

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2022  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000  Bldg. 00	An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62 for an ESRD Provider and Supplier.  Survey Dates: September 8, 9, and 12, of 2022.  Census: 58  At this Emergency Preparedness survey, Jasper Dialysis was found to be in compliance with Conditions of Participation 42 CFR 494.62 Emergency Preparedness requirements for Medicare Participating Providers and Suppliers.  QR Completed on 9/26/2022 A4	E 0000		
V 0000  Bldg. 00	This visit was for a Federal Recertification Survey of an ESRD provider.  Survey Dates: Sptember 8, 9, 12, of 2022.  Census by Service Type:  In-Center Hemodialysis: 44 Home Peritoneal Dialysis: 14 Home Hemodialysis: n/a Total Active Census: 58  Isolation Room / Waiver: 1 isolation room	V 0000		
V 0113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
--------------------	----------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

Bldg. 00	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff and patients performed hand hygiene after removing gloves and before going from a dirty area or task to a clean area or task for 2 of 2 post dialysis access site care of an AV fistula/graft (Patient 6 &amp; 8) (PCT 2); and for 3 of 3 cleaning and disinfecting of the dialysis station observations. (PCT 1, 7)</p> <p>Findings include:</p> <p>1. A revised October 2021 policy titled Infection Control for Dialysis Facilities was provided by the FA (Facility Administrator) on 9/9/2022 at 2:10 p.m. The policy indicated, but was not limited to, "1. Hand hygiene is to be performed ... prior to gloving, after removing gloves, after contamination with blood and other infectious material, after patient and dialysis delivery system contact, between patients ... before touching clean areas such as supplies and on exiting the patient treatment area. ... 34. Patients are encouraged to wash their hands ... after treatment before leaving treatment area."</p> <p>2. During an observation on 9/8/2022 at 11:20 a.m. patient 8 held pressure to access sites with a gloved hand and a 4 x 4 gauze dressing post treatment to achieve hemostasis. Patient 8 ungloved, walked to scale to weigh him/herself and pressed scale button to obtain a ticket. Patient 8 proceeded back to station 5 and laid ticket on computer table designated as clean. PCT 2 failed to offer hand sanitizer or remind patient 8 to wash hands after removing his/her glove,</p>	V 0113	<p>The Facility Administrator or designee will inservice all clinical teammates on Policy 1-05-01 "infection Control for Dialysis Facilities" beginning 9/10/22. 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:</p> <p>1) Hand hygiene is to be performed...prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients...and on exiting the patient treatment area.</p> <p>2) Patients are encouraged to...wash their hands after treatment before leaving treatment area. The Facility Administrator or designee will conduct observational infection control audits 2 times a week for two (2) weeks then</p>	10/15/2022
----------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>before touching the scale button, and before leaving the treatment area.</p> <p>3. During an observation on 9/8/2022 at 3:15 p.m. patient 6 held pressure to access sites with a gloved hand and a 4 x 4 gauze dressing post treatment to achieve hemostasis (stopping the flow of blood). Patient 6 then ungloved, walked to scale to weigh him/herself and pressed scale button to obtain a ticket. Patient 6 proceeded back to station 18 to retrieve personal items and left the treatment area. PCT 1 failed to offer hand sanitizer or remind patient 6 to wash hands after removing his/her glove, before touching the scale button, and before leaving the treatment area.</p> <p>4. During an observation on 9/8/2022 at 3:20 p.m. PCT 1 removed blood lines and products from station 20 with both hands gloved and placed items in biohazard bin. PCT 1 removed both gloves and proceeded to type on computer board designated as a clean area. PCT 1 failed to perform hand hygiene after removing gloves and before moving from a dirty task to a clean area. At 3:24 p.m. PCT 1 was observed removing blood lines and products from station 18 with both hands gloved and placing the items in the biohazard bin. PCT 1 removed both gloves, reapplied gloves, and applied a Band-Aid to patient 6's access site. PCT 1 failed to perform hand hygiene between glove changes.</p> <p>5. During an observation on 9/9/2022 at 7:13 a.m. PCT 1 removed both gloves after applying CVC (central venous catheter) dressing to patient 5. PCT 1 proceeded to the designated clean treatment cart to obtain more clean supplies and reapplied gloves. PCT 1 then placed a sterile paper field under the CVC site and taped the paper field down. PCT 1 removed both gloves and proceeded</p>		<p>weekly for four (4) weeks to verify compliance with facility policy for hand hygiene. Ongoing compliance will be verified monthly during internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the plan of correction.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0122 Bldg. 00	<p>to document on a computer that was designated as a clean area. PCT 1 failed to perform hand hygiene before gloving and after removing soiled gloves and before moving from a dirty to clean area.</p> <p>6. During an observation on 9/12/2022 at 10:15 a.m. PCT 7 disinfected dialysis chair at station 15 with a bleach wipe with both hands gloved. PCT 7 proceeded to a clean area to obtain more bleach wipes. PCT 7 failed to unglove and perform hand hygiene before touching clean supplies in a designated clean area.</p> <p>7. During an interview on 9/9/2022 at 2:00 p.m. the FA indicated hand hygiene should be performed after removing gloves and before touching clean surfaces. FA indicated PCT 1 came back to work full time this week and would receive additional education on infection prevention and control.</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure all surfaces of the treatment chair were disinfected and countertops directly behind the treatment chairs were wiped wet with disinfectant once the patient left the station for 2 of 2 cleaning and disinfection</p>	V 0122	The Facility Administrator or designee will inservice all clinical teammates on Policy 1-05-01 "infection Control for Dialysis Facilities" beginning 9/10/22. Verification of	10/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>of the dialysis station observations. (PCT 3) (Stations 6 &amp; 8)</p> <p>Findings include:</p> <p>1. A revised October 2021 policy titled Infection Control for Dialysis Facilities was provided by the Administrator on 9/9/2022 at 2:10 p.m. The policy indicated, but was not limited to, "46. Equipment including the dialysis delivery system, ... the dialysis chair and side tables including opening the chair to reach crevices, ... work surfaces will be wiped clean with a bleach solution ..."</p> <p>2. During a treatment floor observation on 9/9/2022 at 12:40 p.m. a white tissue was used to wipe countertops directly behind dialysis stations 6 and 8. Gray dust was found on countertops directly behind the treatment chairs at stations 6 and 8. At that time, PCT 1 indicated the countertops behind the dialysis treatment chairs are to be disinfected after each treatment.</p> <p>3. During an observation on 9/12/2022 at 10:55 a.m. PCT 3 failed to recline the dialysis treatment chair in order to reach crevices and disinfect appropriately as indicated in the facility policy.</p> <p>4. During an interview on 9/9/2022 at 3:30 p.m. the FA indicated the countertops are to be cleaned and disinfected. On 9/12/2022 at 11:10 a.m. the FA indicated the expectation was for staff to fully recline the treatment chair when disinfecting.</p>		<p>attendance will be evidenced by a signature sheet.</p> <p>Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to, the following: 1) Equipment including the dialysis delivery system...the dialysis chair and side tables including opening the chair to reach crevices...as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength... The Facility Administrator or designee will conduct observational infection control audits 2 times a week for two (2) weeks then weekly for four (4) weeks to verify compliance with facility policy for hand hygiene. Ongoing compliance will be verified monthly during internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0196 Bldg. 00	<p>494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY 6.2.5 Carbon adsorption: monitoring, testing freq Testing for free chlorine, chloramine, or total chlorine should be performed at the beginning of each treatment day prior to patients initiating treatment and again prior to the beginning of each patient shift. If there are no set patient shifts, testing should be performed approximately every 4 hours.</p> <p>Results of monitoring of free chlorine, chloramine, or total chlorine should be recorded in a log sheet.</p> <p>Testing for free chlorine, chloramine, or total chlorine can be accomplished using the N,N-diethyl-p-phenylene-diamine (DPD) based test kits or dip-and-read test strips. On-line monitors can be used to measure chloramine concentrations. Whichever test system is used, it must have sufficient sensitivity and specificity to resolve the maximum levels described in [AAMI] 4.1.1 (Table 1) [which is a maximum level of 0.1 mg/L]. Samples should be drawn when the system has been operating for at least 15 minutes.</p>		meetings, 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The analysis should be performed on-site, since chloramine levels will decrease if the sample is not assayed promptly.</p> <p>Based on record review and interview, the facility failed to ensure documentation on a color blindness test was complete for staff responsible for reading colormetric tests to ensure safe water levels for 1 of 3 (PCT) patient care technician record views. (PCT 1)</p> <p>Findings include:</p> <p>A document titled TeamMate/Patient/Helper Color Vision Test Results indicated, but was not limited to, "Test Kit: Pseudo-Isochromatic Plate by GOOD-LITE (color blindness test) ... For each plate, write the teammate/patient/helper response and circle the correct response below ... Normal ... Color Vision Defect."</p> <p>PCT 1's personnel record was reviewed on 9/9/2022. The facility failed to ensure the colorvision test dated 2/15/2021 was completed by circling either "Normal" or "Color Vision Defect" response for each plate tested.</p> <p>During an interview on 9/9/2022 at 2:00 p.m. the FA acknowledged the colorvision test was incomplete. The colorvision test should indicate a response of normal or color vision defect for each plate tested. The FA indicated PCT 1 would need to be retested.</p>	V 0196	<p>The Facility Administrator or designee will inservice all clinical teammates on Policy 8-02-03 "Color Vison Evaluation" beginning 9/10/22. 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) Teammates/patients/ helpers who will be utilizing test kits or strips that rely on color differentiation for test results will be evaluated for ability to see color. 2) Documentation of the color vision evaluation will be documented in the teammate's file...The Facility Administrator tested PCT # 1 for color blindness and the test results were "Normal". Test results were documented in PCT #1's teammate file. The Facility Administrator or designee will audit 100% of teammate files to verify documentation of color vision</p>	10/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0403  Bldg. 00	494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU 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 build up on drain pipes in the wall box chassis did not occur	V 0403	evaluation results in each teammate's file in compliance with facility policy. Ongoing compliance will be verified with 100% of teammates' files audited annually for documentation of annual color vision test results. Instances of noncompliance will be addressed immediately. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the plan of correction.  The Facility Administrator or designee will inservice 100% of clinical teammates on	10/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>for 2 of 3 observation days (Station 4, 8, 12); failed to ensure dialysis machines were maintained for 3 of 15 dialysis machines (machine 6, 10) (Station 16); and failed to ensure the treatment area was free of personal cell phones for 1 of 3 observation days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. An April 2018 policy titled Physical Environment was provided by the FA (Facility Administrator) on 9/9/2022 at 2:10 p.m. The policy indicated, but was not limited to, "1. The dialysis facility will be ... maintained to provide dialysis patients ... and the public a safe ... environment. ... 3. While in the treatment area where patient care remains primary focus, personal use of ... cell phones ... by teammates is not permitted. ... 4. ... dialysis delivery systems and the water treatment systems area maintained and operated in accordance with the manufacturer's recommendations."</li> <li>2. A revised October 2021 policy titled Infection Control for Dialysis Facilities was provided by the Administrator on 9/9/2022 at 2:10 p.m. The policy indicated, but was not limited to, "61. Teammates will monitor for the occurrence of residue/build up ... drainage backup in the wall boxes and report to the Facility Administrator and Biomedical Services for advance drain care option ..."</li> <li>3. A document titled Physical Plant / Environment audit indicated "Water boxes and floor drains ... are free from leaks ... if present, ... report to FA or BSS."</li> <li>4. During a treatment floor observation on 9/8/2022 at 11:45 a.m. PCT 5 placed 3 paper chux over water coming from out under dialysis</li> </ol>		<p>Policy 8-04-01 "Physical Environment" and Policy 1-05-01 "Infection Control for Dialysis Facilities" beginning 9/10/22. 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 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) While in the treatment area where patient care remains the primary focus, personal use of...cell phones... by teammates is not permitted. 3) The dialysis facility will implement and maintain a program to verify that all equipment, including...dialysis delivery systems and the water treatment systems are maintained and operated in accordance with the manufacturer's recommendations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>machine 10 between station 12 and station 13. PCT 4 was unsure where the water was coming from when queried.</p> <p>During a treatment floor observation on 9/9/2022 at 3:10 p.m. 10 blue chux were placed on the floor next to the dialysis machine at station 16 to soak up wet matter on the floor. At that time, RN 1 indicated when patients run an extra fluid removal the hose in the back that was not connected to anything will spit out bicarb onto the floor. RN 1 indicated that the biomed personnel said that was normal for the Fresenius 2008K2 machines. RN 1 did not indicate why blue chux were used to soak up the drainage instead of mopping up the drainage.</p> <p>During an observation on 9/12/2022 at 11:05 a.m. bicarb solution coming out from under dialysis machine 6 at station 12.</p> <p>5. During a treatment floor observation on 9/9/2022 at 7:15 a.m. observed brown/white dried matter from the joints of the PVC piping and floor under the wall box at station 8. Lifted the panel of the chassis behind station 8 and observed white build-up of the inside wall box. At 7:25 a.m. brown/white dried matter was noted on PVC piping at station 4. At 7:30 a.m. PCT 1 was asked what the brown matter was to which he/she was unsure.</p> <p>During an observation and interview along with the FA on 9/9/2022 at 7:35 a.m. observed brown/white dried matter on the PVC piping under the wall box of station 12. The FA notified the biomed personnel at that time.</p> <p>During an interview on 9/9/2022 at 3:30 p.m. the FA indicated the brown/white matter on the PVC</p>		<p>4) Teammates will monitor for the occurrence of residue/build up, or bubbling/splashing or drainage backup in the wall boxes and report to the Facility Administrator and Biomedical Services for advance drain care option. The drain pipes in the wall chase boxes for Stations 4, 8, and 12 were cleaned to remove the white and brown build-up on 9/11/22. The leak for Dialysis delivery systems #6, #10, and atStation #16 were repaired on 9/11/22 and no longer leak. The Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for maintaining a safe, functional physical environment and the treatment area is free of personal cell phones. Ongoing compliance will be verified monthly during internal safety and infection control audits. Instances of non-compliance will be addressed immediately. The Facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/12/2022
NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V 0800 Bldg. 00	<p>6. During an observation on 9/12/2022 at 11:10 a.m. observed an employee's personal cell phone sitting next to a computer at the nurses desk. At that time, RN 1 indicated staff should not have personal cell phone in the treatment area.</p> <p>7. During an interview on 9/12/2022 at 11:00 a.m. the FA indicated cell phones should not be in the treatment area and the PCT was using the cell phone as an alarm.</p> <p>494.30 (b)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff § 494.30 Condition: Infection control. (b) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its patients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and</p>		Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the plan of correction.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(iv) Individuals who provide care, treatment, or other services for the facility and/or its patients, under contract or by other arrangement.</p> <p>(2) The policies and procedures of this section do not apply to the following facility staff:</p> <p>(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with patients and other staff specified in paragraph (b)(1) of this section; and</p> <p>(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with patients and other staff specified in paragraph (b)(1) of this section.</p> <p>(3) The policies and procedures must include, at a minimum, the following components:</p> <p>(i) A process for ensuring all staff specified in paragraph (b)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its patients;</p> <p>(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(iv) A process for tracking and securely documenting the COVID-19 vaccination status for all staff specified in paragraph (b)(1) of this section;</p> <p>(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;</p> <p>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;</p> <p>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;</p> <p>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:</p> <p>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and</p> <p>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>contraindications;</p> <p>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and</p> <p>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.</p> <p>Effective 60 Days After Publication:</p> <p>(ii) A process for ensuring that all staff specified in paragraph (b)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;</p> <p>Based on observation, record review, and interview, the facility failed to ensure additional precautions were implemented to mitigate the spread of COVID-19 (infectious respiratory disease) for unvaccinated staff that provided direct patient care in the treatment area for 3 of 3 treatment observation days, which has the potential to affect all in-center patients. (PCT 2, PCT 3)</p> <p>Findings include:</p> <p>1. A March 2022 policy titled Covid-19 Vaccination Policy for Dialysis Facilities and</p>	V 0800	100% of clinical teammates were in-serviced on Policy 4-06-08 "COVID-19 Vaccination Policy for Dialysis Facilities and Programs". 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) Contingency plan for	10/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/12/2022
NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS			STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>Programs was provided by the FA 2 on 9/9/2022 at 2:10 p.m. The policy indicated, but was not limited to, "7. Contingency plan for teammates that are not fully vaccinated: ... abide by all applicable DaVita guidance related to COVID precautions (e.g., physical distancing, masking, screening, cleaning and disinfection, etc.) and infection control policies and practices, (e.g., DaVita Breakroom Guidance which requires wearing a mask in breakroom when not eating, staggering teammate breaks to limit number of teammates in room at one time, and social distancing of 6 ft)."</p> <p>2. Review of the facility Covid-19 vaccination exemptions on 9/12/2022 indicated PCT 2 and PCT 3 were exempt.</p> <p>3. During treatment floor observations on 9/8/2022 and 9/9/2022, observed PCT 2 wearing a blue surgical mask while providing direct patient care in the treatment area.</p> <p>4. During a treatment floor observation on 9/12/2022, observed PCT 3 wearing a blue surgical mask while providing direct patient care in the treatment area.</p> <p>5. During an interview on 9/12/2022 at 7:20 a.m. PCT 3 indicated he/she takes a lunch in conference room or outside. PCT 3 indicated there was no additional precautions required while providing patient care in the treatment area.</p> <p>6. During an interview on 9/12/2022 at 11:10 a.m. the FA indicated there were no additional measures for unvaccinated staff while providing patient care while in the treatment area.</p>		<p>teammates who are not fully vaccinated; teammates with approved exemptions, or who are not yet fully vaccinated, or who have a temporary delay will be required to abide by all applicable DaVita guidance related to COVID precautions (e.g., physical distancing, masking, screening, cleaning and disinfection, etc.) and infection control policies and practices (e.g., DaVita breakroom guidance which requires wearing a mask in breakroom when not eating, staggering teammate breaks to limit number of teammates in room at one time, and social distancing of 6 feet). Attachment N for ESRD facility for QSO-22-09-ALL memorandum revised on 4/5/22: Guidance for the Interim Final Rule- Medicare and Medicaid Programs: Omnibus COVID-19 Health Care Staff Vaccination states that "The policy must also ensure those staff who are not yet fully vaccinated, or who have been granted an</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	-------------------------------------------------------------------------------------

(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
			<p>exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19. This requirement is not explicit and does not specify actions that must be taken; there are a variety of actions or job modifications that a facility may implement to potentially reduce the risk of COVID- 19 transmission, examples including but not limited to: Requiring staff who have not completed their primary vaccination series to follow additional, CDC recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e. g. staff meeting rooms, kitchen)....” DaVita policy incorporates this requirement and goes above the CDCrecommended precautions for unvaccinated teammates. Because DaVita has unvaccinated teammates in the facility, all people (including drinking. The</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2022
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
			<p>additional precautions for the breakroom include social distancing, staggering breaks to minimize the number of unvaccinated teammates) who enter the facility are required to do a verbal attestation confirming lack of COVID-19 symptoms and must have his/her temperature taken and documented upon entry. Also all patients and teammates (including unvaccinated teammates) are required to wear a medical grade mask at all times while in the facility. Additionally, DaVita requires all teammates (including unvaccinated teammates) to undertake extra precautions when in the breakroom since this is a time when he/she will potentially be without a mask while eating and people in the room at one time, and continuing to mask unless eating or drinking. All of these measures are additional precautions that DaVita requires of all teammates (including</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2022
--------------------------------------------------	-------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER  JASPER DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 671 3RD AVENUE, SUITE A JASPER, IN 47546
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
			<p>unvaccinated teammates) throughout its facilities in order to mitigate the spread of COVID-19. The Facility Administrator (FA) or designee will conduct a COVID-19 Field Audit Tool weekly x 4 to verify that all teammates including unvaccinated teammates are following the policy. Results of audits will be reviewed with Medical Director during monthly Quality Assurance Performance Improvement (QAPI), known as the Facility Health Meeting (FHM). The FA is responsible for ongoing compliance with this Plan of Correction (POC).</p>	