STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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JEFFERSONVILLE DIALYSIS	365 QUARTERMASTER CT JEFFERSONVILLE, IN 47130

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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: April 17th, 19th, & 21st of 2023. Census: 22 In-Center Hemodialysis 12 Peritoneal Dialysis 12 Home Hemodialysis (On-site Skilled Nursing Facility) At this Emergency Preparedness survey, Jeffersonville Dialysis, was found to be not in compliance with Emergency Preparedness requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62. QR Completed 5/1/2023 A4	E 0000		
E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment §494.62(b)(9) Condition for Coverage: [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (9) A process by which the staff can confirm			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Bowling
TITLE: Facility Administrator
(X6) DATE: 05/11/2023

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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	that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available. Based on record review, observation and interview, the facility failed to ensure that medications located in the emergency crash cart were safe for use and not expired in 1 of 2 facilities observed. Findings Include: A policy titled, "Medication Policy," revised October 2022 was provided by the ROD (Regional Operations Director) on 4/21/2023 at 12:38 PM. The policy indicated but was not limited to, "All mediations are checked monthly for expiration dates." ... "Medications are ordered and replaced prior to expiration." ... "Disposal of expired medications, including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations." During an observation on 4/19/2023 at 9:05 AM at the HHD (Home Hemodialysis) Den, a vial of Sterile Water was found to be expired 5/28/2021 located in the crash cart. During an interview on 4/19/2023 at 9:05 PM, the MCS (Manager of Clinical Services) agreed that the vial of sterile water had expired and disposed of the medication.	E 0028	E 028 The Regional Operations Manager (ROM) held a mandatory in-service for all SNF HHD teammates starting on 04/21/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 14-01-16A “Emergency Equipment Checks” with emphasis on but not limited to: 1) The following equipment checks will be performed by a licensed nurse teammate to verify the designated equipment is available and functional: Weekly: Emergency cart (crash cart) is clean, operational and supplies/medications have not expired. Verification of attendance at in-service will be evidenced by teammate’s signature on in-service sheet. The expired vial of sterile water was immediately removed and appropriately discarded. The ROM or designee immediately completed an audit of all medications in the crash cart to verify inventory is free from expired items. Ongoing compliance will be monitored with weekly checks documented on the Emergency Equipment Checklist. Instances of	06/05/2023

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			non-compliance will be addressed immediately. The Facility Administrator and ROM will review the results of the audits with teammates during homeroom meetings, and with the Medical Director during monthly Quality Assessment 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.	
E 0036 Bldg. 00	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth			

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	in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing			

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	and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview the facility failed to ensure that SNF (skilled nursing facility) staff were appropriately trained in emergency procedures in 1 of 2 facilities observed. (Den) Findings Include: A document titled Home Hemodialysis Contractual Agreement was provided by the Manager of Clinical Services on 4/19/2023 at 1:21 PM. The document indicated but was not limited to; "Communication procedures will allow for 24/7 communication between the Company and Manager. Company will provide to the Manager a telephone support and a list of names and contact information of Nephrologist and/or Company RNs to be called for emergencies." A 12/2020 revised policy titled SNF: HHD (Home Hemodialysis) Services Provided was provided by the Manager of Clinical Services on 4/19/2023. The policy indicated, but was not limited to, "Coordination of Care: The ESRD facility and SNF will establish procedures for 24/7 communication between the two entities. 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 ESRD facility will provide the SNF with the facility ' s normal operating hours	E 0036	E036 The Manager of Clinical Services (MCS) or designee will in-service 100% of SNF HHD teammates and the Facility Administrator (FA) on Policy 14-01-02 “SNF: HHD Services Provided” and Policy 14-01-09 “SNF: HHD Continuous Quality Improvement Program”. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) 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, 3) The ESRD facility will provide the SNF with the facility’s normal operating hours and contact information. In addition, the SNF will be provided with contact information for after hours and emergency issues, 4)	06/05/2023

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	and contact information. In addition, the SNF will be provided with contact information for after-hours and emergency issues." A policy titled, "SNF: HHD Continuous Quality Improvement Program," dated October 2020, was provided by the MCS on 4/19/2023. The policy indicated but was not limited to, "Communication, training, supervision and care coordination between the SNF and the DaVita care teams." ... "Provision of initial and ongoing education and training to the SNF staff related to the following: i. How to detect, report and manage potential dialysis complications, such as vascular access bleeding. ii. Availability of support resources and how to access and use resources. iii. How to report health status information. iv. How to handle medical and non-medical emergencies. v. Infection control precautions. vi. Individualized to meet the needs of the residents. vii. Emergency response" ... "Communication and coordination between the SNF and the dialysis facility in sharing data about outcomes and processes and reviewing indicators and care issues." During an interview on 4/19/2023 at 8:32 AM, RN (registered nurse) 3 indicated that nursing staff and/or nephrologist was not available or on-call after HHD Den hours. Indicated that the dialysis center was only open on Monday, Wednesday, and Friday's, running two patient shifts. The SNF staff are to call 911 in the event of an emergency such as a critical lab value or complication with vascular access. During an interview on 4/19/2023 at 1:37 PM a Non-entity RN G indicated that if an emergency arises with one of the dialysis patients after hours, SNF staff are provided a list of on call physicians available for the SNF. The on-call physicians		Communication, training, supervision and care coordination between the SNF and the DaVita care teams…Provision of initial and ongoing education and training to the SNF staff related to the following: … i. How to detect, report and manage potential dialysis complications, such as vascular access bleeding ii. How to report health status information iv. How to handle medical and non-medical emergencies v. Infection control precautions vi. Emergency response….and 2) Communication and coordination between the SNF and the dialysis facility in sharing 2 data about outcomes and processes and reviewing indicators and care issues. The ROM or designee will meet with the SNF Administrator and SNF DON by 5/19/23 to discuss and establish procedures for communicating urgent patient-care issues that arise outside of normal operating hours to allow for 24/7 communication between the SNF staff and SNF dialysis team. This discussion/meeting will include a list of names and contact information of Nephrologists and SNF dialysis Leadership provided by the ROM or designee for dissemination to the SNF RNs by the SNF Administrator, SNF DON, or designee. The ROM or designee will audit the posted	

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	listed did not include the nephrologists contracted by DaVita. No HHD Den RNs were listed on this on-call sheet. Non-Entity RN G also indicated that there is no on-call nurse to reach out to after hours if needed. Did indicate staff can reach out to Non-Entity E regarding dialysis patients if needed.		on-call schedule provided to the SNF daily x 2 weeks and then weekly x 2 to verify that the SNF staff are aware of how to contact dialysis staff and nephrologists outside of the normal operating hours of the SNF dialysis center. The FA will report findings to the Medical Director in the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).	
V 0000 Bldg. 00	This visit was for a federal core ESRD recertification survey. Survey Dates: April 17th, 19th, & 21st of 2023. Census: 22 In-Center Hemodialysis 12 Peritoneal Dialysis 12 Home Hemodialysis (On-site Skilled Nursing Facility)	V 0000		
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on record review, observation and interview, the facility failed to ensure that hand hygiene and glove changes were completed to	V 0113	V 113 The Regional Operations Manager (ROM) or designee held mandatory in-services for all SNF	06/05/2023

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	prevent exposure to blood and potentially contaminated items in 1 of 2 AVF (arteriovenous fistula initiations) observations. (Patient 10) Findings Include: A policy titled, "SNF Home Hemodialysis (HHD) Infection Control for Dialysis Facilities," revised April 2023, provided by the MCS (Manager of Clinical Services) on 4/19/2023 at 12:57 PM. The policy indicated but was not limited to, "Gloves should be changed when:" ... "When going from a dirty area or task to a clean area or task." During an observation at the HHD Den on 4/19/2023 at 8:55 AM, PCT 5 was observed initiating treatment for an AVF. PCT 5 was cannulating (inserting dialysis needles) into the patient's permanent access, then touched the dialysis machine with gloved hands, and then completed cannulating and connecting dialysis lines to access without changing gloves or washing/sanitizing hands. During an interview on 4/19/2023 at 2:54 PM during the exit conference the MCS was advised of the concern of lack of glove change and hand hygiene from a PCT observed initiating an AVF. The MCS acknowledged the concern and provided no additional information.		HHD teammates starting on 04/21/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 14-04-01 “SNF: Home Hemodialysis (HHD) Infection Control for Dialysis Facilities” revised April 2023, with emphasis on but limited to: 1) All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene... prior to gloving and immediately after removal of gloves... after patient and dialysis delivery system contact... 2) Disposable gloves will be worn when caring for the patient or touching the patient's equipment at the dialysis station... Gloves should be changed when: When going from a “dirty” area or task to a “clean” area or task. Verification of attendance at in-service will be evidenced by teammate’s signature on in-service sheet. The ROM or designee will conduct infection control audits to verify teammates are performing hand hygiene and glove changes per infection control policy: daily for two (2) weeks, and then weekly for two (2) weeks. Ongoing compliance will be monitored with monthly infection control audits. Instances of non-compliance will be addressed immediately. The ROM and Facility Administrator will review audit results with teammates during homeroom meetings, and	

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			with Medical Director during monthly Quality Assessment and Performance Improvement meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on record review, observation and interview the facility failed to ensure that medications and supplies were safe for patient use and not expired in 1 of 2 facilities reviewed. Findings Include: A policy titled, "SNF: Home Hemodialysis (HHD) Infection Control for Dialysis Facilities," revised April 2023, provided by the MCS (Manager of Clinical Services) on 4/19/2023 via email. The policy indicated but was not limited to, "Supplies: 8. Supplies will be stored in a manner that maintains their integrity." ... "Expiration date and package integrity will be verified prior to use." A policy titled, "Medication Policy," revised October 2022, provided by Regional Operations Director on 4/21/2023 at 12:38 PM. The policy indicated but was not limited to, " All mediations are checked monthly for expiration dates." ...	V 0143	V 143 The Facility Administrator or Regional Operations Manager (ROM) or designee held mandatory in-services for all ICHD clinical and SNF HHD teammates starting 04/21/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 14-03-01 “Medication Policy” (SNF) and Policy 1-08-02 “Obtaining Lab Specimen” (ICHD) revised April 2023, with emphasis on but limited to: A. Medication (SNF): 1) Medications with preservatives are dated and initialed once opened. 3 All medications are checked monthly for expiration dates. 2) Disposal of expired medications,	06/05/2023

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	"Medications are ordered and replaced prior to expiration." ... "Disposal of expired medications, including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations." During an observation on 4/17/2023 at 11:01 AM, a 100 count, partially used package of mint top laboratory tubes were found to be expired on 3/31/2023. During an observation on 4/19/2023 at 2:10 PM at the HHD (home hemodialysis) Den, a vial of Hepatitis B vaccination was found in the medication refrigerator with an expiration date of 11/20/2022. During an interview on 4/17/2023 at 11:01 AM the charge nurse agreed that the mint top tubes located in the laboratory area were expired and disposed of them. During an interview on 4/19/2023 at 2:54 PM, the MCS agreed the Hepatitis B vaccine vial located in the medication refrigerator was expired.		including all over the counter and nutritional product samples are removed from the treatment and inventory areas and disposed of per state/local regulations. B. Obtaining lab specimens (ICHD): 1) Teammates are to verify the expiration date on all laboratory specimen tubes prior to collection. Expired laboratory specimen tubes are not to be used and are to be discarded in the sharps container. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. The expired vial of Hepatitis B vaccine was removed from the SNF HHD medication refrigerator and discarded, and expired mint top lab tubes where removed immediately from the ICHD laboratory area and appropriately discarded. The ROM or designee immediately completed an audit of all medications to verify medication refrigerator has no expired medications available for use. The Facility Administrator or designee completed a one hundred percent (100%) inventor of laboratory supplies and removed and discarded any identified expired lab tubes. Ongoing compliance for both audits will be monitored with the monthly infection control audit. Instances of non-compliance will be addressed immediately. The	

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			Facility Administrator or ROM or designee will review audit results with ICHD or SNF HHD teammates during homeroom meetings, and with the Medical Director during monthly Quality Assurance Performance Improvement meeting, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the 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.			

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	Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on record review, observation and interview, the facility failed to ensure that the initiation of a CVC (Central Venous Catheter) hemodialysis treatment was completed to mitigate the spread of infection in 1 of 2 CVC initiations observed. (Patient 10) Findings Include: A policy titled, "Central Venous Catheter (CVC) with ClearGuard HD AntiMicrobial End Caps Procedure," revised April 2023, provided by the FA (Facility Administrator) on 4/21/2023 at 12:30 PM. The policy indicated but was not limited to, "Teammates and patient will wear masks covering the nose and mouth during this procedure" ... "Holding catheter with non-dominant hand and using aseptic technique, clean exit site with 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol Swab for a minimum of 30 seconds, apply to the CVC exit site in a "back and forth" pattern using gentle friction progressing from the insertion site to the periphery using both sides of the swab" ... "Clean each CVC limb/cap with a new LARGE alcohol prep pad, starting from the exit site and finishing with the cap." ... "Using aseptic technique, remove each cap. One at time disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub for 15 seconds including the sides,	V 0147	V 0147 The Facility Administrator or designee held mandatory in-services for all ICHD clinical teammates starting on 04/21/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 1-04-02B "Central Venous Catheter (CVC) with ClearGuard HD Antimicrobial End Caps Procedure," revised April 2023, with emphasis on, but not limited to, the following: 1) Step #1: Teammates and patient will wear masks covering the nose and mouth during this procedure. Rationale: These measures are vital to preventing the exposure of the catheter and exit site to nasal droplets and infectious bacteria such as methicillin-resistant Staphylococcus aureus (MRSA). 2) Step #8: Holding catheter with non-dominant hand and using aseptic technique, clean exit site with 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol Swab for a minimum of 30 seconds, apply to the CVC exit	06/05/2023

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	threads, and end of hub thoroughly with friction making sure to remove any residue, for example blood. Hold the limbs until the antiseptic has dried. Attach sterile 10 ml syringes to the arterial and venous limbs." ... "Secure connections and initiate dialysis per procedure." During an observation of a CVC initiation on 4/21/2023 at 11:40 AM, PCT 1 was observed with face mask on that continually fell below the nose during the initiation of a CVC. With clean, gloved hands, continually adjusted the face mask, pulling it up over the nose without completing a glove change and/or hand sanitation. The exit site was disinfected with chlorhexidine for approximately 10 seconds. The CVC limbs/caps were not disinfected with an alcohol pad prior to connecting dialysis lines. Both caps from the arterial and venous lines were removed and disinfected for 15 seconds each. With both ends open at the same time, PCT 1 continually contaminated the end of the opened CVC limbs while attempting to disinfect each limb. Observed the limb that wasn't being disinfected either resting on the clean field, unsecured, or resting on top of PCT 1's gloved hand, often making direct contact with the open ends with hands. The dialysis lines were retrieved from the machine to connect to the CVC limbs. The ends of the opened dialysis lines were observed to be contaminated due to poor connection. During an interview on 4/21/2023 at 12:05 PM, the FA (facility administrator) was notified of CVC observation findings above and agreed that this is a breach in infection control practices and company policy.		site in a "back and forth" pattern using gentle friction progressing from the insertion site to the periphery using both sides of the swab. 3) Step #9: Clean each CVC limb/cap with a new LARGE alcohol prep pad, starting from the exit site and finishing with the cap. 4) Step #16: Using aseptic technique, remove each cap. One at time disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub for 15 seconds including the sides, threads, and end of hub thoroughly with friction making sure to remove any residue, for example blood. Hold the limbs until the antiseptic has dried. 5) Step #17: Attach sterile 10 ml syringes to the arterial and venous limbs. 6) Step #25: Secure connections and initiate dialysis per procedure. Verification of attendance is evidenced by teammate's signature on the in-service sheet. The Facility Administrator or designee will conduct observational audits to verify teammates initiate treatment for CVC patients following policy steps which mitigate the spread of infection: daily for two (2) weeks, and weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or	

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			designee will review audit results with teammates during homeroom meetings, and with the Medical Director during monthly Quality Assessment and Performance 4 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 0585 Bldg. 00	494.100(a)(3) H-TRAIN CONTENT INCLUDES ER PREP HOME PTS The training must- (3) Be conducted for each home dialysis patient and address the specific needs of the patient, in the following areas: (i) The nature and management of ESRD. (ii) The full range of techniques associated with the treatment modality selected, including effective use of dialysis supplies and equipment in achieving and delivering the physician's prescription of Kt/V or URR, and effective administration of erythropoiesis-stimulating agent(s) (if prescribed) to achieve and maintain a target level hemoglobin or hematocrit as written in patient's plan of care. (iii) How to detect, report, and manage potential dialysis complications, including water treatment problems. (iv) Availability of support resources and how to access and use resources. (v) How to self-monitor health status and record and report health status information. (vi) How to handle medical and non-medical			

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	emergencies. (vii) Infection control precautions. (viii) Proper waste storage and disposal procedures. Based on record review and interview, the facility failed to provide support services to the home dialysis skilled nursing facility (SNF) for 1 of 1 SNF dialysis units reviewed. (Entity 2) Findings include: A policy titled, "SNF: HHD Continuous Quality Improvement Program," dated October 2020, was provided by the MCS (Manager of Clinical Services) on 4/19/2023. The policy indicated but was not limited to, "Communication, training, supervision and care coordination between the SNF and the DaVita care teams." ... "Provision of initial and ongoing education and training to the SNF staff related to the following: i. How to detect, report and manage potential dialysis complications, such as vascular access bleeding. ii. Availability of support resources and how to access and use resources. iii. How to report health status information. iv. How to handle medical and non-medical emergencies. v. Infection control precautions. vi. Individualized to meet the needs of the residents. vii. Emergency response" ... "Communication and coordination between the SNF and the dialysis facility in sharing data about outcomes and processes and reviewing indicators and care issues." A document titled, "DaVita Governing Body Meeting," dated 10/6/2022, was provided by the ROD (regional operations manager) on 4/21/2023 at 9:30 AM. The summarized document indicated but was not limited to, appointing ROM D as interim ROM, ROD J as Group Regional	V 0585	V585 The Manager of Clinical Services (MCS) or designee will in-service 100% of SNF HHD teammates and the Facility Administrator (FA) on Policy 14-01-09 "SNF: HHD Continuous Quality Improvement Program". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Communication, training, supervision and care coordination between the SNF and the DaVita care teams…Provision of initial and ongoing education and training to the SNF staff related to the following: … i. How to detect, report and manage potential dialysis complications, such as vascular access bleeding ii. How to report health status information iv. How to handle medical and non-medical emergencies v. Infection control precautions vi. Emergency response….and 2) Communication and coordination between the SNF and the dialysis facility in sharing data about outcomes and processes and reviewing indicators and care issues. The Regional Operations Manager (ROM) will coordinate with the	06/05/2023

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	Operations Director, and DVP K as Division Vice President for [SNF] Nursing Home Den. During an interview on 4/19/2023 at 8:34 AM, the MCS indicated that DaVita is working on adding dialysis care plans to resident charts in the future, it is not something that is currently not being done. During an interview on 4/19/2023 at 9:30 AM, the MCS, indicated that non-entity SNF (skilled nursing facility) staff were initially educated upon opening the HHD Den just over a year ago on how to appropriately address and respond to dialysis-related complications and provide emergency interventions. No further education has been provided to SNF staff to his/her knowledge since then. Agreed SNF's tend to have high turnover rates with staffing and staff hired after initially opening the HHD Den may not have been trained. Agreed that initial and ongoing training of non-entity SNF staff to care for dialysis patients is important to the health and safety of the dialysis patients.		SNF Administrator to provide education to the SNF staff. This education will include how to detect, report and manage potential dialysis complications, such as vascular access bleeding, how to report health status information, how to handle medical and non-medical emergencies, infection control precautions, and emergency response. This education will be documented on an in-service sign in sheet. The ROM will coordinate with the SNF Administrator to provide annual training, at a minimum, to the SNF staff related to dialysis-related complications. The ROM or designee will audit the SNF staff education sign-in sheet to verify that the education has been completed with the SNF staff. The FA will report findings to the Medical Director in the monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).	
V 0590 Bldg. 00	494.100(c)(1)(ii) H-COORDINATION OF CARE BY MEMBER OF IDT Services include, but are not limited to, the following: (ii) Coordination of the home patient's care by a member of the dialysis facility's interdisciplinary team. Based on record review and interview the facility	V 0590	V590 The standards E036 and V585	06/05/2023

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	failed to ensure that coordination of care was maintained between the Dialysis facility, the HHD (home hemodialysis) den, and the SNF (skilled nursing facility) in 2 of 2 facilities observed. Findings Include: A 12/2020 revised policy titled "SNF: HHD (Home Hemodialysis) Services Provided" was provided by the MCS (Manager of Clinical Services) on 4/19/2023. The policy indicated, but was not limited to; "The skilled nursing facility (SNF) residents who are Home Hemodialysis patients are under the care of a certified DaVita End Stage Renal Disease (ESRD) facility, and the DaVita ESRD facility will provide, through its interdisciplinary team (IDT), SNF hemodialysis services that are equivalent to those provided to in-facility patients ... SNF resident dialysis patients ' status is monitored before, during and after the treatment by the SNF care team in addition to the DaVita ESRD facility clinical teammates ... The DaVita ESRD facility is ultimately responsible for the safe delivery of home hemodialysis to the SNF resident which would include review of the qualifications, training, competency verification, and monitoring of all DaVita ESRD facility clinical teammates who administer dialysis treatments in the SNF ... The DaVita ESRD facility is responsible for the quality and safety of the home hemodialysis treatments and the management of the residents' ESRD-related conditions." A 12/2020 revised policy titled "SNF: HHD (Home Hemodialysis) Services Provided," was provided by the MCS on 4/19/2023. The policy indicated, but was not limited to; "The skilled nursing facility (SNF) residents who are Home Hemodialysis patients are under the care of a		that are not met have detailed POCs referenced to the specific V tags. The Governing Body met on 05/11/23 to confirm adoption of the Home Hemodialysis program providing services at the Skilled Nursing Facility and responsibility of the Facility Administrator for services provided under the dialysis facility CCN including Home Hemodialysis services provided at the SNF location. Governing Body is evidenced by completed minutes signed by the Chief Executive Office and Administrator of the Facility. The Medical Director, Regional Operations Director, and Facility Administrator reviewed and acknowledged the Governing Body Bylaws and Policy COMP-DD-017 5 “Medical Director Qualifications and Responsibilities” as evidenced by a signed attendance sheet. This review included, but was not limited to the following: 1) Associate Medical Director – A Medical Director who works under the direction of a Lead Medical Director and typically has responsibility for modalities other than in-center hemodialysis (ICHD), mainly home hemodialysis (HHD) or peritoneal dialysis (PD) modalities, 2) Lead Medical Director- The primary Medical Director whom DaVita assigns to oversee a center and the in-center	

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	certified DaVita End Stage Renal Disease (ESRD) facility, and the DaVita ESRD facility will provide, through its interdisciplinary team (IDT), SNF hemodialysis services that are equivalent to those provided to in-facility patients ... The DaVita ESRD facility is ultimately responsible for the safe delivery of home hemodialysis to the SNF resident ... The DaVita ESRD facility is responsible for the quality and safety of the home hemodialysis treatments and the management of the residents' ESRD-related conditions." A written agreement titled, "Home Hemodialysis Coordination Agreement," was provided by the MCS on 4/17/2023. The document indicated but was not limited to, "I. Company will provide and install, in accordance with Exhibit C and at its own expense, equipment associated with HHD (i.e., dialysis machines and portable water equipment), and will use commercially reasonable efforts to ensure that all such equipment is maintained in good working order, including testing and monitoring water and dialysate quality. Company will replace or restore, at its own expense, any equipment that is non-functional to avoid interruption of a patient's dialysis treatment." ... "U. If an HHD Patient is discharged from the NF, Manager will provide Company with notice of the HHD Patient's discharge and will coordinate with Company regarding the HHD Patient's ongoing dialysis care. An undated document titled, "Jeffersonville DaVita Dialysis: List of Facility Key Personnel," was provided by the FA (facility administrator) on 4/17/2023 at 2:36 PM. The summarized document did not list the Director of the Skilled Nursing Facility Home Hemodialysis clinic. During an interview on 4/17/2023 at 11:28 AM, the		hemodialysis modality. The Lead Medical Director is responsible for overseeing the clinical operations and quality outcomes of all components of the center, including the activities of any Associate Medical Directors (where applicable), 3) The Lead Medical Director is responsible for overseeing the clinical operations of all modalities at the center, including the activities of all Associate Medical Directors who are responsible for different program components at the center, and 4) The Lead Medical Director is accountable to the center’s Governing Body for the quality of medical care provided to patients. A Governing Body meeting was held acknowledging that Medical Director 1 is the Lead Medical Director and Medical Director 2 is the Associate Medical Director. The GB identified in writing, demonstrated by GB meeting minutes, a single individual (Medical Director1) who meets the qualifications under the Condition for Personnel at V682, and is responsible for the delivery of patient care and outcomes over all of the certified modalities under the facility CCN. The GB will designate in writing, demonstrated by GB meeting minutes, an Associate Medical Director (Medical Director 2) to direct the HHD/SNF dialysis program, but ultimately all programs report to	

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	FA indicated that the oversight of the HHD (home hemodialysis) den was provided by Employee D who was currently scheduled off the week of this survey. Indicated that personnel records, patient medical records, QAPI, and water documentation were not available onsite at the dialysis facility and did not have access to even a patient list. Agreed to reach out to obtain, at minimum, a patient list. During an interview on 4/17/2023 at 12:00 PM, the FA and ROD (Regional Operations Director), indicated that the HHD den opened just over a year ago and Employee D attends the monthly FHM (facility health meeting) or QAPI (Quality Assurance Performance Improvement) onsite at the dialysis facility each month to present all HHD Den material. Neither the FA, nor ROD have access to the HHD Den QAPI information. During an interview on 4/17/2023 at 3:45 PM, the ROD and FA were notified that the HHD Den patient list appeared to be incorrect. Surveyor was advised that there were 6 chairs, with only 2 patient shifts, however, the patient list provided indicated 16 active patients. The FA agreed that the patient list was not accurate and/or up to date. Aware of one patient death on the active list. The ROD indicated that during the HHD Den visit on 4/19/2023, staff will be available to answer all questions that the FA and ROD could not answer. During an interview on 4/19/2023 at 8:00 AM, the MCS (Manager of Clinical Services), Employee C, indicated that all water documentation and preventive maintenance logs for dialysis equipment were only kept onsite at the HHD Den. MCS Employee C indicated that the Social Worker employed by the SNF coordinates all post discharged patient dialysis care including finding		the facility Medical Director, and are under the same QAPI and GB oversight. The Manager of Clinical Services (MCS) or designee will in-service the QAPI team reviewing Policy & Procedure 1-14-06 and 5-15-06: Continuous Quality Improvement Program and Policy 14-01-09 SNF- HHD Continuous Quality Improvement Program. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team: Facility Medical Director, Facility Administrator (FA)/designee, Registered Nurse, Biomed Technician, Registered Dietitian, and Social Worker, and 2) The Facility Medical Director is responsible for verifying the execution of the Quality Improvement Program, including implementation, continuous monitoring, development of action plans and program evaluation. The QAPI team was instructed that the meeting will include all modalities under the facility's Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) including In-center hemodialysis,	

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	a new dialysis facility. During an interview on 4/19/2023 at 8:34 AM, the MCS indicated that DaVita is working on adding dialysis care plans to resident charts in the future. This is not currently being done. During an interview on 4/19/2023 at 9:30 AM, the MCS Employee C, indicated that non-entity SNF (skilled nursing facility) staff were initially educated upon opening the HHD Den just over a year ago on how to appropriately address and respond to dialysis-related complications and provide emergency interventions. No further education has been provided to SNF staff to his/her knowledge since then. Agreed SNF's tend to have high turnover rates with staffing and staff hired after initially opening the HHD Den may not have been trained. Agreed that initial and ongoing training of non-entity SNF staff to care for dialysis patients is important to the health and safety of the dialysis patients. During an interview on 4/19/2023 at 1:37 PM Non-Entity G indicated that if there was an after-hour emergency or concern with a dialysis patient a list of on call physicians would be notified. This list is not inclusive of dialysis staff members or nephrologists. Denied any on-call dialysis staff that can reached after hours, however, can reach out to Non-Entity E. Non-Entity G indicated that dialysis care plans are not shared with SNF staff. During an interview on 4/19/2023 at 2:54 PM, the MCS Employee C, agreed that water documentation, preventative maintenance of equipment, personnel records, clinical records, and QAPI should be kept on site at the dialysis facility to maintain coordination of care and		Peritoneal Dialysis, and Home Hemodialysis/SNF dialysis. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. The Governing Body will review FHM-QAPI meeting minutes for the next 3 months to verify team reviews all modalities at the meeting. The Facility Administrator and Medical Director are responsible for compliance with this plan of correction. The Manager of Clinical Services (MCS) or designee will in-service 100% of SNF HHD teammates and the Facility Administrator (FA) on Policy 14-01-02 “SNF: HHD Services Provided”. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The skilled nursing facility (SNF) residents who are Home Hemodialysis patients are under the care of a certified DaVita End Stage Renal Disease (ESRD) facility, and the DaVita ESRD facility will provide, through its interdisciplinary team (IDT), SNF hemodialysis services that are equivalent to those provided to in-facility patients, 2) SNF resident dialysis patients’ status is monitored before, during and after the treatment by the SNF care team in addition to the DaVita ESRD facility clinical	

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	indicated that the FA at the dialysis facility is also the FA for the HHD Den and should have access to all information to assist in oversight. Aware that this is an ongoing issue that DaVita is attempting to resolve. During an interview on 4/19/2023 at 4:05 PM the FA indicated that she was unaware that she was the FA for the HHD Den. Was advised that there is a team that provides oversight for the HHD Den. Had in the past attempted to coordinate care but was advised not to. Unaware of any HHD Den personnel records, QAPI, patient medical records, water documentation being stored on site at the dialysis facility. Agreed to ensure that all information would be made available for review on the next survey date, 4/21/2023. During an interview on 4/21/2023 at 8:08 AM the FA indicated that all information requested for surveyor review was available and brought over from the HHD Den. Indicated that that the ROD will inform the survey team on who is providing direct oversight of the HHD Den. During an interview on 4/21/2023 at 9:25 AM the ROD indicated that the FA does not provide oversight of the HHD Den, that the Employee D provides oversight. Indicated Employee D's title as ROM (Regional Operations Manager) and provides oversight to multiple HHD Dens. Also providing oversight is Employee J, and Employee K. During an interview on 4/21/2023 at 2:00 PM, the ROD indicated that the Associate Medical Director for the HHD Den meets quarterly with the IDT (interdisciplinary team) while the Medical Director attends monthly QAPI meetings.		teammates, 3) The DaVita ESRD facility is ultimately responsible for the safe delivery of home hemodialysis to 6 the SNF resident which would include review of the qualifications, training, competency verification, and monitoring of all DaVita ESRD facility clinical teammates who administer dialysis treatments in the SNF, 4) The DaVita ESRD facility is responsible for the quality and safety of the home hemodialysis treatments and the management of the residents' ESRD-related conditions, 5) Both the ESRD facility and the SNF are responsible for collaborating to provide dialysis care coordination to each nursing home resident receiving dialysis treatments, 6) 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, 7) The ESRD facility will provide the SNF with the facility's normal operating hours and contact information. In addition, the SNF will be provided with contact information for after hours and emergency issues, and 8) The ESRD facility interdisciplinary team (IDT) must coordinate with the SNF staff for the development and implementation of an individualized care plan based on the patient's assessment. The	

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(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
			Facility Administrator was provided access to the SNF dialysis patients' EMR on 5/10/23 and will be provided access to all SNF dialysis personnel records by 5/19/23. All water documentation, preventative maintenance of equipment records, and QAPI will be kept on-site at the dialysis facility for oversight by the Facility Administrator. The Manager of Clinical Services (MCS) or designee will in-service 100% of SNF HHD teammates and the Facility Administrator (FA) on Policy 14-01-08 "SNF: Hemodialysis Patient Assessment and Plan of Care". Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) For patients residing in the skilled nursing facility (SNF), the interdisciplinary team will also include a representative of the SNF to verify that an adequate coordination of care is accomplished. The complete disciplinary team will meet at the SNF to establish a plan of care for the resident, and 2) Each patient will be assigned a primary DaVita registered nurse (RN) caring for the patient onsite at the SNF and who will be responsible for coordination of the patient's dialysis care in collaboration with the patient's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152651	A. BUILDING 00 B. WING	04/21/2023

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			SNF registered nurse. The Regional Operations Manager (ROM) will coordinate with the SNF to verify that a SNF representative participates in the patient's plan of care. The ROM or designee will audit 100% of SNF dialysis patient medical records monthly x 2 to verify that patient assessment/care plans are completed per policy. Ongoing compliance will be monitored by 10% of medical records monthly per the medical record audit. Results of audits will be reviewed with Medical Director during monthly QAPI meeting, known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).	