STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152630	A. BUILDING 00 B. WING	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PORTAGE DIALYSIS	5823 US HWY 6 PORTAGE, IN 46368

(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
V 0000 Bldg. 00	This visit was for a Federal complaint survey of an ESRD supplier by the Indiana Department of Health. Survey Dates: 04-05, and 04-06-2023 Complaint#: IN 00394014-deficiencies were cited Facility #: 011896 CCN#: 152630 Stations: 16, no isolation room. Census by Service Type: In Center Hemodialysis: 53 Home Hemodialysis: 5 Home Peritoneal Dialysis: 4 Total Census: 61 QR by Area 3 from 4-11 to 4-18-2023	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 facility failed to ensure that staff had completed appropriate hand hygiene and gloving according to their hand hygiene and gloving policies and procedures in 4 of 4 observations completed. (Employees: Patient Care Technician (PCT) # 3, 4, and 5, and Regisitered	V 0113	The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities", Policy 1-05-01A "Use of Alcohol-Based Hand Rubs", and Policy 1-05-01B "Handwashing"	05/05/2023

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

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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	Nurse (RN) #1, and 2) Findings Include: 1. A review of a DaVita Incorporated policy dated September 2007, and revised on April 2023, was provided by the Facility Administrator, Admin #1, on 04-06-2023 at 11:09 AM. The "Infection Control For Dialysis Facilities," policy indicated but was not limited to, " ... Hand Hygiene: 1. All teammates ... will perform hand hygiene ... a. prior to gloving and immediately after removal of gloves ... d. after patient and dialysis delivery system contact, e. after interacting with wall boxes ... g. before touching clean areas such as supplies, supply cart, and chairside keyboard/mouse ... 3. Use of an alcohol-based hand rub may be substituted for handwashing ..." 2. A review of a DaVita Incorporated policy dated September 2007 and revised on April 2023 was provided by the Facility Administrator, Admin #1, on 04-06-2023 at 11:09 AM. The "Use of Alcohol-Based Hand Rubs" policy indicated but was not limited to, " ... Alcohol-based hand rub containing 60%-95% ethyl alcohol, isopropyl, or a combination of both ... 2. Apply product in palm of one (1) hand. 3. Rub hands together, covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry ..." 3. A review of a DaVita Incorporated policy dated September 2007 and revised on October 2020 was provided by the Facility Administrator, Admin #1, on 04-06-2023 at 11:09 AM. The "Handwashing" policy indicated but was not limited to, " ... 2. Wet hands and apply antibacterial liquid soap. 3. Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds ..."		starting on 4/5/2023. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor's observations as examples with emphasis on, but not limited to the following: 1) HAND HYGEINE…All teammates, Physicians and Non-Physician (NPP) 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. 2) Use of an alcohol-based hand rub may be substituted for handwashing. 3) Alcohol-based hand rub containing 60% - 95% ethyl alcohol, isopropyl alcohol, or a combination of both. 2) Apply product in palm of one (1) hand. 4) Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. 5) Wet hands and apply antibacterial liquid soap. 6) Cover hands (palms, back of hands, between fingers) and wrists with lather and wash vigorously for a minimum of 20 seconds. The Facility Administrator or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing	

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	4. During an observation on 04-06-2023 at 6:14 AM, the Patient Care Technician (PCT), PCT #5, was observed accessing a fistula (an abnormal connection between an artery and a vein) for the initiation of dialysis at station #1. PCT #5 performed hand hygiene, donned gloves, and used a grey stethoscope from around their neck to locate and palpate Patient #16's left upper arm fistula. PCT#5 applied antiseptic over Patient #16's access site and inserted the cannulation (placed inside the vein) needles, and taped the needles in place. PCT #5 failed to discard their gloves after locating and palpating the cannulation site and failed to perform hand hygiene and don clean gloves prior to applying antiseptic to Patient #16's access site prior to initiation. 5. During an observation on 04-06-2023 at 6:35 AM, PCT #5, was observed accessing a fistula for the initiation of dialysis at station #2. PCT #5 performed hand hygiene, donned gloves, and used a grey stethoscope from around their neck to locate and palpate Patient #18's left upper arm fistula. PCT#5 applied antiseptic over Patient #18's access site and inserted the cannulation needles, and taped the needles in place. PCT #5 failed to discard their gloves after locating and palpating the cannulation site and failed to perform hand hygiene and don clean gloves prior to applying antiseptic to Patient #18's access site prior to initiation. 6. During an observation on 04-06-2023 at 7:40 AM, was observed accessing a fistula for the initiation of dialysis at station #8. PCT #5 performed hand hygiene, donned gloves, and used a grey stethoscope from around their neck to locate and palpate Patient #15's left upper arm		compliance will be verified monthly during the infection control audit. Instances of non-compliance will be address immediately. The FA will review results of all audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

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	fistula. PCT#5 applied a spray antiseptic over Patient #15's access site and inserted the cannulation needles, and taped the needles in place. PCT #5 failed to discard their gloves after locating and palpating the cannulation site and failed to perform hand hygiene and don clean gloves prior to applying antiseptic to Patient #15's access site prior to initiation. During an interview on 04-05-2023 at 3:15 PM, Admin #1 confirmed that teammates should perform hand hygiene before and after gloving, before touching the computer, and when going from dirty to clean areas.7. During an observation on 04-05-2023 at 9:58 AM with RN #2, took a blood sample from Patient #1, took blood collection tubes to the centrifuge (a machine that spins the samples to separate the blood) returned to Patient #16, doffed their gloves and donned a clean pair of gloves, RN #2 failed to use hand sanitizer between changing gloves upon the inititation of dialysis of Patient #1.8. On 4/5/23 at 2:35 PM, RN #1 was observed at station 10 providing direct patient care to Patient 11. Prior to RN 1 leaving the patient's chairside, PCT 3, who was providing care at station 9, requested assistance obtaining supplies. RN 1 removed and discarded his right glove and obtained the requested supplies from the center island cabinets. RN 1 passed the supplies to PCT 3 via the ungloved right hand, returned to station 10, donned a new right glove, and continued direct care to Patient 11. RN 1 failed to complete hand hygiene before and after all glove changes and failed to complete hand hygiene and change gloves before and after patient contact, obtaining supplies, and moving from a contaminated area to a clean area. 9. On 4/5/23 at 2:42 PM, RN 1 was observed after			

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	completing direct patient care for Patient 11, at station 9. PCT 3, seated at station 8 was providing direct patient care and asked RN 1 to get some supplies from the center island. RN 1 removed his right glove and went to the center-island cabinets. RN 1 entered 3 separate drawers using the ungloved hand, obtained the supplies, and passed them to PCT 3, using the ungloved right hand. RN 1 discarded the left glove, completed hand hygiene, donned new gloves, and began scrolling and entering patient information on the pump screen for Patient 11. RN 1 failed to change gloves and complete hand hygiene when changing tasks between patients, when going from clean to dirty, and in advance of obtaining and passing clean supplies for use on a separate patient and failed to perform hand hygiene and gloving before and after all glove changes. 10. On 4/5/23 at 2:48 PM, PCT 4 was observed, ungloved, entering data via the computer keyboard at station 9. PCT 4 moved to station 11, donned gloves, silenced an alarm, discarded her gloves, moved to station 4, donned new gloves, and began data entry via the computer keyboard. PCT 4 failed to complete hand hygiene before and after all glove changes, before and after moving between patients or care areas, and before and after contact with dirty areas/equipment. 11. On 4/5/23 at 2:57 PM, PCT 3 was observed to pull a glove from the glove box at station 11. PCT 3 wadded the glove into the palm of her hand and left a portion of it out to use as a barrier while scrolling through the pump screen, silencing alarms, and typing on the computer keyboard. PCT 3 failed follow the agency's policy for infection control related to hand hygiene and gloves, failed to complete hand hygiene and don gloves in advance of gloving and/or touching			

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	clean equipment and patient areas, and failed to complete hand hygiene before and after touching the computer keyboard. 12. On 4/5/23 at 2:59 PM, PCT 4 was observed walking to station 9, where she donned gloves, obtained wipes, and proceeded to clean the station. PCT 4 failed to complete hand hygiene prior to donning gloves. 13. On 4/6/23 at 9:02 AM, the FA (Facility Administrator) indicated gloves should be fully donned for use and hand hygiene should be completed before and after all glove changes. The FA indicated the computer and keyboard was shared by 2 stations and employees and was considered dirty to the patient. Employees were expected to complete hand hygiene before and after typing and gloves should not be worn when using the keyboard. The pump and its screen were considered clean to the patient and employees should complete hand hygiene and gloving before and after contact with the machine or the patient and chair.			
V 0115 Bldg. 00	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on observation, record review, and interview the facility failed to ensure all	V 0115	The Facility Administrator or designee will in-service all clinical	05/05/2023

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	individuals in the treatment area wore face shields and fluid resistant gowns, for 1 of 7 employees observed. Findings include: 1. A review of agency policy 1-05-01, "Infection Control for Dialysis Facilities," last revised April 2023, indicated fluid resistant/fluid impervious gowns will be worn by all teammates, physicians, and visitors when in the treatment area and appropriate PPE (Personal Protective Equipment) will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, and contaminated equipment/environmental surfaces. Section chairside cart, terminals mounted on the counter, the monitor, and the keyboard are considered clean areas ... " 2. On 4/5/23 at 2:25 PM, the FA (Facility Administrator) entered the treatment area wearing street clothes and a surgical face mask. The FA approached RN 1, who was providing direct patient care at station 8, and had a brief chairside conversation, then exited the treatment area. The FA failed to don a face shield and a fluid resistant gown while present in the treatment area. 3. On 4/6/22 at 9:02 AM, the FA indicated everyone in the treatment area, other than patients, should wear a mask, gown, and face shield.		teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 4/5/2023. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Appropriate fluid resistant/fluid impervious gowns will be worn by all teammates, Physicians and Non-Physician (NPP) and visitors when in the treatment area. 2) Appropriate PPE will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces, for example, patient care areas. 3) The chair side cart, terminals mounted on the counter, monitor and keyboard are considered clean areas. The Facility Administrator or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (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 immediately. The FA will review results of all audits with teammates during homeroom meetings and with the Medical Director during monthly Quality	

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			Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0117 Bldg. 00	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. Based on observation and interview, the facility failed to ensure the proper storage of supplies and biohazard materials for 2 of 2 survey days. Findings include:	V 0117	The Facility Administrator or designee will in-service all clinical teammates on Policy 8-04-01 “Physical Environment” starting on 4/5/2023. Verification of	05/05/2023

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	1. A review of a DaVita Inc. policy with a revision date of April 2018, "Physical Environment," was provided by Dietician #1 on 04-06-2023 at 11:09 AM. The policy indicated but was not limited to: "Purpose: To provide guidance on the physical environment of the dialysis facility and treatment area ... The dialysis facility will store supplies in a manner that is consistent with fire safety and other appropriate regulations ..." 2. During the flash tour on 04-05-2023 at 9:50 AM, Day 1 of 2 observations, the following was observed: a small empty jug under a clean sink across from Station 16, a jug of bleach across from Station 11, an open gallon of Natural Lyte under a clean sink across from Station 10, a jug of Pure Bright Bleach under clean sink across from Station 6, an empty cylinder tube and spray bottle of Glance RTU under dirty sink across from nurses station at the patient entrance door, and blank labels under the clean sink across from the opening between nurses stations, Station 1 had a patient binder on top of the dialysis machine, Station 2 had patient medical information on top of the dialysis machine, Station 3 had patient medical information, syringes, and blood collection tubes on top of the dialysis machine, Station 4 had patient medical information and blood collection tubes on top of the dialysis machine, Station 5 had patient medical information on top of the dialysis machine, Station 11 had patient medical information on top of the dialysis machine, Station 12 had patient medical information and a paper towel on top of the dialysis machine, Station 13 had patient medical information and syringes on top of the dialysis machine, and Station 14 had patient medical information, syringes, and blood collection tubes on top of the dialysis machine.		attendance is evidenced by a signature sheet for e each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) PURPOSE: To provide guidance on the physical environment of dialysis facility and treatment area. 2) The dialysis facility will store supplies in a manner that is consistent with fire safety and other appropriate regulations. All items, to included: empty jugs, containers of bleach, spray bottles, containers of bleach, containers of Natural Lyte, and empty cylinders, were removed from underneath the clean and dirty sinks. All items, to include binders, patient medical information, syringes, blood collection tubes, caps, and clipboards were removed from on top of the dialysis delivery systems. The Facility Administrator or designee will conduct observational infection control audits daily for one (1) week and then weekly for two (2) weeks to verify nothing is stored in cabinets under sinks and nothing is placed on top of the dialysis delivery system in compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed immediately. The FA will review	

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	3. During Day 2 of 2 observations on 04-06-2023 at 6:14 AM, observed a jug of Pure Bright bleach under the clean sink across from Station 6, a jug of Pure Bright Bleach, a spray bottle of Glance RTU, and an empty cylinder tube under the dirty sink across from the patient entrance door, blank labels under the clean sink across from the opening between the nurse's stations, rusty shelving under dirty sink across from Station 9, a Natural Lyte Jug under clean sink across from Station 10, a jug of Pure Bright Bleach un clean sink across from Station 11, and an empty plastic jug under dirty sink across from Station 16. 4. During Day 2 of 2 observations at 6 AM Stations 1-4, 6-9, and 11-16 had the patient's medical information and caps on top of the dialysis machines. Station 5 had patient medical information, a syringe, and a cap on top of the dialysis machine, Station 10 had a clipboard with the patient's medical information and a cap on top of the dialysis machine. 5. During an interview with the facility Administrator on 04-06-2023 at 9:23, they indicated nothing should be under the sinks or on top of the dialysis machines.		results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on observation, record review, and interview, the facility failed to ensure the staff initialed and dated opened 2 multidose containers	V 0143	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Policy	05/05/2023

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	of medication in 2 of 2 survey days. Findings Include: 1. A review of a DaVita Incorporated policy dated September 2007 and revised on October 2022 was provided by the Facility Administrator, Admin #1, on 04-06-2023 at 12:00 PM. The "Medication Policy," policy indicated but was not limited to, " ... All medications in the facility are checked monthly. Insulin and other medication with preservatives are dated and initialed opened ..." 2. During a flash tour observation on 04-05-2023 at 9:50 AM, observed on the counter of the medication preparation area a half-full open container of Acetaminophen 325 milligrams (mg) tablets, and in the wall cabinet above on the first shelf, a quarter-full container of extra strength Tums chewable tablets. The containers of Acetaminophen 325 mg tablets and extra strength Tums chewable tablets failed to have the date open and staff initials label. 3. During an observation on 04-06-2023 at 7:26 AM, observed in a basket, on the counter of the medication preparation area a half-full open container of Acetaminophen 325 milligrams (mg) tablets, and in the wall cabinet above on the first shelf, a quarter-full container of extra strength Tums chewable tablets. The containers of Acetaminophen 325 mg tablets and extra strength Tums chewable tablets failed to have the date open and staff initials label. During an interview on 04-06-2023 at 7:55 AM, the Registered Nurse (RN), RN #4, indicated they did not put the date open and their initials on the open bottles of Calcitriol, Acetaminophen, or Tums.		1-06-01, "Medication Policy" starting on 4/5/2023. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) All medications in the facility are checked monthly. 2) Insulin and other medications with preservatives are dated and initialed once opened. The opened, undated bottles of Tums, Acetaminophen. And Calcitriol observed in the wall cabinet and basket of the medication preparation area were removed and discarded. The Facility Administrator or designee will conduct observational audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal medication audit. Instances of noncompliance will be addressed immediately. The Facility Administrator will review results of all audits with teammate during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

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	4. During an interview on 04-06-2023 at 11:55 AM, the FA, Admin #1, confirmed that the medications should be labeled with the date opened and staff initials.			
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 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].			

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	152630	A. BUILDING 00 B. WING	04/06/2023

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	Based on observation, record review, and interview, the facility failed to ensure all patient care technicians (PCTs) implemented their training in the performance of central venous catheter (CVC) care and dressing changes for 1 of 1 PCT (PCT 8) observed during CVC care. Findings include: 1. A review of agency procedure 1-04-02, "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure," last revised April 2023, indicated a 15-second hub scrub of the CVC should be completed during the process of connection or disconnection form the blood lines, including line reversal, or if the patient is disconnected during treatment for any reason. The procedure was as follows: 3. "Place ... barrier under catheter limbs ... 4. Remove old dressing and discard ... 7. Remove gloves and discard. Perform hand hygiene ... and reglove. 8. Holding catheter with the non-dominant hand and using aseptic technique, clean exit site ... for a minimum of 30 seconds, apply to the CVC exit site in a back and forth pattern ... progressing from the insertion site to the periphery using both sides of the swab ... Then wait 60 seconds for air dry time. 9. Clean each CVC limb/cap with a new LARGE alcohol prep pad, starting close to the exit site and finishing with the cap. 10. Remove gloves and ... perform hand hygiene ... 12. Place sterile 2 x 2 gauze over the catheter exit site leaving connections accessible ... 14. Remove gloves and discard, perform hand hygiene ... 15. Holding catheter with non-dominant hand, use other hand to place sterile 4 x 4 under catheter limbs. Minimize contact with the 4 x 4 gauze by holding only a corner. 16. Using aseptic technique, remove each cap. One at a time, disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub ...	V 0147	The Facility Administrator (FA) held mandatory in-service(s) for all clinical teammates on Procedure 1-04-02B: “Central Venous Catheter (CVC) With ClearGuard HD Antimicrobial End Caps Procedure” starting on 4/5/2023. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Perform a 15 second hub scrub of the CVC during the process of connecting or disconnecting from the blood lines, including line reversal, or if the patient is disconnected during treatment for any reason. 2) Place the second moisture proof barrier under catheter limbs. Instruct patient to turn head to opposite side of CVC exit site. 3) Remove old dressing and discard. 4) Remove gloves and discard. 5) Perform hand hygiene per procedure and re-glove. 6) Holding catheter with the non-dominant hand and using aseptic technique, clean exit site with 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol swab for a minimum of 30 seconds, apply to the CVC exit site in a “back and forth” pattern, using gentle Friction progressing from the insertion site to the periphery using both sides of the swab…Then wait 60 seconds for air dry time. 7) Clean	05/05/2023

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	Hold the limbs until ... dried. 17. Attach sterile 10 ml (milliliter) syringes to the arterial and venous limbs. 18. Aspirate ... 33. Remove syringes and disinfect the CVC hubs with a new alcohol prep pad for each CVC hub. Scrub the sides, threads, and end of hub thoroughly with friction for 15 seconds ... Hold the catheter until the antiseptic has dried. 34. While holding the shield and catheter hub in one hand, remove the single ClearGuard HD cap ... insert the ClearGuard HD rood into the catheter hub ..." 2. On 4/9/22 at 9:15 AM, PCT 8 was observed completing a CVC dressing change for Patient 15. PCT 8 completed hand hygiene and donned gloves, removed her visor, and placed it over her face, and set up supplies for the dressing change, including a chux barrier on the patient's chest and under the capped CVC limbs. PCT 8 discarded the cap to the red port, cleaned the port with an alcohol swab, attached a sterile syringe, and aspirated/flushed the port to assess for patency. PCT 8 discarded the flush syringe and released the uncapped limb onto the chux barrier. PCT 8 removed the cap to the blue port, cleaned the port with alcohol, aspirated and flushed to assess patency, discarded the syringe, and released the uncapped port onto the chux barrier. PCT 8 removed her gloves, walked to the center island, and obtained supplies. PCT 8 returned to Patient 15's chairside, donned gloves, cleaned both ports with alcohol, released them onto the chux again, opened 2 new ClearGuard caps, and secured each cap to a respective port. Using an alcohol swab, PCT 8 wiped the tubing from cap back toward the patient, released both limbs onto the chux, then obtained a gauze pad from the chairside tray and slid it between the limbs and the chux, wrapped the limbs in the gauze, and secured the gauze with tape. Wearing the same gloves, PCT 8 adjusted		each CVC limb/cap with a new LARGE alcohol prep pad, starting close to the exit site and finishing with the cap. 8) Remove gloves and discard, perform hand hygiene per procedure and re-glove. 9) Place sterile 2x2 gauze over the catheter exit site leaving connections accessible. 10) Remove gloves and discard, perform hand hygiene per procedure and re-glove. 11) Holding catheter with non-dominant hand, use other hand to place sterile 4x4 under catheter limbs. Minimize contact with the 4x4 gauze by holding only a corner. 12) Using aseptic technique, remove each cap. One at a time, disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub for 15 seconds including the sides, threads and end of hub thoroughly with friction making sure to remove any residue, for example blood. Hold the limbs until the antiseptic has dried. 13) Attach sterile 10 ml syringes to the arterial and venous limbs. 18) CVC hubs with a new alcohol prep pad for each CVC hub. Scrub the sides, threads and end of hub thoroughly with friction for 15 seconds…Hold the catheter until the antiseptic has dried. 19) While holding the shield and catheter hub in one hand, remove the single ClearGuard HD cap…20) Carefully insert the ClearGuard HD rod into the	

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	the patient's sweatshirt to expose the CVC dressing and removed and discarded the dressing. The patient's clothing was noted to be approximately 0.5 inches from the entry point of the CVC. PCT 8 cleaned the CVC entry site/area using a back-and-forth motion, covered the site with the previously opened gauze pad, secured it with silk tape, and dated/timed/initialed the gauze using a piece of tape. PCT 8 discarded her gloves and completed handwashing with soap and water. When asked when hand hygiene should be completed during a dressing change, PCT 8 indicated they always wash hands with soap and water after a CVC dressing changes. 3. On 4/6/23 at 9:02 AM, the FA (Facility Administrator) indicated all PCTs receive training on CVC care and dressing changes. The FA agreed the uncapped hubs should not be placed on the chux barrier and the PCT failed to follow aseptic and/or sterile technique as trained when doing CVC care and dressing changes.		catheter hub…The FA or designee will conduct observational audits for CVC care daily for one (1) week and then weekly for two (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 immediately. The Facility Administrator will review results of all audits with TMs during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
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 and interview, the agency failed to maintain the building's structural integrity to ensure the safety of patients and staff, as noted over 2 of 2 survey days. Findings include: 1. A DaVita Incorporated policy dated September 2008 and revised on April 2018, was provided by Dietician #1 on 04-06-2023 at 11:09 AM. The	V 0402	The Facility Administrator or designee will in- service all clinical teammates on Policy 8-04-01 “Physical Environment” starting on 4/5/2023. Verification of attendance is evidenced by a signature sheet for each in-service. Teammates were instructed using surveyor observations as examples with	05/05/2023

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	policy, "Physical Environment," indicate but was not limited to " ... The dialysis facility will be ... maintained to provide dialysis patients, teammates ... a safe, functional, and comfortable treatment environment ..." 2. During an observation on 04-05-2023 at 9:50 AM, observed a rusty shelf with a hole in it under dirty sink across from Station 9. 3. During an observation on 04-06-2023 at 6:14 AM, observed a observed a rusty shelf with a hole in it under dirty sink across from Station 9. 4. During an interview with the facility Administrator on 04-06-2023 at 9:23, they indicated nothing should be under the sinks and wasn't sure why there was a hole in the shelf.		emphasis on, but not limited to the following: 1) The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. The Facility Administrator submitted a work order for repair/replacement/removal of the shelf under the dirty sink across from Station 9. Repair/ replacement/removal of the shelf will be completed by 5/5/23. The Facility Administrator or designee will conduct observational audits daily for one (1) week and then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal OSHA/Safety audit. Instances of non-compliance will be addressed immediately. The FA will review results of all audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meeting (FHM). The Facility Administrator is responsible for ongoing compliance with this plan of correction.	