STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152603	A. BUILDING 00 B. WING	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN DIALYSIS	1140 W JEFFERSON ST STE A FRANKLIN, IN 46131

(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 Survey Dates: 07-22, 07-23, and 07-24-2024 Active Census: 27 CCN: 152603 Facility #: 011351 Census by Service Type: In Center Hemodialysis: 27 No Home Peritoneal Dialysis No Home Hemodialysis Stations: 14 No Isolation Room: Copy of waiver provided At this Emergency Preparedness survey, Franklin Dialysis was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers at 42 CFR 494.62. QR completed by Area 3 on 7-29-2024.	E 0000		
E 0039 Bldg. 00	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Cowan	Facility Administrator	08/09/2024

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.

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	§483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed			

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	messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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	to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]			

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	(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE			

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	organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual			

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	natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview the facility failed to complete a post emergency disaster drill response to analyze the results and actions taken by the facility in a simulated and an actual emergency event in 1 of 1 facilities. The Findings Include: 1. A review of a binder titled Emergency Preparedness received from the Facility on 07-23-2024 at 2:36 evidenced 3 Emergency Events activated in the facility including a cardiopulmonary resuscitation drill on 11-27-2023, a full scale severe weather event on 03-28-2024 and simulated fire drill on 07-05-2024. Each event	E 0039	E0039 The Facility Administrator (Clinical Preceptor) or Clinical Coordinator (Registered Nurse) will in-service all clinical teammates on Policy 4-07-01 “Facility Emergency Management Plan”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations with emphasis on, but not limited to the following: 1) The facility will conduct and/or participate in one (1) exercise to test the facility	08/24/2024

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	failed to evidence an after action review identifying the response by the facility. 2. During an interview on 07-23-2024 at 3:20 PM the Facility administrator reported the staff had talked about the events but had not completed any documentation or had any formal review of drills or actual events to identify actions or processes needing improvement.		EMP at least ANNUALLY, conducted on OPPOSITE years (one year full-scale exercise, next year facility-based / exercise of choice)…2) Documentation is required. 3) Utilize FACILITY EMERGENCY PLAN ACTIVATION template and document: Event that occurred b. Plan and policies activated c. Evaluation of plan d. Plan revisions required e. Governing Body review. 4) Maintain copy with facility EMP. The Facility Administrator or Clinical Coordinator will audit the facility Emergency Management Plan quarterly to verify compliance with facility policy. Ongoing compliance will be verified annually. Instances of non-compliance will be addressed. The Facility Administrator will review audit findings with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator will be responsible for compliance with the plan of correction. 8/24/22	
V 0000 Bldg. 00	This visit was for a CORE Federal recertification in	V 0000		

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	conjunction with 1 complaint survey of an ESRD provider. Survey dates: 07-22, 07-23, and 07-24-2024. Complaint #: IN00437961 Facility #: 011351 CCN: 152603 Census by Service Type: In Center Hemodialysis: 27 No Home Peritoneal Dialysis No Home Hemodialysis Total Census: 27 Stations: 14 No Isolation Room: Copy of waiver provided. QR completed by Area 3 on 7-29-2024.			
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 facility failed to ensure that the staff changed gloves and performed hand hygiene during central venous catheter (CVC) (a long flexible tube inserted into a large vein to receive drugs, fluids, or blood) dressing changes in 2 of 3 observations, (Patients #4, and 19) (Employee: Patient Care Technician (PCT) 6, (twice)), failed to ensure all staff performed hand hygiene between glove changes in 6 (Employees: PCT 1 (four	V 0113	V 113 The Facility Administrator (Clinical Preceptor) or Clinical Coordinator (Registered Nurse) will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” and Policy 1-04-02B “Central Venous Catheter (CVC) With CLEARGUARD HD Antimicrobial	08/22/2024

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	times), PCT 5, and PCT 6) of 25 staff observations conducted, and failed to ensure patient were instructed or offered hand hygiene in 2 of (Patients: #16, and 18) of 5 patient observations post-treatment. (Employees: PCT 1 and PCT 5) Findings Include: 1. A review of a DaVita Incorporated policy revision dated April 2023, titled "Infection Control For Dialysis Facilities," was provided by the Regional Director of Operations (ROD), Corp 1, on 07-24-2024 at 12:15 PM. The policy indicated but was not limited to, " To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment ... All teammates ... will perform hand hygiene ...prior to gloves and immediately after removal of gloves ...after patient and dialysis delivery system contact ... before touching clean areas such as supplies, supply cart, and chairside keyboard/mouse ... Patients and caregivers will be encouraged to ... Perform hand hygiene after treatment before leaving the treatment area ... " 2. A review of a DaVita Incorporated policy revision dated October 2023, titled "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure" was provided by the Regional Director of Operations (ROD), Corp 1, on 07-24-2024 at 12:15 PM. The policy indicated but was not limited to, " ... 4. Remove old dressing and discard ... 5. Observe site for signs and symptoms ... 7. Remove gloves and discard. Perform hand hygiene ... 8. ...using aseptic technique, clean exit site ...9. Clean each CVC limb/cap with new LARGE alcohol prep pad. ... 10. Remove gloves and discard, perform had hygiene ... "		End Caps Procedure" beginning7/31/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations with emphasis on, but not limited to the following: 1) PURPOSE: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. 2) All teammates…will perform hand hygiene: … prior to gloving and immediately after removal of gloves… after patient and dialysis delivery system contact… before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. 3) Patients and caregivers will be encouraged to … Perform hand hygiene after treatment before leaving treatment area. 4) Remove old dressing and discard. 5) Remove old dressing and discard. 6) Observe site for signs and symptoms…7) Remove gloves and discard. 8) Perform hand hygiene. 9) Clean each CVC limb/cap with a new LARGE alcohol prep pad…10) Remove gloves and discard, perform hand hygiene…The Facility Administrator pr Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the	

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	152603	A. BUILDING 00 B. WING	07/24/2024

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	2. On 07-22-2024 at 10:05 AM, a sign posted at the patient prep sink was viewed. The sign stated, " Did you wash them?" 3. On 07-22-2024 at 1:25 P.M., the Facility Administrator (FA) provided facility documents dated 03-30-2024 through 07-01-2024 titled "Monthly Infection Control Audit." The documents indicated a review of infection control treatment floor observation audits completed by RN 1 and FA. 4. During an observation on 07-22-2024 at 9:42 AM, PCT 1 was observed initiating dialysis treatment for Patient #20. The PCT evaluated and palpated Patient #20' 's left upper access using a burgundy stethoscope. PCT 1 then placed the stethoscope around their neck, applied antiseptic to the skin over the cannulation sites, and inserted the cannulation needles. PCT 1 failed to remove their gloves, perform hand hygiene, and don new gloves after evaluating the patient's access. 5. During an observation on 07-22-2024 at 11:35 AM, PCT 6, was observed performing CVC exit site care. PCT 6 removed the port dressing and CVC exit site dressing from Patient #19's CVC site and discarded them into the trash receptacle. PCT 6 failed to remove their gloves, perform hand hygiene, or don new gloves. The PCT cleansed around the CVC exit site, applied dressing, and initiated dialysis treatment. 6. During an observation on 07-22-2024 at 11:51 AM, PCT 6, was observed performing CVC exit site care for Patient #4. PCT 6 removed the port dressing and CVC exit site dressing from Patient #4's CVC site and discarded them into the trash receptacle, discarded their gloves and donned		internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction. 8/22/24	

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	new gloves, and did not perform hand hygiene. PCT 6 went to the supply cart, obtained tape, did not remove their gloves or perform hand hygiene, and placed the tape on the chair side tray. The PCT removed their left-hand glove and discarded the glove in the trash receptacle, obtained a dressing from the supply cart, and donned a new glove without performing hand hygiene after the removal of the glove or prior to donning a new glove. PCT 6 reached into a supply bag hanging on the dialysis machine pole and obtained a syringe. The PCT failed to remove their gloves, perform hand hygiene, and don new gloves prior to initiation of dialysis treatment. 7. During an observation on 07-22-2024 at 3:15 PM, PCT 6, was observed discarding unused supplies from Station #7. The PCT discarded the supplies in the trash receptacle, removed their gloves, and discarded them into the trash receptacle. Then, PCT 6 was observed touching the computer keyboard for Station #7 without performing hand hygiene. During an interview on 07-22-2024 at 3:59 PM, PCT 6 confirmed hand hygiene should be completed before applying gloves, upon removal of gloves, every time they touch a chair, or touch the machines, after removing old CVC dressing, and applying new gloves. 8. During an observation on 07-24-2024 at 9:50 AM, PCT 5 was observed initiating dialysis with CVC for Patient #6. PCT 5 was observed connecting sterile syringes to each port, removing indwelling solutions, discarding their gloves in the trash container, donning new gloves without performing hand hygiene, and continuing to initiate dialysis treatment for Patient #6.			

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	9. During an observation on 07-24-2024 at 10:30 PCT 1 discontinued the dialysis treatment for Patient #16. Patient #16 removed the glove from their right hand after holding the left upper access and discarded their glove in the trash receptacle. Patient #16 was not offered hand hygiene or instructed to perform hand hygiene prior to leaving the treatment area. 10. During an observation on 07-24-2024 at 10:38 AM, PCT 5, discontinued the dialysis treatment for Patient #18. Patient #18 removed the glove from their right hand after holding the left lower access and discarded their glove in the trash receptacle. Patient #18 was not offered hand hygiene or instructed to perform hand hygiene prior to leaving the treatment area. During an interview on 07-24-2024 at 10:51 AM, Patient #18, when queried regarding the staff instructing on hand hygiene before and after they held their access, stated, "They are new staff, so they did not." 11. During an observation on 07-24-2024 at 10:40 AM, PCT 1, was observed on the computer keyboard at Station #4. PCT donned gloves without hand hygiene, removed the blood pressure cuff for Patient #16, removed their gloves, discarded them in the trash, and touched the keyboard computer without hand hygiene. During an interview on 07-24-2024 at 11:26 AM, PCT 1, confirmed hand hygiene should be completed prior to donning gloves, after the removal of gloves, after removing a CVC dressing, after they touch the patient, after they touch a dialysis machine or the keyboard on the computer.12. During an observation on 07-22-2024 at 3:45 PM, PCT 1 disconnected patient			

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	#9's dialysis treatment, discarded supplies, removed gloves, and doffed clean gloves. PCT 1 failed to sanitize hands after removing gloves and doffing clean gloves.			
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 the proper disinfection and cleaning of the dialysis station in 4 of 6 observations. (Employees: Patient Care Technician (PCT) PCT 1(twice), PCT 3, PCT 5) Findings Include: 1. A review of a DaVita Incorporated policy revision dated April 2023, titled "Infection Control For Dialysis Facilities," was provided by the Regional Operational Director (ROD), Corp 1, on 07-24-2024 at 12:15 PM. The policy indicated but was not limited to, " To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment ... Disinfection ... At the end of each treatment, the dialysis station will be cleaned and disinfected ... Surfaces to disinfect include ... all surfaces in contact with the patient or their belongings ... dialysis chair, tray tables, blood pressure cuffs ... frequently contacted by healthcare personnel ... control panel, top, front and sides of dialysis	V 0122	V122 The Facility Administrator (Clinical Preceptor) or Clinical Coordinator (Registered Nurse)will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning7/31/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations with emphasis on, but not limited to the following: 1) PURPOSE: To minimize the spread of infections or bloodborne pathogens in the dialysis facility environment. 2) DISINFECTION: … At the end of each treatment, the dialysis station will be cleaned and disinfected. 3) Surfaces to disinfect include but are not necessarily limited to: all surfaces	08/22/2024

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	machine: touchscreens; countertops ... " 2. During an observation on 07-22-2024 at 11:05 AM, PCT 1, was observed cleaning Station #3. PCT 1 failed to clean the prime container inside and out as well as the tv monitor and arm wall mount. 3. During an observation on 07-24-2024 at 10:34 AM, PCT 5, was observed cleaning Station #3. PCT 5 failed to clean the prime container inside and out. 4. During an observation on 07-24-2024 at 11:10 AM, PCT 1, was observed at cleaning Station #3. PCT 1 emplyed the prime container fluids into the wall unit box and placed it back on the dialysis machine. PCT 1 failed to clean the prime waste container inside and out. During an interview on 07-24-2024 at 11:20 AM, when queried regarding the process of cleaning the machines and the prime waste container, PCT 1 indicated they emptied the prime waste into the wall unit drain and should empty it into the dirt sink. PCT 1 further indicated they were to give the prime waste container a quick swipe after each patient and then a deep clean after all the shifts were completed.5. During an observation on 07-22-2024 at 11:25 AM PCT 3 was observed cleaning station #14. PCT 3 failed to clean the prime container inside and out and failed to clean the television. During an interview on 07-22-2024 at 11:30 AM PCT 3 reported when queried regarding cleaning the prime container and the television they replied, "I usually do that, I forgot."		in contact with the patient or their belongings…dialysis chair, tray tables, blood pressure cuffs…frequently contacted by healthcare personnel (e.g., control panel; top, front and sides of dialysis machine; touchscreens; countertops). The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction. 8/22/24	

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V 0190 Bldg. 00	494.40(a) SOFTENERS-AUTO REGENERATE/TIMERS/SALT LVL 5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution. 5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration. The face of the timers used to control the regeneration cycle should be visible to the user. 6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated. The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and			

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	pistons and clog orifices in the softener control head. Based on observation, interview, and record review, the facility failed to monitor and maintain the water softener equipment accurately and allowed the brine tank to lack salt pellets to the manufacturer's required levels. This failure had the potential to negatively affect the health and well-being of all 27 in-center hemodialysis patients. Findings Include: 1. A review of a DaVita Incorporated policy, with a revision date of March 2008, titled, "Daily Water Treatment System Monitoring" was provided by the Facility Administrator (FA), on 07-23-2024, at 4:05 PM. The document indicated but was not limited to " ... verify the dialysis water system operates safely and reliably through daily observations and/or testing of specific component performance parameters ... All observations and test results will be within the limits specified on the Daily Water Treatment Log ... " 2. During a flash tour of the Water Room on 07-22-2024 at 10:15 AM, the brine tank was observed to be less than 1/2 full, and water covered the salt pellets approximately six inches. During an interview on 07-22-2024 at 12:30 AM, the Biomed Technician, when queried regarding the brine tank salt and water levels, confirmed that salt pellets should be added. 3. A review of a manufacturer's label on the brine tank, on 07-24-2024 at 10:17 AM, stated, "Brine Tank. Contains salt used for softener regeneration. Verify salt level is above water level	V 0190	V190 The Facility Administrator (Clinical Preceptor) or Clinical Coordinator (Registered Nurse) will in-service all clinical teammates on Policy 1-17-02 “Daily Water Treatment System Monitoring” and Policy 1-17-02E “CWP Daily Water log”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations with emphasis on, but not limited to the following: 1) PURPOSE: To verify the dialysis water system operates safely and reliably through daily observations and/or testing of specific component performance parameters. 2) All observations and test results will be within the limits specified on the Daily Water Treatment Log. 3) Monitored Process or Component: Salt Level in Brine Tank? - Acceptable Limit(s): Tank at least half full , Above the water Y / N / NA - Monitor Location: Brine Tank. The Facility Administrator or Clinical Coordinator will conduct observational audits of the bine tank and audit the “CWP Water log” daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with an internal observational and water log audit monthly. Instances of	08/22/2024

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	in the brine tank." 4. During an interview on 07-24-2023 at 8:40 AM, the FA indicated they were aware of the issue of the water level in the brine tank, and the Biomed technician adjusted the water level. The FA further confirmed that the salt pellets should cover the water in the brine tank. 5. A review of the documents titled "Daily Water Log" dated 01-01-2024 through 07-24-2024, was provided by the FA on 07-24-2024, at 9:35 AM. The documents indicated in the section titled, "Salt Level in Brine Tank? Acceptable limit(s) Tank ½ full, Above the water Yes/No/NA " documented "Yes."		non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction. 8/22/24	
V 0402 Bldg. 00	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. Based on observation, record review, and interview, the facility failed to provide a safe and conformable environment for 1 of 1 stand-alone in-center dialysis facilities. Findings include: 1. A review of a DaVita Incorporated policy revision dated April 2018, titled "Physical	V 0402	V 402 The Facility Administrator (Clinical Preceptor) or Clinical Coordinator (Registered Nurse) will in-service all clinical teammates on Policy 8-04-01 “Physical Environment”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will	08/22/2024

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	Environment," was provided by the Regional Operation Director (ROD), Corp 1, on 07-23-2024 at 8:58 AM. The policy indicated but was not limited to, " ... The building in which dialysis services are furnished will be constructed and maintained for the safety of the patients, the teammates and the public ... " 2. On 07-22-2024 at 9:40 AM, observed missing ceiling tiles and pipes were visable in the women's bathroom and a brown rust-colored substance on the back wall behind the toilet of the wall in the men's bathroom in the main lobby upon entering the dialysis facility. During an interview on 07-22-2024 at 3:55 PM, the Facility Administrator (FA), confirmed their was a leak in the ceiling and the pipes had to be replaced in the women's bathroom. The FA further indicated the brown discoloration on the back walls of the men's bathroom was rust from the hand rails. 3. During a flash tour observation on 07-22-2024 at 9:30 AM, observed in the lab area room next to the treatment area debris, tubing, and a copper pipe with a discolored cloth wrapped around it at the base of the cabinet under the eyewash sink counter. During an interview on 07-22-2024 at 10:15 AM, the Facility Administrator indicated that this was the first time in 15 years they had looked in that cabinet. The FA further indicated that it needed to be fixed. 4. During a flash tour of the water room on 07-22-2024 at 10:05 AM, observed that the entrance door had a ½ to ¼ inch gap at the bottom and between the two adjoining doors. The		be educated using surveyor observations with emphasis on, but not limited to the following: 1) The building in which dialysis services are furnished will be constructed and maintained for the safety of the patients, the teammates and the public. The Facility Administrator submitted the following work orders: Web-553616 for replacement of ceiling tiles in the women's bathroom. New tiles will be installed in the women's bathroom in the lobby by 8/24/24. The men's bathroom in the lobby will be deep cleaned with removal of brown rust colored substance on the back wall by 8/22/24. The debris will be removed from the lab area room and the cabinet under the eye wash sink will be deep cleaned and repaired, as indicated, to include the tubing and copper pipe by 8/22/24. The Facility Administrator submitted work order # WEB-561636 for repair/replacement of the water room door. Measurements were taken for replacement of water room door and the door was ordered on 8/7/24. The door will be installed when it is delivered to the facility. The Facility Administrator submitted work order WEB 556719 for repair/replacement of the counters on the wall units, nurse's station, supply storage units, and islands and will be installed when received	

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	doors had a covering on the left side, covering cracks and splintering. The right and left lower corners of the water room doors had areas of damaged cracked and splintered wood. During an interview on 07-22-2024 at 11:00 AM, the FA confirmed the entry doors to the water room were damaged from the storage pallets. 5. During a treatment room observation on 07-24-2024 at 10:20 AM, noted that the counters on the wall units, nurse's station, supply storage units, and islands were made from particle board and a non-solid surface covering. During an interview on 07-24-2024 at 10:22 AM, when questioned regarding the surfaces of the counters and surround, the FA confirmed that the surrounds and countertops are not solid surfaces as required for infection control and prevention.		at the facility. The Facility Administrator or Clinical Coordinator will conduct observational audits to monitor the progress of repairs/replacements daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal audit. Instances of non-compliance will be addressed. Issues requiring physical plant repair will be escalated to the Regional Operations Director and a timeline developed for completion of repairs. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction. 8/22/24	