a BFR of 410 ml/min. Ordered BFR was 450. The facility failed to follow the prescribed BFR during treatment. On 4/29/2021 patient 3's treatment sheet evidenced a prescribed BFR of 400ml/min. Patient 3 ran a BFR of 450 ml/min for the first 2 hours of treatment. The facility failed to follow the prescribed BFR during treatment. 3. On 4/10/2021 patient 5's treatment sheet evidenced a BFR of 400 ml/min during the entire treatment. Patient 5's ordered BFR is 350 ml/min. The facility failed to follow the prescribed BFR during treatment. 4. An interview with the manager of clinical services was conducted on 5/5/2021 at 9:15 a.m. Discussed findings found with medical record review, including but not limited to, unreported blood pressures outside the parameters defined in the facility's policy, unmet target weights post treatment, and wrong blood flow rates documented during treatment. Manager of clinical services did not verbalize any additional response to these findings.		10% of post treatment record review monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (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,			

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	including attending physicians and nonphysician providers; Based on observation, record review, and interview, the medical director failed to ensure that all staff followed policy and procedure, demonstrating proper infection control procedures by removing PPE (Personal Protective Equipment) when exiting the treatment area in 1 of 1 facility observed. Findings include: A policy titled, "Infection Control for Dialysis Facilities" revised October 2020 provided by the manager of clinical services on 5/4/2021 at 9:00 a.m., indicated but was not limited to, "PPE is to be removed prior to leaving the treatment area. PPE is not to be worn in non-treatment areas, for example, teammate lounge, teammate offices." A revised March 2017 CDC (Centers for Disease Control and Prevention) publication titled, "Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings - Recommendations of the Healthcare Infection Control Practices Advisory Committee" indicated but was not limited to, "remove and discard PPE, other than respirators, upon completing a task before leaving the patient's ... care area." During an observation on 5/3/2021 at 10:45 a.m. during the flash tour the charge nurse was observed exiting the treatment area and entering the patient waiting room with gown, mask, face shield, and gloves on. During an observation on 5/3/2021 at 10:52 a.m. during the flash tour PCT E was observed exiting the treatment area and entering the patient waiting	V 0715	100% of teammates will be in-serviced on Policy 1-05-01 “Infection Control For Dialysis Facilities”. Verification of attendance at the inservice will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) PPE is to be removed prior to leaving the treatment area. 2) PPE is not to be worn in non-treatment areas, for example, teammate lounge, teammate offices. Teammates will be instructed to remove PPE prior to leaving the treatment area and don clean PPE for screening in the lobby. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly infection control audit. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction.	06/04/2021

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	room with gown, mask, face shield, and gloves on. An interview with the manager of clinical services and the regional operations director was conducted on 5/3/2021 at 3:38 p.m. during the daily conference meeting. Discussed findings found with staff exiting the treatment area to the waiting room in full PPE. The manager of clinical operations agreed this was policy, but with COVID 19 pandemic, questioned how to follow this policy if full PPE is required to screen patients prior to entering the treatment area.			