STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152574	A. BUILDING 00 B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TELL CITY DIALYSIS CENTER	1602 MAIN ST TELL CITY, IN 47586

(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 State Department of Health in accordance with 42 CFR 494.62. Survey Dates: 12/12/2022-12/14/2022 Census: 37 At this Emergency Preparedness survey, Tell City Dialysis Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR Completed 12/20/2022 A4	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: 12/12/2022-12/14/2022 Census by Service Type: In Center Hemodialysis: 37 Total Census: 44 Isolation Room/Waiver: No	V 0000		
V 0111 Bldg. 00	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Denu BSN CDN RN	Facility Administrator	12/28/2022

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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	transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, record review, and interview, the facility failed to ensure PPE (personal protective equipment) was used, maintained, and stored appropriately for 1 of 3 treatment floor observation days (Treatment floor); and failed to ensure a sanitary environment was maintained to minimize the spread of infectious agents regarding 12 worn treatment chairs with tape residue for 12 of 12 treatment chair observations. (Treatment chairs) Findings include: 1. A revised policy titled Personal Protective Equipment [gloves, gown, mask, face shield] Plan was provided by A1 (Facility Administrator) on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "5. Appropriate PPE will be provided, used, and maintained in a sanitary and reliable manner ... " 2. During an observation on 12/12/2022 at 11:46 a.m. 1 (one) green disposable face shield and 1 non-disposable face shield was observed hanging from hooks below the designated clean computer station located between station 1 and station 2 while patients were dialyzing. The green face shield was observed touching the treatment tray attached to station 1's treatment chair while a patient was dialyzing. The facility failed to ensure staff face shields were not cross contaminated with a designated dirty station. 3. During the treatment floor observation on 12/12/2022 at 11:47 a.m. observed 1 red non-disposable face shield with a staff member name written on the side sitting on a designated	V 0111	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 4-05-01 “Personal Protective Equipment Plan” beginning 12-22-2022. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Appropriate PPE will be provided, used, and maintained in a sanitary and reliable manner…The Facility Administrator or designee will conduct observational audits daily for two (2) weeks starting 12-27-2022, 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 the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for	01/12/2023

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	clean countertop next to unused IV (intravenous) supplies. 4. During the treatment floor observation on 12/12/2022 at 3:20 p.m. observed 1 blue non-disposable face shield lying next to the computer at nurses' desk, 1 red face shield on countertop in a designated clean area, and 3 face shields hanging from hooks under the computer station located between station 1 and station 2 while patients were receiving dialysis treatment. 5. During the treatment floor observation on 12/12/2022 between 9:07 a.m. to 1:00 p.m. all 12 blue treatment chairs appeared worn with white bleach stains and separation at the seams. All 12 treatment chair side trays on both sides of the chairs had tape residue stuck to the trays. The facility failed to ensure worn treatment chairs were replaced timely and tape residue was removed from all treatment chair trays between patient treatments. 6. During an interview on 12/12/2022 at 2:35 p.m. B1 (BioMed) indicated he/she was aware of the worn treatment chairs and the plan was to replace the chairs in January 2023. BioMed 1 indicated the treatment chairs were not ordered yet. 7. During an interview on 12/12/2022 at 10:32 a.m. A2 (Clinical Coordinator) indicated the facility does not have approval yet for new treatment chairs and agreed tape reside should be removed from the treatment chair trays. At 4:00 p.m. A1 indicated that face shields should be hung in the designated area for PPE and face shields should not touch the patient's treatment chair during dialysis. A1 indicated the treatment chairs were worn and agreed that tape residue should be removed from the trays.		compliance with this plan of correction. 1/12/23	

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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 clean tape was applied to an AV (arteriovenous) site for 1 of 2 access care for an AV site (PCT1); and failed to perform hand hygiene prior to applying gloves for 3 of 3 medication administration observations. (RN2) Findings include: 1. A revised March 2015 policy titled AV Fistula or Graft Cannulation with Nirpo or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose was provided by A1 (Facility Administrator) on 12/13/2022 at 6:23 a.m. The policy indicated, but was not limited to, "24. ... Aseptically place ... adhesive tape ..." 2. A revised policy titled Infection Control for Dialysis Facilities was provided by A1 on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "1. Hand hygiene is to be performed ... prior to gloving ..." 3. During an observation on 12/12/2022 at 10:15 a.m. observed RN1 (Registered Nurse) disinfect the biohazard (infectious agent harmful to humans or environment) sharps (needle or blade) container with gloved hands at station 6. RN1 proceeded to a designated clean area, opened a cabinet to obtain additional clothes, and placed the clothes in the bleach container. RN1 then took the wet bleach clothes back to station 6 to	V 0113	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 1-04-01E “AV Fistula Or Graft Cannulation With Nipro Or Medisystems Safety Fistula Needles (SFN) And Administration Of Heparin Loading Dose” and Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning 12/12/22. . Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Aseptically place sterile gauze or an adhesive type dressing over the needle insertion site. Sterile dressing prevents contamination of needle insertion site. 2) Hand hygiene is to be performed…prior to gloving…The Facility Administrator or designee will conduct observational audits daily for two (2) weeks starting on 12-27-2022, then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. The Facility Administrator	01/12/2023

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	continue disinfecting the station. RN1 failed to remove soiled gloves and perform hand hygiene after disinfecting the biohazard container and before obtaining clothes from a designated clean area. 4. During an observation on 12/12/2022 at 3:12 p.m. stacked pre-torn strips of tape were taped to patient 11's left tray attached to the treatment chair at station 1. PCT1 (Personal Care Technician) applied all strips of tape including the barrier tape strip attached to the tray to patient 11's left AV access site gauze dressing after discontinuation from dialysis (treatment for failing kidneys). The facility failed to ensure cross contamination was prevented by using the barrier strip of tape over the patient's clean gauze dressing. 5. During two observations on 12/13/2022 at 8:30 a.m. along with RN2 (Registered Nurse), RN2 failed to perform hand hygiene before applying gloves to administer IV (intravenous) iron (supplement to treat low blood level) medication and IV Micera (treats low red blood cell count) medication to patient 8. 6. During an observation on 12/13/2022 at 8:50 a.m. RN2 picked up patient 13's personal pillow from the floor and positioned the pillow behind patient 13's head. RN2 then proceeded to apply gloves to administer IV medication to patient 13. RN2 failed to perform hand hygiene before applying gloves to administer patient 13's IV medication. 7. During an interview on 12/12/2022 at 3:50 p.m. A1 indicated the barrier piece of tape should not be placed over the clean gauze dressing.		or designee will focus on hand hygiene prior to gloving and also will focus on taping of access sites. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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V 0116 Bldg. 00	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. Based on observation, record review, and interview, the facility failed to ensure clean items were not brought to a station treatment chair that was still wet for 1 of 2 supply management and contamination observations. (Station 1) Finding include: A revised October 2022 policy titled Infection Control for Dialysis Facilities was provided by A1 (Facility Administrator) on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "74. Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time." During an observation on 12/12/2022 at 10:24 a.m. observed PCT3 (Personal Care Technician) set clean supplies on a wet disinfected dialysis treatment chair at station 1 (one). PCT3 failed to ensure the treatment chair was allowed time to air dry before laying new supplies on the treatment	V 0116	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning 12/2722. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Sufficient disinfectant should be applied so that surfaces are visibly wet. 2) Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks starting on	01/12/2023

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	chair. During an interview on 12/12/2022 at 1:00 p.m. A1 indicated the treatment chair should be dry before setting clean supplies on the treatment chair.		12-27-2022, 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 the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0121 Bldg. 00	494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [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- (i) Handling, storage and disposal of potentially infectious waste; Based on observation, record review, and interview, the facility failed to ensure facility policy was followed on labeling the centrifuge, laboratory refrigerator, and blood specimen tube holders for 1 of 1 laboratory room observations. (Lab room)	V 0121	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning 12/2722. Verification of attendance at in-service is	01/12/2023

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	Findings include: A revised October 2022 policy titled Infection Control for Dialysis Facilities was provided by A1 (Facility Administrator) on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "54. Biohazard labels well be affixed to all refrigerators and freezers containing blood, centrifuges, and containers used to transport blood or body fluid containers. Biohazard labels will be posted in areas where tasks involving contact with blood ... lab prep area." During the lab room observation along with A2 (Clinical Coordinator) on 12/13/2022 at 8:25 a.m. observed an unlabeled gray refrigerator containing 9 (nine) blood specimen tubes in an unmarked test tube holder. At the same time, observed 1 (one) centrifuge (device used to separate fluids) and 3 (three) test tube holders without a biohazard (infectious agent harmful to humans or environment) label. At that time, A2 indicated the refrigerator was new and a biohazard label was on order. A2 agreed the facility did not follow policy and failed to affix biohazard labels on the lab refrigerator, centrifuge, and 4 test tube holders.		evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Biohazard labels will be affixed to all refrigerators and freezers containing blood, centrifuges, and containers used to transport blood or body fluid containers. 2) Biohazard labels will be posted in areas where tasks involving contact with blood or body fluids are performed, for example, lab prep area. The Facility Administrator submitted a purchase order for Biohazard stickers on 12-14-2022. When received, the Biohazard stickers will be placed in the lab prep area, lab refrigerator (where blood/bodily fluids are stored), four lab test tube holders, and the centrifuge. The Facility Administrator or designee will conduct observational audits of the laboratory area daily for two (2) weeks starting on 12-27-2022, then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and	

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			Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation 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 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			

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	use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on observation, record review, and interview, the facility failed to ensure a CVC (central venous catheter) was disinfected appropriately for 1 of 1 observation of initiation of a CVC (Patient 13); and for 2 of 2 observations of discontinuation of a CVC. (Patient 8 & 13) Findings include: 1. A revised October 2022 policy titled Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure was provided by A1 (Facility Administrator) on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "16. Scrub each CVC hub for 15 seconds ... 33. ... Remove the syringes ... Scrub the sides, threads, and end of hub thoroughly with friction for 15 seconds ..." 2. During an observation on 12/13/2022 at 6:50 a.m. PCT1 (Patient Care Technician) scrubbed patient 13's red CVC (tube placed in a large vein) hub (end of a CVC that connects blood lines) for 6 seconds and the blue hub for 5 seconds during the initiation of dialysis with a CVC. The PCT1 failed to scrub each CVC hub for 15 seconds. 3. During an observation on 12/13/2022 at 10:37 a.m. RN1 (Registered Nurse) scrubbed patient 8's blue CVC hub for 3 seconds and the red hub for 8 seconds during discontinuation of dialysis with a CVC. The RN failed to scrub each CVC hub for 15 seconds. 4. During an observation on 12/13/2022 at 10:40 a.m. PCT1 scrubbed patient 13's blue CVC hub for 6 seconds and the red hub for 11 seconds during	V 0147	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 1-04-02B “Central Venous Catheter (CVC) With Clearguard HD Antimicrobial End Caps Procedure” beginning 12/27/22. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Scrub each CVC hub for 15 seconds…2) Remove syringes… Scrub the sides, threads and end of hub thoroughly with friction for 15 seconds…The Facility Administrator or designee will conduct observational audits for CVC care daily for two (2) weeks starting on 12-27-2022, 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 the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with	01/12/2023

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	discontinuation of dialysis with a CVC. The PCT failed to scrub each CVC hub for 15 seconds. 5. During an interview on 12/13/2022 at 12:00 p.m. A1 indicated CVC hubs should be scrubbed according to policy.		supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0250 Bldg. 00	494.40(a) DIALYS PROPORT-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. Based on observation, record review, and interview, the facility failed to ensure proper procedure was completed for use of the Myron L DS (RO-1) meter for 2 of 2 preparation of a hemodialysis machine observations, creating the potential for harm to affect all 37 in-center dialysis patients. (RN2) Findings include: 1. A revised October 2021 In-Center Hemodialysis Equipment, Water and Testing Devices Procedure 2-05-03B titled "OPERATION OF MYRON L DS METER (RO-1)" was provided by the BioMed Technician (B1) on 12/12/2022 at 2:35 p.m. The policy indicated, but was not limited to, "Materials required: Myron L DS Meter (RO-1), Water sample to be tested ...Procedure 1. Rinse built-in cell cup 3 times with sample of water to be tested. 2. Fill the cell with another sample to at least ¼ (6mm) above the upper electrode. 3. Push black button. 4. Read while button is pressed (Pointer indicates true	V 0250	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 2-05-03B “Operation of Myron L DS Meter (RO-1)” beginning 12/27/22. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Materials required: Myron L DS Meter (RO-1); Water sample to be tested. 2) Procedure: a) Rinse built-in cell cup 3 times with sample of water to be tested. b) Fill the cell with another sample to at least 1/4" (6 mm) above the upper electrode. c) Push black button. d) Read while button is pressed (Pointer indicates true	01/12/2023

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	parts per million {ppm} of dissolved solids ..." 2. On 12/13/22 at 7:40 a.m. Registered Nurse (RN2) 2 was observed checking water quality with the Myron L DS Meter (RO-1) (instrument used to test dialysate) . The water sample taken from the dialysis machine was used to rinse the cell cup two (2) times and then tested receiving a result of 13.9. RN2 failed to follow the proper procedure and manufacturer's instructions by rinsing the cell cup three (3) times before testing the water sample.3. On 12/12/2022 at 11:32 a.m. RN2 was observed checking water quality with the Myron L DS Meter (RO-1). The water sample taken from the dialysis machine at station 3 was used to rinse the cell cup 1 (one) time and then tested receiving a result of 13.6. RN2 failed to follow the proper procedure and manufacturer's instructions by rinsing the cell cup 3 times before testing the water sample. 4. During an interview on 12/13/2022 at 9:51 a.m. B1 indicated the procedure should be followed by anyone checking the water quality with the Myron l DS (RO-1) Meter.		parts per million {ppm} of dissolved solids). The Facility Administrator or designee will conduct observational audits for 5 conductivity testings utilizing the Myron L daily for two (2) weeks starting 12-27-2022 then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0401 Bldg. 00	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment. Based on observation, record review, and interview, the facility failed to ensure a safe and secure environment was maintained for 1 of 3 survey days; and failed to ensure needles and syringes were secured for 1 of 1 medication area	V 0401	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 9-01-04 “Dialysis Facility Physical Security Guidance” and Policy	01/12/2023

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	and 1 of 1 lab room area observations. (Medication area, Lab room) Findings include: 1. A June 2021 policy 9-01-04 titled, Dialysis Facility Physical Security Guidance was provided by the Facility Administrator Registered Nurse (A1) on 12/12/2022 at 4:00 p.m. The policy indicated, but was not limited to, "PURPOSE: The purpose of this Physical Security Guidance is to establish and implement appropriate protective measures and practices to maintain the physical security of the facility ... POLICY: 1. .... i. Assist in safeguarding Teammates, patients, partners, and assets ... 3. Access Controls ... b. Access Control. DaVita Facilities have access control to prevent unauthorized individuals from accessing restricted areas ..." 2. An updated October 2021 article titled What are the Joint Commission requirements regarding storage of needles and syringes? from the www.jointcommission.org website indicated, but was not limited to, "The Joint Commission does not have a standard to address needle and syringe storage. These items should be kept secure to protect from tampering or theft. A secure area may be described as an area where the staff is providing patient care, or staff is present and effectively ensures that access to the area or storage device is restricted to authorized individuals, and patients and visitors are not allowed without the supervision or presence of a health care professional. ... organizations may determine that use of a locking device or storage unit may be needed to prevent unauthorized access to these supplies." 3. Upon entrance into the facility on 12/12/2022 at		8-04-01 "Physical Environment" beginning 12/27/22. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) PURPOSE: The purpose of this Physical Security Guidance is to establish and implement appropriate protective measures and practices to maintain the physical security of the facility. 2) POLICY: … Assist in safeguarding Teammates, patients, partners and assets; 3) Access Control. DaVita facilities have access control to prevent unauthorized individuals from accessing restricted areas. 4) Access to Patient treatment areas…supply storage…is restricted to authorized personnel only. 5) The dialysis facility will store supplies in a manner that is consistent with fire safety and other appropriate regulations. On 12/12/22, the Facility Administrator immediately locked the side door in the patient restroom to prevent unauthorized access to the treatment area and informed teammates that this door is to remain locked at all times. On 12/12/22, the Facility Administrator relocated sharps form the treatment area and lab area to a locked cabinet. The Facility Administrator submitted a work order to an outside vendor for	

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	9:00 a.m., the restroom door was opened to see if the call light and bell worked. A door on the opposite wall was checked and it was unlocked and opened directly to the treatment floor, giving access to the treatment floor to anyone entering the lobby. 4. During the flash tour on 12/12/2022 at 9:16 a.m., a drawer in the lab room was opened and evidenced needled syringes loose and unsecured. 5. During observations on 12/12/2022, 12/13/2022, 12/14/2022, the medication cabinet and refrigerator were both unsecured and unsupervised at all times during treatment while unlicensed staff were in the area. 6. During an interview on 12/12/2022 at 0905 a.m., A1 indicated the door should not be unlocked.7. During the treatment floor flash tour on 12/12/2022 at 9:07 a.m. 1 (one) unlocked cabinet contained 1 half full box of 10 cc (cubic centimeter) syringes and a half full box of 3 cc needled syringes. The medication area was unsecured and unsupervised at the time of the observation. 8. During the lab room observation on 12/12/2022 at 9:55 a.m. 1 unlocked drawer contained 21-gauge needles and 1 unopened box of Eclipse needles. The lab room was unsecured and unsupervised at the time of the observation. 9. During an interview on 12/12/2022 at 3:50 p.m. C1 (Manager of Clinical Services) was unable to provide a specific policy that indicated needles and syringes are to be secured / locked up.		placement of installation of additional locks on cabinet doors for storage of sharps… The Facility Administrator or designee will conduct observational medication audits daily for two (2) weeks starting 12-27-2022 then weekly for two (2) weeks to verify compliance with facility policy for security of the treatment area and supply storage. Ongoing compliance will be verified monthly during the Safety audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0403 Bldg. 00	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU			

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	The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. Based on observation, record review, and interview, the facility failed to ensure treatment chairs were maintained to allow effective cleaning and disinfecting for 12 of 12 treatment chair observations. (Treatment chairs) Findings include: A 2022 Core Audit Physical Plant/Environment document was provided by A1 (Facility Administrator) on 12/13/2022 at 6:23 a.m. The document indicated, but was not limited to, "Integrity of all surfaces (... treatment chairs) is intact, free of damage that would prevent effective cleaning. ... " During the treatment floor observation on 12/12/2022 between 9:07 a.m. to 1:00 p.m. all 12 blue treatment chairs appeared worn with white bleach stains and separation at the seams that would prevent effective cleaning. During an interview on 12/12/2022 at 2:35 p.m. B1 (BioMed) indicated he/she was aware of the worn treatment chairs and the plan was to replace the chairs in January 2023. B1 indicated new treatment chairs were not ordered yet.	V 0403	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 8-04-01 “Physical Environment” and 4-08-03A Monthly OSHA and Safety Checklist” beginning 12/27/22. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) 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. 2) The dialysis facility will implement and maintain a program to verify that all equipment… are maintained and operated in accordance with the manufacturer’s recommendations. 3) Are all patient chairs in good condition (not torn…The Facility Administrator submitted a purchase order to an outside vendor on 12/21/22 for 12 new dialysis chairs. The Facility Administrator will follow-up with	01/12/2023

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			chair vendor weekly for expected delivery date of the dialysis chairs. Until the new dialysis chairs arrived, a disposable barrier will be utilized to cover separated seams, worn areas, and tape residue on dialysis chairs to promote infection control and prevent cross contamination. The disposable barriers will be changed between each patient. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks, then weekly for two (2) weeks to verify compliance with facility policy for infection control and physical environment. 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 the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction. The Governing Body will review physical plant audits and will oversee the timeline for physical plant repairs until all repairs have	

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			been completed. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on record review and interview, the facility failed to ensure incenter patient prescriptions for treatment were verified by the nurse within 60 minutes of start of treatment for 4 of 5 record reviews (Patient 3, 6, 8, and 10); and failed to ensure heparin pumps were stopped 60 minutes prior to the end of infusion per physician order for 5 of 5 record reviews (Patients 3, 6, 8, 9, and 10). Findings include: 1. A revised April/2021 policy 1-03-08 titled "CWOW-PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT" was provided by Manager of Clinical Services (C1) on 12/13/2022 at 12:05 p.m. The policy indicated, but was not limited to, "PURPOSE To obtain and document baseline and ongoing information about the patient before, during, and after dialysis treatment through data collection and nursing assessment ...POLICY: 3. Patient identity, prescription, and machine settings are verified prior to initiation of treatment ... the prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation along with the nursing assessment ....."	V 0543	The Facility Administrator or designee will in-service 100% of clinical teammates on Policy 1-03-08 “CWOW-Pre-Intra-Post Treatment Data Collection, Monitoring, And Nursing Assessment” and Policy 1=-06-01 “Medication Policy” beginning 12/27/22. Verification of attendance at in-service is evidenced by a signature sheet. Teammates were instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment through data collection and nursing assessment. 2) Patient identity, prescription and machine settings are verified by teammate prior to initiation of treatment…3) he prescription components are confirmed by a licensed nurse within one (1) hour of treatment	01/12/2023

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	2. A REVISED October 2022 policy 1-06-01 titled "MEDICATION POLICY" was provided by Facility Administrator (FA) Registered Nurse (RN) (A1) on 12/12/2022 at 11:05 a.m. The policy indicated, but was not limited to, "PURPOSE: To provide guidance for medication management ... POLICY: ... 9. Medications are administered as prescribed and then documented in the patient's medical record ..." 3. The clinical record review for patient 3 was reviewed on 12/12/2022 with orders for Heparin (prevent blood clots) Pork Infusions of 600 Units/hour given every dialysis treatment with infusion rate of 0.6 mL/hr to be stopped 60 minutes before the end of treatment. The record review indicated the following: On 12/09/2022 at 11:22 a.m. Patient Care Technician (PCT1) 1 verified patient prescription (dialysis parameters ordered by a physician), at 11:32 a.m. started the heparin infusion, dialysis treatment began at 11:34 a.m. and ended at 2:58 p.m., Heparin infusion stopped at 3:05 p.m., and at 4:00 p.m. Registered Nurse (A2) confirmed the patient's prescription. The time between verification of treatment prescription and confirmation by the RN (A2) was 4 hours and 38 minutes, and the heparin infusion was documented to have stopped after the dialysis treatment ended. The facility failed to administer Heparin infusion as ordered and confirm patient dialysis prescription within one (1) hour per policy. On 12/05/2022 at 12:40 p.m. PCT2 verified patient prescription and at 2:46 p.m. A2 confirmed the patient's prescription. The time between verification of treatment prescription and		initiation along with the nursing assessment…4) PURPOSE: To provide guidance for medication management in the facility and to provide guidance for the safe and aseptic preparation of all medications. 5) Medications are administered as prescribed and then documented in the patient's medical record. The Facility Administrator or designee will audit on twenty five percent (25%) of the treatment data reports daily for two (2) weeks starting on 12-27-2022, then twenty five percent (25%) of the treatment data reports weekly for two (2) weeks to verify compliance with facility policy for verification of dialysis prescription within 1 hour of treatment initiation and medication administration. Ongoing compliance will be verified with 10 treatment data reports audited monthly x 3 months during the medical record audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility	

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	confirmation was 2 hours and 6 minutes. The facility failed to confirm patient dialysis prescription within one (1) hour per policy. On 12/02/2022 at 11:23 a.m. PCT3 verified patient prescription, at 11:30 a.m. started the heparin infusion, dialysis treatment began at 11:30 a.m., at 12:52 p.m. A2 confirmed the patient prescription, at 2:00 p.m. Heparin infusion was stopped, and at 2:47 p.m. dialysis treatment was terminated. The time between verification of treatment prescription and confirmation by A2 1 hour and 29 minutes, and the heparin infusion is documented to have stopped 47 minutes before dialysis treatment ended. The facility failed to administer Heparin infusion as ordered and confirm patient dialysis prescription within one (1) hour per policy. On 11/28/2022 at 11:25 a.m. PCT3 verified patient prescription and at 12:39 p.m. A2 confirmed the patient's prescription. The time between verification of treatment prescription and confirmation was 1 hour and 14 minutes. The facility failed to confirm patient dialysis prescription within one (1) hour per policy. On 11/18/2022 at 11:02 a.m. PCT4 verified patient prescription and at 3:30 p.m. A2 confirmed the patient's prescription. The time between verification of treatment prescription and confirmation was 4 hours and 28 minutes. The facility failed to confirm patient dialysis prescription within one (1) hour per policy. 4. The clinical record review for patient 10 was reviewed on 12/14/2022 and indicated the following: On 12/01/2022 at 8:18 a.m. PCT3 verified patient prescription and at 9:49 a.m. A2 confirmed the		Administrator is responsible for compliance with this plan of correction.	

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	patient's prescription. The time between verification of treatment prescription and confirmation was 1 hours and 31 minutes. The facility failed to confirm patient dialysis prescription within one (1) hour per policy. On 11/29/2022 at 7:24 a.m. A2 verified patient prescription and at 9:13 a.m. A2 confirmed the patient's prescription. The time between verification of treatment prescription and confirmation was 1 hours and 49 minutes. The facility failed to confirm patient dialysis prescription within one (1) hour per policy. 5. During an interview on 12/13/2022 at 10:00 a.m. the Manager of Clinical Services (C1) indicated patient prescriptions are supposed to be confirmed by the nurse within one (1) hour of verification and initiation of dialysis treatment per policy. 6. During an interview on 12/14/2022 at 11:13 a.m. the C1 indicated heparin infusions should be administered per the doctor's order stopping 60 minutes before the end of treatments.7. The clinical record for patient 6 was reviewed on 12/12/2022 with orders for Heparin Pork Infusions of 600 Units/hour given every dialysis treatment with infusion rate of 0.6 mL/hr to be stopped 60 minutes before the end of treatment. The record review indicated the following: On 12/09/2022 at 11:27 a.m. patient 6's dialysis was started by PCT1. A2 confirmed patient 6's prescription at 3:57 p.m. 4 hours and 30 minutes later. The facility failed to confirm the patient's prescription within 60 minutes of start of treatment. Patient 6 ended dialysis treatment at 3:02 p.m. The recorded stop time for Heparin was 1:07 p.m., 2 hours early. The facility failed to stop			

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	Heparin 60 minutes before the end of treatment. On 12/05/2022 at 12:11 p.m. patient 6's dialysis was started by PCT1. A2 confirmed patient 6's prescription at 3:05 p.m. 2 hours and 54 minutes later. The facility failed to confirm the patient's prescription within 60 minutes of start of treatment. On 12/02/2022 at 11:10 a.m. patient 6's dialysis was started by PCT1. A2 confirmed patient 6's prescription at 12:31 p.m. 1 hour and 21 minutes later. The facility failed to confirm the patient's prescription within 60 minutes of start of treatment. 8. The clinical record for patient 8 was reviewed on 12/12/2022. The record review indicated the following: On 11/29/2022 at 7:12 a.m. patient 8's dialysis was started by PCT3. A2 confirmed patient 8's prescription at 9:09 a.m. 1 hour and 57 minutes later. On 11/17/2022 at 7:41 a.m. patient 8's dialysis was started by PCT1 and ended at 10:41 a.m. A2 confirmed patient 8's prescription at 12:38 p.m. 4 hours and 57 minutes after initiation of treatment. The facility failed to confirm the patient's prescription within 60 minutes of start of treatment. 9. The clinical record review for patient 9 was reviewed on 12/12/2022 with orders for Heparin Pork Infusions of 400 Units/hour given every dialysis treatment with infusion rate of 0.4 mL/hr to be stopped 60 minutes before the end of treatment. The record review indicated the following:			

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	On 12/09/2022 at 11:44 a.m. patient 9's dialysis was started by PCT3. Patient 9 ended dialysis treatment at 2:43 p.m. The recorded stop time for Heparin was 2:08 p.m., 35 minutes before treatment ended. The facility failed to stop Heparin 60 minutes before the end of treatment. On 12/05/2022 at 2:03 p.m. patient 9's dialysis was started by PCT1. Patient 9 ended dialysis treatment at 4:43 p.m. The recorded stop time for Heparin was 5:02 p.m., 19 minutes after treatment ended. The facility failed to stop Heparin 60 minutes before the end of treatment.			
V 0632 Bldg. 00	494.110(a)(2)(iv) QAPI-INDICATOR-ANEMIA MANAGEMENT The program must include, but not be limited to, the following: (iv) Anemia management. Based on record review and interview, the facility failed to ensure anemia management was tracked monthly for 1 of 1 QAPI (Quality Assessment Performance Improvement) review. Findings include: A revised April 2021 policy titled Continuous Quality Improvement Program was provided by A1 (Facility Administrator) on 12/14/2022 at 11:45 a.m. The policy indicated, but was not limited to, "4. The Facility Medical Director is responsible for verifying the execution as well as participation in the Quality Improvement Program including implementation, continuous monitoring ... 7. The facility will measure, analyze, and track quality indicators or other aspects of performance. ... Patient Safety ... Anemia Management ... 8. Continuous monitoring ... Any area identified as underperforming will be reviewed to identify root	V 0632	The Facility Administrator or designee will in-service Continuous Quality Improvement committee members on Policy 1-14-06 “Continuous Quality Improvement Program”. Verification of attendance at the in- service will be evidenced by a signature sheet. CQI committee members will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The Facility Medical Director is responsible for verifying the execution as well as participation in the Quality Improvement Program including implementation, continuous monitoring, development of action plans and	01/12/2023

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	causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained." During an interview on 12/12/2022 at 11:25 a.m. the data core worksheet was reviewed along with A1 and agreed that anemia (hemoglobin/red blood cells less than 10) was a concern and a focus area for the survey. During an interview on 12/14/2022 at 9:00 a.m. the QAPI was reviewed along with A1. A1 indicated the facility tracks anemia (hemoglobin less than 9) and indicated the facility goal is 15%. Anemia management percentages of patients with a hemoglobin less than 9 were as followed: June 0%; July 7%; August 14 %; September 15%; and October 4%. The facility failed to measure, analyze, identify root causes, and track quality indicators or other aspects for low hemoglobin levels for the patients identified.		program evaluation. 2) The facility will measure, analyze, and track quality indicators or other aspects of performance. 3) The program must include, but not be limited to, the following: … Patient Safety… Anemia Management…4) Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained. The Facility Administrator will review facility patients' hemoglobin test data with the CQI committee during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The CQI committee will analyze, trend, and develop action plans for hemoglobin results < 10 g/dl that will result in performance improvement. The CQI committee will track this change in performance over time to verify improvements are sustained. The Governing Body will meet monthly for 3 months for review of QAPI/FHM meeting minutes and verify trending and development of action plans for patients with Hemoglobin levels <10g/dl. The	

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	152574	A. BUILDING 00 B. WING	12/14/2022

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			Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on observation, record review, and interview, the Medical Director failed to ensure all policies and procedures relative to patient care and safety were adhered to by all individuals who treated patients in the facility. Findings include: A revised April 2021 policy titled Continuous Quality Improvement Program was provided by A1 on 12/14/2022 at 11:45 a.m. The policy indicated, but was not limited to, "4. The Facility Medical Director is responsible for verifying the execution as well as participation ... continuous monitoring ... 7. The facility will measure, analyze, and track quality indicators or other aspects of performance. ... Patient Safety ... Infection Control ... Anemia Management ... 8. Continuous monitoring ... Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in	V 0715	V715 A Governing Body meeting with the Medical Director, Facility Administrator, Director of Nursing and Regional Operations Director was conducted on 12/23/22 for review of the citations from the survey conducted on 12/14/22. The Governing Body reviewed Policy COMP-DD-017 “Medical Director Qualifications and Responsibilities” with the Medical Director. Verification of attendance is evidenced by the Medical Director signature on the policy. The Governing Body reviewed the following with the Medical Director: 1) Medical Director responsibilities include, but are not limited to, the following… : 1) …The Quality Assurance (QA)/Quality Improvement (QI) program…2)	01/12/2023

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	performance over time to verify improvements are sustained." The Medical Director failed to ensure adherence to policies and procedures regarding the following: Sanitary Environment (See tag V0111), Wearing Gloves/Hand Hygiene (See tag 0113), Cleaning/Disinfecting Dialysis Station (See tag V0116), Handling Infectious Waste (See tag V0121), Staff Education (See tag V0147), Safe Environment (See tag V0401), Monitoring pH/conductivity (See tag V0250, Equipment Maintenance (See tag V0403), Manage Volume Status (See tag V0543), QAPI (See tag V0632) During an interview on 11/13/2022 at 11:15 a.m. P1 (Medical Director) indicated the expectation was for all staff to adhere to policies and procedures at the facility.		Oversight of policies and procedures relative to …patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility…The Medical Director has agreed to active involvement and oversight regarding teammates' adherence to policy and procedure for adherence for prescribed dialysis regimen, infection control, safe/secure physical environment, measuring conductivity, medication administration, provision of patient care, facility processes, and patient outcomes. These actions are outlined in depth in the POC for V111, V113, V116, V121, V147, V250, V401, V403, V543, and V632. This plan of correction will be reviewed monthly during Quality Assurance Performance improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator will report progress, as well as any barriers to maintaining compliance, to the committee. If compliance is not met a root cause analysis will be completed and new plan of correction implemented by the Governing Body. The Facility Administrator is responsible for ongoing compliance with the plan of correction.	