STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152597	A. BUILDING 00 B. WING	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAFAYETTE HOME DIALYSIS	2 EXECUTIVE DR STE B LAFAYETTE, IN 47905

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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: July 14th, 15th, 16th, and 17th of 2025 Active Census: 63 At this Emergency Preparedness survey, Lafayette Home Dialysis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey Dates: July 14th, 15th, 16th, and 17th of 2025 Census by Service Type: Home Hemodialysis 20 Home Peritoneal Dialysis 43 Total Active Census: 63 Isolation Waiver: Not applicable Abbreviations: RN Registered Nurse	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Ferguson	Facility Administrator	08/06/2025

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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	PCT Patient Care Technician FA Facility Administrator HHD Home Hemodialysis PD Peritoneal Dialysis CVC Central Venous Catheter IV Intravenous AVF Arterial Venous Catheter SNF Skilled Nursing Facility DEN Dialysis Extension of Nursing Home			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained for 1 of 1 peritoneal dialysis initiations observed. (Patient #5) Findings Include: A policy titled, "Infection Control for Dialysis Facilities" (April 2023) indicated hand hygiene is to be performed prior to entering/exiting the patient treatment area, prior to gloving and immediately after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, and before touching clean areas. A policy titled, "Baxter Home Choice Claria Cycler" (March 2024) indicated materials required for initiating therapy to include a mask for everyone in the room. When initiating treatment, wash hands and apply personal protective equipment (PPE). During an observation on 07/16/2025 at 8:05 PM, RN 8 was observed initiating the PD treatment for Patient #5 in the SNF. She failed to complete a	V 0113	The Facility Administrator or Regional Operations Manager (ROM) will in-service all clinical teammates on Policy 1-05-01 Infection Control For Dialysis Facilities" and Policy 5-04-05A "Baxter Home Choice Claria Cycler" beginning 7/18/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will educated using surveyor observations as examples, to include, but not limited to the following: 1) HAND HYGEINE - All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene: upon entering and exiting the patient treatment area, prior to gloving and immediately after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact…before touching clean areas…2) Materials required for	08/15/2025

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	1-minute hand wash prior to initiating treatment, failed to provide a face mask for the patient during bag connection, and failed to change gloves and perform hand hygiene after inserting the cycler drain line into the toilet. RN 8 then secured her hair away from her face twice during the dressing change with gloves on and failed to remove the contaminated gloves, perform hand hygiene and apply new gloves. During an interview on 07/17/2025 at 9:09 PM, RN 1 indicated that SNF staff are taught to complete a one-minute hand wash using soap and water prior to initiating treatment. Everyone in the room is required to wear a mask during cycler set-up. After touching the toilet and securing her hair RN 8 should have removed her gloves, completed hand hygiene, and redonned new gloves. Hand sanitation is required before and after glove removal.		initiating therapy: Mask for everyone in room...PPE-personal protective equipment (face protection, mask(s), gloves, fluid resistant/fluid impervious barrier garment). 3) Initiating the therapy - Wash hands. Put on PPE. The Facility Administrator Or ROM 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 an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE	V 0147	The Facility Administrator or	08/15/2025

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	Based on observation, record review and interview, the facility failed to ensure adequate documentation of the CVC (dialysis access) dressing change for 1 of 2 HHD patient records reviewed (Patient #7) and adequate disinfection of the CVC catheter limbs using an alcohol pad for 1 of 1 CVC initiations. (Patient #8) Findings include: 1. A policy titled "Central Venous Catheter (CVC) Care (April 2025), CVC dressing changes are performed prior to each dialysis treatment. 2. According to the "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure" policy (April 2025), using aseptic technique, remove each cap and disinfect each CVC hub for 15 seconds including the sides, threads, and end of hub thoroughly with friction making sure to remove any residue. 3. A review of Patient #7 ' s treatment records from 05/07/2025–07/09/2025 failed to evidence documentation for CVC dressing changes. 4. During an observation at the DEN on 07/16/2025 at 10:25 AM, RN 5 accessed Patient # 8's CVC, did not disinfect the CVC hubs, then attached a syringe. 5. During an interview on 07/16/2025 at 10:50 AM, RN 5 indicated the CVC hubs are considered sterile when the caps are first removed, therefore, she did not need to disinfect prior to attaching the syringes, but once the initial syringes are removed the hubs are to be disinfected for 15 seconds. 6. During an interview on 07/17/2025 at 8:40 AM, RN 1 indicated that Patient#7's wife completes		Regional Operations Manager (ROM) will in-service all clinical teammates on Policy 1-04-02 “Central Venous Catheter Care” and Policy 1-04-02B “Central Venous Catheter (CVC) With CLEARGUARD HD Antimicrobial End Caps Procedure”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will educated using surveyor observations as examples, to include, but not limited to the following: 1) CVC dressing change is performed prior to each dialysis treatment. 2) Using aseptic technique, remove each cap. 3) One at a time, disinfect each CVC hub with a new alcohol prep pad. 4) Scrub each CVC hub for 15 seconds including the sides, threads and end of hub thoroughly with friction making sure to remove any residue… The Facility Administrator or Regional Operations Manager 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 an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health	

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	dressing changes due to the patient's vision failing. RN 1 also indicated that the dressing changes are done every other treatment due to the patient's sensitive skin but could not provide a physician order to do so.		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.	
V 0196 Bldg. 00	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY Based on observation, record review, and interview, the facility failed to ensure chlorine testing was performed per policy and procedure for 1 of 1 chlorine test observed. (PCT 2) Findings Include: A policy titled, "Total Chlorine Test Using RPC Ultra Low Total Chlorine Test Strip" (October 2023), indicated to dip the RPC strip in the water sample for 60 seconds. A policy titled, DSD Total Chlorine Monitoring of Portable Reverse Osmosis (RO) Water Treatment System" (October 2024), indicated if utilizing RPC Ultra Low Total Chlorine Test Strips and a water temperature is not available, teammates should use 60 second dip time. During an observation on 07/16/2025 at 9:15 AM, PCT 2 obtained a 100-milliliter sample of product water from the portable RO and submerged the RPC strip into the sample for 90 seconds to obtain	V 0196	The Facility Administrator or Regional Operations Manager (ROM) held mandatory in-services for all clinical teammates on Policy 1-18-05 “Total Chlorine Test Using RPC Ultra Low Total Chlorine Test Strip” and Policy 1-12-26 “DSD Total Chlorine Monitoring Of Portable Reverse Osmosis (RO) Water Treatment Systems beginning on 7/21/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Remove one test strip from the foil package and dip it in the water sample for 60 seconds. 2) If utilizing RPC Ultra Low Total Chlorine Test Strips and a water	08/15/2025

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	a chlorine level. During an interview on 07/16/2025 at 9:15 AM, PCT 2 indicated the policy states the RPC testing strip should be submerged into the sample for a total of 60-90 seconds. She submerges it for 90 seconds each time to ensure saturation. During an interview on 07/16/2025, RN 5 indicated an RPC strip should be submerged into the product water sample for 60 seconds. During an interview on 07/16/2025 at 2:45 PM, the ROM indicated she completed chlorine testing education with PCT 2 last week and is unsure why she is not following policy to submerge the strip for 60 seconds.		temperature is not available, teammates should use 60 second dip time. The Facility Administrator or Regional Operations Manager will conduct observational audits of water testing daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	
V 0585 Bldg. 00	494.100(a)(3) H-TRAIN CONTENT INCLUDES ER PREP HOME PTS Based on record review, and interview, the facility failed to ensure the DEN (dialysis extension in nursing home) provided contact information for the physician and/or RN for 1 of 1 Den's observed.	V 0585	The Facility Administrator or Regional Operations Manager (ROM) will in-service all teammates on Policy 1-12-02 “DSD: HHD Services Provided”. Verification of attendance will be	08/15/2025

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	Findings Include: A document titled, ""Home Hemodialysis Coordination Agreement" indicated the facility will communicate with the SNF as urgent patient-care issues arise and take action where appropriate. The facility will collaborate with the SNF as necessary to provide dialysis care coordination to each patient admitted to the facility. Communication procedures will allow for 24/7 communication between the facility and SNF. The facility will provide the SNF a telephone support and list of names and contact information of Nephrologist and/or RN to be called for emergencies. During an interview on 07/16/2025 at 10:10 AM RN 8 indicated she had created her own list of ESRD contacts if needed. She was unaware of the requirement of the ESRD to provide this information. If she needs to contact the on-call ESRD physician, she calls the hospital to obtain the on-call physician. During an interview on 07/16/2025 at 10:14 AM, the Regional Operations Manager indicated SNF management was provided contact information for the physician and/or RN and was unsure why SNF staff do not have access to the information. She further indicated being aware of this requirement. During an interview on 07/16/2025 at 10:15 AM Entity 2 / RN 9 indicated that she was not provided with contact information for the nephrologists and/or the dialysis RN. She would call the DEN if they were open to obtain the physicians' phone numbers if needed.		evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, to include, but not limited to the following: 1) Coordination of Care: The ESRD facility and SNF will establish procedures for 24/7 communication between the two entities. 2) The ESRD facility must provide to the SNF an on-call schedule with the names and contact information of physicians and/or ESRD facility RN's to be called for emergencies. The Facility Administrator or Regional Operations Manager will audit for documentation of a current "On Call" schedule for physicians and Registered nurses to be contacted for emergencies daily x 2 weeks, then weekly x 2 weeks in compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of noncompliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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	

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			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.	
V 0587 Bldg. 00	494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS Based on record review and interview, the facility failed to ensure that HHD records were reviewed, and concerns addressed for 1 of 1 HHD patients reviewed. (Patient #7) Findings include: The clinical record for Patient #7 was reviewed and evidenced the following: A document titled "Patient Summary Report" evidenced an order for HHD using NxStage five times a week for 7 hours. Treatment records dated 05/07/2025 - 07/09/2025 evidenced the following: Shortened treatment times on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025.	V 0587	The Facility Administrator or Regional Operations Manager (ROM) will in-service all clinical teammates on Policy 1-12-05 “DSD Monitoring And Ongoing Patient Education”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Retrieve and review complete self-monitoring data and other information from home hemodialysis and/or selfcare patients or their designated caregivers at least every two (2) months. 2) Maintain information in the patient’s medical record. 3) Home treatment records of patients that reside in residential or long term care facilities will be maintained in the patient’s medical record at the dialysis facility and in the medical record at the residential or long term care facility. 4) The facility interdisciplinary team monitors the	08/15/2025

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	Incomplete pre-intra-post blood pressures/pulse rates/ temperature on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete bloodline connector clip use on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete vascular access leak detector use on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete CVC assessment documentation on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025,		patient's status to determine if the patient is following the individualized treatment plan and/or is having any problems at home. The Facility Administrator or Reginal Operations Manager will audit twenty-five percent of home hemodialysis treatment records daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent of home treatment records audited monthly x 3 months. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	

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	05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete dialysate rate/volume and/or ultrafiltration rate/volume on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete HHD maintenance on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025, 06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. Incomplete chlorine testing on 05/07/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/17/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/23/2025, 05/25/2025,05/27/2025, 05/28/2025, 05/30/2025,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152597	A. BUILDING 00 B. WING	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAFAYETTE HOME DIALYSIS	2 EXECUTIVE DR STE B LAFAYETTE, IN 47905

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	06/01/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/08/2025, 06/09/2025, 06/11/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/18/2025, 06/19/2025, 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/27/2025, 06/29/2025, 06/30/2025, 07/03/2025, 07/05/2025, 07/07/2025, 07/08/2025, and 07/09/2025. A document titled "Patient Summary Report" for Patient #7 indicated an order for HHD using NxStage five times a week for 7 hours. During an interview on 07/17/2025 at 8:40 AM, RN 1 indicated Patient #7 does not report missed treatments. She prints a monthly treatment report and reviews it with physician and patient at monthly appointments. She indicated that there is not a policy for nocturnal HHD vital signs frequency and does not have a physician order indicating the patient expectation. She is aware of the documentation not being completed by the patient but is not the only staff member responsible for reviewing Patient #7's treatment sheets, sometimes RN 2 reviews them. Patient #7 does not document the use of the bloodline connector clip but indicated it is attached to the cartridge and has been trained to use them. Patient #7 has gastrointestinal issues and often stops treatment due to this. She has educated the patient verbally several times but is unable to provide any documentation.			
V 0589 Bldg. 00	494.100(c)(1)(i) H-MONITOR HOME ADAPT;HOME VISIT=POC Based on record review and interview, the facility failed to ensure home visits were completed for 1 of 7 patients reviewed. (Patient #7) Findings include:	V 0589	The Facility Administrator or Regional Operations Manager will in-service all clinical teammates on Policy 12-01-07 “Home Hemodialysis (HHD) Home Visit Policy”. Verification of attendance will be evidenced by an in-service	08/15/2025

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	According to the "Home Hemodialysis (HHD) Home Visit Policy" policy (February 2025), the ESRD Conditions for Coverage state an initial home visit is required to be completed when a patient starts home dialysis and when problems are identified as part of monitoring the patient's home adaptation. A document titled "HHD Home Visit Evaluation" dated 06/27/2022, indicated that Patient #7 received a home visit on the last day of HHD training. During an interview on 07/17/2025 at 08:40 AM, RN 1 indicated that Patient #7 had not had a home visit since 06/27/2022 despite his/her history of non-compliance with treatments to include missed/shortened treatments, incomplete documentation of treatments and dialysis machine maintenance. During an interview on 07/16/2025 at 2:45 PM, RN 1 indicated the policy for home visits does not provide the minimum frequency of home visits to be completed for home hemodialysis patients. She verified that no other home visits were completed after 06/27/2022, start of home dialysis, despite the ongoing concerns of non-compliance. RN 1 indicated education has been provided to the Patient #7 regarding missing/short treatments and incomplete treatment documentation however this concern has not been documented in the patient's medical record. RN 1 could not verbalize any other interventions completed to assist with patient compliance, including home visits. During an interview on 07/17/2025 at 8:41 AM, RN 1 indicated that Patient #7 frequently shortens and/or misses treatments. She pulls a report of his missed treatments and discusses them with him monthly at clinic visits. She indicated Patient #7		signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) The ESRD Conditions for Coverage state an initial home visit is required to be completed when a patient starts home dialysis and when problems are identified as part of monitoring the patient's home adaptation. The Facility Administrator or Regional Operations Manager will audit one hundred percent of home dialysis medical records monthly x 3 months to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of medical records audited monthly during the internal medical record audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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	

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	often reports his IPAD used to document treatments does not connect. She indicated the physician is aware of this concern. RN 1 was unaware Patient #7 has not run on the correct physician ordered blood flow rate and dialysate flow rate and plans to address this with him/her. Education is provided to the patient regarding his/her noncompliance, although it is not documented. Vital signs are to be completed pre and post treatment for nocturnal patients. Chlorine testing is to be completed with each new SAK (every other treatment) but did not realize he had not been documenting any results. She indicated the bloodline connector clip (used to prevent bleeding out during treatment) should be used and documented as on the treatment sheet. Patient #7 has been trained to use the blood leak detectors both for the dialysis machine and under the patient's access (alarms when blood/fluid is detected while patient is sleeping) but does not know if this is being used as it is not documented. She indicated that Patient #7 and/or spouse are to complete CVC dressing change every other day despite the order indicating daily. RN 1 is aware Patient #7 fails to document any of his dressing changes. RN 1 further indicated Patient #7 has been noncompliant since starting HHD in 2022.		this plan of correction.	
V 0590 Bldg. 00	494.100(c)(1)(ii) H-COORDINATION OF CARE BY MEMBER OF IDT Based on record review and interview, the facility failed to maintain coordination of care between the facility and SNF for 2 of 2 dialysis den patients reviewed. (Patient #3, 4) Findings Include: 1. A policy titled, "Incenter Hemodialysis Policies and Procedures DaVita Skilled Nursing Facility	V 0590	The Facility Administrator or Regional Operations Manager (ROM) will in-service all teammates on Policy 1-12-02 “DSD: HHD Services Provided”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using	08/15/2025

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	Dialysis (DSD) (April 2024) indicated the SNF Coordination Agreement will include how communication and responses will be coordinated and documented between the ESRD facility and nursing home staff. 2. A document titled, "Home Hemodialysis Coordination Agreement" indicated the facility and SNF will maintain communication regarding all required supportive care of the patient both during and after dialysis treatments. The facility will communicate with the SNF necessary post treatment monitoring required related to fluid overload/depletion, infection, and electrolyte imbalances. The facility and SNF will communicate, and document responses related to medication administration, physician and treatment orders, lab values, vital signs, changes in patient status, weights, compliance with food/fluid restrictions or provision of meals, dialysis treatments provided and patient response, and concerns with dialysis accesses. 3. The clinical record for Patient #3, admission date 05/20/2025, included 3 coordination notes from 05/20/2025 -- 07/15/2025. All three coordination notes failed to include the dates of treatments. 4. The clinical record for Patient #4, admission date 08/11/2023, included 4 coordination notes from 01/01/2025 - 07/15/2025. Two coordination notes were dated 06/04/2025 and 06/30/2025 while the other 2 coordination notes failed to include any date. 5. During an interview on 07/16/2025 at 9:54 AM, RN 5 indicated the SNF sends a communication document with each patient upon arrival to the DEN. The SNF and DEN use this document to		surveyor observations as examples, to include, but not limited to the following: 1) The coordination agreement delineates the responsibilities of the DaVita ESRD facility and the SNF regarding care of the resident before, during and after home hemodialysis treatments. 2) The SNF is responsible for providing a safe environment for the home hemodialysis treatments, monitoring the resident before, and after home hemodialysis treatments for complications possibly related to home hemodialysis, and provides all non- dialysis related care to patients before, during and after home hemodialysis treatments. 3) The SNF is responsible for providing a safe environment for the home hemodialysis treatments, monitoring the resident before, and after home hemodialysis treatments for complications possibly related to home hemodialysis, and provides all non- dialysis related care to patients before, during and after home hemodialysis treatments. 4) Both the ESRD facility and the SNF are responsible for collaborating to provide dialysis care coordination… The Facility Administrator or Regional Operations Manager will audit twenty-five percent (25%) of treatment records daily for two (2) weeks then weekly for two (2)	

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	communicate with the facility on each individual patient. Once the patient's treatment is completed the form is filled out by the dialysis nurse, a copy is made for the DEN, and the original is sent back to the SNF staff with the patient. RN 5 indicated she gets busy and forgets to make copies of these communication documents prior to sending the original back with the patient, indicating this was the reason they were missing from the patient's clinical records. RN 5 indicated she needs to ensure she is getting a copy for the facility's records.		weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of treatment records monthly x 3 months. Instances of non-compliance will be addressed immediately. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	
V 0599 Bldg. 00	494.100(c)(2) H-RECORDKEEPING SYSTEM Based on record review and interview, the facility failed to ensure clinical records reflected trained SNF staff were completing PD (dialysis via catheter in abdomen) treatments for 1 of 1 SNF reviewed. (Entity 1) Findings Include: A document titled, ""Home Hemodialysis Coordination Agreement" indicated the facility will ensure SNF staff are trained prior to	V 0599	The Facility Administrator or Regional Operations Manager (ROM) will in-service all clinical teammates on Policy 1-12-02 “DSD: HHD Services Provided”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but	08/15/2025

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	completing care/treatments. The PD treatment records for Patient #5, dated 04/29/2025 - 06/30/2025, failed to evidence the SNF staff member performing the dialysis initiation and discontinuation of treatments completed. During an interview on 07/16/2025 at 2:45 PM, RN 1 indicated she could not identify which SNF staff member were completing the PD treatments to determine their training status by the facility. All SNF staff performing dialysis treatments for Patient #5 are to be trained by the facility staff prior to completing patient treatments.		not limited to the following: 1) The dialysis treatments are administered, monitored, initiated, terminated and supervised by the DaVita HHD RN and patient care technician (PCT). 2) The DaVita HHD RN meets the training and competency requirement as stated in the CMS Conditions of Coverage V685, a registered nurse with at least 12 months of experience in providing nursing care and an additional 3 months of experience in the specific modality. 3) The DaVita HHD patient care technician (PCT) meets the training and competency requirement as stated in the CMS Conditions of Coverage V692-695 and works under the direct supervision of the DaVita HHD RN. 4) DaVita HHD RNs and PCTs will have annual skills competency verification completed by a trained and competent HHD RN by way of visual observation of the teammates performing the skills. Additionally, the HHD RNs and PCTs will complete an annual competency exam. Documentation of training and competency for each teammate will be maintained in their teammate file. The Facility Administrator or Regional Operations Manager will audit one hundred percent of teammate files to verify compliance with facility policy.	

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			Ongoing compliance will be verified quarterly. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	
V 0634 Bldg. 00	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS Based on record review and interview, the facility failed to ensure the health and safety of patients with identified medication allergies for 1 of 2 Home Hemodialysis DEN patients. (Patient #3) Findings Include: A policy titled, "Anticoagulation" (September 2024) indicated Heparin (medication used to prevent clotting of blood) is contraindicated when patients have documented allergies to pork heparin. A policy titled, "DSD Medication Policy" (April	V 0634	The Facility Administrator or Regional Operations Manager will in-service all clinical teammates on Policy 1-06-02 “Anticoagulation” and Policy 1-12-16 ĐSD Medication Policy”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following; 1) Heparin is contraindicated when	08/15/2025

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	2024) indicated prior to administration of medications, check for patient allergies when receiving or entering a medication order and prior to administering any medication. A document titled, "Patient Summary Report" for Patient #3 indicated an allergy to Heparin. The clinical record for Patient #3 was reviewed and evidenced the following Heparin administrations. A document titled, "Treatment Details Report" indicated RN 5 administered 2000 units of Heparin into both the arterial and venous lumens of the CVC (dialysis catheter) on 07/01/2025 at 11:00 AM. A document titled, "Treatment Details Report" indicated PCT 2 administered 2000 units of Heparin into both the arterial and venous lumens of the CVC on 07/03/2025 at 11:04 AM. A document titled, "Treatment Details Report" indicated RN 5 administered 2000 units of Heparin into both the arterial and venous lumens of the CVC on 07/05/2025 at 8:10 AM. A document titled, "Treatment Details Report" indicated RN 5 administered 2000 units of Heparin into both the arterial and venous lumens of the CVC on 07/08/2025 at 11:20 AM. A document titled, "Treatment Details Report" indicated RN 5 administered 2000 units of Heparin into both the arterial and venous lumens of the CVC on 07/10/2025 at 7:29 AM. A document titled, "Treatment Details Report" indicated RN 7 administered 2000 units of Heparin		patients are experiencing active bleeding, have documented allergies to pork heparin or patients who refuse pork heparin. 2) Prior to administration of medication, verify physician or NPP order. Check for patient allergies when receiving or entering a medication order and prior to administering any medication. The Facility Administrator or Regional Operations Manager will audit 25% of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent of treatment detail reports audited monthly x 3 months. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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	

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	into both the arterial and venous lumens of the CVC on 07/12/2025 at 11:37 AM. During an interview on 07/15/2025 at 11:03 AM, RN 5 indicated Patient #3 reported Heparin as an allergy to her. The order for Heparin was discussed with Physician 1 and she was given approval to administer Heparin in the CVC lumens. RN 5 indicated there was no documentation in the patient ' s clinical record of this discussion and/or the approval to administer. During an interview on 07/15/2025 at 10:37 AM, the FA indicated Patient #3 has a Heparin allergy listed in the clinical record and Heparin should not be administered without a physician order. During an interview on 07/15/2025 at 3:15 PM, the FA indicated that if a patient has an allergy listed for a medication, that medication should not be administered to the patient.		this plan of correction.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P Based on observation, record review and interview, the medical director failed to ensure staff followed policy and procedure related to expired supply monitoring for 1 of 1 facility reviewed and failed to ensure staff followed policy and procedure related to disinfection of vascular accesses for 1 of 1 AVF (dialysis access) initiations. (Patient #3) Findings include: Expired Supplies A policy titled, "Infection Control for Dialysis Facilities" (April 2023), indicated supplies will be	V 0715	A Governing Body meeting was conducted on 7/31/25 with the Medical Director, Facility Administrator, Regional Operations Director, Regional Operations Manager for review of the survey findings from the CMS survey completed on 7/17/25. The Governing Body will review Policy COMP-DD-017 “Medical Director Qualifications and Responsibilities” with the Medical Director to include: 1) : 1) Medical Director responsibilities include, but are not limited to, the	08/15/2025

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LAFAYETTE HOME DIALYSIS	2 EXECUTIVE DR STE B LAFAYETTE, IN 47905

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	monitored for expiration date prior to use. During an observation of exam room 2 on 07/14/2025 at 1:27 PM, a bottle of ExSept (skin disinfectant) had a manufacturer's expiration date of 05/06/2025. During an observation of exam room 3 on 07/14/2025 at 1:31 PM, a bottle of ExSept had a manufacturer's expiration date of 05/06/2025. During an observation of the laboratory area on 07/14/2025 at 1:48 PM, 10 light blue lab tubes expired on 02/28/2025 and 10 Cobas PCR Media Uni Swab Sample Packet (used to test for COVID infection) expired on 04/30/2024. During an observation on 07/14/2025 at 1:59 PM, the wall hand sanitizer outside of exam room 3 expired 01/2025. During an observation of exam room 4 on 07/14/2025 at 1:36 PM, 1-1000 milliliter bag of 0.9% Sodium Chloride intravenous fluid (fluid used to rehydrate) expired 03/2025. During an observation of the medication preparation area on 07/14/2025 at 1:43 PM, 2 BD SafetyGlide 1milliliter syringes expired 04/30/2025 and 2 Acta Medical Intravenous Administration Sets (used to administer fluids into the vein) expired 04/19/2025. During an observation of the medication preparation area on 07/14/2025 at 1:46 PM, a bottle of hand soap found at the clean sink expired 03/2023. During an observation of the DEN on 07/16/2025 @ 8:42 AM, 73 recirculation connectors found in a cabinet of the medication preparation area, expired		following…: Oversight of 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….Verification of the Medical Director's attendance and understanding is evidence by his/her signature on the policy. The Facility Administrator or Regional Operations Manager will in-service all clinical teammates on Policy 1-05-01 "infection Control For Dialysis Facilities" and Procedure 1-04-01D "AV Fistula Or Graft Cannulation With JMS SYSLOC Mini Safety Needles (SFN) And Administration Of Heparin Loading Dose". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Supplies will be stored in a manner that maintains their integrity. 2) Expiration date and package integrity will be verified prior to use. 2) Skin Antiseptic: Isopropyl Alcohol – Effective Contact Time: 60 seconds – Air Drying Time: 15 seconds. The Facility Administrator or Regional Operations Manager removed the following expired supplies from use and discarded them in accordance with State and local	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152597	A. BUILDING 00 B. WING	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	03/31/2025 and 1 Microorganism collection and transport system (used to obtain cultures) expired 06/22/2025. During an observation of the DEN on 07/16/2025 at 8:52 AM, 2 bottles of E-Z Chek Blood Leak test strips (strips used to detect blood leaks) found in a cabinet of the medication preparation area expired 03/31/2025. During an observation of the DEN on 07/16/2025 at 8:56 AM, 100 yellow top laboratory tubes found in the laboratory cabinet expired 5/31/2025 along with 43 BD Vacutainer blood collection sets (used to collect blood samples) expired 06/30/2025. During an interview on 07/14/2025 at 2:35 PM, RN 1 indicated that all nurses are to take responsibility for checking for expired supplies when stocking every week and that a staff member is currently being trained to regularly complete supply checks. AVF Disinfection According to the "AV Fistula or Graft Cannulation with JMS Systolic Mini Safety Fistula Needles and Administration of Heparin Loading Dose" policy (April 2025), teammates are to apply alcohol to the access site using a circular rubbing motion, center out for 60 seconds and allow to dry for 15 seconds prior to cannulation. During an observation at the DEN on 07/17/2025 at 7:10 AM, RN 5 initiated Patient #3's AVF (dialysis access) treatment. RN 5 disinfected the AVF with an alcohol prep pad using a swiping motion for 6 seconds and failing to allow the alcohol to dry prior to cannulation (inserting needle).		requirements: (1) bottle of ExSept skin disinfectant in exam room 2 with an expiration date of 5/6/25; (1) bottle if ExSept skin disinfectant in exam 3 with an expiration date 7/14/25; (10) Cobas PCR Media Uni Swab Sample Packets with an expiration date of 4/30/24; (1) wall hand sanitizer outside of exam room2 with an expiration date of 1/2025; (1) 100 milliliter bag of 0.9% Sodium Chloride intravenous fluid with an expiration date of 3/2025; (2) BD Safety Glide 1 milliliter syringes with expiration dates of 4/30/2025; and (2) Acta Medical Intravenous Administration sets with an expiration date of 4/19/25; in the medication prep area (1) bottle of hand soap with an expiration date of 3/23. The following items were observed in the DEN: (73) recirculation connectors in the medication prep area with an expiration date of 3/31/25; (1) Microorganism collection and transport system with an expiration date of 6/22/25; (2) bottles of E-Z Check Blood Leak test strips with an expiration date of 3/31/25: (100) yellow top laboratory tubes with an expiration date of 5/31/25; 43 BD vacutainer blood collection sets with an expiration date of 6/30/25. The Facility Administrator or Regional Operations Manager will conduct observational audits daily x 2	

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	During an interview on 07/17/2025 at 7:20 AM, RN 5 indicated that she was unsure of the amount of time needed to disinfect a AVF or what the policy stated. She usually does a couple swipes and sticks the patient.		weeks, then weekly x 2 weeks to verify compliance with facility policy for expired supplies and vascular access care. Ongoing compliance will be verified monthly during an internal audit. Instances of noncompliance will be addressed. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance and 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.	